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INSTITUTO NACIONAL DE GERIATRÍA

Conference Series on *Aging in the Americas*

CONACYT

Embajada de los Estados Unidos, México

LBJ

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Seminario – Taller

Sistemas de Apoyo Formal e Informal Para Personas Adultas Mayores

en México y Estados Unidos, en el Contexto de las Reformas en Salud y Seguridad Social

17 y 18 de septiembre, 2015
Ciudad de México

Making Our Health and Care Systems Fit for an Ageing Population:Considerations for Mexico.

Luis Miguel F Gutiérrez Robledo MD PhD

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Por un envejecimiento sano y activo

The challenge

- By 2030, one in six people in Mexico will be aged over 60.
- That we are living longer is a cause for celebration, but it already presents major challenges to our health and care system.
- We could do better coordinating care around old people needs and focusing on keeping people well and out of hospital and Long Term Care.

KEY ISSUES

- People are living longer, many with one or more long-term medical conditions, and for a significant number, **advancing age brings frailty.**
- The **complexity** of this problem has been recognized; policies and guidance for the care of older people are being developed.
- The **challenge is to turn the rhetoric** of personalized geriatric care into the **reality of everyday care**.
- Actions can be taken at different levels of the system to deal with this issue, but **the responsibility for quality of care** and outcomes is located at the **level of the team**.
- Decisions and **actions** taken at any level of the system should **enable frontline staff** to do their work.

The King's Fund Ideas that change health care

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Red Temática Envejecimiento, Salud y Desarrollo Social

Introduction

- A report from the UK proposes a range of interventions to make care better for older adults, especially those who are frail.
- We discuss the proposed shift from the acute care hospital to other models of care in the Mexican context.
- The key concept is a **fundamental shift to care** that addresses the full range of individual needs rather than specific illnesses.
- Strategies are needed to keep people out of hospital but still give them needed care.

Whole-system changes are needed to deliver the right care at the right time, and in the right place, to meet older people's health needs, care preferences and goals.

Age well and stay well

- Major **inequalities in life expectancy** and healthy life expectancy at birth in different settings in Mexico.
- **Loneliness** (30% of elderly people households are unipersonal)
- 70% of the population is **obese** or overweight
- Uptake of influenza and pneumococcal **vaccinations** is 58%, slightly below the levels set by international targets (60%)

What we know can work

- Life course approaches to health and wellbeing that address the **social and economic determinants of health**.
- Preventing **social isolation**
- Promoting healthy **lifestyles**
- **Vaccination**
- Screening programs
- **Frailty** prevention

10-7-2011

The Impact of the PROGRESA/Oportunidades Conditional Cash Transfer Program on Health and Related Outcomes for the Aging in Mexico

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PNAS

Effects of income supplementation on health of the poor elderly: The case of Mexico

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Edited by Kenneth W. Wachter, University of California, Berkeley, CA, and approved November 18, 2014 (received for review July 29, 2014)

We use an income supplementation experiment we designed in the state of Yucatan in Mexico for residents 70 y and older to evaluate health impacts of additional income. Two cities in the State of Yucatan, Valladolid (treatment) and Motul (control), were selected for the income supplementation experiment. Elderly residents of Valladolid were provided the equivalent of an additional $67 per month, a 44% increase in average household income. We designed a survey given to residents of both cities before and 6 mo after the income supplement about their health and other aspects of overall well-being. Both baseline and follow-up surveys collect self-reported data on health, physical functioning, and biomarkers. Anthropometric measurements for every age-eligible respondent, including height, weight, and waist circumference, were collected. We also collected lung capacity, grip strength, a series of balance tests, and a timed walk. Our results show significant health benefits associated with the additional income. Relative to the control site, there was a statistically significant improvement in lung function and an improvement in memory. These improvements are equivalent to a reduction in age of 5–10 y. Residents used their extra income to go to the doctor, buy their medications, and alleviate their hunger. The fear that this extra income could be undone by reduced transfers from other family members or unwise expenditures by the poor elderly appears to be unfounded.

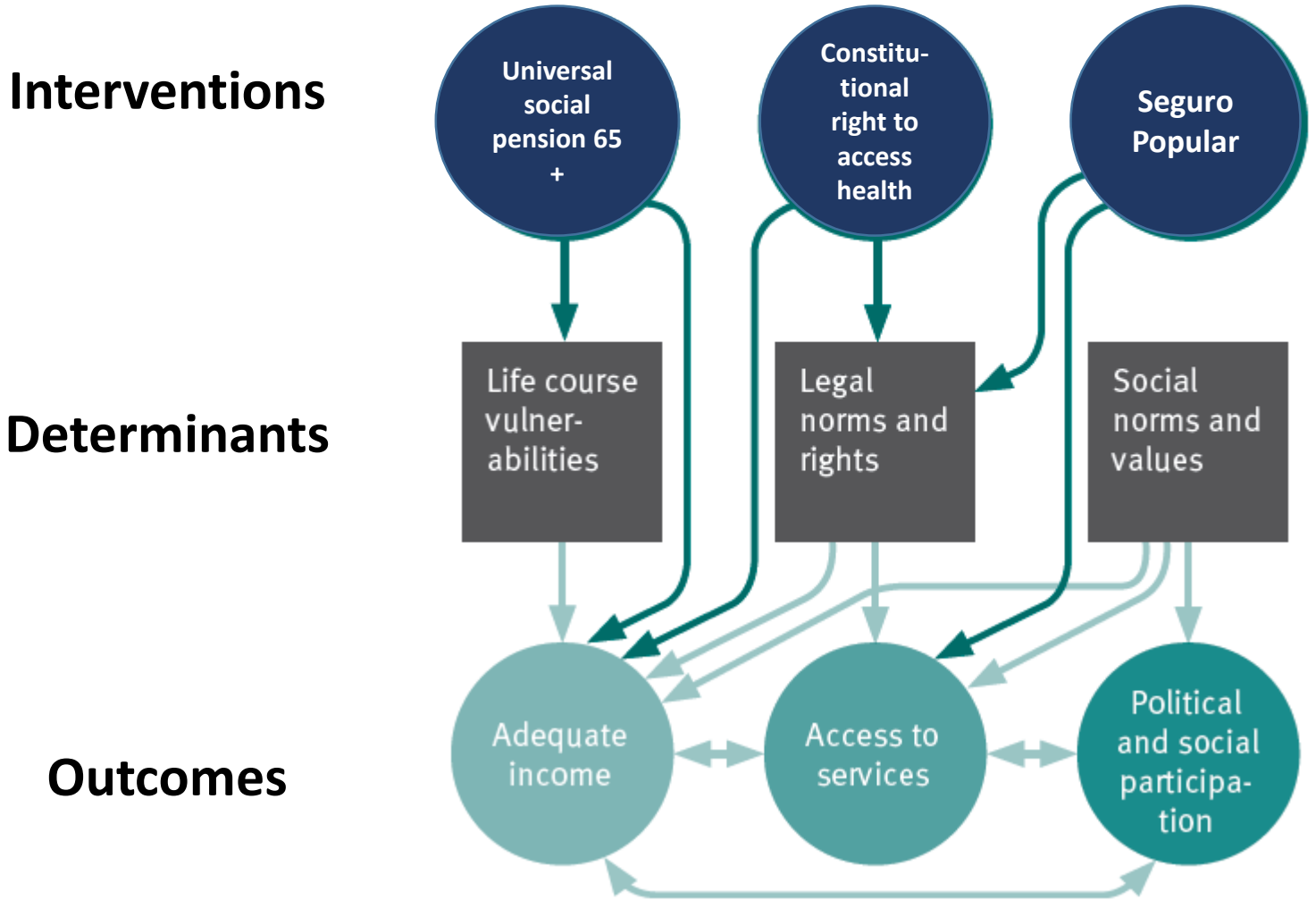
out to the entire community. We find that this income supplement leads to a statistically significant and quantitatively important health improvement in many dimensions including memory, low hemoglobin, and breathing. We also find this income supplement was not undone by reduced transfers from relatives and that a significant part of the extra money was spent on doctor visits and medications, and to alleviate hunger.

Methods

Study Design and Participants. The government of Yucatan was interested in providing a noncontributory pension equivalent to the one provided by the federal government program, which paid 1,000 pesos per 2 mo. The Yucatan government conducted an analysis of financial sustainability of the program and the highest pension that the government could provide was 550 pesos per month, which is equivalent to $67 USD per month at purchasing power parity (PPP) (which translates standards of living between different countries). The amount of the pension is similar to other countries in Latin America such as Colombia and Peru where in USD$ PPP the amounts were $44 and $75, respectively (4). It is of course below that of the richer countries in Europe and the United States.

This study presents the evaluation of a social policy intervention using a quasiexperimental design with rich data capturing health and well-being in old age. The income supplement program is designed for all individuals 70 y or older living in urban areas of more than 20,000 inhabitants in the State of Yucatan, Mexico. It provides a flat rate pension of 500 pesos per month, an

The impact of social protection on determinants of dependence and vulnerability in Mexico



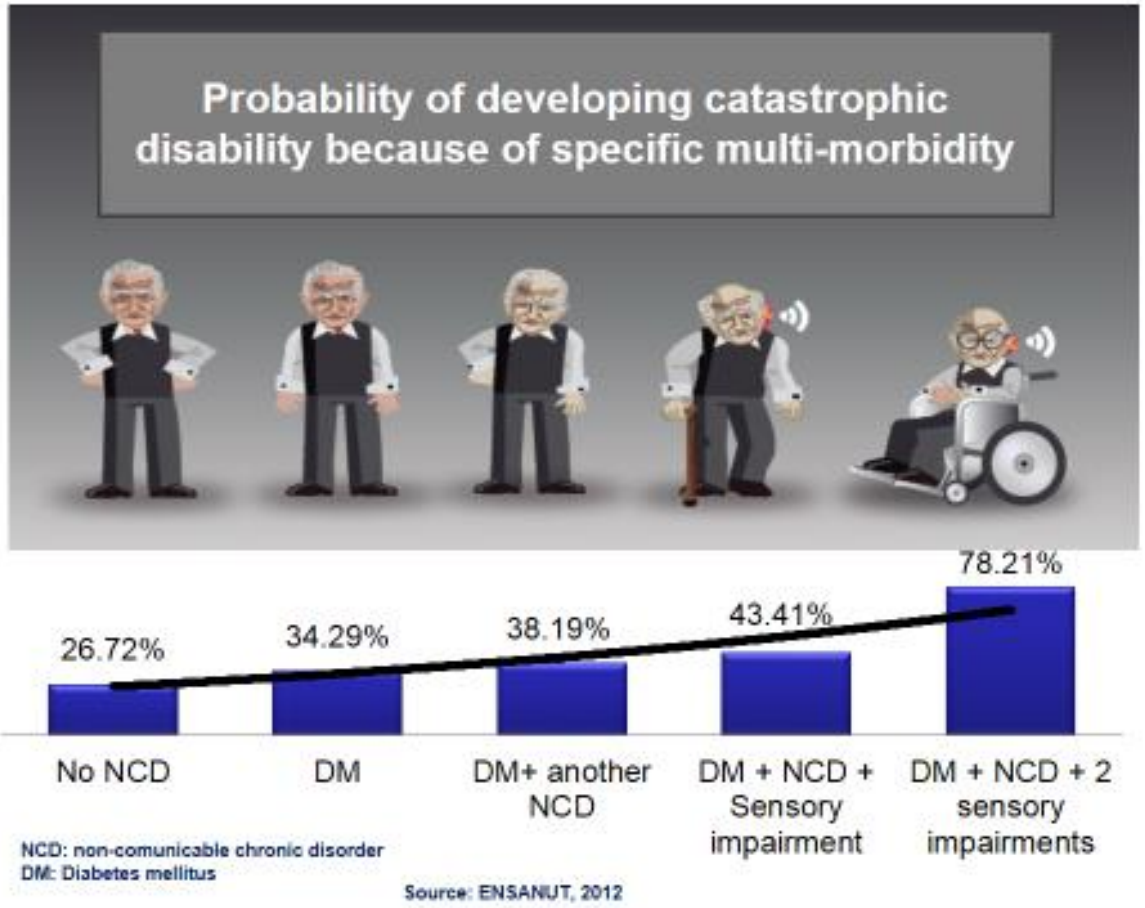
Live well with simple or stable long term conditions

- Most people over 60 in Mexico live with long term conditions (**Diabetes** 24%, **Hypertension** 40%, **Osteoporosis** and **Sarcopenia** over 30%, major cognitive impairment over 8%)
- Older people receive **poorer levels of care** and are less likely to receive optimal therapy (lower rates of HT and DM control)
- General medical conditions are treated more effectively than common **geriatric conditions** (which often remain unrecognized)

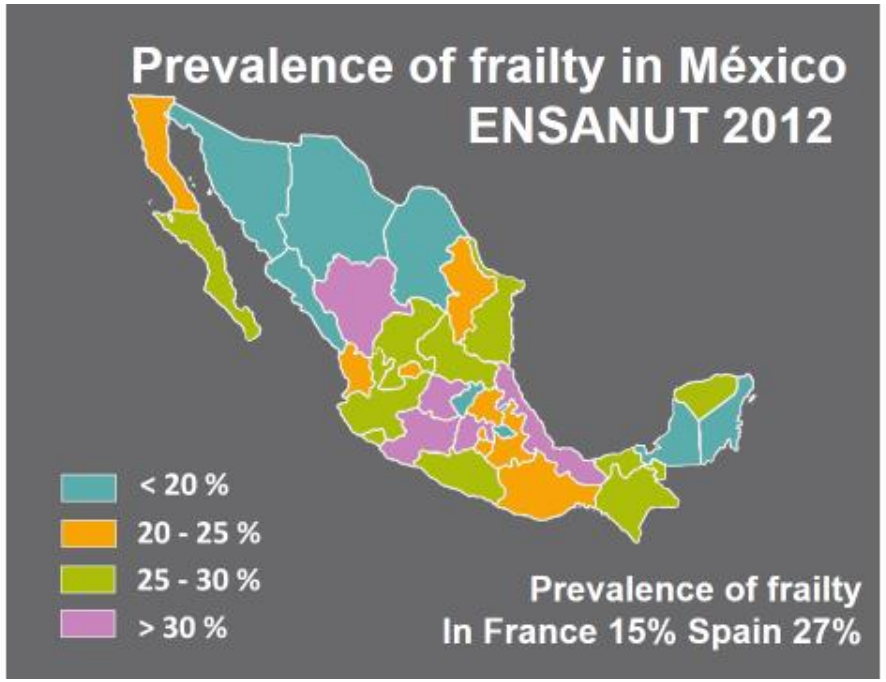
What we know can work

- **Universal coverage** (over 85% in Mexico today)
- Introducing population **risk stratification**
- **Educating** family and care workers
- Improving **care** and treatment for common geriatric conditions
- **Empowering** and involving older people and their families in planning and coordinating
- **Case management** delivered through locally based teams (liaison geriatric medicine)
- Providing **continuity** and care coordination

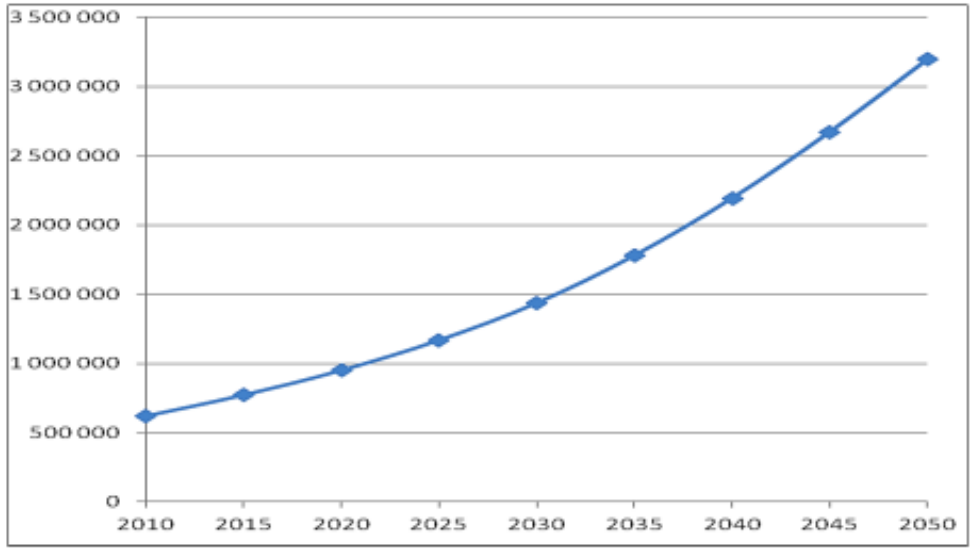
Multimorbidity



- Health services and care for older people with complex co-morbidities, including frailty and dementia to **remain as well** and independent as possible and to avoid undue deterioration and complications.

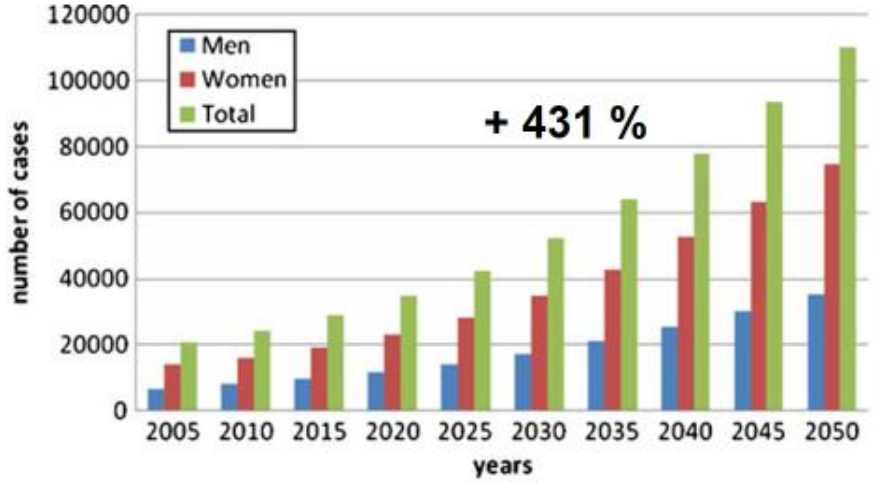


Dementia incidence in Mexico



Sosa AL Epidemiology, costs and burden of Dementia in Mexico (2013) 10/66 group

Hip fracture incidence



Clark P Epidemiology, costs and burden of osteoporosis in Mexico (2008) Arch Osteoporos DOI 10.1007/s11657-010-0042-8

Current situation

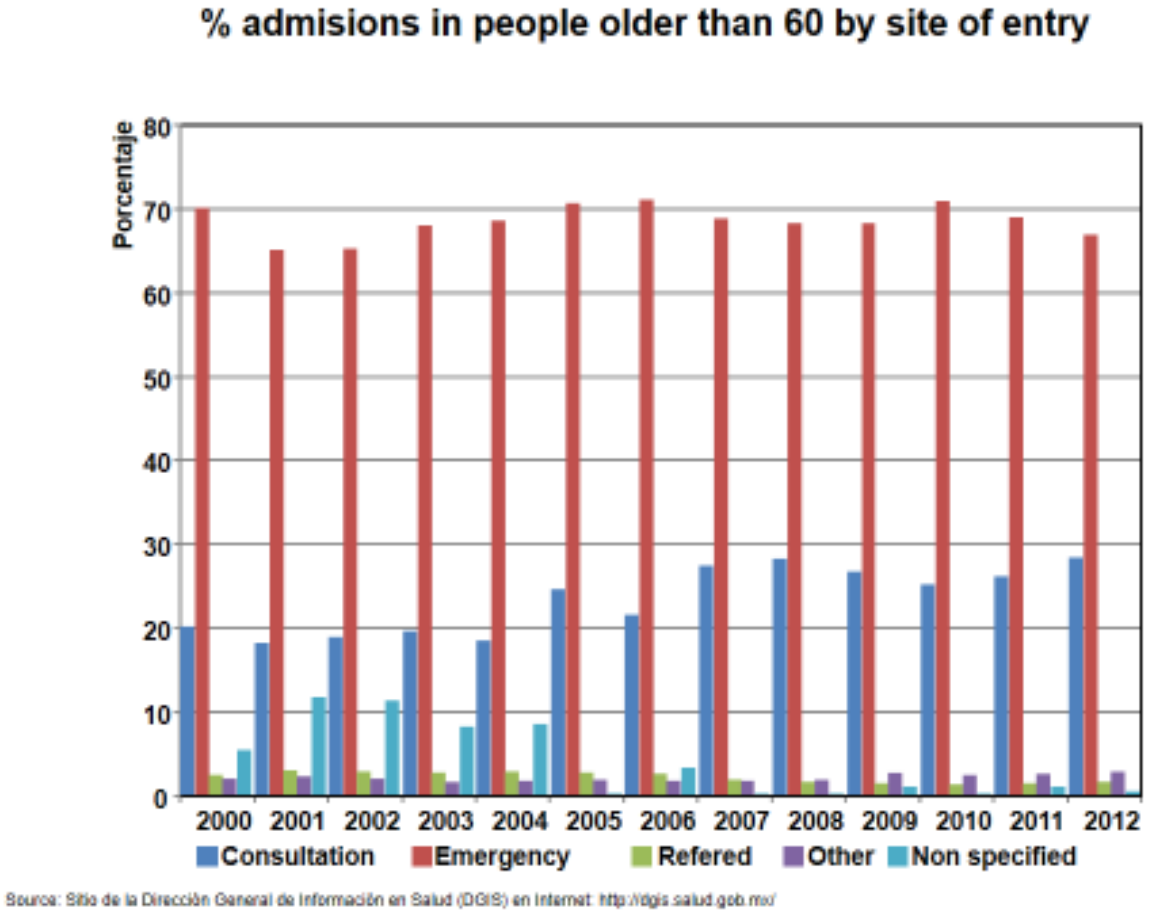
- **Frailty** is common and usually neglected (>25% of elders in Mexico)
- More than 1 in three people 60 and older **fall** each year (35%)
- There is considerable under diagnosis of **dementia** (800,000 cases in Mexico, Incidence rate 25/1000 per year)

What we know can work

- Recognizing the importance of **frailty**
- Using frailty risk assessment and case finding
- Using proactive **comprehensive geriatric assessment** and follow up for frail people
- Falls **prevention**
- Providing **good care** for people with dementia
- Reducing inappropriate **polypharmacy**

Accessible effective support in crisis

- When health or independence rapidly deteriorates, access to **urgent care** including effective alternatives to acute hospital care.



Source: Sitio de la Dirección General de Información en Salud (DGIS) en Internet: http://dgis.salud.gob.mx/

Current situation

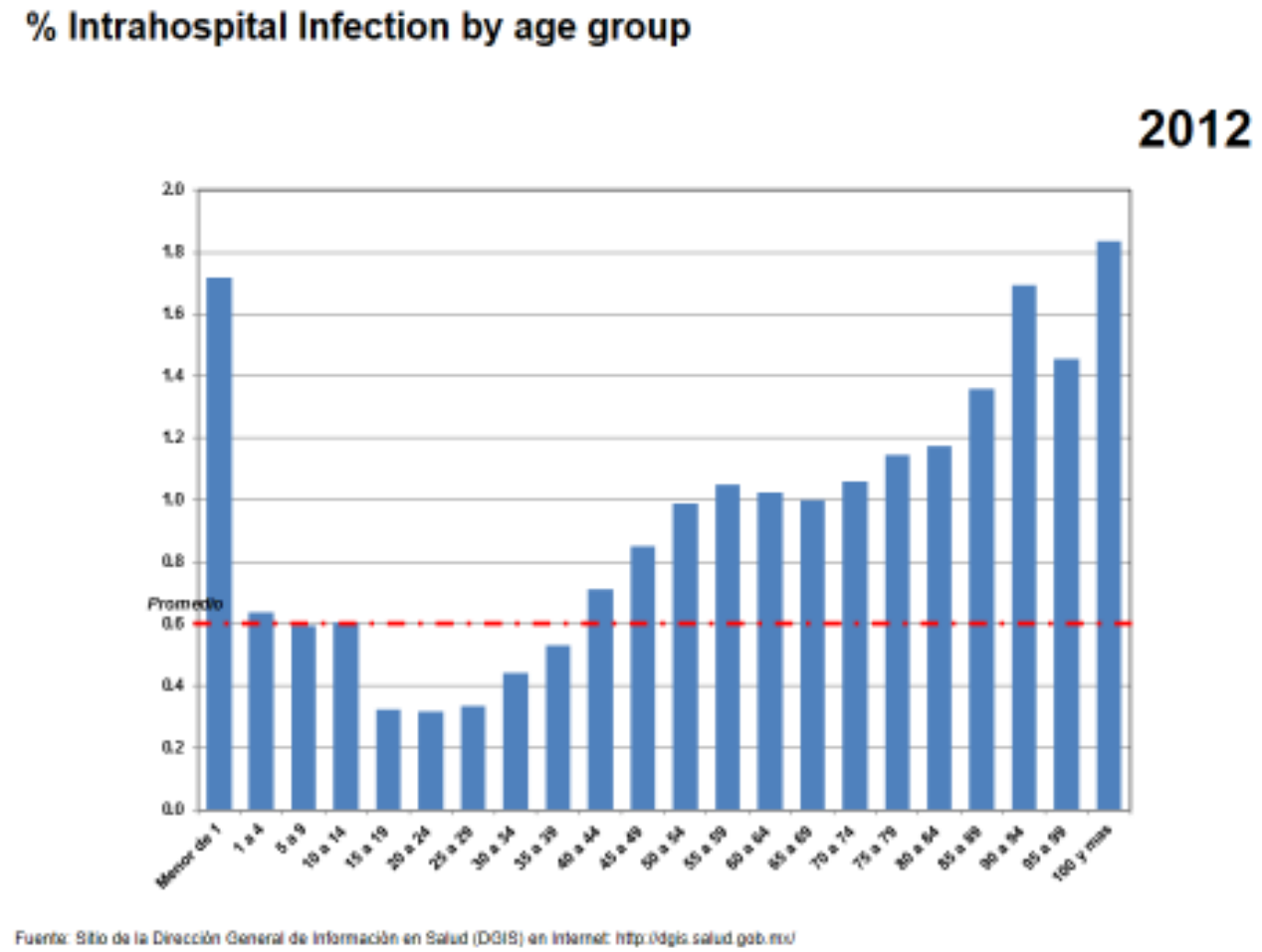
- Older people **tend to remain at home** without care, longer than they should
- When led to the hospital they attend **overcrowded emergency wards** where functional impairment aggravates
- They are often discharged without a clear solution to their condition and **no care plan**
- The **main entry port** to the hospital is the emergency ward (70% of admissions)

What we know that can work

- Promoting **continuity** of primary care
- **Rapid Access** ambulatory care clinics
- Providing urgent, coordinated **social care**
- Using home care **prevention** services
- Community and **liaison geriatrics**:
  - Tele-care for people at risk
  - Providing urgent access to primary care
  - Developing virtual or community wards
  - Develop “discharge to assess” programs

Person centered acute care

- Acute hospital care must meet the needs of older patients with **frailty**, complex comorbidities and dementia
- Services should provide adequate access to specialist input, **minimize harms** and provide compassionate and person centered care



Current situation

- People aged 60 and over account for **>20 percent** of hospital admissions.
- Consistent failures to provide even basic assessment or treatment plans for most common **harms of hospitalization** (only decubiti prevention is addressed systematically)
- Older people suffer more commonly **adverse effects of hospital care** (falls, infection, undue functional impairment)
- Older people with complex needs including long-term conditions and frailty are at high risk of **readmission**.
- Older people frequently lack **support on discharge**

What can work

- **Focusing on frailty**, early risk stratification and immediate discharge planning from admission
- **Minimizing harms** of hospitalization
- Targeted comprehensive geriatric assessment
- Involving **carers** and older people in discharge plans
- Focusing on **person centered dignified care**
- Specialized geriatric care units
- **Liaison** and in reach services for other wards
- Maximizing **continuity** of care (ability to discharge 7 days a week)
- Developing **post discharge remote assessment** and support
- Assuring **communication** for continuity of care

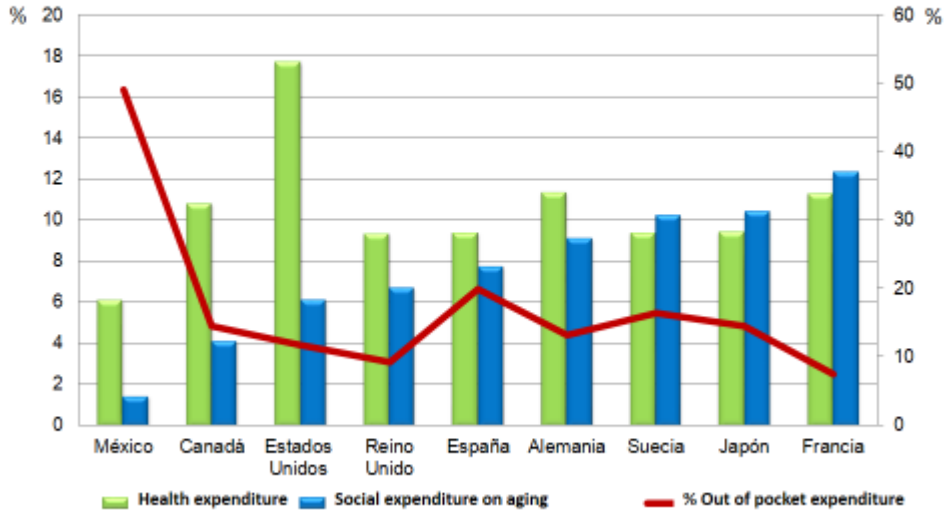
Person centered dignified long term care

- Though some make a positive choice to enter long-term care, older people should only move into when treatment, rehabilitation and other alternatives have been exhausted
- Residents should consistently receive high quality **care that is person-centered** and dignified, and have the same access to care as other people living at home

Current Situation

- There is an estimated of 1,000,000 dependent older people in Mexico
- Less than 100,000 living in care homes, more than 90% remain at home
- Families are investing time and money in excess of their capabilities
- Levels of dependency are rising, so that the population will endure a significant growth in care expenditure
- People living in such conditions face wide variation in their access to all necessary health services

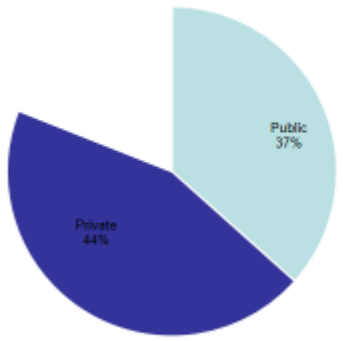
Social expenditure on aging, health expenditure (% GDP) and out of pocket expenses (2010 or more recent)



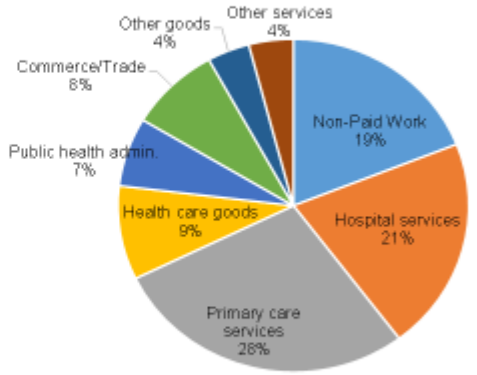
OECD: Databases of health expenditure and Social Expenditure, 2012

Cost of non-paid health care (informal care)

Structure of GDP in Health, 2010



% GDP in Health by type of goods or services, 2010



Source: Sistema de Cuentas Nacionales de México: Cuenta satélite del sector salud de México, 2008-2010 / Instituto Nacional de Estadística y Geografía.-- México: INEGI, c2011.

What we know can work

- Developing community based LTC services
- Conducting systematic global geriatric assessments in LTC settings
- Providing training and support for care staff
- Using evidence based frameworks for assessment of quality of life and improvement of relationship-centered care

Support control and choice at the end of life

- Older people nearing the end of life should receive **timely help** if they want or need it, to discuss and plan the end of life.
- End of life care services should provide high quality care, support, choice and control, and should **avoid over-medicalizing** what is a natural phase of the life course.

Current situation

- Older people receive poorer quality care towards the end of life and are often discharged without support because of “maximal benefit attained” of hospital care
- They are rarely involved in discussions about their options, less likely to die where they choose, and less likely to receive specialized end of life care

What we know can work

- Learning to identify people in their last year of life
- Providing workforce training and support
- Disseminate knowledge about advance directives
- Ensuring effective assessment and advance care planning
- Ensuring provision of specialist end of life and palliative care services
- Support people at care home and home to die in their settings rather than in the hospital

Making it happen: integration

- Must happen at the **local level** in each of the 9 components
- We need to **drive whole system changes towards integrated, person centered care** at the **community level** which is coordinated around people's needs and goals

Health and Aging in Mexico Policy Time line

1999 — CREATION OF THE NATIONAL COMITEE ON AGING AND HEALTH

2000 — PAHO SABE SURVEY

FIRST SPECIFIC ACTION PLAN ON AGEING

2001 — FIRST UNIVERSAL SOCIAL PENSION PROGRAM IN MEXICO CITY (BECAME A RIGHT IN 2003)

Mexican Health & Aging Study

MHAS 2001-2013 BEGINS

2002 — LAW ON THE RIGHTS OF OLDER ADULTS

Martes 29 de julio de 2003 DIARIO OFICIAL (Primera Sección) 81

SECRETARIA DE SALUD

DECRETO por el que se crea el Instituto de Geriatría.

Al margen un sello con el Escudo Nacional, que dice: Estados Unidos Mexicanos.- Presidencia de la República.

FELIPE DE JESÚS CALDERÓN HINOJOSA, Presidente de los Estados Unidos Mexicanos, en ejercicio de la facultad que me confiere el artículo 89, fracción I, de la Constitución Política de los Estados Unidos Mexicanos, con fundamento en los artículos 17, 31, 37 y 39 de la Ley Orgánica de la Administración Pública Federal; 2, fracciones I, II, V y VII, 3, fracciones X y XI, 6, fracción I, 7, fracciones III, VII y XII, 90 y 97 de la Ley General de Salud; 6, 10, fracciones I y XVII, 18, fracciones I, II, III y VII, de la Ley de los Derechos de las Personas Adultas Mayores, y

2004 — CREATION OF SEGURO POPULAR

70 y + Adultos Mayores

70 AND MORE SOCIAL PENSION

2007 — INSTITUTO NACIONAL DE GERIATRÍA
POR UN ENVEJECIMIENTO SANO Y ACTIVO

2008 — RESEARCH NETWORK ON AGEING

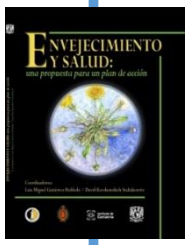
Red Temática REDESDS Envejecimiento, Salud y Desarrollo Social

NEW GERIATRICSPECIALTY PROGRAM

2010 — CONSTITUTIONAL REFORM ON RIGHTS TO ACCESS TO HEALTH CARE

2011 — NATIONAL UNIVERSAL SOCIAL PENSION 65 AND +

ENSANUT
Encuesta Nacional de Salud y Nutrición



NAM POSITION STATEMENT ON HEALTH AND AGING

2012 — FISCAL REFORM TO FINANCE IT ALL

2013 — FIRST EVIDENCE BASED ACTION PLAN ON AGEING PROPOSAL

2014 — AN AGENDA FOR RESEARCH ON AGEING

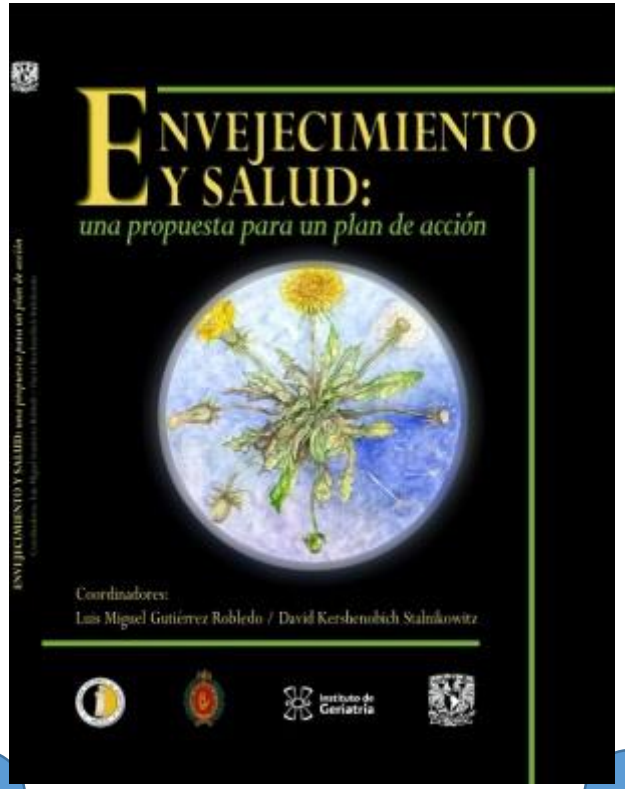
1. Adequate health services to the emerging needs of the aging population

2. Train the necesary health workforce to satisfy the emerging needs

3. Generate information in order to develop and monitor programs and interventions

4. Generate a medico/social coordination instrument

5. Position the health and aging policy issues in the National agenda



Roadmap

- Map out elements of good practice already provided and where the gaps are
- Identify early priorities for change and quick wins
- Agree some key performance standards that all actors can aspire to achieve
- Walk the journey from healthy aging to end of life care recognizing dependency

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THANK YOU FOR YOUR ATTENTION