Introduction

This situation analysis presents a summary of Mexico’s health system’s responsiveness to the needs of the aging population. This evaluation assesses the effectiveness of the country’s health system and aims to facilitate open dialogue toward further evaluation, decision-making, and development of an action plan with the implementation of cost-effective policies. The document first presents the current demographic and epidemiological situation, followed by a summary of the health system’s responsiveness.
More people reach old age as demographics change

According to Mexico’s 2020 Housing and Population Census, the total population was 126 million. Of this total, 12% were 60 years or older. By 2050, this older cohort will represent 25% of the total population (1). In 2015, for the first time, there were more adults 60 years and older than children 0-4 years old. However, the population aging process is advancing differentially among states in the country. Adults 60 years and older represent 16% of the total population in Mexico City and the state of Veracruz, while in the states of Baja California Sur, Chiapas, and Quintana Roo, older adults represent 10% (1).

Mexico is also undergoing epidemiologic transition, with noncommunicable disease being the most prevalent form of morbidity (2). Among adults 60 years and older, 27% of women and 22% of men reported being diagnosed with diabetes, with visual impairment being the most frequently reported complication. A significant proportion of older women (20.9%) and 15.3% of older men reported being diagnosed with hypertension (3). In addition, results of the anthropometric measures taken during the survey show that 40.2% of women and 30.5% of men were obese, while 36.6% of women and 42% of men were overweight (4).

Figure 1. Aging patterns in Mexico and the Region of the Americas (2019)

Increased life expectancy for Mexicans does not necessarily mean an increase in years spent in good health

Average life expectancy at birth in 2020 was 75 years. Average life expectancy at age 60 years was estimated at 21.8–22.9 years for women and 20.9 years for men. While life expectancy has increased, healthy life expectancy has not. For many, those years gained are spent with disabilities or premature death. Estimates for 2019 (Figure 2) show that of the 21.8 additional years a person is expected to live at age 60, only 16 are lived in good health (15.3 years for men and 16.8 years for women) (5).

Figure 2. Are the Life Expectancy and Healthy Life Expectancy gaps increasing over time? The case of Mexico

Another way of assessing the burden of chronic disease among older adults in Mexico is by looking at estimates of disability-adjusted life years (DALYs), calculated as the sum of the years of life lost to due to premature mortality (YLLs) and the years lived with a disability (YLDs) due to prevalent cases of specific chronic diseases.

In 2016, DALYs in older persons ranged from 19.0% to 36.0% among the states in Mexico, and the burden of disease was comprised mainly of YLLs (68%). Diabetes mellitus, ischemic heart disease, and chronic kidney disease were the main causes of DALYs. On the other hand, visual and hearing impairment, lower back and neck pain, and depression contributed to the highest burden of years lived with disability (YLDs) in both men and women (6). Alzheimer’s disease and other dementias appear as the ninth cause of disability in the 70–79 years age group. Dementia rises to being the third main cause of disability in the 80–89 years age group and is the second main disabling condition for those aged 90 years and above (6).

**High burden and negative outcomes because of increasing chronic diseases that are not optimally diagnosed and managed**

Increasingly, chronic diseases that are not properly treated and managed impact individuals’ daily life. In 2020, the National Population Census reported that 16.5% of the population either had some limitation in performing daily activities, a disability, or a self-reported limiting cognitive condition. Among those with limitations, 45% are adults 60 years and older (7). Severe functional disability, measured as having limitations in performing three or more activities of daily living (ADLs), increased from 3.4% to 5.6% in older adults in the period 2001–2015 (8) (Figure 3).
Figure 3. Burden of disease throughout the life course in the Americas, 1990—2019

Mexico
Percentage of DALYs from all causes by age in 1990 and 2019

DALY rates per 100,000 population by age in 1990 and 2019

Summary of the health system’s responsiveness to the needs of older adults

I. Capacity of services to provide care centered on older adults and their communities

Concerning access to health services and system response, a main issue is the absence of a universal national health system. Instead of a single system, Mexico has three subsystems of health care insurance and service provision. The Mexican Social Security Institute (IMSS) is available to those in the private sector, while the Institute for Social Security and Services for State Employees (ISSSTE) is for those employed in the national or state-level public sector. In addition, the Ministry of Health provides health services for those employed in the informal sector or who did not accrue enough time in formal employment to be eligible for services through IMSS or ISSSTE.

Mexico and other countries in the Region have not yet fully implemented person-centered, integrated care for older adults. The only known integrated care strategy is a pilot project initiated in Mexico City in 2020, which includes WHO Integrated Care for the Older People (ICOPE) within primary care services, and evaluating its results toward implementation at the national level in the medium term (8).

Results of health care for older adults are mixed. In 2020, 51.7% of older adults reported having an Older Adult’s National Health Card (Cartilla Nacional de Salud del Adulto Mayor), an official document for Mexican older people that allows them to access preventative, diagnostic and follow-up health care free of charge in all the medical units of the national health system. The national prevalence of vaccination was 56.5% (±0.97) for influenza, 44.3% (±0.98) for pneumococcus, and 61.8% (±0.96) for tetanus (9).

Without comprehensive evaluation and detection, management of chronic diseases and their consequences is deficient. Therefore, functional evaluation needs to be put in place to allow follow-up and treatment adherence. Multimorbidity is present in 30% of older people and 20% are obese (4). According to the 2018 National Health and Nutrition Survey, 75.2% had hypertension. Of this total, only 47.3% were previously aware of their condition, while the rest were identified as hypertensive at the time of the survey (10). Among those diagnosed with diabetes only 19% reported having a glycosylated hemoglobin test and 12% a microalbuminuria test in the past 12 months. These are two of the main tests to evaluate and manage diabetes. The low percentage of people getting the test suggests suboptimal care (4). In terms of access to health care services, 72% of people aged 60 years and older report at least one doctor visit in the past year. On average, they make eight visits a year (11).
II. Impact of health funding on out-of-pocket spending for older adults and their families

Even when the majority of older adults report having some form of health insurance, Mexico has one of the largest out-of-pocket expenditures and national allocations for health care in the Region of the Americas.

GDP allocated to health expenditures in Mexico is low, amounting to 6.2% of total spending in 2020. Total expenditure per capita on all health care services is around 1000 Purchasing Power Parities (PPP) (US$ 2017), which is low compared to other countries (12). Health care services offered in the private sector are significant, and most of this privately purchased health care is paid for out of pocket. Private insurance makes up a small segment of the market (approximately 4% of total health expenditures), while out-of-pocket health spending (paid directly by patients) in 2017 reached 40.4% of total spending (13).

In 2018, 73.5% of adults 60 years and older were insured in one of the three schemes (IMSS, ISSSTE, Ministry of Health) (up from 64.6% in 2010) and as a result, 74% are cared for in public health institutions (approximately 47% in social security institutions and 25% by the Ministry of Health) (11).

Estimates for 2020 show that 19% of older people remained with no health insurance and experienced lack of access to health services and increased out-of-pocket expenditures (14). Moreover, it is estimated that in households with older adults, health spending is 36% higher and catastrophic health spending more than doubles, compared to other households in the country (15), with expenditures being particularly high in the last year of life (16).

This high expenditure and risk of catastrophic health expenditures is particularly relevant given the prevalent poverty among older adults. A study by the National Council for the Evaluation of Social Policy in Mexico showed that, on average, 41% of adults 65 years and older were in poverty in 2018, ranging from 23% in Mexico City to 72% in the state of Chiapas and 65% in Oaxaca (17).

III. Impact of health leadership and governance on care for older adults

Rights of older adults, legislation, and actions

The main law that protects older adults in Mexico is the 2002 Law on the Rights of Older Persons. Although legislation ensures the rights of older people, in

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1 Purchasing power parities (PPPs) are the rates of currency conversion that try to equalize the purchasing power of different currencies, by eliminating the differences in price levels between countries. The basket of goods and services priced is a sample of all those that are part of final expenditures: final consumption of households and government, fixed capital formation, and net exports. This indicator is measured in terms of national currency per US dollar (12).
practice, these protections are not fully achieved. Mexico has established an institution within the federal government dedicated to the aging population, which is responsible for generating all public policy on aging and older adults, as well as developing methods for implementing these policies.

This institution, the National Institute for Older Adults, has been in place for decades. During its tenure, it has only managed to establish six day-care centers and six permanent residences for older adults in Mexico City. Based on the last census, there are around 1.5 million older persons living in Mexico City (1). However, there are agreements with private companies and public institutions to allow older adults to access preferential or discounted services (foods, public transportation, legal services, health services, monthly deductions on electricity and water).

**Lack of specialized care and overall low satisfaction with care provided**

Satisfaction with health care services in Mexico is low. In 2013, 60% of older adults reported not being very satisfied (18), and 31% considered the health services they received as deficient or bad in 2018 (4).

In 2018 it was estimated that the country had one certified geriatrician for every 25,000 older adults, while only 13 public and private educational institutions included Geriatrics in their postgraduate or specialty academic programs. Overall, 22 out of 89 universities offer a degree in Gerontology or Social Gerontology (24.7%), in contrast to 36 out of 89 (40.4%) universities offering degrees in pediatrics (19). The Mexican Institute of Social Security (IMSS) is the nation’s specialist institution, with 170 geriatric doctors in hospitals and 80 geriatric nurses (20).

**IV. Effectiveness of cross-sectoral response on health determinants in older adults**

**Social determinants of health do not reflect favorable or healthy aging**

Despite specific legislation, adverse social conditions hamper overall health and well-being. Older Mexicans live primarily in urban areas, are married, or have a partner, and 12% of older people live in alone (7). In 2020, 18.1% of older people reported having no formal schooling, 47.8% had completed primary school, and about 25% were illiterate (21). Census data shows that 26% of Mexican households reported at least one household member 60 years or older (22).

A study on social deprivation shows that 37.5% of older people live in poverty (income below the poverty line) and 76.5% experienced at least one out of six indicators of social deprivation (inadequate access to health services,
access to social security benefits, inadequate housing type and quality, inadequate education, access to adequate household services, and access to food). Inadequate education was the most prevalent and affects 54.5% of this age group, causing additional adverse effects throughout the life course by impacting employment, income, and social security opportunities (17).

In 2018, 40.9% of the 65 years and older population had cash transfers as their primary source of income, mainly in the form of pensions, social programs, and support from other households. By 2020 approximately 33% of older adults received a contributory pension (requiring employee contributions) and 53% received a non-contributory pension (not requiring employee contributions). There is a marked difference in the amount received in each (23).

In 2019, only 7% of people aged 55 years and older had a cell phone and 35% were Internet users, compared to 75% and 70% of the population aged 6 years and older, respectively, showing a lag in use and access to diverse telecommunication services (22).

V. Long-term care in Mexico

In Mexico, strategies for dependent or disabled people are practically non-existent. The country does not have a publicly funded long-term care system or specific public services that provide care for people with loss of functional capacity or who are disabled. As a result, unpaid family carers provide long-term care at home (24).

On the other hand, care needs are increasing, and the supply of publicly funded services for older adults is practically non-existent. Currently, 16% of older people have difficulty in some basic activities of daily living (BADL) (walking, bathing, eating, going to bed, using the toilet) and 14% with some instrumental activities of daily living (IADL) (preparing hot food, shopping for groceries, taking their medicines, managing their money) (11). The 2020 census identified 1504 care homes for older adults, of which only 10 were publicly funded, and overall suboptimal resources were available. Only 1% of the staff working in care homes had skills for the care of older adults (22).

Mexico’s health expenditure represented 5.7% of total GDP in 2018. Of this total, 4.1% represents total production of goods and services of the health sector and 1.6% represents unpaid work designated for health care; that is, all health-related care that is performed within the household for those who are ill or disabled (25).

When total expenditure is disaggregated by goods or services provided, unpaid health care represents 29.1% of the total GDP of the health sector, whereas
production of goods and services within the sector represents the remaining 70.9%. According to the latest estimates (2018), unpaid health care represents a larger proportion of health service provision compared to all hospital services (20.3%) and ambulatory or primary care services (17.0%) (25). It is estimated that around 40% of total unpaid home health care is provided to older adults, at an economic value of 73 679 million pesos (approximately US$ 4 604 937, in 2015) (26).

There are only two programs that provide home care for adults and older adults with chronic conditions: the Chronic Patient Care Program (Atención de Enfermos Crónicos) by the IMSS, and the Health in Your Home program (Salud en tu Casa, formerly Médico en tu Casa) from Mexico City's Health Services. The main conditions treated are chronic degenerative diseases and their sequelae, such as cerebral vascular type, chronic obstructive pulmonary disease (COPD), heart failure, chronic kidney failure, Alzheimer’s disease, and terminal cancer conditions. However, its scope and reach have been limited and based on chronic diseases and not specifically on needs of older adults and conditions related to the aging process that might require care, such as frailty (27).

Under the current administration, Mexico City’s program targets adults 68 years and older who are considered “at risk” and who can no longer travel to obtain health services in person, and those in need of palliative care (28). However, no information on how the program operates, its target population, or its performance is publicly available.
Conclusion

In response to the challenges caused by the accelerated demographic and epidemiologic transitions, it is necessary that federal, state, and local levels prioritize population aging and the relevant health policies. Concrete actions need to be taken in the short term.

While different strategies to support older adults are in place, these have been focused mostly on providing minimal income via support programs and non-contributory pensions. Fragmented health and social services result in suboptimal care and, incorrect management and treatment of chronic diseases and their adverse health outcomes.

Therefore, as with many countries in the Region, Mexico needs to implement nationwide integrated and person-centered care for all older adults that is effective in responding to individual and population level needs and provides optimal, timely care.

For long-term care, the absence of national standards and regulations is a significant challenge. Standards of care, safety and evaluation systems, and a national registry of public, private, and non-profit institutions that cater to older adults and people with disabilities are measures that should be implemented immediately.

During the COVID-19 pandemic, it was evident that in addition to optimal standards of care, long-term care institutions need care guidelines for crisis situations, which could be a pandemic, earthquake, hurricane, or other frequent natural disaster. Adequate information systems that require care homes to gather and report specific information are also urgently needed.

There is a great need to recognize and implement support strategies for particularly vulnerable groups in these crisis situations, such as for unpaid family carers, persons living with dementia, and persons living with disabilities.

Finally, the obvious pressure on the health care system in crisis situations highlights the urgent need for a universal health care system that prioritizes integrated, person-centered care, which is adequately funded and equipped in terms of infrastructure and human resources.
References


