PANORAMA

MEXICO

Demand for Support Services for Functional Dependence

Process of Demographic Aging

Mexico is at an advanced stage of the demographic transition according to the typology developed by the Economic Commission for Latin America and the Caribbean (ECLAC 2008).[1] Brazil, Colombia, and Costa Rica are also in this advanced stage, which is characterized by low natural growth rates between 1.3 and 1.4 percent, global fertility rates of around two children per woman of reproductive age, and life expectancy at birth that exceeds 75 years (ECLAC 2008).

Specifically, the population of older people in Mexico is growing at a faster rate than the total population.[2] According to data from the United Nations, in 2015 this population group reached 12 million people, which is equivalent to 10 percent of the total population, exceeding for the first time the group that includes children from 0 to 4 years old. If the fertility and mortality trends continue as they have been, it is expected that in 2050 older people will represent 25 percent of the Mexican population, reaching 40 million people. The population of persons 80 years and older will also increase dramatically: from 1.3 percent of the population in 2010 to 5 percent in 2050 (United Nations 2017). These data show the clear process of population aging in the country, which is expected to continue in the coming decades.

Dependency

As people get older, there is an increase in the likelihood that they will have difficulties in carrying out basic activities

of daily living (ADLs) and instrumental activities of daily living (IADLs) and that, consequently, they will depend on the support of third parties to carry out those activities. This in turn generates a growing need and demand for long-term care services.

In 2015, according to the National Survey of Health and Aging in Mexico (Encuesta Nacional sobre Salud y Envejecimiento en México - ENASEM), 22.1 percent of people over 60 reported experiencing difficulties in performing at least one of the ADLs, while 14.6 percent reported having difficulty performing at least one of the IADLs. The prevalence of difficulties is greater for women: 25.1 percent of women age 60 and older reported difficulties in performing ADLs and 18.5 percent reported difficulties in performing IADLs, compared to 18.6 percent and 10 percent in the case of men, respectively. These figures coincide with the data from the National Health and Nutrition Survey (ENSANUT 2012).
Difficulties increase as age advances. For example, the percentage of people with difficulties in carrying out ADLs is 15 percent in the 60-69 year-old age group and increases to almost 44 percent in the 80 and over group (Table 1). This pattern is also observed in the case of IADLs, both for men and women. As with ADLs, the difficulty in carrying out IADLs grows as age increases, and it is the 80 and over age group that has the highest prevalence of difficulty reported in the four activities studied, as well as in the assistance received (Table 1).

In addition, with increased age people are more likely to have difficulties performing more than one activity: among those over 60, 12 percent have difficulty performing two or more ADLs, while among those over 80 this percentage rises to more than 25 percent. Regarding the difficulty in carrying out specific activities, among the ADLs the activities for which the highest percentage of elderly men and women report having difficulties are lying down and getting out of bed, walking, and getting dressed. The most difficult IADL is making purchases, with percentages for women that range from 8 percent among the 60-69 age group to 41 percent among the group of persons 80 and older.

Table 1. Presence of Difficulties by Age and Sex among Persons over 60 Years of Age (percent)

	ADLs			IADLs		
Age	Men	Women	Total	Men	Women	Total
60+	18.6	25.1	22.1	10.0	18.5	14.6
60-69	12.0	18.2	15.4	4.6	10.0	7.6
70-79	19.9	26.7	23.5	11.9	21.9	17.2
80 and over	39.4	47.3	43.7	27.2	49.0	38.6

Source: Authors' calculations based on data from the 2015 Encuesta Nacional sobre Salud y Envejecimiento en México (ENASEM)
Note: ADLs: basic activities of daily living; IADLs: instrumental activities of daily living.

Epidemiological Profile of the Elderly Population

The epidemiological profile of Mexico is dominated by chronic noncommunicable diseases, both in men and women, which account for more than half of the country's deaths. Data from the Global Burden of Disease Study in Mexico indicate that diarrhea and other infectious diseases represented the second cause of mortality in 1990 and the eighth in 2016. In contrast, diabetes went from being the fourth cause of death to the second, and neurological disorders went from being the 10th to the fourth cause of mortality. Among the elderly, cardiovascular diseases account for the largest share of the total percentage of deaths, followed by diabetes and other endocrine diseases, which together account for between 41 percent (in 1990 for the 50-59 year old group) and 51 percent (in 2016 for the 70 and over age group) of total deaths.

During 1990–2016, for both age groups, neoplasms were the third highest cause of death, accounting for 18 percent of total deaths in 1990 for the 50-59 year old group and 12 percent of total deaths in 2016 for the 70 and over age group (IHME 2017). In 2016, among the elderly, cardiovascular diseases, diabetes and other endocrine diseases, neoplasms, neurological disorders, and cirrhosis accounted for more than 60 percent of deaths (IHME 2017).

According to ENASEM data, of the total number of elderly people interviewed in 2015, 66 percent reported having been diagnosed with at least one chronic disease, and that prevalence increases with age and is higher among women for most diseases. The main chronic conditions

are hypertension (40 percent), diabetes (24 percent), and hypercholesterolemia (20 percent), followed by heart conditions (9 percent), embolism (4 percent), and cancer (4 percent) (Manrique-Espinoza et al. 2013). Similarly, among those who reported having a chronic disease, 27 percent also reported difficulties in performing ADLs, while among those who did not have chronic conditions, 10 percent had such difficulties. By separately analyzing the situation of people age 60 and older suffering from chronic diseases and investigating their relationship with functional dependence, it was determined that chronic diseases that are most related to having difficulty performing at least one ADL are embolism, arthritis, and having had a heart attack.

The Role of the Government in Long-term Care

Even though Mexico has specific laws, norms, and programs for the elderly and/or disabled, it lacks public programs to provide support services to people in a status of dependency. Similarly, although there are public programs focused on improving the living conditions of the elderly, those programs are limited to the delivery of monetary transfers. They generally focus on the poorest people and seek to compensate for the low coverage of contributory pensions, which is a particularly pronounced problem among women and the rural population. In this sense, the approach that prevails involves poverty alleviation (universal pension) or social reintegration of persons with disabilities, without explicit consideration of the care needs of this population, nor of recognition of the care work that is carried out. Currently, that burdens falls mostly on households through unpaid family care.

For example, a review by the National Council for the Evaluation of Social Development Policy (CONEVAL 2015) of social programs in force in 2014 identified 33 programs aimed at older people at the state level. Most of these programs aim to improve the quality of life of beneficiaries by providing in-kind or monetary support, access to health services, and recreational activities. In addition, two federal programs stand out: the PROSPERA conditional cash transfer program, and the Pension Program for Older Adults, a non-contributory pension program. PROSPERA, which was established to financially support the country's poorest population, included a support component for adults 70 and older for members of families already affiliated with the program, as long as they reside in localities of at least 20,000 inhabitants. The program provides monthly monetary support of 370 pesos (approximately US$19.50), subject to attendance at biannual medical appointments by the beneficiary. This support is provided as long as the beneficiaries are not served by the Pension Program for Older Adults.

Supply of Long-term Support Services

In Mexico, the role of the state with regard to supporting long-term care is virtually non-existent, except for the administration of some residential houses or day centers. Therefore, the care provided is largely carried out in the private sphere of the home, through unpaid family care, with little support or training. There is a growing private supply that covers a wide variety of services and costs, but those services are only available to the population with the highest income. Table 2 summarizes the provision of support services, including public services provided by federal and/or state governments, as well as services provided by the private and non-profit sectors.

Analysis and Perspectives of Long-term Care

From this brief review it is clear that Mexico does not have a national system of care, and that it is urgent to continue the discussion on how to resolve the long-term care challenge associated with the increase in the demand for care and the change in the structure of families. The current absence of state policies generates enormous inequities in access to long-term care in which only the most privileged sectors of the population have access to specialized private services. In addition to including the right to care as a fundamental right of people under Mexican law, certain actions are a priority.

First, it is essential to develop programs for people who provide support services in a way that allows them to reconcile work and personal life with their care work, gives them opportunities for respite, and lessens their current burden. This could be achieved, for example,

Table 2. Participation of Sectors in Providing Long-term Care Support Services

Type of Service	Public Sector	Private Non-profit Sector	Private For-profit Sector
Services in institutions	• Offers services in a few institutions at the national and state/municipal levels through INAPAM and the national, state, and municipal systems of the Integral Family Development Program	• Provides services	• Provides services
Home care services	• Does not offer services	• Provides services	• Does not offer services
Day centers	• Provides services at the national and state/municipal levels through INAPAM and the national, state, and municipal IFD systems	• Provides services • Promotes active aging, recreational activities, and health education	• Provides services • Promotes active aging, recreational activities, and health education
Telecare services	• Does not offer services	• Provides services	• Does not offer services
Services for those who provide care services	• Provides training for family members of the person who needs support • Does not provide respite services directly • Although day centers usually aim to promote the well-being of older adults, they can serve as a respite service if they are perceived by those in charge as an opportunity to provide caregivers with some personal time	• Does not provide respite services	• Does not provide services in general • Some associations that work with Alzheimer's and other dementias offer training courses
Other services	• National tele-health program • Medical services at home	• Telemedicine services • Medical and paramedical services at home	• Distance education (by universities) • Few institutions provide palliative care for people with terminal illnesses to help manage symptoms and pain at the end of life

through day centers that expand service offerings to include care for the dependent elderly. Regarding permanent residence institutions, it is urgent to organize existing services and, if necessary, evaluate their adequacy to ensure that the services provided have a positive impact on the well-being of dependent elderly people.

To achieve progress, it is urgent that the executive and legislative branches at the federal and state levels recognize the fundamental role of family members in caring for the sick and dependents in the home. Continued efforts are needed to make care visible beyond the private sphere of homes and to assess this work. These strategies should be formulated emphasizing the prevention and promotion of health in such a way that the incidence of chronic diseases that generally create dependence can be reversed and, in cases where people already suffer from such diseases, the dependence associated with them can be delayed as much as possible.

Finally, in a country as diverse as Mexico, it will be essential that states participate and incorporate local cultural values in the development of care strategies at the national level. This will allow for the generation of ad hoc programs, based on local needs and preferences in terms of specific support services, thus ensuring greater acceptance of those services.

[1] The review of 2008 (ECLAC 2008) of this typology adopts the global fertility rate and life expectancy at birth as indicators to identify the stages of the demographic transition, unlike the birth and mortality rates used in its first typology produced in 1993 (CEPAL1993 quoted in ECLAC 2008). For the period 2005-2010 were defined four major groups or transition stages: 1) Very advanced: 1.5 children per woman, natural demographic growth of 0.29% and life expectancy at birth highest in the region ≥ 78 years; 2) Advanced: Demographic growth of between 1.0% and 1.4%, life expectancy exceeding 75 years and level of fertility less than or equal to replacement; 3): Countries with growth rates of 1.4% and 2.3% and intermediate fertility level; and moderate transition: countries where the fertility rate is higher with an average of 4 children per woman, high demographic growth (around of 3%) and life expectancy at birth from 60 to 65 years.

[2] The Law on the Rights of Older Persons defines as an older adult those who are age 60 or older (DOF 2002).

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