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Benefits, programs and health networks for older adults in Chilean primary care

Abstract

Chile is undergoing a stage of accelerated population aging, projecting that by 2050, older adults will constitute more than one-third of the population. This demographic shift brings challenges related to social isolation, access to health services, and the management of support networks. This article aims to review the main health benefits, programs and networks that can be activated by health professionals in Primary Health Care in Chile for the benefit of older adults. A narrative review of the literature was conducted, focusing on benefits, health support networks and programs available for this age group. Among the main programs reviewed, there is home care for people with severe dependency, home hospitalization, preventive health examination for older adults, the "More Self-Reliant Older Adults" program, complementary feeding for older adults and the National Immunization Program. These programs are complemented by explicit health guarantees specific to older adults, the Preferred Care Law for older adults and other benefits available through municipal and government channels. Knowledge of these programs and benefits is of vital importance for healthcare teams working in family health centers, as healthcare professionals and students are often the main source of information for older adults. Promoting and disseminating the use of these relevant programs and health benefits is a key step toward building a better country that is better prepared to address the health challenges of an aging population through coordinated, team-based care and a network-oriented approach.

Keywords: primary health care, elderly, support networks, social determinants of health, community networks

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Introduction

The world's population is experiencing an increase in life expectancy. Data from the World Health Organization (WHO) estimates that by 2030 one of every six people will be 60 years old or older and by 2050 the number of people aged 80 years and above reach 426 million people.[1]

Chile has not remained unaffected by this demographic aging. While in the 1990s people over 65 years old constituted just 6.6% of the total population, by the year 2024 this number rose to 14%, which translates into an increase in the aging index from 22.3 to 79.[2] Along these lines, it is projected that by the year 2050 around a third of the country's population will be sixty years old or more.[3]

According to data from the Pan-American Health Organization (PAHO), Chile has a total life expectancy of 80 years, while healthy life expectancy reaches 70 years, in other words, the last 10 years of life are lived with some degree of morbidity or disability.[4] While the definition of *health* is controversial, one of the most accepted is "complete physical, mental and social well-being".[5] In this scenario, having support networks and specific programs for older adults (OA) in Primary Health Care (PHC) is essential. These allow us to comprehensively address the physical, emotional and social needs of this age group, promoting active aging, articulation with the environment, preventing health complications, and alleviating the burden on the health system.[4]

Regarding the Chilean health system, it is important to mention that it is of mixed character, as it is made up of public, private and armed forces subsystems. Public health insurance is called Fondo Nacional de Salud (National Health Fund, FONASA).[6] Their beneficiaries can access institutional care in the public network, which includes PHC, administered by municipalities, and secondary and tertiary levels, managed by Health Services, depending on the complexity of the case.[6]

The model that guides PHC in Chile is the "Modelo de Atención Integral en Salud" (Integral Health Care Model, MAIS), defined as a "set of actions that promote efficient, effective and timely care, centered on the person in their physical, mental and social dimension, considering their family and community environment".[7] This model is based on three principles: comprehensiveness, which addresses different levels of prevention and the multidimensional understanding of health problems; person-centered care, which considers individual needs and expectations within a framework of co-responsibility between users and healthcare team; and continuity of care, understood as the experience of a coherent and connected care process over time.[7]

According to the Real Academia Española, solitude is defined as the "voluntary or involuntary lack of companionship".[8] Studies have demonstrated that loneliness in OA leads to an increase in mortality in all causes.[9] Psychosocial interventions, multiple interventions, multicomponent strategies and case management have been shown to be effective in reducing loneliness in OA.[10]

The growing proportion of OA living alone in Chile poses challenges in terms of isolation and access to support networks. This situation is aggravated by the decrease in fertility rate and changes in family composition.[11] It has been demonstrated that, while some OA maintain active social ties, a significant group experiences social isolation, associated with a low educational level, scarce support networks and support needs. Creating new friendships today is challenging, and is hampered by the lack of spaces that promote listening and mutual care. This adds up to the fragility of traditional family networks, the decline of family nuclei and the limited participation in community or intergenerational spaces, factors that aggravate social exclusion in this age group.[11]

To face accelerated demographic aging, loneliness and management of support networks and health benefits, it is essential that the healthcare team that serves the OA, is aware of the existing healthcare programs and benefits that exist for them, so as to be able to link them appropriately with the system.[11]

The objective of this article is to provide health students and professionals with a brief review of the main benefits, programs and support networks that are available for OA in Chile, with a special emphasis on PHC, with the aim of favoring the connection of older people with these benefits.

Method

A narrative review of the available bibliography was carried out regarding benefits, support networks and programs at national level, aimed at the OA in Chile. Scientific articles, grey literature and other references have been selected at the discretion of the research team based on the most relevant contributions applicable to OA and PHC in Chile, as well as their potential to be understood in a simple and brief way by students and healthcare professionals. Summed up from the previous one, the authors add their own contributions based on clinical and teaching experience in the field of PHC and Family Medicine.

The sources consulted included the PubMed, Scopus and Web of Science databases, as well as official websites and technical guidelines from the Ministry of Health in Chile, published between 2010 and 2025 in Spanish. This article intends to be a synthesis, guided by the clinical and teaching experience of the authors, with the aim of stimulating teaching in this subject in undergraduate and graduate students in health careers and practical application by students and health professionals in Chile.

Results

Based on the search carried out, the following main benefits, programs and support networks for older adults in PHC were selected:

A. National Primary Health Care Programs for Older Adults (Aged 65 and Over)

I. Examen de Medicina Preventiva del Adulto Mayor (Older Adult Preventive Health Examination, EMPAM)

EMPAM delivers a comprehensive view of the health status of the OA through functionality as the main indicator, which allows the detection of risk factors associated with this loss, and, accordingly, be incorporated into the corresponding Health Plan, intervening in a timely manner according to the needs of each patient.[12]

From the above, the three main objectives of EMPAM emerge:

a. Evaluate the integral health and functionality of the OA.

b. Identify and manage risk factors associated with functional decline.

c. Develop a care and follow-up plan, to be carried out by the healthcare team.

This exam includes several items to be analyzed:

a. Anthropometric measurements: Include blood pressure measurement, pulse, weight, height, body mass index, waist circumference, physical activity.

b. Background: Vaccination, physical activity, associated pathologies and drugs used.

c. Functional diagnosis of the OA:

i The Examen Funcional del Adulto Mayor (Functional Examination of the Older Adult EFAM), is an instrument that predicts the loss of functionality of the OA. It allows to fully detect the risk factors of OA who live in the community and are self- sufficient. According to the results, it allows classifies OA as self- sufficient without risk, self- sufficient with risk and risk of dependence.

ii Presence of support networks.

iii Barthel's index for the classification of dependency in OA: It is used in people who present loss of functionality, as well as in those who use technical assistance and/or orthosis, patients with severe dependence, older people who need help from another person to receive attention from the healthcare team and OA with psychic disability. Furthermore, this instrument applies to those belonging to the Programa de Dependencia Severa (Home Care Program for Persons with Severe Dependence, PDS).

iv The brief Geriatric Depression Scale: It is used as a screening test for depression in OA. It is useful to guide the health team in assessing the mental health status of people.

v Pfeffer functional activities questionnaire (informant): Complements the assessment of cognitive status with information obtained by family members and/or caregivers of the PM. It applies to the companion of the greater person who presents a score lower than 13 points in the Abbreviated Minimental test.

vi Fall risk: Single-leg station tests (static balance measure) and Timed up and go (dynamic balance measure) are applicable.

vii Search for mistreatment of the mayor:

a) Abuse: Check in OA with evidence of injury (especially if they are multiple and are found in different degrees of resolution and/or have not been attended to), dehydration and/or malnutrition, fractures that have no determined cause, signs of being tied, tied and/or beaten, sexually transmitted infections in people unable to consent, among others.

b) Neglect: Monitor PM for poor hygiene, severe malnutrition, dehydration, hypothermia, unattended pressure injuries, among other symptoms and/or warning signs.

Tests: once a year and if you don't belong to anyone's health program, blood glucose, total cholesterol and VDRL are requested. If applicable, the smear test is also added.

With everything previously obtained, a care plan must be established and derived if it corresponds to other professionals according to the results found.[12]

II. Más Adultos Mayores Autovalentes ("More Self-Reliant Older Adults Program", Más AMA)

This program corresponds to a health promotion and prevention intervention, through OA participation in group activities of health education, self-care, functional stimulation and cognitive stimulation. It is developed by the PHC team, following a comprehensive and community-based approach to care and its main objective is to prolong self-reliance among individuals aged 60 and older.[13] The program includes a physiotherapist/occupational therapist pair, and requires for its implementation that the municipal health center has more than 20,000 registered people.

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To be able to join the program, the following elements are required:

a. Be over 60 years old and have one of the following conditions:

i If you are between 60 and 64 years old, you must have a current EMPAM or cardiovascular health check.

ii If you are over 65 years old, you must have the current EMPAM check and be categorized as a self-valent person without risk, self-valent with risk, or at risk of dependence. If you do not have a current evaluation, you must refer to its application before entering the program.

b. Be registered with FONASA.

c. Be registered with a primary care health center.

The program includes two areas of work:

a. Functional stimulation for OA: Workshops on stimulation of motor and cognitive functions, self-care, health education and fall prevention.

b. Promoting self-care for OA in social organizations: First, a catalog of social organizations and related local services is compiled. Then, a participatory assessment is carried out to identify community training needs in self-care and functional stimulation for OA. This training is then designed and subsequently implemented by community leaders from the registered social organizations for OA.

These two areas are divided between three workshops, comprising 24 sessions. The Más AMA program graduates once the cycle has ended and at least 60% of the program has been completed.

There are few contraindications for carrying out physical activity, however, in case of doubt, a medical evaluation is suggested before starting sporting activity in high-risk patients.[13]

III. Programa de Alimentación Complementaria del Adulto Mayor (Older Adult complementary nutrition program, PACAM)

PACAM is part of a set of preventive and recovery nutritional food support for OA in chile. Micronutrients-fortified foods are distributed in PHC establishments. In turn, it is an integral component of the Integral Health Program for OA and is linked to other preventive and curative medicine activities, such as promoting healthy aging and maintaining and improving physical and cognitive functionality.

Its objectives are:[14,15]

1. Contribute to preventing and treating the nutritional deficiencies of OA by delivering a food supplement specially designed for their needs.
2. Contribute to maintaining or improving the physical and mental functionality of OA.
3. Encourage adherence to the activities of the Integral Health Program for OA in PHC establishments.
4. Promote a comprehensive approach to working with OA in PHC facilities, with the participation of professionals from the fields of medical, nutrition, social work, family and community organizations.

The program includes all FONASA patients and beneficiaries of the Integral Health Care and Reparation Program (PRAIS) as beneficiaries, regardless of their health insurance.[14] Entry to the program is free[15]

Its target audience is:[15]

1. FONASA beneficiaries over 70 years old.
2. People aged 65 and over who are beginning or undergoing tuberculosis treatment and after discharge.
3. Beneficiaries of the Security and Opportunities Subsystem
4. People aged 60 and over who are beneficiaries of Hogar de Cristo, who are cared for in PHC establishments of the National Health Services System (Sistema Nacional de Servicios de Salud, SNSS).

Once admitted to PACAM, there are no exit requirements, regardless of the admission criteria. However, to be able to collect food, the following requirements must be met:[14,15]

1. Have up-to-date health check, as established in the Integral Health Program for OA or PDS.
2. Have up-to-date vaccinations according to the current ministry's schedule and campaign.

Notwithstanding the above, there are certain special situations that are important to highlight:[14]

i Vaccine refusal: Food supplements may still be withdrawn if the individual submits a written, informed refusal of the recommendations provided by the Programa Nacional de Inmunizaciones (National Immunization Program, PNI). In cases where a contraindication to a specific vaccine exists, a medical certificate must be presented.

ii Transient Population: any eligible individual who is temporarily away from their residence or PHC when they are registered, may withdraw the products from any PHC facility in the country, provided they meet the requirements established for each subprogram. For the transient population, shaving up-to-date health check-ups and vaccinations is a mandatory condition.

iii Institutionalized users: Beneficiaries residing in Establecimientos de Larga Estadía del Adulto Mayor (Long-Term Care Facilities for Older Adults, ELEAM) such as the Hogar de Cristo or affiliates homes in agreement with the Servicio Nacional del Adulto Mayor (National Service for Older Adult, SENAMA) may access the benefits through a formally designated representative of the establishment. This person, as his alternate, must be registered with the corresponding health establishment, with documentation issued by the institution's legal representative.

iv Distribution of products in rural and medical health stations or locations far from the health center due to geographic, climatic, access, transportation or other conditions: The delivery of products to beneficiaries is authorized on a bimonthly basis or at a lower frequency according to the criteria of the establishment and safeguarding the expiration dates of the products.

PACAM products are distributed monthly to the corresponding health center, and include the following:[15]

1. **1 kilogram of Crema Años dorados:** An instant powdered food product used to prepare a cream-based dish made from cereals and legumes. It is low in sodium, cholesterol free and fortified

with vitamins A, B, C, E, D, and folic acid. It also contains calcium, zinc, iron, phosphorus and magnesium. Packaging: 1 kg.

2. **1 kilogram of Bebida Láctea Años Dorados:** a powdered product used to prepare an instant dairy drink based on milk and cereals, fortified with vitamins and minerals, and reduced in lactose, fat and sodium. It is also fortified with vitamins B12 and C, calcium and folic acid. It can be consumed alone or with the addition of cereals.

B. PHC programs mainly for OA and include other age groups

I. Home care for people with severe dependence (Atención Domiciliaria para Personas con Dependencia Severa, PDS)

This program aims to improve the opportunity and continuity of care for people with severe dependence, through comprehensive care (physical, emotional and social) within the family home. It is centered on the individual with severe dependency and their caregiver, providing the families with the necessary tools to take on the integral care of the patients.[16]

To be eligible for this program, the following requirements must be met:[17,18]

i Be registered in a PHC facility.

ii Present a condition of total or severe dependency according to the Barthel index (score less than or equal to 35) and/or some psychiatric diagnosis or intellectual disability certified by a physician at the corresponding health facility. Home-based assessment must be requested at the corresponding PHC establishment

This program is not specific for OA, as it is a cross-cutting intervention designed to benefit any person who meets the eligibility criteria. Since the inclusion of Alzheimer's disease and other dementias in the GES (Garantías Explícitas en Salud, Explicit Health Guarantees) in 2022, home care also corresponds to this special group.[19]

The program consists of a "basic care package" designed for 12 months, which includes 2 comprehensive home visits to plan care, followed by at least six treatment visits to be scheduled accordingly. Additionally, caregivers are also provided with training both on care techniques and on self-care strategies.[20]

The program also allows access to a caregiver subsidy, which consists of a monetary benefit provided to the individual performing the caregiver role. To qualify for this benefit, the caregiver must meet at least one of the following requirements: be a FONASA A or B beneficiary, have a score below 8,500 points on the Social Protection Record (Ficha de Protección Social), be part of Chile Solidario or benefit from welfare pensions (PASIS). This financial support is around $30,000 (USD 31).[21]

The benefit is ongoing as long as the condition of severe dependence persists. Discharge criteria include improvement in the level of dependency or the death of the beneficiary.

II. Home hospitalization

Home Hospitalization (HH) is an alternative care modality and strategy to traditional hospitalization, where the user receives health care in a similar way that is provided in hospital establishments (in quality and quantity). This program is carried out by a specialized HH unit that delivers care at home from a team of the Health Service, to patients with a defined medical diagnosis and stable clinical condition in the acute phase, in addition to end of life care, or patients who are undergoing an acute pathology with an indication of proportional management, and with an expected stay no more than 10 days. The referral requirement, medical controls, and the end of this process are defined by the HH team.[22]

Currently, global trends point toward seeking alternatives to traditional hospitalization that favor self-care and to contribute to strengthening family and community participation in the treatment and recovery of patients. The current improvement in health adaptations for home care and communications, favors medical treatment at home and promotes the application of the HH Model. The main objectives of HH are:[22]

1. Avoid hospitalizations in hospital facilities in patients with acute illnesses and chronic risk conditions, suitable for home care.
2. Improve the quality of life and comfort of the sick person, maintaining them in their social and family environment.
3. Optimize the hospital bed resource, to favor the early discharge of patients to complete their therapeutic plan at home.
4. Favor the integration of the health network teams into common processes and agreements between the Hospital and PHC, strengthening the functioning of the healthcare network.
5. Avoid complications secondary to prolonged hospitalization like infections associated with health care and delirium.
6. Reduce hospital care costs.

Entry and exclusion criterias:[22]

Patients who meet at least the following characteristics may be presented through consultation, for the assessment of income:

1. General criteria

i Beneficiaries of FONASA or PRAIS.

ii Have an acute or chronic re-aggravated pathology, clinically stable and susceptible to treatment at home.

iii Having adequacy of therapeutic effort and proportional management.

iv Appropriate socio sanitary conditions in the home or institution including support of basic services and communication system).

v Appropriate family or social network in charge of home care.

vi Acceptance by the user, guardian and family to access the HD modality, by signing an informed consent document.

vii Appropriate geographic home range, defined by each HH unit, considering accessibility and travel time from the hospital.

2. Clinical criteria

i Clinical stability and diagnosis based on baseline health status (with the exception of patients entering end-of-life care).

ii Confirmed admission diagnosis.

iii Medical treatments that can be managed by the healthcare provider and their family at home.

iv Other clinical criteria that are specific to each HH unit.

3. Exclusion criteria for entry

i Not comply with general requirements.

ii Not comply with clinical requirements.

iii Possibility of resolution by PHC in outpatient consultations.

iv Patient care needs exceed the technical capabilities and/or professionals of the HH unit.

v Chronic patients with acute conditions who require specialized care through prolonged hospitalization, with the possibility of resolution by PHC or other home care programs, such as palliative care, severe dependency care, ventilator assistance, among others.

It is worth noting that the patient must be accepted by the HH unit and must have completed the entire admission process before being transferred to their homes.

C. Programs available for all OA in Chile

I. National immunization program (PNI)

The PNI is intended to prevent morbidity, disability and mortality from transmissible and immune preventable infectious diseases, with the vaccines included in the PNI at no cost. While the vast majority of vaccines included in this program are administered during the first months and years of life, there are also special coverage aimed to the OA[23] Since 2010, the pneumococcal polysaccharide vaccine with 23 serotypes (VNP23) has been administered to people over 65 years old.[24] Furthermore, the OA are included in the aimed population for the annual campaign against influenza and COVID-19.[26] Finally, even though it is not a strict part of the PNI, vaccination against influenza and COVID-19 are known campaigns, where the target population and start and finish dates are indicated annually. During the last few years, the population has always been included for over 60 years, thus giving coverage to the largest people in our country. Information regarding vaccination is constantly being updated, which is why we suggest that the reader review the latest existing guidelines.[25,26]

II. Explicit health guarantees (GES) for persons over 65 years old

The Explicit Health Guarantees (GES), constitute a set of benefits guaranteed by law, which include access, opportunity, (maximum waiting times), financial protection and quality of care, in case of suffering any of the 87 health problems defined by the Ministry of Health.[27] Some of these pathologies are exclusive to OA, which are listed below:

a. Total hip endoprosthesis is recommended for OA who have hip arthrosis with severe functional.

b. Community-acquired pneumonia of outpatient management.

c. Technical helps (orthosis).

d. Bilateral hypoacusis in OA who requires the use of a hearing aid.

e. Refractive errors,

f. Comprehensive oral health care for people 60 years old.

There are also other pathologies that are not specific to the greater person, but are common in this age group, such as Alzheimer's disease and other dementias, Parkinson's disease, Cerebrovascular accident, acute myocardial infarction and surgical treatment of cataracts.[27]

III. Health support networks with the municipality and government of Chile

Many communes in the country have departments for the OA, which include special programs for the people of this group. Some examples of these social health support are: monetary contribution for the purchase of clothes, postulation of jobs for the OA, delivery of clothes and food baskets, and organization of instances of the OA participation, such as workshops or elderly clubs.

The Ministry of Social Development (MIDESO) also offers benefits to OA through the Servicio Nacional del Adulto Mayor (SENAMA). These can be economic like the winter economic bonus, national adult fund, subsidy for ELEM and social health support (volunteer work for the country of OA, senior advisors, good care for the OA, day centers for the OA, home care programs, and ELEAM).[28]

The universal guaranteed pension (PGU) is an economic benefit from the Chilean government that is granted as a complement to the OA, with a variable amount up to a maximum of CLP $224,004 (USD 236).

Its requirements are:[29]

i You must be 65 years old to access the benefit.

ii Family group that is not among the richest 10% of the population, according to data from the Social Home Registry (RSH).

iii Accredit residence in Chilean territory:

iv A period of more than 20 years continuous or discontinuous living since 20 years of age.

v A period of more than 4 years of residence in the last five years immediately preceding the benefit.

vi Have basal pension equal to the lesser of $1,210,828 Chilean pesos (USD 1,280).

For the request for these benefits, the role of the Social Worker in PHC or the Municipality is fundamental, because is the professional that has the knowledge of existing programs and the contacts to carry out guidance or linkage.

Preferred attention law

In 2019, a paragraph was added to Title II of Law No. 20,584, Law of Rights and Duties of the Patient (30), which defines that every person over 60 years old and every person in a situation of disability has the right to be attended to in a preferred and timely manner by any healthcare provider. This aims to facilitate access to health care, without compromising other priority care such as emergencies or urgencies in the event that there is one (31).

These benefits include:

i Priority assignment of hours for care in outpatient and emergency consultations.

ii Priority in referral to specialists.

iii Priority in the dispensing of medicines in the pharmacy.

When prescribing and dispensing medications, you must issue and manage the medical prescription, deliver a number for the dispensing of medications at the pharmacy with subsequent dispensing. Finally, in relation to taking exams or carrying out procedures, the number must be given to the attention request, assigning a day and time for this and prioritizing the user at the time of its performance.[31]

Discussion

We see that the benefits, programs and health networks available to OA in Chile have shown important advances in recent decades, which has allowed Chile to build a robust support network, which responds appropriately to the challenges of the accelerated aging process, but

still remaining challenges for the next years. Programs and benefits such as EMPAM and Más AMA, among others, reflect an approach that seeks to promote autonomy and prevent functional deterioration. These benefits are aligned with the principles of the Chilean integral health care model, to consider the bio psychosocial dimension of care in OA, and to favor the continuity of health care.

A key aspect for the implementation of what was previously described is team work in the healthcare network. The OA care requires a multidimensional perspective, which combines biomedical, functional, psychosocial and community aspects. This requires active collaboration between the different professionals of the healthcare team and the related social supports. Coordination, effective communication and co-responsibility in PHC allows to detect complex needs early, but also design health and social interventions that are more pertinent, sustainable and centered on people.

However, relevant challenges persist. Despite the existence of this wide range of benefits, its effective access still depends on multiple factors, such as the knowledge of healthcare infrastructure, health teams, administrative issues and health networks. Also, it is relevant to have effective communication with OA and their families, an efficient coordination between levels of care and the availability of local resources. Furthermore, aspects such as social isolation, the digital gap and the fragmentation of the system can limit the capacity of OA to actively link themselves with these programs.[11]

In this context, it is essential that healthcare teams and future professionals can actively recognize and utilize these benefits and healthcare networks for the OA. Having the knowledge to identify, activate and derive opportunely to the programs and local networks can improve the quality of care, which also enhances the role of PHC as a guarantee of health rights for OA, for dignified, participatory and a protected aging.

Conclusion

The sustained increase in the population in Chile requires rethinking and strengthening the response of the health system from a preventive, community and person-centered approach, with a health network perspective. PHC has multiple programs and benefits aimed at the OA, which, if they are known and activated effectively, can contribute significantly to the bio psychosocial well-being of older people. This article is a contribution primarily to health care teams that details the main programs, health networks and benefits available to OA in Chile, with a special focus on those that are most relevant to PHC setting, highlighting the fundamental role that fulfills this level of assistance as an articulator of care and promoter of healthy aging. In coherence with the integral health care model, these programs respond to the principles of integrality, person-centeredness and continuity of care.

The existence of benefits such as EMPAM, the Más AMA program, PACAM and home care for people with severe dependence, among others, allows addressing the multiple health determinants that affect older people. Promoting knowledge and use of these networks by healthcare staff, students and professionals in training is a key step towards advancing a more inclusive PHC prepared for the challenges of aging.

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Conflicts of interest

The authors declare that they do not have any conflict of financial interest or of any other nature that could compromise the impartiality of the article.

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