

## Research Report

# It Is Not Just Mortality: A Call From Chile for Comprehensive COVID-19 Policy Responses Among Older People

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## Abstract

**Objective:** Provide a synthesis of the COVID-19 policies targeting older people in Chile, stressing their short- and long-term challenges.

**Method:** Critical analysis of the current legal and policy measures, based on national-level data and international experiences.

**Results:** Although several policies have been enacted to protect older people from COVID-19, these measures could have important unintended negative consequences in this group's mental and physical health, as well as financial aspects.

**Discussion:** A wider perspective is needed to include a broader definition of health—considering financial scarcity, access to health services, mental health issues, and long-term care—in the policy responses to COVID-19 targeted to older people in Chile.

**Keywords:** COVID-19, Health care policy, Health-related quality of life, Policy analysis

On January 30, 2020, the World Health Organization (WHO) declared the COVID-19 outbreak a Public Health Emergency of International Concern, due to the emergence of cases in five WHO regions within 1 month (WHO, 2020a). On February 8, 2020, Chile declared a national health emergency in the country, beginning Phase 1 of the epidemic (no cases reported), to deal with the imminent arrival of the virus (Diario Oficial de Chile, 2020a). On March 3, 2020, the first case was announced—a man who had returned to Chile from Southeast Asia—moving the country into Phase 2, that is, the presence of imported cases exclusively.

To deal with this new scenario, on March 6, 2020, the Ministry of Health (MoH) issued a new legal order to

increase its powers and face the stage of the local spread of the virus (Diario Oficial de Chile, 2020b). Twelve days later (March 18, 2020), President Piñera declared a state of constitutional exception due to the national catastrophe (Diario Oficial de Chile, 2020c), after the WHO declared the COVID-19 a pandemic on March 11 (WHO, 2020a). This decree gave the government the power to restrict freedom of movement and association, with some measures implemented at the national level (e.g., curfew and prohibition of massive events) and others at the local level (e.g., quarantines announced on a weekly basis and sanitary checkpoints), depending on the local COVID-19. Public transportation has been available since the beginning of the pandemic without interruption.

By June 23, 2020, Chile had 250,767 people with a confirmed diagnosis of COVID-19. The number of cases has been particularly high in the metropolitan region (which includes Santiago, the capital), which accounts for nearly 40% of the country's total population (Gobierno de Chile, 2020a). Chile has the highest testing rate in the Latin American region, with almost 1 million tests carried out by June 23 (Gobierno de Chile, 2020a; Institute of Health Metrics and Evaluation, 2020). Overall case fatality remains low (1.8%), but a recent change in the definition of "COVID-19 deaths" used by the government could change this figure. Confirmed cases reached 4,505 but the government informed that more than 3,000 deaths occurred in the same period without a confirmed COVID-19 positive test (Gobierno de Chile, 2020a). After 6 weeks of full lockdown, intensive care units (ICUs) in the metropolitan region have an occupation rate of 95%. Nationally, ICU occupancy rate reached 91% by June 22, with 2,009 people connected to mechanical ventilators; this number has increased (from 63.1%) since periodical reports started in mid-April (Gobierno de Chile, 2020a; Sociedad Chilena de Medicina Intensiva, 2020). Currently, people older than 60 years represent 16% total cases, but 51% hospitalization and 85% of deaths (Gobierno de Chile, 2020a).

This research report intends to provide a critical analysis of the policy response to COVID-19 for older people (OP) in Chile, calling for a more comprehensive response that considers a broad conception of health. This article describes the main policies adopted so far and outlines short- and long-term policy challenges for the country. First, we briefly describe the social context of OP in Chile to understand properly the country's structural conditions in which COVID-19 policies are being introduced.

### The Social Context of OP in Chile

Chile is a developing mid-to-high-income (2018 gross domestic product per capita purchasing parity power = US\$25,222), highly unequal country (Gini coefficient = 0.55), which is currently facing a process of rapid population aging: While the share of people older than 65 years is 12%, in 2020 it is expected to reach 25% by 2050 (United Nations, 2019a). The regional distribution of OP is heterogeneous, with the central regions showing higher shares of people older than 65 years (around 14% for Valparaíso and Ñuble) than northern regions (less than 10% for Atacama and Antofagasta; Instituto Nacional de Estadísticas, 2017). The situation of OP there unfolded in a context characterized by an unstable economy, meager welfare state provisions, limited education and health systems, and large informal sectors in the labor market (Madero-Cabib, Azar, et al., 2019; Madero-Cabib, Biehl, et al., 2019). Social security is a recurrent topic of debate due to low pension incomes, as well as increasing long-term care (LTC) needs in the population. A United Nations report (2017) estimated that the proportion of retirees receiving less than

the minimum pension income (approximately US\$368 per month) is 73% when state subsidies are not considered and 47% when subsidies are included. The legal age of retirement is 65 for men and 60 for women, although the difference between legal and effective age of retirement is around 6 years for men and 7 years for women, one of the highest among the Organisation for Economic Cooperation and Development (OECD) countries (Madero-Cabib, Palomo Vélez, et al., 2019). Unsurprisingly, the share of workers aged older than 65 years in Chile grew from 15.9% in 2002 to 24.5% in 2018 (OECD, 2020), among which approximately 41.0% work informally (Centro de Estudios de la Vejez y el Envejecimiento [CEVE-UC], 2018). Additionally, negative stereotypes toward OP persist in Chile: 72.9% of Chileans think that OP are not able to manage on their own (Thumala et al., 2015). Furthermore, although the country has nearly universal health coverage (Frenz et al., 2014), access to LTC services remains limited and is mainly provided by families that bear significant health and financial consequences of care (Hojman et al., 2017; Villalobos Dintrans, 2019). In addition, there is a significant (unknown) number of informal LTC facilities—the so-called "clandestine facilities"—that are completely unregulated. Information about the location and features of these informal facilities is scarce, although they could be hosting many OP.

### Policy Response to COVID-19 for OP

In mid-March 2020, the Chilean government gathered an expert advisory group—including epidemiologists from the MoH and several universities—to plan the response to COVID-19. Since then, restrictions have increased, with the country moving rapidly toward more stringent measures (University of Oxford, 2020). Although there are no statistics available, the government has insisted that the main cause of increasing infections is the low level of compliance with measures (Ministerio de Salud, 2020a). In addition to the general measures taken, specific regulations for OP were also implemented (Gobierno de Chile, 2020b; Ministerio de Salud, 2020b):

- Mandatory home-quarantine for people older than 80 years (changed to 75 years on May 15).
- Visits to people in LTC facilities were banned.
- Day centers for OP were closed.
- Some OP-specific health prevention activities were canceled.
- Meeting ban for all OP clubs.

Many of these recommendations follow guidelines issued by international institutions. These guidelines, nevertheless, also highlight the need to protect OP in other dimensions, considering that restrictions may affect their mental health and well-being (Centers for Disease Control and Prevention, 2020; WHO, 2020b). Therefore, as a complement to the general and specific restrictions, other measures were taken (Gobierno de Chile, 2020b):

- A hotline to provide emotional containment for OP.
- A website for community support (<https://www.gob.cl/cuentaconmigo/>).
- Special permits for buying food and drugs for OP living in municipalities in quarantine.
- Special permits for people working in LTC facilities.
- “Sanitary houses” for nondisabled people who are unable to comply with mandatory isolation (an initiative started in April and relaunched in May).

The National Service for Older Adults (*Servicio Nacional de Adulto Mayor*, SENAMA) is currently setting a more holistic plan to prevent the spread of COVID-19 in roughly 220 LTC facilities throughout the country (which corresponds to less than 25% of formalized LTC facilities in Chile). This plan is based on a public–private partnership that aims to ensure access to personal protective equipment, staff replacement when needed, and setting transitory LTC services for facilities’ residents with COVID-19.

In late May, the government launched a food supply campaign with home delivery of boxes of basic supplies. This initiative responds to the increasing level of unemployment and it is expected to benefit families (including many OP) living in vulnerable settings. To date, the food supply chain has not been the main concern, and food prices have remained stable during the crisis (*Instituto Nacional de Estadísticas*, 2020). Finally, an “emergency family income” for households financially affected by the COVID-19 was announced, consisting in a transfer of roughly US\$120 per person (up to four) for a period of 4 months (*Gobierno de Chile*, 2020c). Both initiatives are mean-tested.

The WHO advocates for “healthy aging,” understood as “the process of developing and maintaining the functional ability that enables wellbeing in older age” (WHO, 2015). Consequently, it is debatable whether the current policies are aligned with this concept. Although the set of restrictions targeted toward OP are understandable as a first-reaction policy to control and deal with an unknown virus, the short- and long-term challenges of these regulations should also be taken into consideration. Those enacting these measures should not just ask about unintended consequences in OP, but also people’s ability to comply with these restrictions. This should consider, for example, the inability to stay at home (due to a need to work or access services), the need to make residential arrangements (moving in or out from the usual home), and restrictions’ effectiveness (e.g., mandatory quarantine for people older than 75 years who live in a household with unrestricted persons).

### Short-Term Challenges

First, most regulations intended to protect OP include severe restrictions on movement and social contact. “Social

distancing” was the concept used to communicate the initial set of restrictions; consequently, the first measures recommended limiting contact with OP, whether they lived in their own houses or in nursing homes. However, “social distancing” becomes isolation in a country in which more than 30% of the OP live on their own or with another older person (*United Nations*, 2019b). Furthermore, the social context of OP in Chile should be considered as general and OP-specific measures are likely to worsen their conditions. For example, mandatory quarantines are expected to create a barrier for OP to satisfy their basic needs (e.g., getting supplies) and also to generate income, particularly considering their low pensions and informal jobs.

Second, the effects restrictions have on the mental health of the population should be taken into account. This is particularly important in Chile, a country with a relatively high burden of disease due to mental conditions and low access to health care services (*Vicente et al.*, 2016). Specifically, among OP, the prevalence of mental health problems is higher and consequences are more harmful than in younger groups (*Fuentes & Albala*, 2014); data from the MoH show that mortality rates by suicide are significantly larger for the older than 65 years age group.

Third, the provision of health services for non-COVID-19 diseases has been negatively impacted due to the partial closure of nonessential services. Furthermore, even available services could be susceptible to new barriers to access to care. For example, when comparing the sum of weeks 1–4 of 2020 (January) with the sum of weeks 20–23 (May), emergency room data show a 38.9% and 34.9% drop in consultations for acute coronary syndromes and stroke, respectively, among OP (older than 65 years; *Departamento de Estadísticas e Información de Salud*, 2020). This is relevant considering the sharp increase in noncommunicable diseases observed in the country during the past decades (*Bambs et al.*, 2020). Although there is no publicly available data yet, similar figures could be expected for cancer treatment, cardiovascular prevention, and other non-COVID-19-related essential services. Extra efforts will be required to “return to normal” in terms of health care services. For instance, in June 2020, the MoH informed that mostly due to the social outbreak started in October 2019, waiting lists of the National Program “Explicit Guarantees in Health” (or GES) which legally ensure access, financial protection, and service quality to 85 diseases and conditions increased from 7,944 to 19,653 between December 2019 and March 2020 (*Chávez*, 2020). This suggests that this number is expected to increase still more due to the prioritization of COVID-19 patients in the health system.

Fourth, support for LTC services outside of authorized LTC facilities is required to ensure continuity of care. The impact of policies targeting institutionalized OP is uncertain considering the number of unauthorized LTC facilities. A strategy to grant access to personal protective equipment, staff replacement, and technical support to implement prevention measures in all LTC facilities is needed. Additional

measures are required to reach OP with functional dependency living in the community and caregivers providing LTC services at home; these people are currently excluded from sanitary houses. Moreover, the care services post-hospital discharge for OP recovering after COVID-19 are also expected to increase the demand for LTC services in different settings.

Finally, the country needs guidelines and protocols to confront ethical issues arising from the “last-bed debate.” As seen in other countries, this discussion is required to help health professionals making decisions and that these are not made based exclusively on chronological age (Emanuel, 2020; Wikler, 2020). This issue has been debated in the press; age-based prejudices need to be acknowledged when supporting different views (Browne Salas et al., 2020; Santibañez, 2020).

### Long-Term Challenges

The COVID-19 crisis has demonstrated a series of deficiencies in the health system and public policies for OP in Chile. While rapid changes to deal with the short-term challenges of the pandemic are necessary, the country can also learn from this experience and plan for structural, long-term adjustments. One of the main issues arising from the crisis is the situation of the institutionalized OP. LTC facilities have shown to be structurally vulnerable and therefore unsafe against the threat of COVID-19. Hence, a key lesson from the pandemic calls us to rethink the public health response to meet the needs of OP. Here, we identify at least two broad areas of action for the coming years.

First, the country needs to reconsider its LTC policy. So far, two main features have characterized the government’s response to the increase in LTC needs: institutionalization and supply-side subsidies. This strategy requires changes, considering its problems in terms of efficacy (solving the LTC needs and services coverage), efficiency (providing LTC services at lower cost), and equity (alleviating the unequal burden of care; Villalobos Dintrans, 2018, 2019). The country needs to move toward the implementation of an LTC system that addresses the WHO’s call to implement these systems in each country (WHO, 2016). This would better meet the increasing LTC needs in the Chilean population, while also offering different schemes of service provision, including not only institutionalized but also home-based LTC. Many countries have experiences with new ways of providing care, moving away from institutionalization (in line with the concept of “aging in place”) and offering services closer to people’s preferences and at a lower cost (Colombo et al., 2011; Swartz, 2013). Additionally, an LTC system can also be viewed as a strategy to improve OP social conditions: While the pension system addresses the income side of the problem, an effective LTC system can help reduce OP expenses, contributing to improving their health and well-being (Villalobos Dintrans, 2018, 2019).

Second, even a home-based LTC system cannot eliminate institutionalization as an alternative. The country’s

first challenge is moving away from financing LTC facilities as its main policy response. Assuming institutionalization is still the best option for some people, the second challenge is to tackle the fragmentation of social and health services to improve quality. This has proved to be a key issue in many countries, as the COVID-19 has illustrated: A large share of COVID-19-related deaths reported by several countries came from LTC facility residents (Comas-Herrera et al., 2020). This change requires rethinking the role of the government and highlighting its importance in setting and regulating quality standards in LTC services, a challenge for every country (Castle & Ferguson, 2010; Centers for Medicare & Medicaid Services, 2020).

### Conclusions

Thus far, Chile has experienced relatively few COVID-19-related deaths compared with other countries. Nevertheless, results need to be critically reviewed when discussing OP-targeted policies. The WHO defines health as “a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity” (WHO, 1946). New measures to fight COVID-19 need to include this wider perspective of health that considers social, mental, and non-COVID-19 health conditions, particularly for OP. This article aimed to increase the awareness of OP policy-related short- and long-term challenges, by using the current pandemic as an opportunity to rethink the traditional public policy response regarding the needs of this population group.

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### Conflict of Interest

We, the authors of this manuscript, certify that we do not have any actual or potential conflict of interest, conflict on ethical standards, financial and non-financial interests and compensations, ethical approvals, personal relationships

with people or organizations, which could inappropriately influence, or be perceived to influence, our work.

## Author Contributions

P. Villalobos Dintrans, J. Browne Salas, and I. Madero-Cabib planned and wrote the report.

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