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Speaker 1 ([00:00](#)):

Welcome to our podcast series on Aging in Developing Countries. I'm Barbara Bowers Amerit to professor at the University of Wisconsin Madison School of Nursing. I'm here today with Assistant Professor Jing Wang from the University of New Hampshire School of Nursing, and she'll be talking to Dr. Patrick Wolds. Dr. Wolds is a geriatrician and Sao Paulo Brazil. He's professor at the Bocato Medical School at Sao Paulo State University. He's also a researcher at the Brazilian National Front for strengthening long-term care. This is a network that promotes and supports initiatives for long-term care and advocates for stronger public policies for older adults in long-term care. Dr. Wolts also holds a PhD in public health. He served as director of the Department of Geriatric Medicine in a long-term care facility in Brazil as a consultant to the Pan-American Health Organization for the long-term care sector in Latin America, and is currently the executive editor of Geriatrics, gerontology and Aging.

Speaker 1 ([00:57](#)):

It's the Scientific Journal of the Brazilian Society of Geriatrics and Gerontology. He's particularly interested in national and international collaborations to develop and implement long-term care data systems. Now a bit about Brazil, a little background. Brazil is a middle income developing country with a population of over 212 million. The latest information on aging in Brazil estimates that 13.7% of the population is now over 60. 60 is the age at which Brazilians are considered older adults, and it's actually the cutoff that many developing countries use to determine when people enter into old age. The current life expectancy for Brazilians is 76.4, up from 70 in the year 2000. The percentage of people over 60 in Brazil is projected to reach 25% by 2050. So Brazil is clearly a rapidly aging country. The fertility rate in Brazil has steadily declined from six in 1950 to the current 1.7. While free healthcare is considered a right for all Brazilians, they continue to experience access challenges as the country with the largest landmass in the Americas and much of it dispersed rural populations, Brazil continues to struggle with achieving their universal access goal. Dr. Wol, welcome to our podcast series. Now I'll turn it over to Dr. Wang. Thank

Speaker 2 ([02:21](#)):

You, Dr. Bowers. Hello Patrick. Could you please give us an overview of long-term care in Brazil?

Speaker 3 ([02:29](#)):

Yes. Couple weeks ago, the Pan-American Health Organization asked me to develop a report exactly on how long is structured in Latin American owned. So when started to return information and reports, and Brazil is unfortunately a lot back when comparing to chi to or Hawaii to Costa Rica, for example. We don't have policies, national policies for care. So most of care to tenant older people is, uh, <inaudible> inside the, the <inaudible> homes, Chile and <inaudible>, for instance. They have governmental or financial support to hire personal assistance. They have financial support to start, uh, building or maintaining space centers for people. And unfortunately during Brazil, we only have to a few cities pay center. We don't have any kind of, uh, fundamental and financial support for hiring personal assistance.

So hire formal caregivers. So most of the care really done by the families and mostly by women inside the families as most Latin American and probably low middle income countries,

Speaker 2 (03:55):

I think family plays an important caregiving role in countries around the world. As you just said, it's quite helpful to have support to hire assistance at home. What about residential long-term care? Is that developing in Brazil and what does that look like?

Speaker 3 (04:13):

We have long-term care facilities that are good for profit. They work in the, some of them are keen to European or North American facilities. We only have small number of specialized care homes for, for dementia for people living with dementia. For reasons, I guess we only have probably two or two in the county that are specialized. For example, we, for people living with dementia, we have a high number of, uh, non-profit care homes. So they are what we call here at student traffic homes. So they usually have a financial support from the municipalities to pay for their use for water for ING material, but they usually don't have support for healthcare demands. Brazil has one of the, the biggest unified health system. So supposedly healthcare should be free for all citizens, but we know that people, uh, living with dependency inside their homes and in long-term care facilities, they usually have difficulties reaching healthcare system. So usually they try to have some attention, usually primary care, but to have the physicians, the nurses going to the homes where people are living with the dependancy, not all cities have personal do visits in homes. And when another citizen is living in car homes, it's even more difficult to have health personal going inside the homes to fuel the health demands that these people need.

Speaker 2 (06:01):

How about funding for both home and residential care? Is that mostly private pay?

Speaker 3 (06:09):

Yes. For the, the for-profit homes, they are a hundred percent based on families to paying for this kind of services. Within the nonprofit homes, they usually have access, uh, when the, the public state prosecutors initiate a kind of, of legal action for vulnerable older person to get access to, to these facilities. So mostly when the public prosecutors identify with other government sectors, particularly for the social assistance that an older people doesn't have family or doesn't have funding living in a nonprofit home, the government issued a minimal for this person. But most of this money goes to the institution to pay for the, their needs. And usually a small proportion, less than five or 10% of these pensions or retirements, uh, funding goes to the individual, uh, for their, uh, healthcare needs when they, they have sometimes to pay for a medication or to pay for a healthcare appointment with a physician. So mostly they have access when the public prosecutors or the other equipments and leading dealing with social assistance help these people getting to their homes.

Speaker 2 (07:37):

I assume it could be difficult to get a public preor to take these cases. So what happens to people who don't have a public preor working on their behalf

Speaker 3 (07:50):

When it's, uh, something really difficult to, to understand? Because currently we don't have a national database to understand the number of, uh, homes we have in Brazil. The last census on the sector was

in 2010, and then at, at the time it was exd on 2,500 facilities in Brazil, only 30% of the cities in Brazil has had at least one facility. We are developing a research in Brazil from last August. Currently we ex another of facilities in more than 7,000 in Brazil, but we are still looking for not registered facilities. They are difficult to access in some parts of the country, and the country is really huge. It's a continental country. But yes, we have a, a lot of durable order people that did not have access to the facilities because it's really difficult to have facility, particularly in small cities. So they sometimes live in chronic hospitals that have, uh, people living for a long period of time.

Speaker 3 (09:01):

Uh, I'm not sure how it's, it's called in, in other countries. We, we call here. And it's something interesting is that according to national solution, in the long-term, tech facilities don't have to hire healthcare professionals. So they are mostly related to housing, to shelter, particularly for the nonprofit homes, sheltering, vulnerable people, and obviously this resident healthcare needs. And so when they develop health needs, these small facilities or facilities in small cities, they try to get access using the national health system that is <inaudible>, but it, it's no difficult to have all the medications these residents needs and sometimes even helping with nursing procedures, small facilities sometimes can hire caregivers from <inaudible>, but usually losing the residents funding from this <inaudible>.

Speaker 2 (10:08):

Patrick, you made a distinction between registered and non-registered homes. How are they different?

Speaker 3 (10:17):

Yeah, for our home to be registered, they have to complete some requirements from the national legislation, including infrastructure, a new number of formal caregivers according to the level of dependency from the residents. So for, I guess it's one caregiver for, I'm not sure, but I I think it's 10 older residents south. Any kind of difficulties in activities of <inaudible>? Well, the residents have difficulties whenever reduces to a caregiver for eight. And when they're total the payment, I guess it's one caregiver for each four or six residents, when a small facility is particularly count, count, answer to all these requirements, they don't register. They, they only offer their services in a local community. They usually are for profit, but they are small. They don't have health professionals. They don't have, uh, sometimes funding for buying personal protective equipments and for example, passion for covid. Um, but they probably find it easier to survive without having to apply for all the requirements that national sistance on state.

Speaker 2 (11:39):

So what's the advantage of being registered then?

Speaker 3 (11:43):

Well, one guest being registered, they can offer their services, particularly for profit care homes and their nonprofit care homes. They can ask permission exactly to receive their pensions and retirement funding from the older residents leaving inside.

Speaker 2 (12:03):

So what you have told us is that nursing homes provide mostly social care that people in nursing homes still need to make their own arrangements to pay for medications and healthcare. The registered homes

offer some healthcare depending on the dependency level of the residents. So who works in these homes and how are they trained?

Speaker 3 (12:29):

Yes, for working as a a formal caregiver, usually they have to participate in training, but you don't have legislation setting where formal caregiver as a profession, for instance. So there is no standard to train these caregivers. Usually the the workforce, uh, depends highly on funding from each their homes. So when they have fundings, they can hire nurses or physicians. Most of the physicians are hired just to visit the residents. For example, once a week or twice a week. Most of them don't have doctors, but I'm not sure about the number. But when they have a nurse hired the facilities, usually it's because they have not only caregivers, but they have registered nurses. And when they don't, they are not registered nurses, what they are called. Yes, when facilities hire is not graduated, uh, nurses, we need to have registered nurses, parents from these workforce. So it's more common to have nurses when they are hired. Not only caregivers, but they hire not the silent nonsense for nurses.

Speaker 2 (13:46):

So the workers you have just described are found in registered homes then who works in non-registered homes then

Speaker 3 (13:57):

Mainly caregivers that have probably, they have training on regular, usually from six months or less than six months. It's not, we don't have a standardized, uh, training for caregivers, but mostly care provided from hybrid caregivers in this small facilities.

Speaker 2 (14:19):

And could you tell us where's the training done?

Speaker 3 (14:23):

Well, uh, some scientific, some at universities or some scientific societies like the Brazilian Iatric Society, they offer this kind of training. There are some schools related to preparing younger people to enter the work markets. And they have these technique process is what they call that usually have six months or no more than one year of training. What,

Speaker 2 (14:51):

What about training for home care workers? Is it the same?

Speaker 3 (14:57):

Not necessarily, because this training is not, do not have national standards. So in one region of the council, the training could be for a short period and with minimal requirements to understand how to help, uh, people with difficulties for doing activities. And sometimes the, the courses are longer for a year and with more practice. So really depends on the region and what kind of society or institution is given this training. Because when you want to work as a caregiver, particularly in why you have to participate in a course that is certified by the government, then they can be called personal assistant and funding from the government to pay for this personal system at home. Usually they can't be related, they cannot be, uh, related from to the family. So the, it's not for transfer money to the family. So if you

want to work as a caregiver, you do the parts and then you offer yourself to work, but not in your own family.

Speaker 2 ([16:09]):

Thank you, Patrick. So is there any oversight, any regulatory agency that comes in and say you meet the standards or you don't meet the standards?

Speaker 3 ([16:24]):

Yes. It's the also relevance. When facility wants to be registered, they have to send a requisition or to fill a form, and then the household veterans go to this facility and says, okay, if you are not hiring someone to do the cleaning to care for the their meals, you have this kind of requirements. If you are having your own, uh, personnel working for you and for preparing the meals inside the homes, you have another kind of requirements. And for the caregivers, they usually try to understand weekly residents have higher on lower degree of care dependency to understand how much caregivers are needed for huge possible.

Speaker 2 ([17:11]):

So Patrick, is the process repeated or is it just one time when they apply to be registered?

Speaker 3 ([17:20]):

Before the pandemic, they usually have the first visit. And when the facility doesn't see all the requirements, they usually states a period when they are coming back to understand if the facility completed all the requirements or not. But after the pandemic, they could be prosecutors to the facilities, particularly those small facilities, because we had, I'm not sure how much, but a lot of facilities closing after the, the pandemic because they can't pay for the abuse. They can't buy means they can't hire more caregivers because when their caregivers are ill, it's difficult to hire new, uh, workforce. So a lot of, uh, small facilities closed and then the, the residents didn't have another facility to enter. After that, the covid prosecutors start getting more in touch with these facilities to help them to assure, uh, most of them received the funding that the federal government delivered, I guess last May last now May, 2020, but it stopped I guess in last January. But it's only when they have more close and repeated visits to, to the facilities really something that it's regional in, in states like Sao Paulo or Janeiro, the health surveillance teams are bigger and then they can go to make inspections twice a year at least. But in the northeast region, usually they have visits, I don't know, once each three years, five years or sometimes they never.

Speaker 2 ([19:09]):

What about the specialized health workers, nurses, doctors who are caring for patients in nursing homes or in their own homes? Are there many healthcare providers trained in geriatrics?

Speaker 3 ([19:25]):

No. I guess 2018 there was assumptions to understand how much geriatricians we have in the country. And we have a huge deficit on the number of geriatricians in the country. Dermatological training is something that's not standardized for the county. The President Society of Ology have anyone certificating process to, for, uh, health professionals that want to provide their ontological training recognize, but the profession, societies, some usually they don't offer any kind of visibility or help having training this kind of chronological needs. So particularly for understanding what is personal centered

care, I guess we are still, well, it's inference. We, we don't have this concept understand and discuss it both in the academy and particularly in the long-term care sector.

Speaker 2 (20:29):

So what care do you think that most families would expect for their older family members?

Speaker 3 (20:37):

Yeah, so I guess most of the family want to gain access to medication to help caring for older adult and probably they try to reach this kind of expectations, probably not related to improving the quality of care.

Speaker 2 (20:56):

So if you went into a care home, can you think of one or two things that you would observe that would tell you this is probably good, it's probably providing quality care?

Speaker 3 (21:10):

Yeah. Well, I would try to observe how the workforce try to understand and to build relationships to engage with the residents so they can easily understand their needs, their option of their demands when they are on a difficulty or a crisis or when it's a time to, to understand they need end of life care. So I would try to to observe how the, the workforce build relationships with the residents. I guess how the, the cartons ize the activities for the residents. They're not only treated as sheep in, in a, a large building, if they have some meaningful activities,

Speaker 2 (21:57):

What happens to someone living in a care home who becomes much more dependent than when they first arrived

Speaker 3 (22:05):

In some small facilities, if you get access to these facilities, having any ability to deal, to cope, your reflect and then you get new or decreases your ability. Some facilities have contacts with the family that if this happened, they had to go to another kind of facilities. Usually the nonprofit facilities that have receive these residents through the public prosecutors, they don't have this option. So they have to hire nurses and to increase their workforce, but they don't have the option of transferring these resident to another facility.

Speaker 2 (22:48):

Do you use ma many volunteers in nursing homes or hospitals to help take some of the burden off the staff? Yes.

Speaker 3 (22:56):

In their homes and in hospitals. There are a lot of volunteers that during the pandemic, they probably from March, 2020 to last June, they were not allowed to enter the, their homes. And these were even more the workforce. But outside of the pandemic context, yes, we have, particularly in bigger cities where there are a lot of groups that offer help for people living in care homes and in chronic units for care inside homes, I don't think so. Really difficult.

Speaker 2 (23:34):

So what would you like to say to any researchers, uh, who might be listening to this podcast? What are some issues you might like to collaborate on with researchers around the world?

Speaker 3 (23:47):

Yes. For us, it's more important to understand how we can build national data sets. We find it's very important to build long-term care policies to understand how the sector is available in the country, how long-term care can be funded. It's something that it's, you will be probably the, the, the most challenge, I guess for society and for tenants, I guess how we can build, uh, a long-term care sector and different services, housing, residential services, <inaudible> centers, and how we can not only build but fund these kind of options because I think we have difficulties even in Latin American and Caribbean crowd understand how dependency is evaluated in national service. So we, we don't have a pattern to ask the questions to understand that what is the number of people living with difficulties on activities of being with. So usually as the questions are drawn by the government needs. So if you want less people in, in the long term needs of financial and funding, you have different questions. And I think this is something that we have to develop across national research to understand how we can maximize the inclusion of people even with disabilities and difficulties and particular families, but also in the need of long-term care

Speaker 2 (25:23):

Is this issue of any interest to the policy makers?

Speaker 3 (25:26):

A movement from researchers from long-term care managers from non-governmental, uh, institutions. We start exactly to create a movement to dual reform legisl on the needs of long-term care. We observe that a lot of small facilities closed and then we start to create a movement to understand how the sector is sector in Brazil and how we can start to build, uh, research priorities and an agenda to construct long term care policies. So now we have at least mostly meetings with national chambers, with researchers, with academia, and with managers of long term care facilities and public prosecutors to let them understand what difficulties they are facing and how we can build national policies for the long-term post center.

Speaker 1 (26:28):

Thank you so much, Dr. Wol and Dr. Wang. Something I found particularly interesting is the focus you talked about on shelter and safe accommodation with much less emphasis I noticed on medical issues of residents. I think think you're at an interesting developmental crossroads here. Many in developing countries are struggling with this balance between medical issues and quality of life or support, social, what many refer to as social care. They're certainly both important, but sometimes really at odds. Some like particularly in the west and developed countries would suggest that we've gone a little too far in the direction of a medical care focus with insufficient attention to quality of life. It's certainly a focus of discussion in the US and in many Western countries. This is a place I think where collaboration between researchers and practitioners in the US and Brazil could be really useful and could have, I think, global implications.

Speaker 1 (27:21):

Another issue you raised, which I found interesting, is the need for more specialized training in geriatrics. We know that high quality care for older adults requires this very particular expertise, and not all older adults across the world, not just in Brazil, have access to geriatric care specialists. I know this is something you are particularly working on, Dr. Wol and a lot of the training that you've been involved in, it's an issue worldwide. So thank you for that, another area for us to collaborate on. Thanks so much for a great discussion, and thank you Dr. Wang.

Speaker 4 (27:58):

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