Progresses and gaps in access to health

For Older People in the Andean Countries

A Qualitative Cross-Sectional Study Conducted within the Framework of the Revision of the Madrid's Plan After 10 Years of Implementation

HelpAge International

personas mayores protagonistas

HelpAge helps older people claim their rigths, challenge discrimination and overcome poverty, so that they can lead dignified, secure, active and healthy lives.

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A Qualitative Cross-Sectional Study Conducted within the Framework of the Revisión of the Madrid´s Plan After 10 Years of Implementation.

Study developed by:

- María Dolores Castro, Consultant Researcher, Bolivia
- María del Pilar Zuluaga Guerrero, Consultant Gerontologist, Colombia
- William Waters, Researcher SFQ University, Ecuador
- Elizabeth Sánchez, Consultant, NGO CAPIS Director, Peru

Under the coordination of Catherine Dusseau de Ibarra, Regional Health Advisor HelpAge International Latin America Regional Development Centre.

Regional report written by Catherine Dusseau

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Vincenti Street N° 576; Sopocachi. La Paz, Bolivia

Web site: www.helpagela.org

Email: info@helpagela.org

Tel: (591) (2) 2 416830
Fax : (591) (2) 2 410957

Designed: Mariela Aramayo

Cover photo: Jaime Ayra / Horizons Foundation HelpAge International affiliate

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Asdi

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Introduction

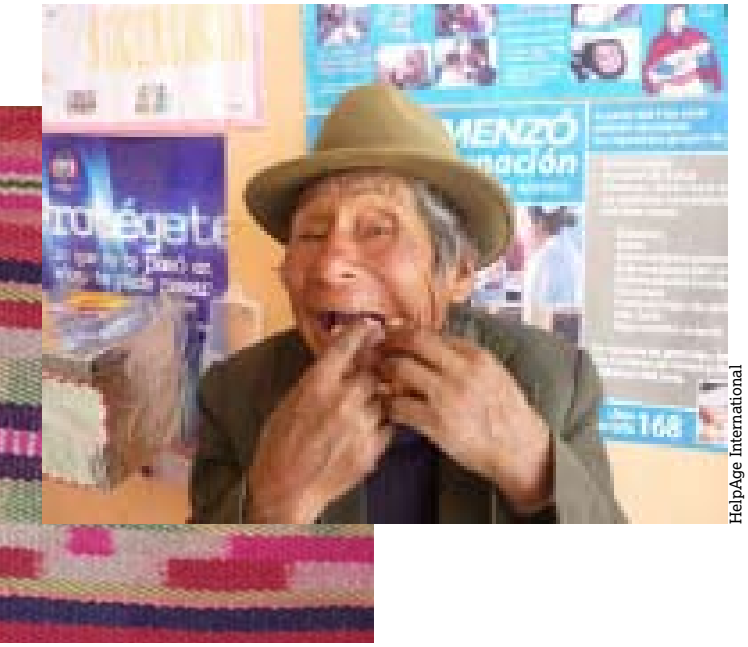
When older people speak

we listen

In 2012, the United Nations organization assessed the degree of implementation of the International Plan of Action on Ageing since its approval ten years ago during the Madrid Assembly in 2002. National governments are expected to provide a report on the advances attained in their countries. Most countries will inform about the progress made reflected in the enactment of policies and laws to support older people. Besides the governments, international agencies such as United Nations will also inform about their actions to support the implementation of the Plan. These organizations are best fitted to provide figures and statistical data. We believe that the contributions of society and the very older people organizations can provide what other organizations cannot, which is the voice of older people, their own experiences in the implementation of the Madrid Plan and changes in their lives thereof since 2002. Listening and learning from older people's opinions is a mandate of the United Nations Social Economic Committee responsible for the Madrid Plan implementation bottom up revision.

Through the network of older people partners and organizations, HelpAge International has the capacity to organize consultation processes and systematize the opinions of older people. By the other hand, its Regional Development Center for Latin America and the network members have been involved in developing, spreading and implementing the Regional Plan of Action on Older People's Health as approved by the executive committee of the Pan American Health Organization in October 2009. In the framework of this work, we are obliged to look for not only a better access to health for older people, but also to look into and monitor the advances made in this area.

In 2011, the regional office of HelpAge decided to develop a qualitative study and conduct a consultation to older people on the access to the health care in the Andean countries under a "reality check" process:



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Hypothesis

P. ONG / HelpAge International

Those people, who work with older people, and the very older people's organizations, feel empirically that the access to health has been changing since 2002. Some advances are perceived, yet several limitations still exist. Health systems are strengthened and there are more health facilities. Some initiatives of health insurance are in place in order to make the economic access easier, but public complaints from rural areas about inadequate services or lack of medicines are made on a daily basis.

Thus, it is necessary to discuss in a more systematic and precise manner the access to the health care among older people. In the context of the International Plan on Ageing 10th anniversary, it is intended to explore the advances in the implementation of the Plan and the national policies that make it possible.

It is important to recognize the advances not only to encourage the actors to see that their efforts have been visible, but also to analyze the successful experiences in order to strengthen the results and impacts. In parallel, it is necessary to analyze in depth the gaps that have to be filled in the short and medium term.

A gap is understood as the distance between a desirable situation as expressed in the Madrid Plan and relevant policies, and the daily reality of people. It is important to identify the greatest gaps in order to take actions to fill them. Toward where should we direct the efforts for the next years?

To strengthen what already exists

To identify what is needed

Health is an important asset for older people. Besides feeling healthy, older people need to continue to be active, without being dependent on others.

Testimony

"If we are healthy, we can help our families and communities"

José, an older person, Chile

Metodology

The study was conducted in four countries of the Andean region: Bolivia, Colombia, Ecuador and Peru.

The general objective of this study was to analyze, based on the older people's voices and other key witnesses, the scope and impact of the health policies on older people.

This is a cross-section qualitative study from different perspectives in order to compile and validate the collected information. It was intended to implement an innovating methodology in order to reinforce the scope of the qualitative methodology.

Research questions:

1- How is the access to the health care (characteristics of the access, particularly the bottlenecks and the facilitators) for different kinds of older people in the region's four countries: urban/rural, male/female, mestizo/indigenous, retired/economically active?

2- How is the access, the routes and patterns for diverse needs of older people, such as chronic diseases (e.g. high blood pressure), "catastrophic" events and disabling effects (post AVC and/or hip fracture), the access to preventive health and continued services (e.g. gynecological cancer or dementia)?

3- Are there repetitive patterns or significant differences in these routes?

4- Are the gaps between reality and laws/policies identified?

5- When is this access expedite, and when it is not? For example, is it better to not have an insurance scheme? Are the services available?

6- From Madrid and Madrid+5, have the policies, the access and the gaps changed?

7- Are older people involved in the health care? How are they involved?

The methodology includes three information gathering techniques to validate the information:

- In-depth interviews based on common guidelines for all of the 4 countries in order to explore the real routes of access to health care for older people.
- Focal groups composed of older people over 70 years old, to validate the routes of access and explore the changes perceived by older people since Madrid 2002. This is the reason why people who were already older than 60 years in 2002 were recruited for the groups.
- Focal groups composed of older people who are leaders or involved in the health system's monitoring in order to learn about the routes and advances in policies.

In addition, interviews with key people were conducted in order to validate the routes and the change perception, and to explore the participation of older people from the perspective of other groups of people (different from older people).

1) Routes of access

Specific objective: To draw and illustrate the diverse routes of access to health care for diverse groups of older people who face different health problems.

The interviews allow us to develop the routes of access experienced by people when they need care. A "route" is understood as the set of steps and the conditioning factors that result in such steps in order to find a solution for their health problems.

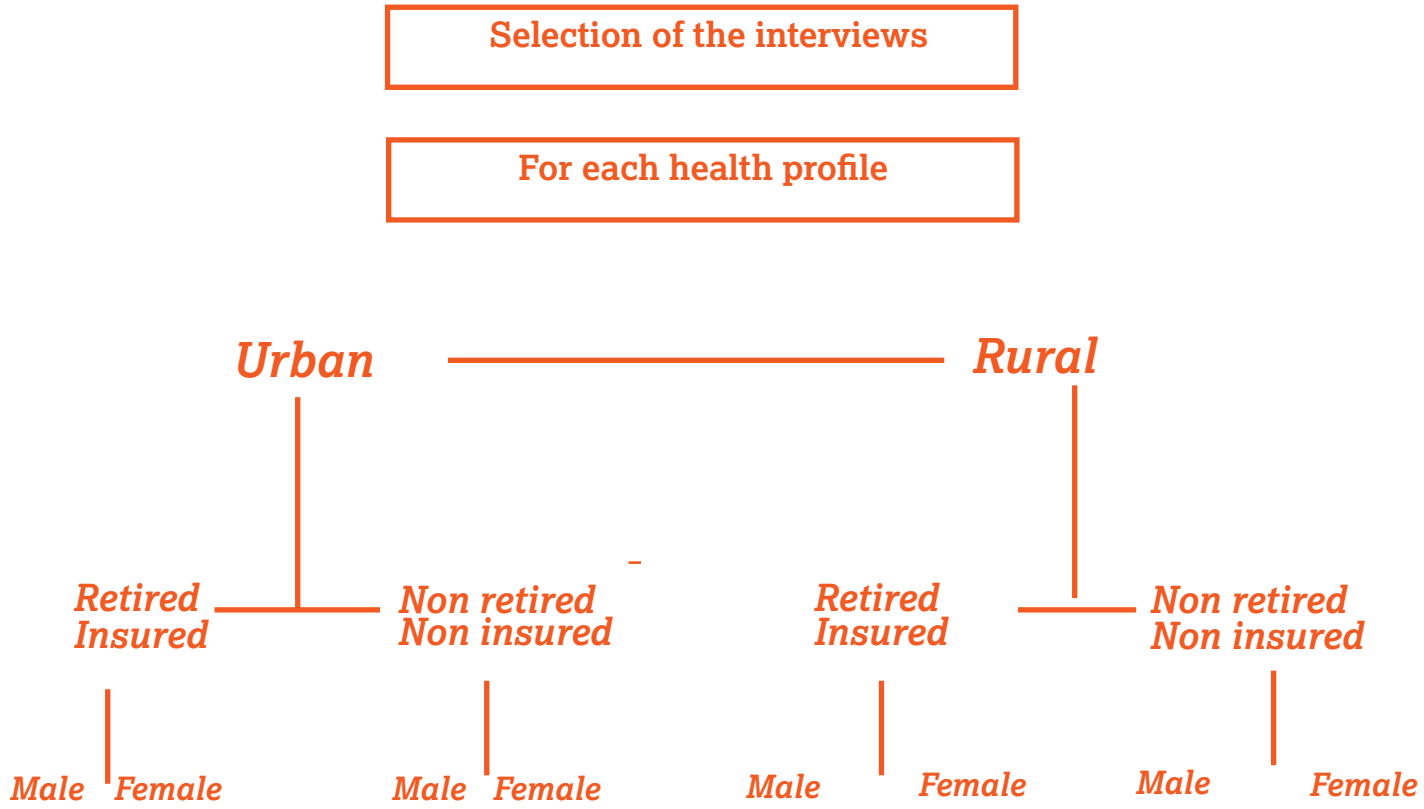
The sample includes a variety of groups of people with contexts that result in differences in accessing health: people from urban areas, people from rural areas, people with and without a health insurance, different geographic, education and cultural backgrounds (indigenous population) and gender.

However, different health conditions which lead to different responses are also explored:

- People with high blood pressure: representing a group of non communicable diseases who should benefit from preventive actions, early detection, simple treatments and regular follow-up. The services required have a low level of complexity.
- Fractures (hip and others): these are acute events which need an immediate response and need a potentially higher level of complexity but little prevention actions (apart from fall prevention and osteoporosis); which need continuing services (monitoring, re-education). If these situations are not well managed, they could have significant consequences on people's autonomy.
- Dementia: this is an emerging issue of mental health. The practice suggests that there are few solutions in place. A good management of this situation needs prevention, medical and social care and follow-up, but also family care and education.

The methodology used has little existing literature. There was no clue about the necessary amount of cases to reach a level of "saturation" in the information gathered. In other words, it is important to know how many cases are deemed to be enough to stop collecting more information because no new information is coming in. We used 30 cases as an acceptable basis to validate the findings.

1. Definition: from the definition used in Medicare 46, a catastrophe event is "a health problem, usually severe and costly, which can threaten the patient's life or generate a disability in a long term, as well as produce severe financial difficulties, due to the high cost of the medical services required" see www.medicare.gob; in a more common language: health event which was not expected and can have an impact in people health as well as on their finances.



The gathered information was analyzed based on the following axes (for every sickness / health profile):

- **First axe:** What are the steps taken to get responses: "I had this", then "I went there", "They made me this", "Then it happened that…". Reconstruction of the story in order to generate the existing trends/route patterns.
- **Second axe:** Identification of the decision-making criteria which led to the steps.
- **Third axe:** Based on the above, identification of the bottlenecks and facilitators for the decisions and of access to the health responses.
- **Fourth axe:** Exploration of the real costs to be afforded by people.

Then, the identified patterns were compared to the official routes under the current regulations, health models and programs.

2) Focal groups

The focal groups were intended:

- **Validate the results of the first methodology and discuss the routes of access experienced by people.**
- **Gather people's perceptions about the changes occurred (or not) in the last ten years (the Madrid Plan is in force since ten years ago).**

People older than 70 years were recruited in compliance with the requirements: to be an older adult currently and to have been already an older adult ten years ago, which is the period of time where the Madrid Time is in force (they lived the change).

3) Focal groups with monitors

The purpose of these focal groups comprising leading or monitoring older people was to develop the same outputs as the focal groups done previously (see point 2), which is to validate the routes and discuss the changes, but this time with people who have deeper knowledge of the right to health and with a collective vision (contrast with the individual vision in the first two methodologies). The issue of older people's participation could be explored taking advantage of the expertise of the leaders/monitors in the subject.

Application

91 interviews, including 60% women, were conducted regarding the ***routes of access.***

42% of these interviews applied to people with high blood pressure; 29% to people with fractures; and 25% to people with dementia. Some people had several diseases (co-morbidity).

20 focal groups comprising 152 older people (55% women) were held and 3 focal groups with monitors (Bolivia) comprising 20 older people were organized[2].

28 interviews with key witnesses were conducted, where most of them worked in the health sector.

In addition, the results were compared and reinforced with the information collected in another research conducted by HelpAge International jointly with the United Nations Population Fund (UNFPA) at a global level. Although the selected countries were not the same as the present study (Chile, Paraguay and Nicaragua), it was confirmed that the trends shown in the focal groups (which constituted the main methodology of that research, which will be presented in October 2012)[3] reflect very similar situations and perceptions.

A lesson learned was that it is necessary to take into account that enough time is required, besides making the usual contacts at the study sites, to identify the cases. For example, those cases of high blood pressure were easy to find among the older people's organizations and the services provided to them. However, it was more difficult to find cases of fractures, and even more difficult to find cases of dementia within this short-term study.

On the contrary, it has been relatively easy to saturate the information about the routes of access with the number of interviews done in the study. The results were reiterative enough so as to have a reasonable certainty about their validity. However, the study was not able to assess the ideal number of interviews to ensure the information's "saturation" and thereby the validity and comprehensiveness of the results found in this type of research.

The need to move the extensive narrative information to diagrams and models has challenged our capacity as social researchers to include comprehensively all of the descriptions and stick to them as much as possible in order to make the collective schemes visible. It has been a stimulating activity.

2. Monitors: people who have been trained to monitor the implementation of health services and the SSPAM; although this project have been replicated in other countries, the monitors involved in this study were from the Bolivian project.

3. Consultation with older people to develop the document entitled "Ageing in the 21st Century: A Celebration and A Challenge, October, 2012, UNFPA and HelpAge International.

Communities involved in the study

Country	Urban locations	Rural locations
Bolivia	La Paz El Alto Santa Cruz Tarija	Tito Yupanqui Cotoca
Colombia	Bogota	Montes de María Córdoba Nariño
Peru	Lima Urban Piura Ayacucho	Piura Rural Ayacucho rural Lima rural
Ecuador	-	Alangasí y Sangolquí, Sur Quito

Elizabeth Mayta / Horizons Foundation / HelpAge International

Findings

Most of the following results may not be novel ones. However, the findings not only support the existing empirical perceptions but also identify and specify significant gaps. On this basis, some significant actions can be undertaken at policies and programmes levels to ensure a better access for all older people.

In the Andean countries, the rural older population still continues to be a significant portion (40-50%) of the national older population. Likewise, native cultures still have a significant influence on, not only the usages and traditions, but also on the older people's perceptions about services and their health status.

Maria Dolores Castro / HelpAge International

General Hospital. This is a third-level state health facility in the city of La Paz, Bolivia.

Testimony

I work in the fields. I take care of some animals. I spend most of my time in the fields. At home I do not take care of myself; if I get sick, then I prepare an herbal tea. This is the first time I joined the SSPAM[4]"

Jesusa, 71 years old, lives in the community of Parki-Corco, pertaining to the municipality of Copacabana, La Paz, Bolivia.

4. SSPAM, Oder People Health Insurance. This is a right established in the Bolivian Law 3323 by which all of the Bolivian people aged 60 years and over receive this insurance (meant to cover 75% the total older population). eguro de Salud para las personas adultas mayores en Bolivia.

Finding 1: the health care routes are reiterative and short.

The routes of access to health care that we found, no matter what kind of diseases, people categories and countries are about, are quite easy to be established because they are basic and reiterative. The basic pattern is the following:

Disturbing symptoms or "catastrophic" events → ***Consultation in a public or close institution***

Testimonies

"One can make things up with drinking or bathing with plants: camomile, hierbabuena and another…. These three plants."

Concepción, 80 years old, Bogotá Colombia

"They do not look at us nor look for a diagnostic. Without examination, they give us medicines."

Older person, Bolivia

- A concrete event drives the search/demand for a health resource out of the very person (as the very person is a resource with her/his knowledge or habits).

  "it hurts too much" or "an accident prevents me from working" or "I passed out"

The reason to look for health services is not determined by the desire to be sure that a person is not sick nor by preventive reasons.

- However, this first step - to look for an external resource - is made after a "contention" strategy to cope with the event without resorting to external resources. In other words, the person either ignores the symptoms, tolerates the sickness, and/or treats her/himself. This strategy is valid both for the city, with home medicines and out-of-pocket purchases, and for the fields, with their knowledge of medicinal plants.
- In most of the cases, the first step taken (the first visit to a health service) is not followed-up. The relationship with the service ends with this first step. The route is interrupted, when in theory it should not be stopped (no matter whether the problem was solved or not, there must be a follow up whether a reference to a more complex level of care, or a control visit or a NCD treatment).
- No differences between women and men in these routes were detected.
- It has to be noted that this first step/consultation is based mainly on the drugs. People expect drugs and the health staff give drugs.

Older people rigths are human rigths too

Finding 2: Scarce prevention or detection…

It is necessary to emphasize that the first contact between the person and the health service is made after having experienced disturbing symptoms or a "catastrophic" event. In very few occasions we found a route that starts with a fortuitous early detection or due to preventive activities as proposed by the health services.

- In spite of the suggestions from the physicians and the public awareness of the need of prevention measures (to take care of the health, to detect some diseases on an early basis), in practice there are no preventive measures. Preventive activities are not sufficiently developed.

"I began to take care of myself when I was admitted to the hospital on emergency…"
Older person, Bogota, Colombia

"I have diabetes since 19 years ago. Before this, I was not bothering with health services"
An older adult from Ecuador

Finding 3: Contact with a public and/or close institution…

Generally, the first attempt is to go to a public health center (we include in this definition the social security medical centres). This is the most frequent gate or contact point where the condition is diagnosed and a treatment is recommended.

- This is valid for both rural and urban areas.
- In the city, in spite of the availability of a better private supply, a public institution is preferred, although this decision can change afterwards (swifting from a public to a private facility were commonly found in the stories).
- In the rural area, the alternative is the traditional practionners. Unlike in what could be observed in past studies, this alternative is not always the first or only option. For instance, a lot of people looked for care in both systems, the occidental one and the traditional one)[5].
- The election of a public facility may be based on the proximity.

South West of Colombia, an area habited by the indigenous AWA and where HelpAge International is developing a project to improve health services.

HelpAge Colombia

5. In the impact study for the project "strengthening the SSPAM in rural municipalities of la Paz, Bolivia, project developed by Fundación Horizontes and sponsored by SIDA, it was found that 39% of older people interviews acknowledged that they first go to the traditional practionner while 59% prefer to go to the health center: although the use of the traditional system could be sub estimated, it is not as clear as it was in the past.

Finding 4: The main decision factors are based on the possession of an insurance (versus out-of-pocket expenses) and the proximity to a health facility.

Once a person determines that the situation is not sustainable and that she/he has to seek ”help”, the election is made based on an analysis and convergence of several criteria.The main factors that determine the decision to go to the health center or not, include:

- The possession or not of a health insurance to cover the costs, otherwise, to think ahead in the capacity of payment;
- The proximity of the health facility (distance, schedules) and its (administrative) accessibility
- Other reasons include: References from relatives or acquaintances who already received the services, meaning that if an older person has been in a health service and did not receive a good attention, or on the contrary did receive a good attention, he/she is likely to go back or not go back based on this past experience; the same occurs when a relative or an acquaintance influences the older person because of past experiences.
- No gender differences were detected (beyond the obvious fact that women still have less coverage due to less access to formal social security systems).
- Differences between social status and retirement exist in the first steps, but these differences strengthen the above election criteria (e.g., a retired person who has a health insurance (social security) goes to a health center covered by the insurance, while a person who does not have an insurance may chose a close public facility). tención en primera intención difiera en cada país.
- The possession of a health insurance which motives the election of the care facility, is different in every country, thus the results are influenced and found slightly different from country to country.

A clear example is Bolivia, where the SSPAM is in force and which, in spite of its deficiencies, is recognized as a determining factor. On the contrary, the SIS in Peru or the POS in Colombia are questionable because of the difficult inclusion or because of their lack of comprehensiveness of the benefits.

Poster used to promote SSPAM implemented in Bolivia.

María Dolores Castro / HelpAge International

Testimonies

“I was taken in an ambulance to a private health center, although the public hospital was located nearby. At the private health center, as I did not have money, I was taken to the public hospital. They gave me some pills and sent me home. I felt very sick for some days and then I went to another public hospital. I went to the emergency room and the orthopedic surgeons told me that I had to be surgically intervened, but the prosthesis costs US$4.500 out of the hospital, as the hospital does not have a prothesis. We had to wait for several months in order to save the money, but the government has a free prosthesis program, they gave me the prosthesis at no cost.”

Nelson,71 years old, Quito, Ecuador

“I do not pay because I have an insurance, but the medicines they give me are not enough, so I have to buy them at the drugstore in order to control by blood pressure.”

Felicitas Palomino, 76 years old, Huamanguilla, Peru

Finding 5: Identification of several bottlenecks and facilitators…

The well-known bottlenecks in the access to the health care as identified by older people are the following:

- The lack of a health insurance (or the lack of money) to pay for an external resource such as a consultation or a treatment.
- The fact of living far from a health facility, in particular in the rural areas where there are few facilities.

These two bottlenecks are not exclusive for older people; they are valid for other groups of age and are part of the weaknesses of the health systems in the countries of study. However, due to the poverty levels found among older people from the Andean countries, their capacity of payment to afford health services is not sufficient in particular when this age group is precisely the one who needs health services more than other groups. Likewise, their difficult mobility that affects them, especially the oldest, at the time of getting the service makes this difficulty a key one when accessing services.

However, another two difficulties were surprisingly found in the testimonies given in the four countries, both in the rural and urban areas. Not that it was not expected to see them mentioned but the strength and repetitiveness of the mention deserve our attention:

- **The lack of family (or other) support** in order to go to the health center. As a particular bottleneck is the disability status, it is understandable that the support of the family or community is important.
- In connection with the above aspect, **the transportation costs** (urban and rural areas) or the difficulty to find an appropriate vehicle makes the access to the health care very difficult or almost impossible.

These bottlenecks were pointed out as the key elements in the HelpAge's Projects reports and consultations worldwide[6] . The impact of such difficulties obliges to pay particular attention to these issues.

The study identified the following additional bottlenecks:

- Bad records, particularly regarding the ineffectiveness of the treatments/ solutions proposed by the health centers in previous occasions.
- The lack of health education about self-care leads to wrong decisions such as, for example, the fact of not going to a health center; or to go to a third-level/ maximum complexity facility needlessly; or take out a cast; or to interrupt a therapy, or to demand injections instead of pills, etc.
- Prejudices such as "they never have medicines", or "the physicians are incompetent", etc. It is not always clear when these comments come from real past experiences or general myths circulating.

However, these bottlenecks can be solved more easily (right information, persuasion, and a little bit of attention on the part of the health staff).

"I would suggest to people read the card which is provided by the EPS (Note: private company contracted by the local health authorities in order to provide the care) and thus, know where to go. Because I went to a place where I should not have gone. They had not the kind of service I required… Anyway, one has to take care when walking, to look where to put one's feet; one has to walk slower than before…!"

Emilia, 69 years old, Bogota, Colombia

Testimonies

"If I want to go to the health center, I have to leave the community on foot for one hour until reaching the road, if I feel good. Otherwise, if my blood pressure is high, my head aches and the walk is more difficult. At the road, I take the bus to go to the facility. I am afraid of this disease because I have been told that, if my blood pressure goes up, I could die. I am afraid of this"

Felicitas Palomino, 76 years old, Ayacucho, Peru

"After having been diagnosed,I joined an older people's club organized. There, we developed several activities which made us feel good: walks, exercises, games, among others. Three years afterwards, this club was closed, and then I became more dependent because of my disease, so I began to think a lot. I loved the doctor, she had something that made me feel very encouraged. Currently, most of the members of that club are already dead"

Tulia Ramírez, 72 years old, Bogota, Colombia

"When my blood pressure is high, I have terrible headaches and cannot walk very well because I feel dizzy. Only my pills control this situation, and the health center gives me very few pills, therefore I stop taking them, but then my blood pressure rises to 160. My son took me to the emergency room because I fell very ill".

Felicitas Palomino, 76 years old, Ayacucho, Perú

6. In particular in internal reports from Tanzania and Cambodia

Finding 6: Out-of-pocket expenses are still a burden and a real bottleneck…

Testimony

"Since I did not have money, the SSPAM was the only way to be healed. This service would have had a cost, but it was totally free."

An older adult, Santa Cruz, Bolivia

Chronic non-communicable diseases prevail among older people and generate the need of long-term treatments. The payment of such treatments, specialized care and transportation in lack of an insurance or with an insurance that does not cover these benefits, becomes particularly difficult. High and long term treatment as well as poverty without an insurance scheme coverage, leads to out of pocket expenses that might not be affordable.

The capacity to pay is also affected by the lack of drugs in health centers in particular when the drugs for non-communicable diseases are not available at PHC level (although they are included in national drugs lists).

Testimonies

"My mother takes a drug once a day to treat her memory problems. As the insurance does not have this specialty, she has to expend money every month: the consultation is 50.00 soles and the drugs cost in average 80.00 soles. In sum, she has to pay 130.00 soles in spite of having a health insurance!"

Miriam, Peru
Daughter who takes care of her mother with Alzheimer's disease

"I have to take my wife to the neuropsychologist three times a week, which means approximately 14 sessions per month at $40.000 pesos every session. In addition to that, we have to buy the drugs, which amount to $400.000 pesos."

Francisco, Colombia
Husband of a patient with diabetes and Alzheimer's disease

"We have to buy the drugs; they cost between twenty and thirty, which is expensive, and they are not covered by the insurance. Some drugs exceed $10.000 pesos. We are given with just Diclofenaco, which costs $1.000 the unit, or the Naproxeno, a blister with vitamins."

Focus Group N° 3, Montes de María, Colombia

It is easy to forget that, in a region with middle-income countries, the economic access continues to be a main issue for many older people and thus the affordability of the out of pocket expenses. Many testimonies emphasize the importance of having a health insurance.

However, even with a health insurance, there is still a proportion of health care which is affected by the people's capacity to afford an "out-of-pocket" expense because of the lack of integrality of the benefits within these insurance schemes.

In conclusion, many treatments are not conducted or completed to the end because of the lack of drugs, or inputs, or money.

The particular out-of-pocket expenses to buy drugs have been identified in other countries of the region[7].

7. Consultaltion with older people for the document entitled "Ageing in the 21st Century. A Celebration and A Challenge. October, 2012. UNFPA and HelpAge International.

María del Pilar Zuluaga / HelpAge International

Testimonies

"When I go to the doctor without money, I have to stay with only the prescription. And if I go to the regional hospital, I have to wait for three months before being served"

An older adult, Paraguay

"I am sick. I have diabetes and the health center does not the drugs I need." medicamentos"

An older adult, Nicaragua

"I am sick, but the health center does not have the drugs I need, and they costs 450 córdovas. How can they expect me to buy, if I am poor?"

An older adult, Nicaragua

Finding 7: Some progresses have been made

The information gathered through the testimonies and focal groups confirms the perception of positive changes in the access to health:

- **The service supply** (presence) has improved. There are more health centers and hospitals, even in the rural areas, as compared with ten years ago.

" There are more health centers than before."
An older adult, Chile

- Although people, including older people, do not practice much prevention and although the health system does not develop many preventive activities, all of them recognize the need for prevention. This is an improvement compared with previous research.

"If we do not take care of ourselves, we can die or get sick."
Basilio, Santa Cruz, Bolivia

- The health staff says that more older people visit the health centers than before. There is a perception about the population ageing, which produces reflections and the need of more and better information.

- Although the health staff is not appropriately trained to attend older people and their non-transmissible diseases (because they are more focused on the mother-child health or acute diseases), they are aware of the need to be trained in order to provide a better service and meet the needs of older people. This demand implies that the staff also acknowledges that older people might have other health needs than other age groups.

"I have repeated in meetings and workshops in which I participated, that the first thing the doctors and nurses need to do, is training. There are many people who, despite working in an hospital, do not know about older people care".
Leonor, wife and care giver of Joaquin (older person with Alzheimer), Bogota, Colombia

- On the whole, most of the testimonies show that there is a connection between older people and the health centers. In previous studies , the proportion of older people with no contact with the health centers was more significant.

"This institution did not pertain to the SSPAM before. Now, with the SSPAM, the services have improved. The attention is more fluid. The only problem is the lack of drugs."
Ismael, El Alto, Bolivia

- Another change perceived through all the study is that older people have a better knowledge of their right to health compared to 10 years ago. This is a good starting point to improve their health status and the care provided to older people. This fact was caught through the individual knowledge on rights as well as the active participation of older people organizations and monitoring groups.

Testimonies

"Well, what can I say… This is the first time I come here, since many years ago. I even did not know the place. I have been a healthy person, this is why I did not know this place. I came here many, many years ago. Now, the physician has seen me well. Other people make complaints, but I have to say that it is okay. The premises are better now and the doctor offices are upstairs."

María Luz, 67 years old, Tarija, Bolivia

*"**EsSalud** treats this disease, so I have to make the appointments. Fortunately, now you can make the appointment on the phone, and not like before, when my father had to get in line at dawn to obtain an appointment."*

Marina, Miriam's daughter, Peru

" Well, things have changed very much over time. Before, they did not give us anything, we had to buy everything, a syringe, a catheter, or whatever they told us to buy. We had to buy even the yellow files to put our medical records."

A focal group in Montes de María, Colombia

"There are changes… for example, before I never participate in workshops. Nothing like this. I did not know I had high blood pressure and had heart disease. I did not know I was not to eat too much salt. Everything like that, like physical exercise..." "This has changed. For example my doctor asks me about my needs, if I need exams. Before one had to cry to be taken seriously. Now things are better; care has improved" "Another good thing is that the Secretaria de Salud (note: local health authority) provides us with vaccines, workshops on use of drugs and other important issues for our health".

Focal group, Bogota, Colombia

"It came out of control, having her at home. It has been so difficult, painful to send her to a home. But I go and visit her and I can see that she is well cared for.… Even the girl from the kitchen is committed… I can see my mum seated in a chair with her legs in the girl's lap and the girl giving her massages. The director has well care very much… when ever I want I can go and visit, no restrictions."

Marta, daughter of Ana Cecilia, 77 years old with Alzheimer

Finding 8: There are still many gaps…

In sum, the gaps in the access to health are clustered in four categories:

• **The financial access to health** is still a significant obstacle for older people. Some countries have a health insurance, while others don't. Most of these "insurances" lack many specialties so as to ensure a comprehensive and appropriate care.

• **The continuity of the services** is far from being the rule, although it is crucial to maintain the functionality and quality of life of older people, particularly those who have chronic diseases.

• **The demographic and epidemiologic changes are'nt yet assumed by the health systems and services.** Health programs and budgets are still based on the mother-child health model and acute diseases.

• **Mental health and dementia** are totally neglected.

Testimonies

"The health centers see us only once a month with the SIS insurance. If I have to go more times, I have to pay. The pills they give us are only painkillers, they do not cure. If I stop taking the medicine, I get sick."

"I did not pay anything because I have a health insurance, but the pills they give me are not enough, and when I ran out of them, I have to buy them at the drugstore in order to control my blood pressure."

Felicitas, Palomino, 76 years old, Peru

With high blood presure. She has the SIS.

"I have degenerative osteoarthritis in my knee. I ran out of my medication and I'm about to undergo a prosthesis surgery, but I don't dare yet. The insurance does not cover the prosthesis".

María Luz, Tarija, Bolivia

"A mi me tratan bien, Bueno gracias a Dios sí, porque a uno le dan sus medicinas porque las mandan allá de… le dan a uno sus medicinas gracias a Dios. A veces no se las dan a tiempo porque no las mandan de allá de Cartagena de allá porque las mandan para acá a veces uno dura hasta dos días sin tomarla pero es por eso"

Bertha Maria, 68 años, Montes de María Colombia

8. Municipio saludable y vejez, HelpAge International, 2001; Estudio INTRA, HelpAge International, Ministry of Health and Sports, and WHO, 2005.

Antonio Olmos/ HelpAge International

We have to insist about the insufficient continuity of the service, as it could be observed as:

- The Prevention/Attention/Follow-Up sequence is not fulfilled.
- The route is interrupted, generally after the first contact or after the resolution of an acute problem.
- The interruption has severe consequences on the health, quality of life and functionality of people.
- Mid-term follow-up and other follow-up alternatives (supply) are the most lacking but needed activities.
- The coordination between sectors, is not sufficient, in particular when it comes to home care, family's support or caregivers.

The health service exists, although with questionable quality and effectiveness. The service is based on the current trends, which are generated by acute problems. The resolution of problems is still based on medication.

Testimony

She has a health insurance (social security), but it does not provide services for dementia. She has to be seen by a private physician. The social security in Ayacucho does not have mental specialties:

*"She was diagnosed in **ESSALUD** with her condition, but they cannot treat her because there are no specialists."*

Marina, Daughter of Miriam, an older adult with dementia), Huamanga, Ayacucho, Peru

The service provision under the situation of discontinuity can make the route of access very complicated in spite of having a well-established and safe model of service.

María, 65 years old, from El Alto, Bolivia, tell us her story:

"At times, I have headaches, it seems that I am hot, and my eye is closing. My hands are shrinking as well. In the mornings I heal my eyes with saliva."

During a school campaign she had her blood pressure measured and they told her that she has high blood pressure:

"I won't argue, I told them "Okay"?

At the hospital, through the insurance, she received something for her high blood pressure. As for her eyes, she was referred to another place:

"For my eye pain, they are going to give me a piece of paper to take it to the (2nd level) Satelite Hospital, then, I have to go to the Arco Iris Hospital, in La Paz."

She did not go because it was too complicated, but also because she was distrustful when they told her that she would undergo a surgical intervention (cataracts).

The follow-up place (health center) where she is supposed to go now has changed:

"I went there once, but I had to wait for a long time. They told me that they didn't have the money for the drugs. They tell us to buy them, but we do not have money either, so we have to stay sick."

The lack of information on prevention, services and advice about self-care and control of diseases is still inadequate. We insist that people have the right to be informed.

"I don't know what the SSPAM is. This is the first time I come here. Nobody explained it to me."
Maximiliano, Cotoca, Bolivia

"We need more information about the existing health programs. As we don't know about the existing services, we don't use them."
An older person, from Chile

Finally, different concepts of quality make the analysis of the health systems difficult at the time of assessing the progress. However, not only several pointed gaps disclose the poor quality of the health services, but also the fact that older people's opinions are divided:

Testimonies

"This is a generic issue. They have the right to health, but what kind of health? what kind of services? where?. The relevant regulations include this right, but they are very generic. The same occurs with the preferential treatment and discounts in some events."
Focal group, Bogota, Colombia

"How is the service? It has changed a lot, now it is much more better, for me, it has been wonderful."
Another Focal group ,Bogota, Colombia

"The service has improved. This place was to be overcrowded before, with children, pregnant women, older people, not it is clearer, I don't know why. They provide a good service. The only problem is that I have to come early to obtain an appointment. Sometimes, if the appointments are full, I have to come back another day, and if there are many patients, I have to wait and lose all the day, and there is nothing we can do."

María, 73 years old, Santa Cruz, Bolivia

"I took out the cast because it annoyed me, I could not take a bath. I took it out in person because it is more annoying to go to the service and wait for hours. They didn't tell me how long I should continue to have the plaster. The physicians never give you information, they play the fool. This upsets me because we are treated like beggars. Then I was taken to a private health center. The treating physician told me that the nerves are damaged and I would always fill pain. The doctor gave me a blister to stop the pain."

An older adult, Bolivia

Finding 9: The route is not the same for all of the diseases or needs…

HelpAge Colombia

There are marked differences based on the health profiles.

For high blood pressure:

- Either scarce prevention or no prevention at all.
- Immediate service at all levels. In most of the cases, the treatment provided is based on drugs only.
- It is necessary to work on lifestyles and alternatives to control the disease.

For the fractures:

- There are very few prevention measures (osteoporosis, falls).
- The service usually exists.
- Inappropriate or inexistent rehabilitation and physical therapy produce as a result immobility, insecurity, pain and dependence.

"What can I tell you? I can tell you to walk carefully, that is what I did. I can also tell you that the SSPAM is wonderful because they help us. I suggest you to be registerered ther, that is how I obtained help."

Hilda, La Paz, Bolivia

"I went there around three times. The only good service I received was when I broke my hand. In that opportunity, I went there and they cured me, I won't deny it, not very well, but they cured me".

René, Santa Cruz, Bolivia

"I went there around three times. The only good service I received was when I broke my hand. In that opportunity, I went there and they cured me, I won't deny it, not very well, but they cured me. "I am recovering little by little. The naturist physician has also cured me with some herbs and a lizard. However, she still has a lot of pain."

For dementia:

- Both the health staff and the general population are almost absolutely ignorant in relation to this type of disease.
- Non-existent services nor detection at PHC level.
- The care of dementia is excluded from many insurance plans, which results in a high out-of-pocket expense.
- Lack of support services

Francisco is 80 years old, he is a physician and the main caregiver of Francy. Bogota.

"The truth is that we did not use the EPS services, as we always use the prepaid medicine, or we prefer to go to a private doctor. We do have the service and hospitals for older people, but there is no special care for those people who were diagnosed with Alzheimer's. The health service does not a prevention program due to the lack of knowledge about the causes of this disease.

"The girl who comes in the ambulance service is a volunteer… she does not know about Alzheimer. She says to my mum "Lady, hold your hand…. Are you all right?". My mum cannot answer you, she does not understand, sometimes even not me! Only if I say Mamie she recognizes me. So difficult she will recognize a unknown person. I had to tell this girl 3 times that my mammy does not understand."

Daughter and caregiver to Helena, 78 years old, Bogotá, Colombia.

Conclusions and recommendations

Older people have the following expectations:

"A good service should be fast, especially for those who are about to die. We want to recover quickly. We want to be healthy not just for one or two days. They have to provide the medicines quickly and see what drugs are the most needed ones."

Basilio Cussi, 71 years old
Santa Cruz, Bolivia

"I would suggest the health authorities to make more specialized centers available and admit the patients. It would be advisable for the POS to cover the whole treatment. I would also suggest the relatives of the Alzheimer's disease to be more involved."

Francisco, Colombia

"Quisiera que haya más buenos médicos en la posta de Huamanguilla para que no tenga que ir a Ayacucho. Si me empeoro, ir a Ayacucho que me cuesta mucho dinero".

Felicitas Palomino, 76 años
Perú

Much progress has been made since 2002 in relation to the health policies and programs under the responsibility of the governments, including the WHO's Regional Plan for Health and Ageing (2009), the AUGE Plan in Chile, and the Older People's Health Insurance (SSPAM) in Bolivia, amongst others.

The region is more aware of the impact of the chronic diseases on the epidemiologic burden in Latin America and the Caribbean, as shown by the participation of the region in the New York Summit (2010) and the existence of national programs for the prevention and control of non-transmissible diseases.

However, the reform and improvement of our health systems continue to be a need to be met as soon as possible. The good results of the programmes already in places as compared with the few investment (up to now) in this 60+ age group have shown improvements, which have to be continued.

Considering the identified gaps as confirmed by this study, the work to be done in the future would be as follows:

- To keep improving the network of near services, including more primary-care services. This seems to be a rehashing recommendation, but it turns out to be that primary care continues to be scarcely reflected in the structure of our health systems.
- To work to improve the access to health in the region by considering the distance to the closest health center, the transportation and escorting, and the financial access (comprehensive and inclusive health insurance plans).
- In the framework of access, the epidemiologic adjustment is yet to be included. Since the health model existing in our countries is based on the mother-child mortality, acute diseases and the rather curative medicine, it would be difficult to address the new challenges faced by older people and their non-transmissible diseases.
- To work to continuing the service is part of this adjustment, including an intensified work of prevention and self-care, and the introduction of new follow-up alternatives (home care, physical therapy, etc.)
- As part of the Madrid Plan recommendations and other regional documents, Human resources need to be trained to take care of older people and with knowledge of the new epidemiologic challenges. This is still a key area of work.
- The involvement of the very people during the life cycle; this includes self-care and planning and monitoring of the services. Although some initiatives are in place, more efforts should be put in ensuring people participation in their health and in the planning of services.

The bottlenecks may be overcome in the following ways:

- The opportunity to have an insurance facilitates the access to health (see finding 4).
- To increase primary care health services.
- To organize the transportation system.
- To raise awareness among the families or to develop programs of home care services for the escorts (example of a new experience of PADOMI in Peru).

Although traditional medicine is not anymore the first and single resource for older people, including in rural areas, it is still, together with the use of medicinal plants, a resource, which is close to people and probably quite cheap. In countries like the Andean countries where several native cultures and populations exist, the use of this resource needs to be better studied, and then integrated in the routes of access. A first step has been taken by the Bolivian Ministry of health with the establishment of a Vice Ministry of Traditional medicine and through the acknowledgment of the traditional remedies in the insurance scheme. But a lot more is to be done still.

"I will tell you how I do it to him that you could use for another person…. Have him lying on a bed, move his hands, extend his legs… mix verbena, cloves, cannel, and put it on the sun. Then you put it on his legs, arms…"

Esposa y cuidadora de Aurelio, 99 años
Montes de María Colombia

In the course of this research, we have seen in the four countries and in our own experience that some initiatives to fill the gaps are in place. It is necessary to review, measure the impacts, and spread and intensify these good practices.

The complexity of health in front of the challenges given by the non-communicable diseases and the impact on health of the social determinants, imply that the responsibility of a healthy life course is not only on the shoulders of the health sector. All stakeholders from State, health systems, communities and individuals, need to play their roles in the healthy ageing.

"These institutions provide first-aid services. They respond to your call. You just have to say your ID, you receive a registration card,

Policies and health laws at the four countries

Bolivia

Laws
Law 3323 of the SSPAM (Health Insurance Scheme for Older People).

Policies and programmes
Policy SAFCI (Family, community and intercultural model of care).

Insurance scheme
SSPAM (free Access for older people 60+, paid through a annual prime given by the municipal Budget) o
Social Security system for retirees

Routes and benefits
Three levels of care with an entry point through the first level (less complexity, PHC).

Reference and counter reference between levels.

Benefits: integrality of care (only exception of prosthesis).

Colombia

Laws
Law 100 (1993) , Law 715 (2001), Law 1122 (2007), Law 1438 (2011).

Policies and programmes
Health policy base don assistencialism; with the new law 1438, PHC will be enhanced.

Insurance scheme
Social security (Contributive) for people who can afford it
Social security Subsidized for the others
For people who do not have any insurance or payment capacity, health is ensured by the State.

Routes and benefits
Three levels of care by complexity (first level less complexity, PHC; second level: medium complexity, basic specialties and 3rd level with all specialties and complex care).

System of reference and counter reference between levels
Benefits: a) Obligatory Health Plan includes consultation in general medicine, specialties, hospital stay, treatments, tests, and rehabilitation), b) Collective interventions (emergencies care, emergencies and disasters, professional accidents and diseases and other).

Ecuador

Laws

Policies and Programmes
Transformation for the health sector, Ministry of Social protection, 2009 (organization of levels and mandates: national level for policy decision, regional level for the planning of networks and local level for the provision
Decentralised management model and Integrated policies for health in 2007. ransformación Sectorial de Salud, MSP, 2009 (organización en nivel nacional de políticas, regional de operativización de las redes, nivel distrital de prestaciones), Modelo de gestión desconcentrado, Políticas Integrales de Salud para los adultos mayores, MSP 2007.

Insurance scheme
Social security with different regimens

Routes y benefits:
All benefits (care, drugs, hospital, dentistry, prothesis, transport costs…);
Model of care includes different levels a in other countries.

Peru

Laws
Law 29344 – Law of the universal insurance - AUS.

Policies and programmes
RM 464 - MINSA 2011, on the Model of care based on the family and community -MAIS,
National plan for non-communicable diseases

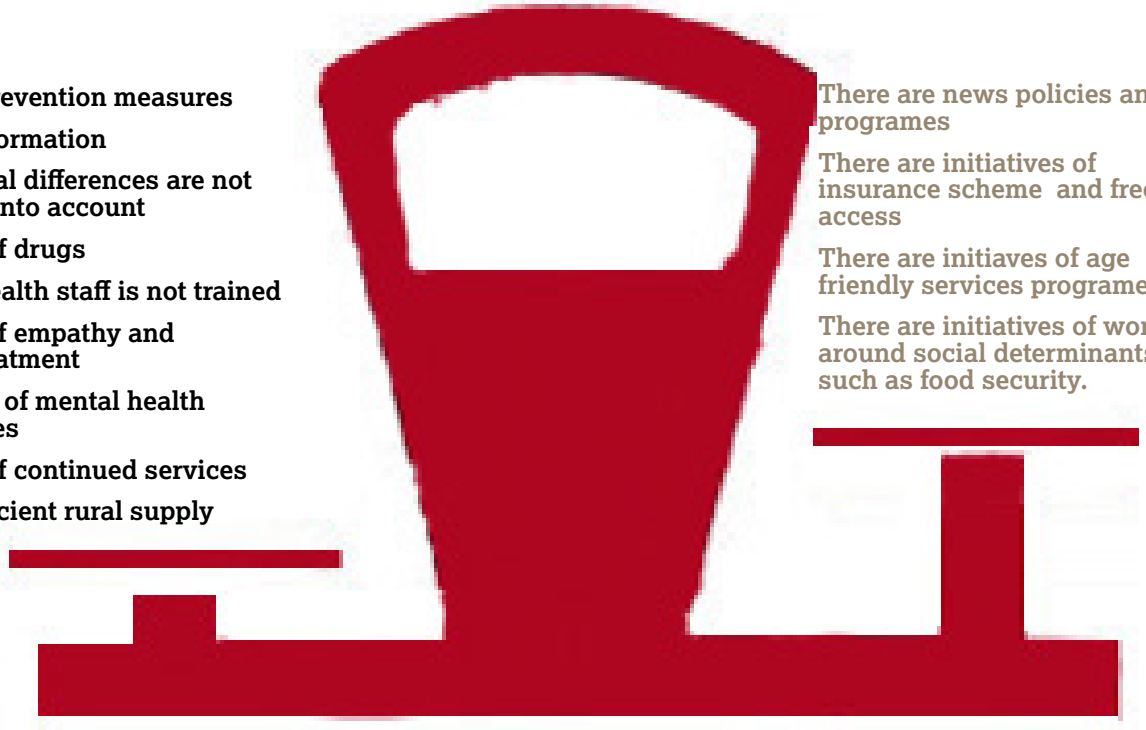
Insurance scheme
AUS includes a subsidary régimen which supports the SIS (integral health insurance scheme) (free Access to health centres of the public system with different levels, for people identified as poor by the national system – SISFOH)

Routes and benefits:
Three levels of care with entry point in the first level (as other countries).

Reference and counter reference between levels
Benefits include packages (consultation, specialties, treatments and tests).

NOTE: Older people benefit from the National non-communicable plan (diabetes, high blood pressure, cataract, cervix and prostate cancer).

There is progress but the gaps are many: the systems of health and health determinants are not friendly, or suitable for older people.



Few prevention measures

Misinformation

Cultural differences are not taken into account

Lack of drugs

The health staff is not trained

Lack of empathy and mistreatment

Deficit of mental health services

Lack of continued services

Insufficient rural supply

There are news policies and programes

There are initiatives of insurance scheme and free access

There are initiaves of age friendly services programes

There are initiatives of work around social determinants such as food security.

...the health systems and determinants of health are still far from being age friendly or adequate for older people.

Antonio Olmos/ HelpAge International