

## PROPOSAL FOR COMPREHENSIVE CARE FOR ELDERLY PEOPLE IN THE MEXICAN INSTITUTE OF SOCIAL SECURITY

In accordance with the proposed conclusions, there are some aspects that could help to improve the investment of resources for the health of elderly people. Far from proposing to decrease the total budget for care, it is pertinent to carry out some forms of re-organisation of health care that will also have the benefit of improving the health conditions in elderly people and decreasing the per capita cost by age and illness. It becomes particularly necessary as part of the Reform process in IMSS. The following proposal is a model for the comprehensive care of the elderly in IMSS. The purpose of this proposal is to integrate different aspects that according to my point of view could respond to the present and future needs of the target group. This model (Table 14.1) is considered to be socially acceptable and economically pertinent.

### 14.1. FINANCING HEALTH SERVICES FOR ELDERLY PEOPLE IN IMSS

One of the first aspects to consider within the IMSS Reform is the way in which health services are going to be financed in order to protect elderly subject's health in IMSS. At the moment it is possible to consider two different alternatives of financing the health care for the elderly in IMSS. The first option is the current system with contributions from three different sources: Government, workers and employers, plus direct contributions through voluntary insurance. The second option is with direct Government budget through

the collection of taxes. The most equitable form of financing is the current one, since independently of the type of the population's insurance (that which automatically gives them right), health care should be guaranteed. 1. Through the fund that should have been accumulated during their working life, 2. Through the fund that should have been accumulated during their husband's working life, 3. Through transfers of the benefits from the funds provided by their children in the voluntary or compulsory type of insurance, or 4. Through their voluntary contributions to the system. Whichever the origin of these funds the financing should be guaranteed as a right but not as a benefit. In this financing system, surely the funds accumulated by those that were active workers in the past, are not longer available since they were invested in the necessary infrastructure that now serves all the generations that enjoy the benefits. In this way, active workers from the past have transferred funds to the existing generation of young people. As a way of putting back those transfers, funds from currently active workers has to be transferred to the elderly in health services and sometimes through pensions. A second form of transferring resources from young to old in the Institution is through the protection for the active workers' parents. There is no doubt that if there are healthy and economically active adults, it is because those that now are the beneficiaries parents made an effort to nurture, to dress and to educate their children accordingly were possible. Therefore transferring resources through the social security benefits should be a right.

The Social Security System in Mexico, and in particular the IMSS was thought as a social solidarity institution since the beginning, with important transfers among the different population groups as for instance from rich to poor, healthy to ill, young to old, etc. Additionally IMSS has transferred resources to the non-insured by training most of the health workers including doctors, social workers, technicians, and nurses that today works for other institutions within the health sector (public or private institutions). Transfers generated by this financing system with more than 50 years of experience has guaranteed the quality of care and the application of the scientific and technological development in the field of medicine in Mexico. Continuing with the same financing system for the insurance of the elderly in IMSS should be a socially unquestionable fact.

An aspect directly related with the financing forms is the possible approval of the law for the universalisation of medical care for the elderly independently of their insurance in one Institution. This law will allow the pro-

tection of one of the most vulnerable population groups and therefore it is socially desirable. However, the immediate question is about the feasibility and economic sustainability of this policy and of how this law could be applied so that it fulfilled those two characteristics that would guarantee its permanency. If the universalisation of services for the elderly in Mexico is approved in Parliament, the government will have to finance services through taxes. With this system transfers from young to old are kept as a mechanism of solidarity. With this financing system elderly people could choose the institution where they would like to be attended, but not more than an institution (in some cases elderly people are entitled to receive services in more than one institution as it was observed among the IMSS insurers. This system would protect all the elderly independently of their labour participation in the past. The most important problem with this system would be focusing on the availability of resources from the government being able to produce the necessary services. If the new law for the protection of the elderly people is approved, the process has to be gradual prioritising the poorest, sickest, and the weakest among the dependent population. At the same time the continuity of the already established health promotion programmes would help make the most feasible and long term sustainable process succeed.

Other scenario could be possible if the private sector is going to have more participation in the delivery of their services in IMSS. Elderly people are not an attractive population for that sector since the likelihood of being chronically ill and of using services are too great to receive profitability. IMSS directives will have to look for policies to protect this group of the population by establishing a compulsory proportion of elderly people to be covered per medical doctor or institution. Otherwise there will be disincentives as most of the elderly need expensive care and the cost has to be shared with other lower risk groups. One possibility is to create a parallel system for the elderly as in the American Medicare system; however, this alternative needs to be evaluated carefully since it has been demonstrated that it is becoming unsustainable even though has been rationed through the DRG's system.

## 14.2. DELIVERY OF SERVICES

Until the present, IMSS has organised the delivery of services, however, the emphasis of most of the Reform programs is to increase the private sector

participation in the production and delivery of health services. Although it has been clear from the beginning that the IMSS privatisation is not the aim of the Reform, it has also been clear that the interest of international organisations as the World Bank and other national groups is to increase this sector's participation. One example of this is the division of the Institution in basic relative autonomous areas with the excuse of decentralisation, even when there is not enough infrastructure, capacity and training neither from doctors nor from directives for the competition or the per capita payment management. These areas in the future will be competing for the delivery of services in IMSS with the private medical sector. Medical doctors (private or from IMSS) will be receiving a specific payment per person and diagnosis. That payment will not fully cover elderly people's health needs. DRGs (which are the base for the reimbursement system) has been hardly criticised because they are one of the first mechanisms for rationing health care among elderly and poor Americans. In Mexico the effect of those GRDs as part of the rationing programs is not yet clear, however, it will be more evident when unethical medical bedside decisions begin to be present when the amount received per capita will not be sufficient for elderly people's health service demands.

Up to this moment the role of private insurance companies in financing health services has been very limited, but with the Reform process, certainly part of the financing system will be in the private sector's hands.

If the definition and operation of the decentralised areas and the per capita payment based on DRGs become a reality in the future as part of the Reform, directives will have to guarantee that the necessary quantity of money is received to keep or improve the availability and the quality of care per subgroup of people with adjustments not only by type of illnesses and complications, but by disability and age. If those adjustments are not calculated, those responsible for the decentralised areas will only have the economic incentive to limit and to reduce the number of interventions and services independently of elderly people's needs.

If the private sector will play a role in the IMSS Reform, medical care for the elderly has to be secured through the law, since there are incentives to leave IMSS to look after the elderly health needs. It is logical that the private sector must attract the youngest and healthy individuals who have a low probability of using services; only in that way it would be a profitable business for this sector. Then the financing of services for the elderly in IMSS is at

risk since solidarity and transfers between groups of insured population will no longer be available. The State will have to surely inject more resources from taxation. Under this reform, the redistribution of the resources and the social solidarity won't be possible because each organisation of health will receive exclusively the quantity of necessary money per person. If the government's support is given, then the system would become even less equitable, the solution then would be the second financing form proposed through taxation but protecting 100% of the Mexican elderly population. This would be one of the most socially acceptable policies under the condition that resources and the infrastructure will be available to provide high quality services.

Policy makers involved in the health sector reform, specially those involved in the decision making process in IMSS should evaluate the possible effect of this particular reform in the elderly health needs and propose sustainable measures to avoid negative consequences and protect elderly subjects.

If privatisation of public institutions or the participation of the private sector in financing or delivery of services is going to be promoted, some alternatives to protect the elderly need to be established. The sustainability of those measures also needs to be evaluated, according to the experience of other countries. If the universalisation of services for the Mexican elderly population is also becoming a reality, the financing system and its sustainability have to be tested.

### 14.3. PERSPECTIVES IN HEALTH CARE FOR THE ELDERLY

#### **Life cycle perspective**

The life cycle perspective was proposed by the WHO considering that healthy aging will only be possible if the health promotion activities and the prevention of illnesses occur as early as it is possible in life. In this perspective genetic factors and those present in the prenatal microenvironment, besides all the risk factors to which individuals are exposed in an intentional or non-intentional form all through their life. These will produce effects on their health that will be more evident as the individuals age. In trying to achieve the compression of morbidity proposed by Fries, the onset of chronic dis-

eases and disability should be delayed as much as it is possible. In this way the desired process of healthy ageing will have more success possibilities. As the WHO has proposed, not all elderly subjects are becoming sick or dependent. There is great variability within this subgroup but the probability of maintaining them as healthy and independent as possible for the longest period can only be achieved with programs starting early in life.

In order to reduce the proportion of people with chronic illnesses and the complexity generated by the co-morbidity, the life course perspective (proposed by the WHO) should be considered as the best alternative to promote healthy ageing and the compression of morbidity. This perspective begins when individuals are in their mother womb and continue through their life. It includes actions from preventing pregnancy expositions to increasing the quality of life in later life.

### **Health promotion**

Health promotion is one of the ways to produce a bigger and more durable health benefits for the population, although the effectiveness of most of these actions has been very difficult to demonstrate. Health promotion should not be restricted to the institutional environment, but has to influence individuals, family, school, work on a permanent basis.

It has been proved that smoking prevention programs in other countries have been more effective through society demands to reduce passive exposure and illness which have been scientifically proven. When society is not convinced about the benefits and actions to be taken, it doesn't serve the propaganda or for other actions to be carried out.

The relevancy of health promotion for the elderly has been questioned, since most of this subgroup is already chronically ill. However, even with the sickest, weakest and dependent elderly subjects there are some health promotion actions that could be applied with the purpose of avoiding new problems, future complications or the worsening of their health conditions. With these actions it will be possible to avoid the onset of new health problems as much as possible. On the other hand and recapturing the life cycle perspective, health promotion actions should start at the earliest possible moment to achieve in the aim of healthy aging. In IMSS, the social benefits area has a fundamental role in promoting health, including; sport, cultural, artistic, and

educational activities, or the training for jobs will achieve in the elderly population's well being directly or indirectly. Social benefits' facilities are a forum but they are also action for the maintenance of the highest level of health. Further collaboration between the Medical Benefits and Social Benefits areas is necessary to achieve in the joint objective of elderly people's health.

### **Geriatric integral care**

In this medically oriented model it has been understood that family physicians or other specialists are able to look after elderly people's health needs comprehensively. In reality, both specialties have failed to influence this group's health condition. On one-hand family doctors in general terms are not qualified for the geriatric integral care since this type of care differs from other sub-groups medical care. On the other hand the internists only receive elderly people by referral because of some complication, the lack of controlling chronic problems, or because of the chronic problem has acute complications. The internist's only responsibility is to stabilise the patient's illness or to establish the best treatment and refer patients back to their family doctor.

Comprehensive geriatric care would mean the complete evaluation of the following aspects: mental health, depression and sleeping problems, sensory integrity, oral health, independence, nutrition, sexuality, chronic problems, co-morbidity, acute health problems, self-perception of health, family life, social support and drugs intake.

Family doctors and other specialists in contact with elderly people should be qualified in Graduate Diploma courses that IMSS has to provide. Those courses have been organised in IMSS for a long time; however, the impact of those courses is limited because of the number of specialists in the geriatrics field and because of the different perspective in each course. Again the mistake of training family doctors with patients in hospital has been repeated, when almost 100% of their patients are external. The objectives of these courses should be clearly established and guided by institutional policies of medical care for this population group.

An important aspect that IMSS requires urgently is the training of Geriatricians. So far the IMSS policy has been to train other specialist (even when they are not required by the Institution) but not Geriatricians. However, it is

essential to change this policy since without the qualified personnel to care for the elderly and to train the rest of the health staff, some problems in the quality of care and in the health needs, health services utilisations and cost increment has been observed. If in the next 20 years the number of necessary specialists are not trained (1,023 geriatricians will be needed in the DF for example, assuming that each subject will only visit this specialist twice a year), then medical care for this population will be chaotic. Not only because of their proportion but also because of the lack of capacity to provide the medical care that they will require attending the complexity of their needs. To achieve the training of 1,023 geriatricians for the DF, it is required to begin with at least 50 students for the first generation in the year 2001. There are insufficient professors for 50 students, because IMSS being the most important Institution training medical doctors in different specialties has not changed its policy as it was mentioned before. In a first stage Geriatricians from other Institutions should be contracted to break the cycle. The annual investment in training this type of specialist would be compared with the effectiveness that would be achieved treating chronic and other problems in the elderly population. At the same time the cost should be compared with the cost of training specialist that IMSS does not need but for other institutions.

Other groups of health professionals should also be trained for the daily contact and in their case the specialized treatment of the geriatric patient. The complexity of diseases observed in this group of population requires highly trained medical doctors and nurses. The implicit policy of exclusion of the geriatric specialisation and training in IMSS has to be radically changed to create the infrastructure of human resources necessary to attend elderly people needs.

The comprehensive care of the geriatric patient should not only include the necessary qualified personnel, as part of the essential resources, it should be through all the processes and adaptations required in medical units for this type of patient. Ramps, lifts, handrails, wide corridors, steps marking, etc., are necessary to avoid the risks of falls and reduce barriers to health services access. In units where there are second levels and there are not lifts, medical care in the first floor should be guaranteed and by carrying out adaptations with the necessary re-organisation. This will reduce the access problem that could generate more needs and cost for the Institution in the long term.

For in-hospital patients, physical improvements should also be made. But organisational adaptations are more important so elderly people do not

perceive themselves alone or be abandoned in the institution for long periods of time, since their physical and mental functions could be deteriorated increasing the required number of days and the cost of medical care.

Infrastructure in IMSS needs to increase in the short term to cover the current un-covered health care aspects. Instead of defining the growth of the Institution based on economic policies, the expanding population covered and their needs have to be considered. Quality of care for any group but particularly for those more in need such as the elderly is going to increase if the effectiveness in health care instead of its efficiency becomes a priority. Medical doctors need to have sufficient time to achieve in examining their patients health, especially when the complexity of the problems require more time to achieve in the proper control of chronic diseases.

## **Tanathology**

This perspective has an influence on elderly people's health care. Not only because of the proximity of death (one's own, that of a couple or of friends), but because of the continuous losses that are not managed well by the geriatric patient and that are very common part of the ageing process.

This perspective seeks the acceptance of the life cycle that finishes with death. But the process of acceptance is not only from the geriatric patient and their family, but also from the professionals involved in the health care beginning with the medical doctors. When medical doctors are asked about the ethical basic principles of practising medicine, they always answer that their main function is to save patients life, when really those principles are focused on helping patients and not to harm them passively or actively with treatment, decisions or omissions.

The acceptance of doctors about the limit of life and about death with dignity is part of the thanatology training for the medical professionals. It doesn't mean to allow geriatric patients to die without any medical care, but accepting the process of dying when it is already an unavoidable fact. An important aspect related to the process of dying with dignity is the regulation on the respect to death bodies that the doctors have to have and the request for permission from patients or their family for practising medical procedures. It is important to recognize that the practice makes the expert, but medical doctors in training have to learn a dead body deserves respect when

individuals pass away. At this moment the process of dying at home or in institutions has not been discussed or legislated.

#### 14.4. ORIENTATION

##### **Gender**

The disadvantage which women in this group of the population covered by IMSS live, force the Institution to establish gender oriented programmes in order to try to equal health conditions at the end of life. This does not mean to reduce health programmes for men but to increase the intensity to improve health conditions for women. These gender oriented programmes should start early in life (life course perspective) and include not only specific health actions but also education, nutrition, housing and employment.

##### **Long term care**

The family participation in taking care of the elderly relative with special needs for a very long period could be at risk according to the expected demographic changes in the Mexican population. Governmental or institutional support for those caring for their elderly relative has proved to be a cheaper community alternative for those in need. A long term care institutionalised system in IMSS seems not possible in the future if other countries experience with the system is evaluated.

Policy makers in developed countries have intended, proven or established additional mechanisms for supporting the family or caretakers when the geriatric patient requires long-term care. Some of those programs are: respite where caretakers receive support per hours, days or weeks in the care of their relatives with the objective of providing time for resting from the oppressive work which cumulates from continuous health care. In some countries caretakers receive a wage and right to pension through the taxes if they provide daily care. In Japan where a long tradition of family care exists they have foreseen additional early contributions to the social security system directed exclusively to the long-term care. Some of these ideas should begin to be analysed in Mexico preventing the moment in which the demographic voucher is over.

## **Palliative care**

A very peculiar type of care for which specialists don't exist in Mexico, but that now represent a true necessity, is the palliative care. This movement has become necessary when the cure and recovery possibilities are impossible, and patients enter into the terminal state period and only require relief from pain and suffering. This type of palliative care includes the treatment of symptoms, the approach with the family when it is necessary and religious support if the patient requires it.

It has been thought that this type of care could be provided in the geriatric patient's home. However, it is necessary to consider that many times the relief of symptoms requires the participation of professionals in the most appropriate facilities. Here it is important to highlight the relevance of the professional training in thanatology in order to learn how to accept the death with dignity in the terminal patient avoiding heroic manoeuvres of resuscitation that sometimes have the objective of doctors' training. Medical care for those in terminal stages in IMSS needs to be defined as policy with all the actions involved. Human resources training in those aspects are also necessary to avoid the misuse of technology or other unethical decisions that occur in the patients' hospital surroundings. The restriction of resuscitation procedures or the excess in manoeuvres are consequence of the lack of better policies and respect for patients autonomy.

### 14.5. LEVELS OF CARE

#### **Self-care**

We have already insisted in the necessity of patients' participation and responsibility in keeping their health up to where it is considered pertinent of according to their physical, mental, cultural and educational conditions. Considering it is not possible to give the responsibility of their diet or medication handling when the patient is physically and mentally dependent. Neither is it possible to ask elderly people to be able to understand the logic of their health problems and treatment. To deliberate and decide to participate actively in decisions about medications or other forms of treatment when their cultural and educational characteristics do not allow it. In the completely active, in-

dependent, and educated elderly person, in who there is an appropriate understanding of their chronic and acute health problems, the active participation in self-care has demonstrated in making a great difference in the exposition to risk factors for other illnesses or complications of the pre-existent problems. Likewise it has been demonstrated that its active participation in handling self-limited problems has generated a reduction in the use of services and medications and of the health care cost.

## **Family**

It has already been mentioned before the importance of the family participation in elderly subjects' health care in Mexico. Firstly, family care has contributed to the health care costs containment since otherwise IMSS should paid the cost of long-term care that is putting health systems under pressure in other countries. Secondly, the participation of the family in elderly people health care helps in the family integration, which also could contribute, to the achievement of chronic and acute problems control. Thirdly, as in other population groups, the medical consultation in the presence of one relative could contribute to a better understanding of the characteristics of the health problem and its treatment and the family could contribute positively with those treatments. It is common to hear that elderly people don't follow diets or the prescribed exercise since these cannot be adapted to the family dynamics or economy.

It is important to emphasise the acceptance of elderly subjects in the family group and promote the reciprocal help or exchange among generations. Still in these modern times of high technology use, children and grandchildren have to accept and learn from elderly subjects' experiences since there will always be information unavailable in the Internet that can be obtained from them. On the other hand, the type and duration of the help provided to the family by the elderly should be quantified in order to demonstrate that they still contribute importantly to the country's economy since the participation of other adults especially women could be stopped without elderly subjects' help.

In a different direction, elderly subjects' abuse and abandonment are unfortunately evermore frequently found in Mexico. Doctors should be attentive to the signs of abuse and take the pertinent measures with social workers support.

## **Social benefits care**

There is an area in IMSS with great participation in promoting elderly subjects' health and in increasing their level of well-being. This social benefits area organises sports, cultural and social activities, training for working or entertainment in handicrafts, and provides rehabilitation. It also organises groups with the objective of increasing the economic income, self-help groups for managing the most frequent chronic problems, and also organise trips for the elderly. It also provides a forum for the discussion of the most common problems between the elderly and their possible solutions, and organises the annual meeting for IMSS' pensioners.

This should truly be the first level of institutional care for the elderly, unfortunately it has been seen as an unrelated health instance. The coordinated participation of actions with the medical benefits area would contribute to maintain and improve elderly subjects' health with direct or indirect promotion, prevention and rehabilitation activities. The integration of these services and facilities and a referral system between social services and the first level of medical care would contribute to improve this group's health conditions and to reduce the use of the services and the total cost.

## **First level of care**

As it was mentioned before, the first level of care in IMSS is based on the family medicine model. Independently of the intention to maintain this policy, it seems that it has not been possible the appropriate development of the specialty and the operation of this model. The only achievement is having the whole family subscribed with the same family doctor, however, the analysis of the structure and family dynamics as one of the important units determining the family health has only become a good intention. The family doctor is generally over worked with an excess amount of patients everyday, the number daily average consultations overcomes IMSS indicators. On the other hand, demands are increasing since special programmes for each group of the population are being established (children, pregnant, workers, diabetics, etc.). The demand of knowledge, experience, and tolerance on behalf of the family doctor has already overcome the limits of any professional. This is reflected in the poor capacity for the comprehensive management of health

problems, in the low quality of care, in the lack of commitment with patients and with IMSS, and in the lack of satisfaction. Local attempts to modify the organisation of family medicine units has not been accepted, and the model is being tried to be preserved independently of the professional's opinion and perhaps only due to political pressures of some sub-groups.

Geriatric care has been affected by this situation since elderly people are treated as any other adult. Family doctors don't have the training neither capacity for the comprehensive geriatric care and the daily number of patients is leaving little time for complete care. It seems that the demographic transition will be able to put the limit to the model that never has worked in ideal conditions. The proposal here is to give the opportunity for elderly patients to receive the medical care from qualified and trained medical doctors with no other responsibility than providing medical care for them. IMSS should provide the opportunity of having medical doctors specialised and highly qualified in different sub-groups medical care (pregnant, children, elderly subjects). It has always happened in other specialties, but not with the family physician since the model of the family doctor from the last century (trained in a very limited number of illnesses and only a few patients) has been retained. The family background of chronic diseases and the different screening procedures already made in IMSS could help family doctors to establish priorities for medical care.

### **Second and third level of care**

Very clear and detail referral norms from the first to the second and then to the third level of care should be established, since a proportion of people being referred are very high compared with current standards. What is more serious is that within the institution there are some situations were unfairly elderly people never have opportunity to visit the third level of care even if they need it. Only health needs not the geographical barriers or advantages should determine the utilisation.

Especially for the most frequent chronic problems, diabetes mellitus and HBP; very detailed norms of care and referral should exist. But these norms have to be sufficiently flexible so if there was an organizational problem the patient doesn't suffer the consequences like what is habitually happening. This is particularly necessary among geriatric patients since the dis-

tance for second and third levels seems much bigger and routinely they have to be accompanied by a relative, with additional indirect costs.

As it was explained before, specific areas in hospitals for elderly people's care should suffer the necessary adaptations to facilitate medical care and allow a quick recovery in case they have to be hospitalised (it doesn't exist until the moment, except for one floor of internal medicine in one specific hospital in Mexico City). On the other hand, the organisational adaptations in order to promote a friendly environment for the elderly in hospital require a new perspective in the relation with the patient. It should be remembered that the patient, in this case the geriatric one is the objective of the medical care and of institutions. The real objective is to provide the best kind of medical care but not to follow institutional norms only or in general. Without patients the IMSS organisation is not justified.

It is unacceptable that the geriatric patient is making more than 20 visits a year to the medical centre, it reflects the organisational problems in the institution, the inclusion of the patients in the protocols, or the lack of the doctors' capacity to solve their health problems. Whatever the reason this intensity should undergo detailed revision of each case, to try and avoid bigger nuisances and to produce the maximum benefit for the patients.

#### 14.6. LEVELS OF PREVENTION

The primary level of prevention is the most commonly used and accepted since the paradigm that prevention is only possible in healthy subjects has not been broken. The idea of the model is to integrate the three levels of prevention in each one of the six levels of care so that patients learn from how to promote the maximum level of health until they learn how to rehabilitate themselves in order to avoid dependency. It also seeks that subjects already sick have the possibility of the opportunity and appropriate treatment of their health problems, and participate in making possible the maximum benefit through the treatment adherence, healthy behaviours, and the detection of alarm signs for their own health problems. It is desirable that medical doctors are able to detect at least all the most common possible problems that can affect elderly people's health and to refer them with the specialist as soon as it is necessary.

A very important aspect to consider is the support that the elderly subjects should receive for purchasing health aids to maintain activity with the

smallest deterioration over the longest period possible. The Mexican government already has a program of help to buy them, however, this has not been extended thoroughly in all the institutions (each institution should have modules of attention for its elderly claimants). Assuming that the reduction of capacities like vision, audition, mastication, and mobilisation is a fact within the ageing and to prescribe corrections with the necessary equipment. Those general health problems that are now taken for granted because of the ageing process need to be included in an integral health care programme for the elderly in the first level of care. The early detection of those problems and their treatment and rehabilitation could help to prevent other consequences and the utilisation of health services with more intensity.

Once the Institution has started to talk about rationing of health care, there will be aspects to be discussed between patients, providers, and policy makers. Rationing by age or by any other population characteristic should be avoided if ethical principles are going to be respected. As it was established before, economics should help to make decisions but not being the deterministic influence in health decisions.

Medical doctors should avoid trying to make bed-rationing. Their social responsibility is improving or preserves people's health. Any other temptations under the social benefit excuse have to be avoided giving preference to patient loyalty. In order to plan for the health of the elderly in the future, it is important to consider alternative scenarios and establish health consequences and the cost in each one.

This is only a concrete proposal of care for the elderly insurers in IMSS that could be total or partially established depending on the possibilities, budget and political acceptance. Perhaps the most discussed aspect in the future will be the financing system to provide medical care for the elderly. The detail in this proposal is adaptable independently of the Reform process in IMSS. This proposal unquestionably will have great social acceptance even in this new millennium, with the respect, consideration, and care for the elderly within Mexican families is the norm although we know that exceptions exist. These exceptions will eventually become the norm perhaps under the influence of the demographic and economic changes in the country. From the economic policies point of view, many of the proposed aspects have to be evaluated carefully, but it has to be carried out anyway and planned for the best alternatives while Mexico has the benefit of the demographic voucher. Now that the low proportion of the elderly population still allows to analyse

and forecast it is important to think in one of the most favourable scenarios for those that without a doubt will be the elderly in their 20's of this new millennium. Elderly people are not in the majority but they are already beginning to organise themselves and becoming a significant pressure group. It has been achieved thanks to the solidarity that still exists with this generation including the media that still consider the commitment with this group that once gave what they had and now are entitled to receive.

Once the philosophy, the policy and the outcomes are well defined, organisation of services has to be changed accordingly. Other scenarios could be created with the information in this project, depending on the actions to be promoted by policies.

Table 14.1  
 Comprehensive medical care for elderly patients in the Mexican Institute of Social Security

FINANCING	DELIVERY	PERPECTIVES	ORIENTATION	FORMS OF CARE ORGANIZATION	LEVELS OF CARE	LEVELS OF PREVENTION
CURRENT SYSTEM	PUBLIC	LIFE CYCLE	GENDER	ACUTE DISEASES MANAGEMENT	SELF-CARE	PRIMARY
					FAMILY CARE	
THROUGH GOVERNMENT TAXATION	PRIVATE	HEALTH PROMOTION	AGE SUB-GROUPS	CHRONIC DISEASES MANAGEMENT	SOCIAL BENEFITS	BENEFITS SECONDARY
					FIRST	
PRIVATE INSURANCE	MIX	INTEGRAL GERIATRIC CARE	RISK FACTORS	LONG TERM CARE	SECOND	TERTIARY
					THIRD	
		TANATHOLOGY	DISEASES	PALLIATIVE CARE		