Chapter 22
Present State of Elder Care in Mexico

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Introduction

Mexico is currently halfway through its demographic bonus, a so-called period of time during the demographic transition of a population when the group under age 15 is reduced to less than 30 % but the proportion of elderly is still not large enough to become burdensome (by definition, 15 %) (Hakker 2007), thus allowing for a window of opportunity to prepare economically and socially for the moment when the elderly become a large proportion of the population. However, for Mexico to take advantage of its demographic bonus, it still has a lot of work ahead.

Life expectancy in Mexico in 1895 was 24.4 years in average, and barely different between men and women (24.3 and 24.5, respectively) (Zavala 1992). It remained practically unchanged until 1930, when the average increased to 33.9 years (Instituto de Geriatría 2010). This means that Mexico began its transition at least 80 years later than Europe. However, by 1950 life expectancy was already 47.6 years and by 1980, 66.3 years. According to estimations by the National Population Council (*Consejo Nacional de Población*, CONAPO), life expectancy at birth in 2014 is 74.3 years on average, 77.5 for women and 72 for men (Consejo Nacional de Población 2013). The last estimation of life expectancy at age 65 by the same organization, dating from 2010, was 18.3 years for women and 16.8 years for men (Consejo Nacional de Población 2011). Although these numbers are still behind the leading developed countries, it is the pace of increase that must be underscored: in the last 80 years, Mexicans gained nearly 40 years in life expectancy at birth, whereas it took Europe 160 years to accomplish a similar gain from about 45 to 85 years (Oeppen 2002). In other words, Mexico started later and from behind but has gained life expectancy twice as fast as Europe. Life expectancy in Mexico is predicted to reach nearly 80 years by 2050 (Consejo Nacional de Población 2013).

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The population 60+ has grown in the past decade at a rate close to 4% and currently represents about 11% of the whole population. In two decades or less, the elderly population will reach 20 million people and by 2040, 1 out of every 4 Mexicans will be 60 years or older. Today, the aged live predominantly in urban areas (74%), are married or have a partner (60%), and have low levels of educational attainment, with 50% having only completed elementary school and 27.2% having never attended formal education (Consejo Nacional de Población 2011).

As most Latin American countries, Mexico is experiencing a “mixed” epidemiological transition with a sharp increase in prevalence of chronic diseases and a marked decrease in communicable diseases in some regions, while still suffering from moderate or high incidence of the latter in the least developed regions of the country. In addition, the country’s health care system is currently not capable of responding adequately to the changing social and health care demands of an aged population. Within the country, differences among states and regions and between urban and rural areas are sharp and mainly obey to lags in economic growth which determine marked inequalities in socioeconomic development.

Data from the Organisation for Economic Cooperation and Development (OECD) reveals that, in 2010, Mexico’s health expenditure as a percentage of GDP was 6.2%; of this, 47.3% came from public sources. In terms of health workforce, while the number of physicians per capita increased substantially over the past two decades reaching two practicing physicians per 1000 population in 2010, this figure still lags behind the OECD average of 3.1. As for nurses, in the same year there were 2.5/1000 population. The number of hospital beds for acute care in Mexico was 1.6/1000 population (Organisation for Economic Cooperation and Development 2013).

Morbidity and Mortality Profile in Elderly Mexican People

As in the rest of the world, women outnumber men at old age in Mexico. There are 112 females for every 100 males in the 60–74 age group, and among the oldest old (85+) there are 135 females for every 100 males. Furthermore, the group of older women is expected to continue to grow, since females aged 40–59 are now a large group of the population, at 13.1 million (11% of the total) (Consejo Nacional de Población 2013). Considering that functional dependence affects predominantly women, this portends that if sanitary programs and policies do not focus on chronic care and avoidance of functional dependence, the care for this group of elders-to-be will be neither attainable nor sustainable, and acute services will be overburdened with them. On the other hand, aging males face their own particular challenges, such as lower survival, higher migration rates and greater rates of violent deaths resulting from accidents, suicides and addictions (Torres 2010).

According to official Health Ministry records, the leading five causes of hospital-bound morbidity in persons 65+ in Mexico are heart diseases (including ischemic heart disease, hypertension and others), accidents (mainly fractures), diabetes

mellitus, cancer and kidney disease (Dirección General de Información en Salud 2014). Multimorbidity is also an issue, since 68.6% of the Mexican population 60+ has at least one chronic disease, and 34.1% has two or more chronic diseases, according to the seven-country survey on Health, Well-being and Aging in Latin America (*Salud, Bienestar y Envejecimiento*, SABE) (Menéndez 2005).

Regarding mental health, the Mexican Health and Aging Survey (MHAS), a population-based, longitudinal study of community-dwelling elderly in Mexico, revealed the prevalence of depressive symptoms to be 37.9% (Ávila 2007), of cognitive decline 28.7% and of Alzheimer's disease 6.1% among persons 60+; the latter's incidence was estimated at 27.3/1000 persons year for the same age group (Mejía 2011).

The 2012 National Survey on Health and Nutrition (*Encuesta Nacional de Salud y Nutrición*, ENSANUT), showed that 34.9% of the people 60+ had had at least one fall in the previous year. Meanwhile, 26.9% of the elderly reported having at least one disability in activities of daily living, with those over the age of 80 having the greatest prevalence (47.5%). Accordingly, the elderly are the group with the highest rate of health care use. In particular, among the oldest old (80+) the rate of health care use rises up to 15.7/100 population, compared to 14.7/100 population between 0 and 4 years—the second largest group of health care users. The main causes for medical consultation in people 70 years and over are diabetes, cardiovascular disease and obesity, which pooled represent 33% of all consultations, followed by acute respiratory diseases (12.9%) (Instituto Nacional de Salud Pública 2013). In spite of this heavy use of health care services by the elderly, providers are in general lacking geriatric expertise, which results in poor quality of care for the main users. In turn, this leads to poor control of chronic diseases and functional decline.

The mortality profile has also changed substantially during the last century: in the 1920s the Mexican population was decimated by war, flu epidemics and migration, so that only 5% of the population reached age 75. In contrast, it is estimated that nowadays 75% of the population will reach age 75 (Camposortega 2014).

A total of 587,826 deaths were registered as occurring in 2012, of which 364,704 (62%) were people aged 60+, the main causes being ischemic heart disease, diabetes and cancer; only 5.7% of the total mortality occurred in children under age 5. As for the causes, 3% of the deaths were attributed to communicable causes (codes A and B from the International Classification of Diseases, tenth edition [ICD-10]), while 85% were caused by non-communicable diseases (ICD-10 codes C through R) and the remaining 12% were originated by external injuries (ICD-10 codes S through Z) (Dirección General de Información en Salud 2014).

An analysis of mortality in elderly people accounting for the Social Inequalities Index (SII) found no difference in causes of death for age or sex. However, there were important socioeconomic differences: elderly people living in small villages and in underprivileged conditions (in terms of the SII) were found to suffer from a higher number of deaths from malnutrition and unknown causes. Of note, "senility" may have been a cause of death in up to 6% of all deaths in people 85+ (Velasco, Personal communication).

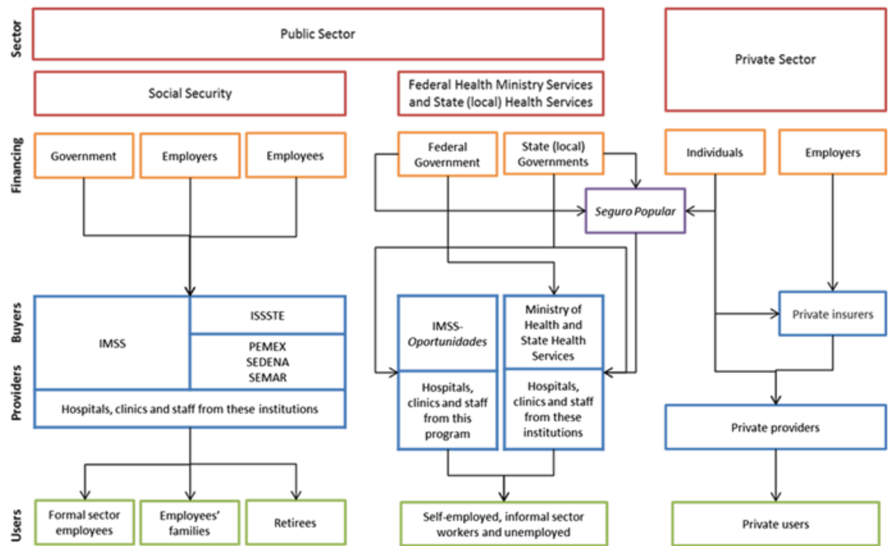

Fig. 22.1 Schematic representation of the health care system in Mexico. (Source: Gómez et al. 2011)

Health Care System

Health protection is granted as a right to all Mexicans by the fourth article of the Constitution. In theory, the older population has the same access to health care provision and services as the rest of the population through the National Health System. However, several issues make access unequal and hinder the achievement of universal coverage that the system strives for.

The National Health System has been highly fragmented since its creation. Health services and users are divided according to the health institution that provides the service (Fig. 22.1). There are three main providers: (a) social security institutions, (b) public services offered by the Ministry of Health, and (c) the private sector. They offer different service packages, work independently and parallel to each other and are financed through different funding sources (Gómez et al. 2011).

Social security is further divided into a number of institutions that provide services to workers from different sectors. The Mexican Institute of Social Security (*Instituto Mexicano del Seguro Social*, IMSS) covers nongovernment employees working in the formal sector of the economy. Government employees are covered by the Institute of Social Security and Services for State Employees (*Instituto de Seguridad y Servicios Sociales para los Trabajadores del Estado*, ISSSTE) and other institutions for specific sectors such as oil company workers (*Petróleos Mexicanos*, PEMEX), military (*Secretaría de la Defensa Nacional*, SEDENA) and naval (*Secretaría de Marina*, SEMAR) officers and employees of the state (local)

governments. Services offered by these institutions extend to the worker's spouse, children and parents (Gómez et al. 2011).

The recently introduced Popular Health Insurance (*Seguro Popular*) is an income-based health care insurance administered by the Ministry of Health which provides coverage to those not insured by any of the social security institutions, including people working in the informal sector and unemployed persons (e.g. homemakers). *Seguro Popular* provides financial protection for more than 50 million Mexicans and is improving access to health services and reducing the prevalence of catastrophic and impoverishing health expenditures, especially for the poor.

According to the 2010 census, 64.55 % of the whole population declared having health insurance of any kind, while 33.8 % remain uninsured. *Seguro Popular* accounts for 36.1 % of the insured population. The two main social security institutions (IMSS and ISSSTE) account for 48.8 and 9.9 % respectively, while private insurance companies account for 2.3 % of the insured population (Instituto Nacional de Estadística y Geografía 2011).

Access to health care in Mexico is still linked for the most part to affiliation to any of the social security institutions, and is thus linked to having a job in the formal sector. This is particularly troublesome in face of Mexico's aging population, because 34.3 % of the elderly continue to work, and more than a third of them (37.4 %) do so in the informal sector, with no access to social security. In total, 27.4 % of the population 60+ remains uninsured (Instituto Nacional de Estadística y Geografía 2011).

Long-Term and Social Care

A formal, long-term care system aimed at the elderly is lacking in Mexico. Some federal and state programs cater for older adults, most of which are responsibility of the Ministry of Social Development and other state agencies. Additionally, there are several private providers (both for-profit and not-for-profit) offering services such as daycare and institutionalization.

A few social services are available through the National Institute for Older Persons (*Instituto Nacional para las Personas Adultas* Mayores, INAPAM) and the National System for Integral Family Development (*Sistema Nacional para el Desarrollo Integral de la Familia*, DIF), a public family-welfare institution with federal and state agencies. INAPAM offers career placement fairs, training, daycare and cultural centers, shelters, socio-cultural activities, health education, psychological and educational services, as well as training for people 65+ to become "certified elderly caretakers" (Secretaría de Desarrollo Social 2014). DIF has a daycare program (*Programa de Atención de Día*) which provides services for a small number of individuals. The supply at state level varies according to the local needs, the available resources or the commitment of the local governments with this age group (Sistema Nacional para el Desarrollo Integral de la Familia 2014).

Most of the government-provided services are an extension of poverty reduction programs or other social care strategies led by the Ministry of social development.

Three specific poverty reduction strategies are on place that have focused or extended their services towards the older population. First, *Programa 65 y más* (65+ Program, formerly 70+), by the Ministry of Social Development, provides a non-taxed fee roughly equivalent to US$ 40 to people 65+ who are not claimant of *Oportunidades* (see below). Its objectives are to provide economic support and social participation activities organized by local authorities (Secretaría de Desarrollo Social 2013).

The second strategy is also supported by the Ministry of Social Development through the extension of the *Oportunidades* (Opportunities) program in order to support individuals 70 years and older who are members of affiliated families. *Oportunidades* is a wide-scoped, comprehensive, human development program aimed at reducing poverty, malnutrition and poor health in rural areas of the country, including money transfers, alimentary aid, education, and medical consultations. Families receive a monthly non-taxed allowance which varies depending on a number of features, such as number of children and the school grade they are in, up to a maximum of US$ 205 per family. The extension for families with older adults consists of an additional US$ 25 per older adult. Participants are required to attend a bimonthly medical consultation in order to get the support (Secretaría de Hacienda y Crédito Público 2013).The third strategy refers to the System of Social Protection in Health, provided through *Seguro Popular*. Its main objective is to ensure effective access to timely, quality health care without discrimination and free at the point of care (Ley General de Salud 2014). Out-of-pocket payments at the point of care are reduced by establishing an annual pre-payment fee for each insured family. The two lowest income brackets of the population are exempt from this fee. The benefits package for men and women 60+ covers diverse areas such as vaccination (anti-influenza and anti-pneumococcal), mental health, oral health, osteoporosis, prevention and control of tuberculosis, and diagnosis of diabetes, hypertension and obesity (Comisión Nacional de Protección Social en Salud/Seguro Popular 2012).

Some initiatives have also been developed locally by the state governments. The first and oldest of these initiatives began in Mexico City in 2001 as a comprehensive program of food support, health care and free medications, but has been modified in the course of the years. In its current form, the Alimentary Pension Program for Older Adults (*Programa de Pensión Alimentaria Adultos Mayores de 68 años*) provides a non-taxed, non-contributory, US$ 66 pension estimated to have reached 100 % coverage of adults 68 years and older living in Mexico City in 2012 (Instituto para la Atención de los Adultos Mayores en el Distrito Federal 2013). The pension is provided through an electronic card that can be used in most commercial establishments in the city for purchasing food, medications and other goods.

On March 18, 2014, a bill in the Congress was voted that will assign a monthly pension of roughly US$ 43 to all those persons 65+ who are not covered by any of the aforementioned programs (Nieto 2014).

Within the private insurance sector, long-term care insurance schemes have begun to emerge but little is known about premiums, coverage and population insured. Given the fact that these schemes are expensive, they are only affordable to a small fraction of the population.

As for institutionalization options, there are currently few public institutions for older adults who are dependent because of medical or mental health problems. A larger number of private institutions exist, offering day and institutional care, as well as a wide range of community services and activities. Unfortunately, a national registry that gathers information and monitors all public and private institutions is lacking.

The current legal framework related to health and social care is extensive but does not enhance or regulate long-term care in itself. Most of the regulatory documents are Official Mexican Standards (*Normas Oficiales Mexicanas*, NOMs), which are a type of regulatory document with a lower hierarchy than a law. Some NOMs regulate medical ambulatory or hospital care for the ill and disabled, but only one of them is aimed at regulating social care for older adults at risk or in vulnerable situations, as defined by lack of family, family rejection, physical or psychological abuse, or lack of economic resources (Secretaría de Salud 2012). Regulatory laws are urgently needed in order to standardize care, and the services provided by public and private institutions.

Few studies have evaluated the quality of the institutions and/or the impact they have on older adults' wellbeing. One study concluded that quality of services provided is unacceptable both in private (profit and nonprofit) and public institutions, due to many factors including unqualified personnel, inadequate facilities and unsafe conditions, to name a few. The authors point out the lack of adequate normative framework and the lack of supervision as the cause and consequence of the increase in the number of institutions providing inadequate or substandard care (Gutiérrez et al. 1996).

Informal Care

Most of the elderly live at home with their spouse or partner, children, grandchildren or other close relatives. The family provides all or most of the care. No special benefits for family caregivers are available, neither fiscal nor social security-wise. Within the families, the responsibility of care often falls upon female members, which in turn limits women's opportunities at professional or personal development. Nevertheless, reduced fertility rates, national and international migration, women's increasing participation in the workforce and activities outside of the household, among other factors, have changed family size and composition and pose future challenges to the availability of household care and support.

A country-wide study on care and its associated burden was lacking until 2012, when the Survey on Work and Shared Responsibility (*Encuesta Laboral y de Corresponsabilidad Social*, ELCOS) was undertaken by INEGI and the National Institute for Women. While not specifically focused on care of the elderly, ELCOS's main objective was to produce indicators on care provided at home, both by household members and external persons, in order to determine whether women are overburdened by caregiving and whether this overburden represents an obstacle to their

insertion in the workforce. Noticeably, this survey is only representative of 32 urban areas (population > 100,000), including the three major metropolitan areas: Mexico City, Guadalajara and Monterrey.

An official report from ELCOS has yet to be published, but preliminary results posted on the survey's official website already reveal some interesting insights into the care needs and caregiving phenomenon occurring in Mexican households. The total number of persons needing care and/or support in urban areas is 12,061,361 (25.1 % of the surveyed population). Of these, 86.6 % are under age 15, 9.9 % have temporary health conditions and 6.1 % have permanent limitations. Out of those who reported having permanent limitations, 468,926 (63 %) were older adults, and of these, 63 % were women and 88.1 % needed permanent care or support from another person (Instituto Nacional de Estadística y Geografía 2014).

In spite of the fact that most of the care in Mexico is provided at home, evaluations of the health system did not take it into account. From 2010 onwards, the National Health Accounts includes information regarding informal care in the Health Sector Satellite Account. In 2011, the total health expenditure (THE) was equivalent to 5.6 % of the national gross domestic product. Unpaid health care provision accounted for 20.5 % of the THE, while the public sector accounted for 37.9 % and the private sector for 41.6 %. Unpaid health care provisions is almost equivalent to the expenses in hospital services (24.4 % of THE) and more than double the expenses in medications and other care goods (9.3 % of THE) (Instituto Nacional de Estadística y Geografía 2013). Although the unpaid health care is not disaggregated by age of the care recipient or type of care provided, it can be assumed that a significant proportion of it is destined to the elderly.

Geriatric Health Care Workforce and Facilities

There is a serious shortage of human resources in health care, spanning not only actual care provision but also teaching and research. At present, the workforce dedicated to caring for the elderly is not enough and the geriatric skills of general practitioners are still suboptimal, even with most medical schools now including undergraduate training programs on geriatrics and/or gerontology as a part of their undergraduate medical curricula, including the National Free University (*Universidad Nacional Autónoma de México*, UNAM). More physicians and other health professionals need to be trained in geriatrics, and there is a need for more social scientists, policy experts, biologists and health practitioners to be trained in gerontology.

The first geriatric medicine residency program in Mexico was established in 1994. Currently, there are approximately 500 certified geriatricians. As of August 2010, seven Mexican universities offered specialization in geriatrics, a 2-year training program requiring 4 years of previous training in internal medicine (Ávila 2012). However, the slot occupation in these geriatric residency programs was only 70 %. In response to this situation, a new, direct entry, 4-year geriatric medicine program was established in 2013 and is set to begin its first academic cycle in March, 2014.

For this program, 58 positions were created and funded by the Ministry of Health, with an occupation rate of 100 % (Secretaría de Salud 2014).

High-specialty programs are also available for geriatricians and other specialists to further specialize in geriatric cardiology, dementia, geriatric neurology and geriatric rehabilitation. Furthermore, a Master of Public Health program with focus on Aging was established in cooperation between the National Institute of Public Health (*Instituto Nacional de Salud Pública*, INSP) and the National Institute of Geriatrics (Instituto Nacional de Geriatría, *INGER*).

In spite of recent efforts for training geriatricians, considering the most conservative recommendations, Mexico would need to produce more than 2,000 geriatricians in the following 10 years to meet the needs of its population (Ávila 2012). Clearly, the current rate of production of human resources is insufficient.

As of 2010, Mexico had 21 geriatrics departments in general hospitals, most of them located in Mexico City. There are also some specialized geriatric services such as memory clinics, a geriatric cardiology ward and a geriatric rehabilitation ward (Ávila 2012).

Instituto Nacional de Geriatría

Mexico's National Institute of Geriatrics (*Instituto Nacional de Geriatría*, INGER) was created in 2008, with the purposes of promoting research on aging, training specialized human resources in elderly care, developing models of care for the elderly and innovating in the field of public policies for the aged population.

The Institute's Research division works on a number of lines, including biological mechanisms of aging, socioeconomic aspects of aging, clinical geriatrics, epidemiology and gerontechnology. There is also a line of health care systems research and development that covers different levels of care (emergency, acute elderly care, primary care, telemedicine). Additionally, in 2011 the Institute created the Aging, Health and Social Development Research Network (*Red Temática de Envejecimiento, Salud y Desarrollo Social*, ESDS). To date, the ESDS has accrued 150 researchers focused on different aspects of aging throughout the country.

In line with its purpose of innovating in public policies for the aging population, the INGER has developed and proposed an Action Plan on Aging and Health together with the UNAM and the Mexican National Academy of Medicine (Gutiérrez and Kershenobich 2012). Published in 2012, this position statement together with an epidemiological report published in 2013 with data from the 2012 ENSANUT survey, led to the introduction of a specific strategy for healthy and active aging in the government's Health Sectorial Program, which will direct the public health sector for the 2013–2018 period (Presidencia de los Estados 2013). Similarly, in collaboration with other institutions, the INGER has started a working group on Dependence and Aging, which is about to publish its first position statement with the main purposes of bringing dependence to the public policy arena and promoting the development of a long-term care system in Mexico. At the same time, the INGER is

on its way to develop a new model of care for the elderly based on primary care. Finally, a new model of age-friendly primary care centers has been jointly developed by the Ministry of Health and the INGER and is soon to be released.

Another major division of the INGER is Education and Knowledge Translation, now working in the development of a large human resources network dedicated to elderly care. This project has been named FORHUM3, because it is a triple alliance program. In addition, the Institute is building its Virtual Library with a specific focus on age and aging.

Last, but not the least, the INGER is committed to promoting positive attitudes towards aging and the aged. It is also interested in promoting intergenerational relationships and social engagement in later life. From this point of view, it strives for the elimination of cumulative disadvantage across the lifespan in order to remove barriers to participation in late life. In Mexico, aging is almost always associated with negative notions of loss, decline and decay. The INGER contributes to convey the idea that many people are still able to live healthy, active and productive lives well into old age.

Preventive Health Approaches

Recent evidence indicates that the extension of healthy life expectancy is achievable, even at old age. With the knowledge that interventions already exist to delay the onset and progression of major fatal and disabling diseases, a preventative strategy with a life course perspective has been introduced in the Mexican public health policies (Presidencia de los Estados 2013).

Across the lifespan, mental health problems such as depression and dementia compromise physical health and quality of life alike. They often go unnoticed or misdiagnosed and may interfere with the effective treatment of other conditions, for example, by compromising therapeutic compliance or hampering help-seeking behaviors. They are also associated with suicide, which is increasingly becoming a public health issue. Structured interventions for depression and dementia have proven to be even more effective than psychoactive drugs, especially in the long term. Accordingly, the INGER is pursuing research and development of such interventions, aiming to implement and Action Plan on Alzheimer's disease and related disorders.

A Look Ahead: The Elderly as Drivers of Policy Making

Policy making is inevitably influenced by political strategy, which is in turn strongly driven by trends in public opinion. Historically, women's health and children's health have dominated the health policy global scenario, mostly as a long-standing consequence of the baby boom and the inequities in the social determinants of

health beginning from an early age, but also very likely due to the fact that most of the voting population was made up of young people of child-bearing and child-rearing ages. As the population grows old, however, the group of older people will become a major source of voters, which will undoubtedly attract the attention of decision makers and politicians. Thus, the so-called grey vote is likely to become decisive in the democracies of the near future around the world.

In Mexico, according to the National Institute for Elections (*Instituto Nacional Electoral*), as of May 9, 2014 the nominal list of voters (the list which is used to identify voters and register their votes by electoral district) contained 78.84 million people, of which 12.12 million (15.3 %) were 60+ years old (Instituto Nacional Electoral 2014). This means that the elderly currently represent 15.3 % of the voting population in the country.

An example of the power of the grey vote has already occurred in the capital of the country. In 1997, a left-wing party won the elections for Mexico City Major. Under this government, the approach to the elderly population shifted from regarding it as a vulnerable group to regarding it as a prioritary one, and a law for the rights of the elderly was passed in 2000 which paved the way towards the introduction of the previously discussed non-contributory pension for the elderly in 2001 (López 2003). With this and several other progressive social policies that have been widely welcomed by the general population, it is not surprising that the same leftist party has maintained the rule over the city for 17 years (that is, three elections for city major in a row after the introduction of the pension). In Mexico City, the elderly currently represent 18.2 % of the voting population.

It is reasonable to anticipate that the elderly will become major drivers of policy making not only as a sheer source of votes, but also as major players in society. As the population ages, more and more people are reaching old age in a better health, which means they are able to participate more in society. It is only a matter of time before they begin to organize into civil society organizations and other associations of the like with the purpose of bringing forward their interests and pushing for their rights.

Conclusions

Mexico's demographic transition is nearly complete, and the aging of its population is beginning to pose stress on the health care and social development systems, as well as on the families and the society in general. The country is largely unprepared to respond to the needs of its aging population. The absence of formal care and support services for the elderly has left informal caregivers, mostly women, overburdened with the responsibility of providing household care throughout the life course. Although the lack of strategies for the older population has not yet originated a major crisis in terms of service provision and financing, presumably due to the support capacity of the families and social networks, the expected growth of the elderly population will further strain households and institutions alike.

Public care offer for the elderly in Mexico is limited, and little is known about the extant private care offer. In any case, the latter is small and informal in nature and there is no real way to assess the quality of the care provided. Elderly care is still a gray area lacking regulation, information and evaluation. Even public institutions which provide some form of care do not conduct comprehensive monitoring and evaluation of their activities.

If Mexico wants to ensure quality care for its present and future generations of elderly people, long-term care, social care and improvement of health care are long overdue priorities that should be addressed immediately. Unfortunately, very little effort is being done in this direction at present. There is still some reluctance in Mexico to include an aging perspective into decision making and policy design, and a tendency to prioritize the perspectives of younger stages of life. However, as the population grows older the grey vote may become a major electoral force, which will hopefully compel politicians and decision makers to turn their looks towards the needs and rights of the elderly. An aging perspective needs to be included not only in health and social issues, but in general all across public policies aimed at well-being and development. Similarly, more spaces for the elderly to effectively participate and engage in civil society need to be made available nation-wide.

There is much that can and must be done today to improve elderly care in Mexico. Whatever the country's answer to this challenge, it will have to include a new interpretation of the elderly as a priority and not a vulnerable group. Furthermore, a health and social agenda is in order that regards care as a personal, civil right and no longer as a mere feature of welfare.

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