Ensayo científico: Estudio comparado de los sistemas de cuidados a adultos en Uruguay, Costa Rica y Cuba

Scientific essay: A comparative study of long-term care systems in Uruguay, Costa Rica and Cuba

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Resumen: Este estudio tiene como objetivo comparar los servicios de cuidados para adultos mayores de Cuba con los existentes en Costa Rica y Uruguay, países que cuentan con sistemas de cuidados formalizados. Para ello, se analiza la situación demográfica de cada país; se compara el marco regulatorio; se aborda las características de los servicios y cobertura, y los esquemas de financiamiento y calidad de dichos servicios.
Los resultados muestran que los tres países tienen niveles significativos de envejecimiento, lo cual aumentará la demanda de servicios de cuidados de adultos mayores. En Costa Rica y Uruguay, varios ministerios participan en la formulación y ejecución de políticas de cuidados junto con los usuarios y sectores público y privado, aunque la integración no siempre está garantizada.
En contraste, Cuba no aplica herramientas de medición de funcionalidad para excluir a los dependientes menos severos y sus servicios son mayoritariamente estatales con un marco regulatorio disperso. Uruguay y Costa Rica comparten un esquema de financiamiento similar, con limitaciones fiscales que dificultan la expansión de la cobertura de servicios. En Cuba, los servicios se financian con el presupuesto del Estado y copagos por los usuarios, cubiertos por la seguridad social si ellos o sus familias no pueden asumirlos.
En general, los tres países tienen estándares de calidad que establecen requisitos mínimos sobre infraestructura, personal y servicios.

Palabras clave: Políticas de cuidado, Servicios de cuidado, adultos mayores, Cuba, Costa Rica, Uruguay.

Abstract: This study aims to compare the elderly care services in Cuba with those in Costa Rica and Uruguay, countries that have formalized care systems. The demographic situation of each country is analyzed, the regulatory framework is compared, and the characteristics of the services and coverage, the financing schemes, and the quality of said services are addressed.

The results show that all three countries have significant levels of ageing, which will increase the demand for elderly care services. In Costa Rica and Uruguay, several ministries participate in the formulation and implementation of care policies, along with users and with the public and private sectors. Although, integration is not always guaranteed.

In contrast, Cuba does not apply functionality-measuring tools to exclude less severely dependent people and its services are mostly state-run with a dispersed regulatory framework. Uruguay and Costa Rica share a similar financing scheme, with fiscal limitations that complicate expanding service coverage. In Cuba, services are state financed and co-payed by users, and covered by social security if users or their families cannot afford them.

In general, all three countries have quality standards that ensure minimum requirements on infrastructure, personnel and services.

Keywords: Care policies, care services, elderly, Cuba, Costa Rica, Uruguay.

Introduction

In the last seventy years, the demographic structure of the population of Latin America and the Caribbean has undergone significant changes that have led to a rapid demographic transition. The sustained decline in mortality and fertility made the region go from high levels of mortality and fertility in the 1950s to low levels in both variables today. As a result, the age structure of countries was profoundly modified, with a significant increase in the proportion of older people (United Nations [UN] & Economic Commission for Latin America and the Caribbean [ECLAC], 2023a).

According to estimates and population projections of Latin America and the Caribbean, the region has experienced a rapid aging process with respect to other regions of the world, without exceeding the rate of aging of Europe or Asia. In 1950, people aged 60 and over accounted for 5.2% of the population, a figure very similar to that of Africa (5.3%). However, since the mid-1960s, the proportion of elderly people in Latin America and the Caribbean has begun to increase in a sustained way and, since the 1970s, it has followed a trend very similar to that of Asia (UN & ECLAC, 2023a). The aging of the population is related to an increase in the need for care and also to a change in the type of care required. All this happens in the most unequal region in the world, with social protection systems still underdeveloped.

In 2023, in Latin America and the Caribbean, people aged 60 and over numbered around 92 million and represented 13.8% of the total population. However, by the end of the Decade of Healthy Aging, in 2030, the population aged 60 and over in the region will have increased by 23 million, reaching 115 million, which will represent 16.5% of the total population (UN & ECLAC, 2023b). This will occur in all the countries of the region to a greater or lesser extent. Looking to the future, it is expected that in 2060 the proportion of people aged 60 and over in Latin America and the Caribbean will exceed that of Asia and Oceania and be closer to the values corresponding to North America and Europe. In 2100, the proportion of older people in the region will reach 38.2%, very close to the estimated proportion for Europe in that same year (UN & ECLAC, 2023a). This situation generates a significant group of challenges, particularly in societies that are not prepared to experience such a transition and whose public policies are not designed to ensure that this process is used as an opportunity, rather than facing it as a problem.

This trend towards the growth of the number of elderly people is a relevant fact for the design of policies and, specifically, of care policies, which in the Latin American context is usually associated with the vision of Integral Care Systems. Although the needs of care are inherent to any person in their life course, the increase in age is also associated with an increase in loss of autonomy. It is important to clarify that there are differences between older adults, people with disabilities, and dependent people. Statistically, older adults tend to have higher levels of dependence and greater affected by chronic diseases, which is associated with a greater demand for care. But not every elderly person is disabled or dependent. This clarification is necessary because there are usually specific policies for people with disabilities, policies for dependents, and policies for the care of older adults, which are usually interrelated, even if they do not refer exactly to the same population group.

The aging of the age structure of the population has generated a proliferation of studies on care in the region, due to the important economic, social, and epidemiological challenges that derive from the interrelationships between the aging process and the increase in care needs. Implementing care systems that guarantee access to the right to care and be cared for is an objective for the design of public policies in the immediate future. It is necessary to incorporate approaches that make visible the centrality of care in the functioning of societies. In turn, the impact of the COVID-19 pandemic has highlighted the inequalities and inequalities experienced by both women and their families, as well as people who work in the field of care and, of course, those who require them. For these reasons, more and more countries in the region are moving forward in laying the foundations for the creation of public care systems.

Cuba is one of the oldest countries in the region, which has caused an increase in the demand for care that falls mainly on families and, within these, on women. Given this scenario, work has been underway since 2022 on the construction of a Comprehensive Care System under the direction of the Ministry of Labor and Social Security (MTSS), the participation of other agencies of the central administration of the State, and the collaboration of the experts who make up the National Network of Care Studies. This effort was developed within the framework of the Unpaid Work project within the Dignified Work Program of the Macroprogram of Human Development, Equity and Social Justice that promotes the government and had the result that on August 5, 2024, decree 109/2024 "National System for Integral Life Care" was published in the Official Gazette of the Republic of Cuba number 99, which aims to create the National System for Comprehensive Life Care as an instrument with a strategic vision of care, implemented based on a model that facilitates coherence and coordination between policies, programs and actions, as well as the articulation Between the agencies of the Central Administration of the State, the local organs of the People's Power and the rest of the economic and social actors, from the national to the local level.

The construction of a comprehensive care system, incorporating the Latin American perspective and adapting it to the Cuban context, entails enormous challenges that must be addressed from the different fields of knowledge, given the multidisciplinary nature involved in care studies. In this sense, this research aims to compare the state of elderly care services in Cuba with those in Costa Rica and Uruguay, countries in the region that have more consolidated care systems. For this purpose, four sections have been drawn up. The first is dedicated to analyzing the demographic situation of the three countries; the second to comparing the regulatory framework; the third addresses the characteristics of the services and coverage; and the last exposes the financing schemes and quality of these services.

Although these three countries have notable differences in terms of their political system, conducting a comparative analysis of Cuba with regional references such as Costa Rica and Uruguay, which have robust institutions, health systems with wide coverage and a regulatory framework that incorporates the right to care within the social welfare system, is essential to perfect the design of care policies on the island and move towards a care society, where the rights of people to care and be cared for are guaranteed, at any time during the course of their lives.

Content

Materials and methods

A systematic, orderly, descriptive review was carried out, based on four sections of vital relevance for the subject in question, which had the greatest amount of data available. The publications of the last five years were analyzed, and the descriptors used were those related to the four sections into which the research is divided. Elements on which it was not possible to establish comparisons between the three countries were excluded, but the four selected sections allow us to accurately locate the level of development of the issue in Cuba when comparing it with two reference countries in the region.

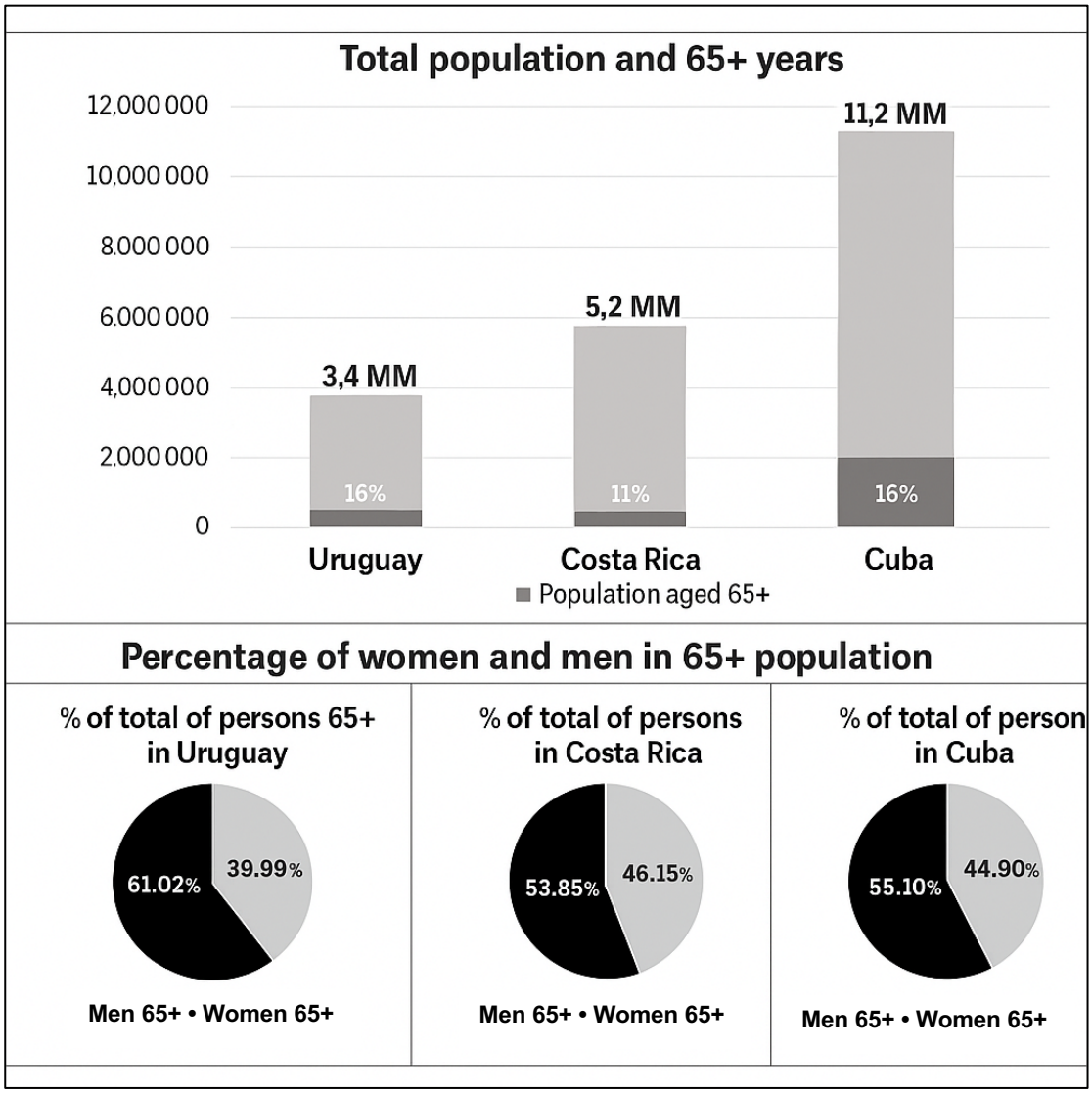
National databases were reviewed with official statistics from which comparisons were made. This made it possible to complement the study with statistical data and strengthen the demographic analysis, to give greater relevance to the subject.

Limitations

The study faced limitations associated with the absence of data and the homogeneity of the same, especially in those of Cuba. It was not the objective of this research to address in depth the care that is carried out in the family environment, although it is recognized that, both in the countries studied and in the rest of the region, the family is the main responsible for care and, within them, the women. Likewise, the study has the challenge of comparing two models that face theoretical visions with different starting points (Uruguay and Costa Rica).

Demographic situation of Costa Rica, Uruguay, and Cuba

The result of the comparison of the aging levels of Costa Rica, Uruguay, and Cuba shows that the three countries have the greatest progress in the demographic transition. (UN & ECLAC, 2021) However, Cuba has twice the population of Costa Rica and almost triple that of Uruguay, Its population over 65 years of age represents more than double that of both countries in absolute terms and, in percentage terms, represents about 16% of the total population, a value similar to that of Uruguay and higher than that of Costa Rica. In all three countries, women predominate over men in this age group, with Uruguay holding the highest value (Graph 1).



Graph 1. Total population, population of 65+ years, and percentage by sex (2022). Preparation from data obtained from the World Bank (2023).

In the three countries, life expectancy in both sexes is higher than in the region, with very similar values. Uruguay stands out as the greatest difference between men and women. As for the Gross Mortality Rate, the highest is that of Cuba, but very similar to that of Uruguay; while the Fertility Rate is similar in the three countries studied: 1.5 children per woman, below the generational replacement (2.1 sons and daughters per woman). As for the Age Dependency Ratio (It is the ratio between the child and older adult population with respect to the percentage adult population), the number of people supported by the active population compared to the non-active population, Cuba has the highest rate with 61.3 dependent people per 100 active people. (Table 1)

Table 1. Panorama of aging in the three countries (2023)

Indicador	Costa Rica	Cuba	Uruguay
Life expectancy at birth	83 years Women	81 years Women	82 years Women
	78 years Men	76 years Men	74 years Men
Crude mortality rate	5,5	10,8	9,3
Total fertility rate, per woman	1,5	1,5	1,5
Age dependency ratio	45	61,3	52,5

Elaboration from (UN, 2023; Ministry of Social Development [MIDES], 2023; National Institute of Statistics and Censuses [INEC], 2023 & National Office of Statistics and Information [ONEI], 2023)

With regard to dependence for the basic activities of daily life, used to define the levels of dependence, in the case of Cuba, the proportion of dependents is 15.2% in the 60-74-year-old group, rising to 39.8% in the group of 75 and more, according to the 2017 National Population Aging Survey. If the same proportion is maintained, the total dependence for the basic activities of daily life in 2022 would be approximately 255,000 people in the 60-74-year-old group and in the 75-year-old group and over, 301,000. Total or severe dependence only affects 0.2% of men under 60 and 0.1% of women of those ages. In the 60-74-year-old group, the proportion in both cases is less than 2%. The issue is aggravated for the group of 75 years and older, since 5.1% of men are classified as total or severe dependence, and 8.5% of women. If a similar percentage were maintained, these figures would amount in 2022 to a total of 15.8 thousand men and 17.8 thousand women between 60-74 years old and 16.8 thousand men and 36.5 thousand women over 75 years of age. (ONEI, 2017; ONEI, 2023) These values far exceed the capacity available in existing senior residences in Cuba.

This situation becomes more complex if we add that 80.6% of older people in Cuba suffer from at least one chronic disease. This proportion rises to 86.9% percent in the group of 75 years and older. (ONEI, 2017) There is a strong relationship between chronic diseases and the increase in care needs; the population that has chronic conditions has a higher rate of dependence. That said, most people with chronic diseases do not have dependence.

In the case of Costa Rica, the prevalence of dependence in older adults is considerably higher than that of minors, reaching 15% in the case of people aged 60 and over and 28% in the case of adults aged 80 and over. (Medellín et al, 2019) According to data from the National Household Survey of Costa Rica 2023, the population over 60 years old in the country is one million 64,165 people. (INEC, 2023) If similar levels of dependence were maintained, the country would have an estimated 159,625 people in the group of people aged 60 and over. In the case of Non-communicable Diseases (NCDs) (diabetes, cancer, and heart disease), these are the most prevalent in Costa Rica. Representing 80.73% of deaths in the national territory for the year 2019, which means prolonged and expensive care by the public health system, hand in hand with a progressive deterioration in the state of health of patients. (Ministry of Health, Government of Costa Rica, 2023) .

Among those who live in Uruguay, approximately 490,000 people are 65 years old and older, and among them, 135,000 are 80 years old and over. Estimates from the Longitudinal Social Protection Survey (ELPS) show that 12.9% of people aged 65 and over are dependent, representing a potential demand for care services of approximately 64,000 people. (MIDAS & National Comprehensive Care System [SNIC], 2020) Regarding the levels of dependence of the elderly, 33% have a mild level of dependence, 39% are in a situation

of moderate dependence, and 28% have severe dependence. The level of dependence (mild, moderate, or severe) increases with the age of the person and is exacerbated among people aged 80 and over. For its part, it is higher among women, and in the quintets of higher income, associated with the difference in age structures according to income. (MIDAS & SNIC, 2020). As for chronic diseases, data from the Global Burden of Diseases (GBD) study show that 81% of the burden of mortality and morbidity in the country can be attributed to chronic diseases. For the population aged 70 and over, the contribution of chronic diseases to the total burden of diseases increases to 90%. (Aranco & Sorio, 2019).

In summary, the analysis of the demographic situation of the three countries shows a high aging process of the population structure, which has led to an increase in the demand for care. Cuba stands out in absolute terms because it has a greater number of older adults to be cared for and needs a greater budgetary effort, as well as the development of a greater offer of care services to meet the demand. All this in economic conditions that are visibly more complex than those faced by the other two countries under study.

Regulatory framework, accessibility, and eligibility in Costa Rica, Uruguay, and Cuba

In the comparison of care policies, it is important to emphasize that Uruguay was the first country in the region to create a Comprehensive Care System in 2015. Costa Rica, for its part, has since 2021 the National Care Policy (2021-2031), more focused on the care of dependence and without integrating early childhood. In 2022, he approved the creation of the National Care and Support System for Adults and Elderly People in a Situation of Dependency (SINCA). In Cuba, the bases for the creation of the comprehensive system have recently been published, but it is necessary to highlight that it starts from a context characterized by a regulatory framework that is dispersed. In all three models, care policies for the elderly are declared universally accessible despite the fact that the levels of real coverage are far from the potential demand for these services.

In the case of Costa Rica, Law No. 79358 grants the National Council of the Elderly (CONAPAM) responsibility for comprehensive care and public policies aimed at older adults and is established as the governing body of maximum deconcentration, attached to the Ministry of the Presidency. It is led by a Governing Board, with instrumental legal personality and composed of representatives of the President of the Republic, of the Ministries of Health, Education, and Labor. (University of Costa Rica & Presidency of the Republic, 2008).

Executive Decree 42878-MP-MDHIS (2021) formalized the public interest in the National Care Policy (2021-2031) towards the implementation of a support system for care and care for dependency (PNC 2021-2031) and its 2021-2023 Action Plan. This National Care Policy is not a policy for all people with disabilities or exclusively for older adults, because not all people with disabilities, nor all older adults, are dependent. This is a specific public policy for dependent people. (Joint Institute of Social Assistance & Ministry of Human Development and Social Inclusion, 2021)

Statistically, these services are used in a greater proportion by older adults because they are the ones who have the highest prevalence of difficulties in carrying out activities of daily living independently. When the cohort of this population segment increases, additional measures must be taken to provide social services. Recognizing the need to expand the coordination of care and support services, it is intended to advance the following action plans to engage the National Child Care and Development Network as a subsystem of the National Care System. (Joint Institute of Social Assistance & Ministry of Human Development and Social Inclusion, 2021)

In 2022, Law 10192 was approved, which creates the National Care and Support System for Adults and Elderly People in a Situation of Dependency (SINCA). It aims to optimize existing resources and articulate the general or specialized care services provided by public and private institutions, to guarantee the quality of life of people subject to care and caregivers (Legislative Assembly of the Republic of Costa Rica, 2022).

Article 2 of this law establishes its scope of application by referring to public institutions and non-governmental and private sector organizations that provide care or care-related services. Article 4 establishes the target population of SINCA as adults and older adults who are in a situation of dependence, which will be determined according to the dependency scale in force in the country. It also includes unpaid caregivers who require training opportunities, job training, job placement, self-care, recognition of their care work, among other tools that allow them to manage care responsibilities and enter the labor market. While article 6 establishes the principles that govern the law: the universality of care and support services, non-discrimination, progressivity in the implementation and access to services and benefits for all people in a situation of dependence (Legislative Assembly of the Republic of Costa Rica, 2022).

For its part, the Uruguayan government created in 2015 the first National Comprehensive Care System (SNIC) in the region with Law 19,353. From it, the State incorporates into the public agenda the issue of care for dependence and assumes the responsibility of actively participating in the design of solutions aimed at responding to the challenges that demographic and social changes impose. However, the decree that regulates the formation of the National Care Board (Decree 445/16), a multisectoral body that leads the SNIC, does not include the participation of the governing body of policies for the elderly (INMAYORES). This element provides a weak institutional framework for the articulation of policies aimed at this population (Venturiello et al, 2021).

The SNIC is conceived as an inter-institutional system, with multiple intervening actors at the level of the central government, departmental governments, private actors, and civil society organizations. The system is under the orbit of the Ministry of Social Development (MIDES) and works in coordination with the Ministry of Public Health and the Ministry of Education and Culture. (UN & ECLAC, 2015). From Uruguay, it is possible to promote an alternative vision to that established in the region, based on the need to promote care as a fourth link in the social protection system. The target population of the SNIC was the early childhood (children under 3 years of age), people over 65 years of age in a situation of dependence, and people with disabilities in a situation of dependence. Another key population is caregivers, the valorization of their task, recognition as paid work, and the encouragement of professionalization. (MIDES, 2015).

The principles of the system are the universality of the rights to care, services and benefits for all people in a situation of dependence, in conditions of equality; progressivity in the implementation and access to services and benefits for all people in a situation of dependence, in the terms established in the applicable regulations; the articulation and coordination of care policies with all policies aimed at improving the quality of life of the population; equity, continuity, opportunity, quality, sustainability, accessibility of services and care benefits to people in a situation of dependence, as well as the consideration of their preferences on the type of care to be received; comprehensive quality, which according to rules and protocols of action, respects the

rights of recipients and care workers; the permanence of people in a situation of dependence in the environment where they develop their daily life, whenever possible; the inclusion of gender and generational perspectives, taking into account the different needs of women, men and age groups, promoting the cultural overcoming of the sexual division of labor and the distribution of care tasks among all actors of society; and solidarity in financing, ensuring sustainability in the allocation of resources for the provision of comprehensive care.

With this policy implemented, both nations seek to create a new model that allows the articulation of existing services, as well as new services according to current and future needs. The co-responsibility of care that currently falls mainly on families and, within these, on women is enhanced.

In the case of Cuba, Decree 109/2024 establishes as an institutional management mechanism for the implementation, monitoring, control and evaluation of the System at the national level that the governing body will be the Governmental Commission in charge of Attention to Demographic Dynamics, chaired by the Prime Minister within it, the Subcommittee of Care System is created: coordinated by the Minister of Labor and Social Security and composed of representatives appointed by the holders of the ministries of Education, Higher Education, Public Health, Internal Trade, Economy and Planning, Finance and Prices, Foreign Trade and Foreign Investment, the National Office of Statistics and Information and the Cuban Network of Studies on Care representative of the academy.

Likewise, representatives of the National Assembly of People's Power, the Federation of Cuban Women, the Central Workers of Cuba, as well as the national associations that represent people with disabilities seeking the greatest possible integration when it comes to the design and monitoring of policies, will serve as permanent guests to the working sessions of the Subcommission. At the provincial and municipal level, the provincial and municipal groups for the Attention of Demographic Dynamics and the Demographic Observatory, chaired by the governors and mayors, and integrated by the directors at these levels, are responsible for the implementation and the integration of institutions and political organizations linked to the theme is also pursued

In terms of eligibility, Cuba is the only one of the three countries that does not use a dependency scale, but uses disability surveys, levels of dependence, and income levels by the competent bodies, as the case may be, and the decree highlights the possibility of creating new instruments by the responsible bodies (Table 2).

Table 2. Regulatory framework, accessibility, and eligibility

	Costa Rica	Cuba	Uruguay
Access	Universal	Universal	Universal
Regulatory Framework	Executive Decree 42378-MP-		Law creating
	MDHIS (2021)	Decree 109 Bases	SNIC (2015)
	Law 10192, Date:	for the National	
	04/28/2022. Creates the	System for Comprehensive	
	National System of Care	Life Care	
	and Support for Adults		
	and Older Aldults		
	in Situations of		
	Dependency (SINCA)		
Eligibility	Dependency Scale	Disability surveys,	Dependency Scale
		dependency levels,	others such as:
		and income levels	Household/Famaily
			composition
			Income level

Services and coverage in Costa Rica, Uruguay, and Cuba

To compare the types of services for elderly care, services in residences, day centers, home care services, and telecare services were selected (Table 3). The public sector can offer these services, the private sector and the private non-profit sector.

Table 3. Comparison of services for seniors

Type of Service	Description	Costa Rica	Cuba	Uruguay
Residential services	These are services provided in facilities that include accommodation, along with a comprehensive package of support services to carry out basic and instrumental activities of daily life; usually more complex health services. Long-term residences are aimed at people with a severe level of dependency.	Private sector	Public sector	Private sector
		Private nonprofit sector	Private nonprofit sector	Public sector (only as regulator)
				Private nonprofit sector
Home assistance service	These are services provided in the place where the person resides. The main focus of this category is the presence of a personal assistant who supports basic and instrumental daily activities. In addition, support may be provided for household tasks and food delivery. Generally, they are aimed at people with a moderate or mild level of dependency.	Public sector (at municipal level)	Public sector	Private sector
		Private sector	Private sector	Public sector (only as regulator) Private nonprofit sector (not implemented)
		Private nonprofit sector		
Day centers	These are services provided in facilities that do not include accommodation. Day centers usually focus on preventive and recreational activities rather than providing support for daily living activities; therefore, in many cases, they are used as a complement to home services. Their target population is people with mild dependency or no dependency.	Public sector (at municipal level)	Public sector	Public sector (provides services in association with civil society organizations)
		Private sector	Private nonprofit sector	
		Private nonprofit sector	Private sector (recently approved)	
Teleassistance service	These are services provided remotely through information technologies. Since teleassistance does not resolve the need for support to carry out basic daily living activities, it is usually considered complementary to home services. They are generally aimed at people with mild dependency and/or chronic illnesses.	Private sector	Public sector (with a pilot program)	Private sector
				Public sector (subsidy for contracting the service)
				Private nonprofit sector

In the case of institutional services of long-term residences, according to Sanders (2019), around 166,000 people over 60 live in residences for older adults in 12 countries in Latin America and the Caribbean for which data are available. This represents 0.54% of older adults. Uruguay has one of the highest percentages of older adults living in these residences, around 1.9%, and Costa Rica has a rate above the average of 0.89%. In most countries, the proportion of older adults in these residences never exceeds 0.2%.

In the case of Cuba, the number of beds in nursing homes, including those of religious and fraternal institutions, was 12,647 in 2022 (ONEI, 2023), which represents 0.52% of the total number of older adults. This figure is also higher than the average, but lower than that of both countries. It is important to note that the number of beds reported in the yearbook is usually higher than the number of actual beds available during the year.

In the case of both Uruguay and Costa Rica, this service is usually offered by private institutions, whether non-profit or for-profit, with the State acting as the regulator of the service. In the case of Cuba, this service is mostly public, although some non-profit religious institutions participate, always regulated by the Ministry of Public Health (MINSAP).

In Uruguay, residential services are not included in the National Care System, and within it, they are limited only to supervision and accreditation. In the case of Costa Rica, the system does include residences; the quality of these is also accredited, and it is expected to increase the places to cover 20% of the seriously dependent. (Chaverri-Carvajal & Matus-López, 2021)

The most developed service in Uruguay is the Personal Assistants at Home Program, which is mainly provided by the private sector because, in the private non-profit sector, it has not yet been implemented. The State only acts as a regulator, delivering subsidies for the purchase of professional care. In the case of Costa Rica, care services are oriented to home care. They include up to 80 hours per month (Chaverri-Carvajal & Matus-López, 2021) and are provided by the public sector at the municipal level, the private sector, and the private non-profit sector. In the case of Cuba, the home care service is provided by the public sector and is restricted to older adults or people with disabilities who live alone, who do not have family members obliged to provide help or cohabitants, and who are bedridden or with restricted mobility. The private sector provides this service has very high prices, which excludes an important part of the families from its use.

Day centers have a low relevance within the care services for the elderly in Uruguay and is a service provided by the public sector in association with civil society organizations. In the case of Costa Rica, day centers are aimed at moderate and severe dependents and are expected to cover 10% of this population. (Chaverri-Carvajal & Matus-López, 2021) They are operated by the public sector at the municipal level, by the private sector with and without profit. In the Cuban case, this is one of the most relevant services. It is offered by the State, although the private non-profit sector and, more recently, the private sector also participate, but still with a low level of development.

Finally, as for the telecare service, in Uruguay, it is for people over 70 years of age with mild or moderate dependence and a personal support network. It is provided by the private sector and the private non-profit sector; the public sector provides a subsidy for contracting the service based on the income of the household and the number of people who compose it. In the case of Costa Rica, it is expected to achieve coverage of all serious dependents and 70% of moderates with telecare. (Chaverri-Carvajal & Matus-López, 2021) It is a service offered purely by the private sector. In the Cuban case, this service is in the testing phase and has very little development.

Financing and quality standards in Costa Rica, Uruguay, and Cuba

Care in Latin America and the Caribbean follows a familiar and commodified scheme, with a scarce supply of public services that has the problem of financing as its greatest obstacle. (Inter-American Development Bank [IDB] & Pan American Health Organization [PAHO], 2023) The mechanisms to finance care services and how to guarantee their quality, avoiding the segmentation and generation of well-differentiated quality standards for different levels of income, is a core issue for the Latin American region. The financing of care systems in the region has been carried out through income from general taxes, premium mechanisms, or through the payment of fees by users (co-payments). The combination of these has also been common.

In the case of Costa Rica, existing services are financed with resources from tax collection through general taxes, payroll taxes, and other contributions, such as the resources of the Social Protection Board that reinvests the surpluses of the lottery between different programs. (Medellin et al., 2019) Estimates indicate that the system will have an annual cost of $235 million USD, around 0.8% of GDP (Chaverri-Carvajal & Matus-López, 2021).

In the case of Uruguay, the system is financed through general income for the most part. The co-payments made by users to make use of some benefits (such as personal assistants or telecare) are intended to cover the subsidy of those who are not in a position to pay for the service, so it is understood that the system is governed by the principle of solidarity in its financing. (MIDES, 2015) estimates for Uruguay that, if fully implemented, with the desired coverage, the SINC would represent 0.19% of Uruguayan GDP (at 2017). However, due to budget cuts, the amount allocated to the system was considerably lower. The latest annual report of the SNIC, at the end of 2017, shows that the budget executed by the Ministry of Social Development in relation to the system amounted to 0.02% of GDP in 2016 and 0.04% in 2017, resulting in an amount of approximately 30 million dollars in two years of operation. (MIDES & SNIC, 2020). It is necessary to point out that the fact that the system is financed by general incomes that are defined in the National Parliament, with a GDP investment of 0.04% (IDB & OPS, 2023) implies that the continuity of the financing of the SNIC depends on political negotiations that are subject to the agreements within the framework of the distribution of political forces for each period of government. This has become evident after the change in government management in Uruguay and the new national budget law approved, which accounts for a process of weakening of the system.

In both countries, support from the public sector through funding transfers of resources to non-profit institutions that provide care services is common. It is necessary to highlight that the mechanism of not providing care services directly by governments and making monetary transfers, which may have a specific purpose (that is, a kind of coupon for the purchase of services) or be freely available, is common in the region. However, free money transfers have been criticized by a part of the literature because they reinforce the traditional model of unpaid family care and waste the opportunity to support the creation of formal employment in the care economy and to contribute to the reduction of gender inequality in the labor market. (IDB & OPS, 2023)

In Cuba, institutionalized care services are mostly financed by public funds, whether they are resources allocated from the national level or resources from municipal budgets. However, updated data are not collected at the country level regarding how much of the GDP is dedicated to care services in an aggregated way. These services may receive donations, but these represent a tiny part of the funds. The users of the services make a co-payment, and in case of not having sufficient resources to assume it, they or their families are covered totally or partially by social security.

In relation to quality, in the case of Costa Rica there are standards in terms of human resources and physical plant that apply to all public and private establishments. However, a monitoring system is not established with the use of indicators focused on verifying the quality of the care provided. An exception is the certification of long-term households by the Ministry of Health, but the indicators focus on inputs (physical plant, human resources) and not on processes and results. (Medellin et al., 2019)

In the care system of Uruguay, the way to ensure the quality of services has been visualized as associated with the training and professionalization of human resources. In addition, certification, accreditation, and improvement processes for long-term residential areas are established, setting standards regarding the physical plant, human resources (ratio and training), the services that must be provided, and the objectives that these institutions must pursue.

In Cuba, Resolution No. 355, dated December 6, 2018, of the Minister of Public Health, establishes the procedure by which the health personnel in charge will execute the control actions that allow evaluating the quality of the care provided to sick, disabled, or elderly people, in the institutions of the National Health System.

In general, the three countries have standardized standards that set minimum requirements for infrastructure, staffing based on the number of residents or the services provided. However, there is much less development in the mechanisms that allow for evaluating and monitoring the quality and effectiveness of the service provided.

Conclusions

The three Latin American countries are already suffering from considerable levels of aging, which will lead to strong pressure on the demand for care for older adults in the coming years. For this reason, the three countries will have to double their efforts in the coming decades, which, despite the progress, is still insufficient. Cuba has the largest number of older adults in absolute terms, which is a criterion to consider when designing the services and their management mechanisms. Quality care is one of the tools to promote healthy aging and a higher quality of life for older adults, as they contribute to maintaining the maximum possible time of functional capacity. In addition, elderly care policies can have many positive externalities. Not only is it a matter of better quality standards for the care provided to them, but they have key impacts on gender inequalities and allow the release of a mostly female workforce towards high productivity activities, and generate new Jobs, something essential to advance gender equality and equity.

Therefore, this study has comparatively analyzed the key characteristics of the systems of the three countries, trying to highlight the positive and negative aspects and detect the possible good practices to be implemented in the future Comprehensive Care System in Cuba.

Strategies to address the care needs of the elderly in the three countries are based differently on the role of three key actors: the public sector, the private sector and families. In the cases of Costa Rica and Uruguay, the participation of the private sector with and without profit is greater. Although in Cuba the development model is based on a greater prominence of the State, Costa Rican and Uruguayan experiences can be a good benchmark for achieving a better articulation of the private sector with the public sector. In a context of expansion of private participation in the provision of care services, this acquires special relevance for the Cuban case. Institutionalized care services in the Cuban case are insufficient, since their demand exceeds the state's capacity to provide them. The experiences of Uruguay and Costa Rica are characterized by greater heterogeneity in service providers without this implying supplanting the role of the State. This logic is relevant in the improvement of elderly care services in Cuba.

The role of governments is fundamental in ensuring access to affordable quality services, through the development of national systems that pay tribute to a better articulation of care policies for the elderly. In both Costa Rica and Uruguay, the participation of more than one ministry, the public and private sectors, and service users in the formulation and implementation of care policies is common; this is essential in order to ensure coordination between social and health systems. Existing care policies in Cuba are also multisectoral and are coordinated across the board by various state institutions. However, fragmentation is evident between them, and, in general, in their design, they do not integrate the private sector that participates in the provision of services.

Another lesson from the cases of Uruguay and Costa Rica for the Cuban case is that integration and coordination are not automatically guaranteed after the approval of the care systems. It is necessary to emphasize that the State must not only participate as a service provider, but that, in the experiences studied, its role as a regulator is key. The latter includes the existence of monetary transfers associated with care services.

Cuba is the only country that does not apply functionality measurement tools to leave out of care for the non-poor, or less severe dependents. The design and implementation of a dependency scale would allow the Cuban model to have a scientific tool with greater robustness to determine the situation of dependence of each older adult and be more efficient in the service offered. Cuba is also the only country whose services are mostly state-owned. None of the three countries considers income levels to provide the service.

Uruguay and Costa Rica have the same financing scheme. The lack of fiscal generosity is what makes it difficult to increase service coverage. In addition, countries must follow the international trend of prioritizing home services over residential services to take advantage of the cost advantage that the former offers. A law that requires the construction of national long-term care systems does not translate into: a) sustained political support over time; b) more funding; c) increases in the coverage of care services for older adults.

The construction of care systems is not only a matter of renewing and improving care services, but it is a commitment to achieve greater levels of articulation and integration between care policies that are usually closely interconnected. In the cases of Uruguay and Costa Rica, at the same time that the systems were developed, the generation of statistical sources was also developed, which allows for identifying how many funds are socially allocated to the objectives of the care system and the impact that care policies have. In the Cuban case, this is another lesson to consider, starting from the lack of availability of official statistics that exist today.

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