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COVID-19 and Long-Term Care in Mexico: Questions, challenges, and the way forward

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1. Key points

- The latest data (8 June 2020) show 120,102 confirmed cases of COVID-19 in Mexico and 14,053 deaths¹.
- While the “peak” of contagions was expected to occur in mid-May, cases continue to increase at a fast rate, almost showing a continuum of incremental peaks (Figure 1)¹.
- A wide media/communications campaign has been implemented in order to disseminate “safe-distancing”, and general public health recommendations, including shutting down public spaces². The impact of the campaigns at national level have not been evaluated.
- However, lockdown measures were not applied by public decree (MoH) until March 23 and have been constantly extended as initial due dates approach (April 20, May 25, now June 15).
- While public spaces (parks, arenas, restaurants, movie theatres) have followed the closure rules, other informal spaces such as street markets countrywide, have been kept open, due to a mixture of economic need of those that tend to them and of those that buy their basic goods there. Unfortunately, many people in these spaces are constantly seen without any protective gear whatsoever and are non-compliant of the 2m-safe distance recommendations.
- Some estimations have put estimated that at least 22% (27.4 million people) of the total population live in poverty³. No direct economic support schemes at national level have been implemented.
- In April, the Mexican Institute of Social Security, IMSS (Instituto Mexicano del Seguro Social) launched a microcredit scheme of \$25,000 MXN (\$1,072 USD⁴) per applicant. This applies to those affiliated to the Institute only. Due to low numbers of applications, they closed the call on May 15 and are reorienting the funds to support specific population groups, which are still to be defined. In late April, the Federal Government announced microcredits following the IMSS initiative, but to date no details on how they will operate have been published.
- With the exception of recommendations for keeping older adults safe as one of the most vulnerable population groups, no other guidance has been generated for other groups such as people with dementia, those with disabilities, etc.
- As in many low- and middle-income countries, economic hardship, extended households and already highly conflicted urban concentrations have generated a peak in domestic abuse, estimated at 120% higher compared to the previous year⁵.

2. Introduction

2.1 Government response

The response of Mexico’s Federal Government to the Covid-19 Pandemic, via de Ministry of Health (MoH), has followed a sentinel surveillance model. This model has also been used for epidemiologic surveillance of influenza. This implies that surveillance is based on modelling

infections and cases instead of testing as recommended by WHO. The Sentinel system bases its estimates on data from a select network of reliable facilities rather than on passive reports of deaths and hospitalisations. Selected hospitals countrywide were defined as “Covid-facilities. The MoH has constantly reported that no massive testing efforts will be conducted in the country. Official guidelines indicate that 100% of hospitalised individuals (with high probability) should be tested, however, this is clearly subject to tests available and no official information on if there have been enough are available. On the other hand, guidelines indicate 10% of those who present symptoms but not as severe as to stay at home, should be tested. No official information on how these 10% should be selected is available.

Regarding the process of the response (on 9 January 2020), the MoH, through the General Directorate of Epidemiology and the Epidemiological and Sanitary Intelligence Unit issued a preventive notice for travel to China given the high incidence of a “new” pneumonia of unknown aetiology. On 21 January 2020, after the confirmation of the new coronavirus by WHO, an indication by the MoH was issued requiring first contact health personnel in public and private medical units throughout the country to inform them about any new coronavirus cases. This was meant to guarantee notification, study, isolation, and follow-up of contacts of the suspicious cases. The need for the timely identification of suspected cases at air, sea and land entry points was communicated. This also enabled the InDRE (Institute of Epidemiological Diagnosis and Reference) to carry out tests to confirm the presence of the new coronavirus in the biological samples of the suspected cases.

From this date, the government issued precautionary travel notices to countries with community transmission of COVID-19, suggesting the avoidance of non-essential trips to China, Hong Kong, South Korea, Japan, Italy, Iran, and Singapore, adding countries as their number of cases made it clear that travelling could imply high risk of contagion. Until 23 March 2020 there were no clear strategies, even contradictory messages in this period. The General Health Council the published in the Official Journal of the Federation an Agreement in which it recognized the COVID-19 pandemic in Mexico as a severe disease of priority attention and established preparatory and responsive activities.

These include, among others, defining plans for hospital reconversion and immediate expansion of capacity to guarantee timely care of COVID-19 cases that require hospitalization. This was followed by a presidential decree, establishing mandatory safe distancing and a first lockdown period until 17 April. Emphasis was made on vulnerable groups (older persons, pregnant women, immunosuppressed individuals, those with asthma and know pulmonary deficiency) and all efforts were focused on preventing a massive need for hospitalisation and critical care.

As the cases have been increasing, the safe distancing and lockdown measure have been pushed forward continuously from 17 to 30 April, then to 30 May and currently to 15 June. However, the response at state level has not necessarily meant waiting for the President or MoH to issue warnings or recommendations but to start/follow on their own measures, as many governors feel more urgent and strict measures are needed as the number of total cases have varied greatly between states (Map 1).

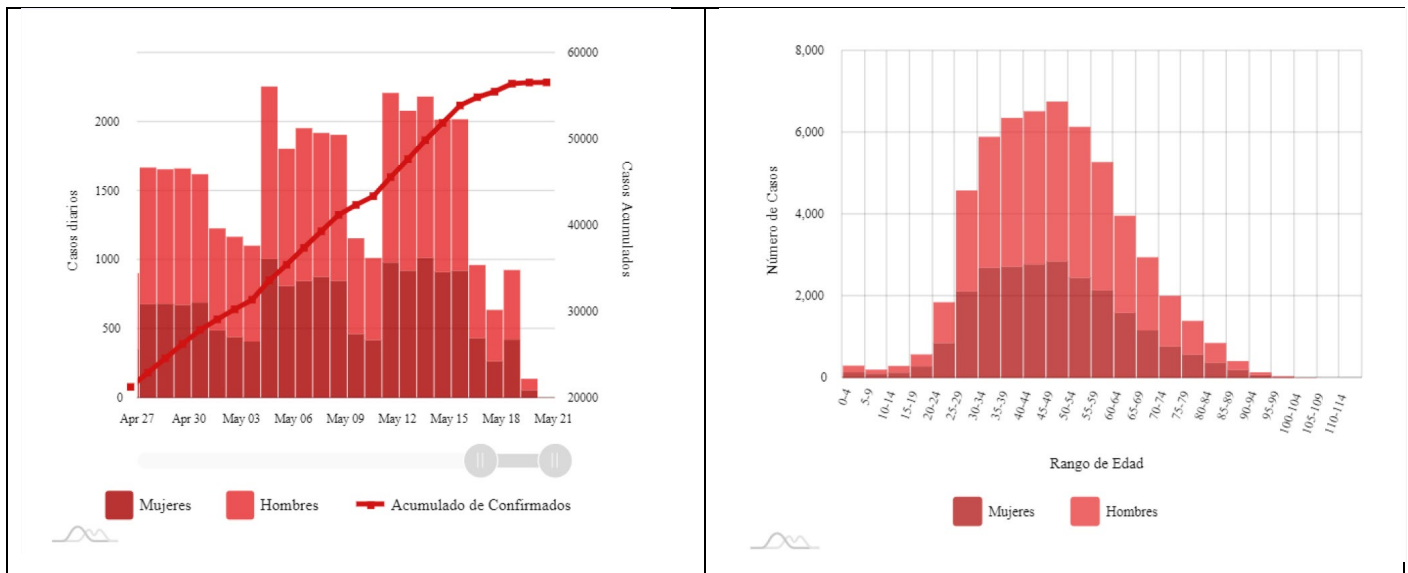
2.2 COVID-19 cases and mortality in the general population

On 28 February 2020, the first identified case of COVID-19 was confirmed in a 35-year-old man from Mexico City, who had travelled to Italy.

From 28 February to 8 June 2020, 120,102 people have been confirmed with COVID-19, of which 73.5% (88,217) have recovered, and 14,053 people have died.¹ Current data shows that 33.3% of all confirmed cases have been hospitalised and 66.7% have been treated on an outpatient basis (at home, with directives via telephone or SMS).¹ However, as testing for COVID-19 is low, it is likely that these numbers are underestimated.

Differences by sex in the total number of cases resemble that of other countries with men (56%) representing a larger number of cases than women (44%) (Figure 1a). However, age patterns are quite different compared to other countries with a larger number of **confirmed cases** to date in the younger age groups with the majority of cases seen in the 45-49 years' age group (Figure 1b). High comorbidity has been present with 20.4% of the total confirmed cases presenting hypertension, 20% obesity, 17% diabetes, and 8.2% currently smoked¹.

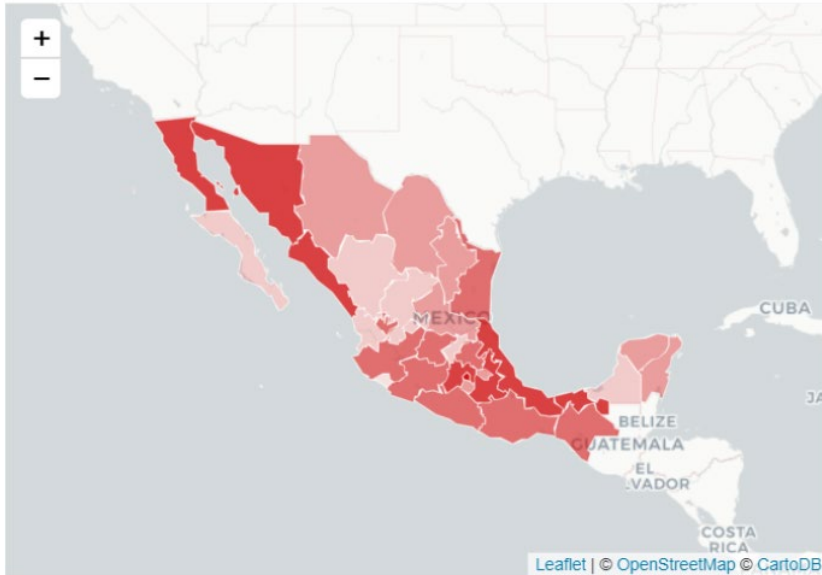
Figure 1. Confirmed COVID-19 cases by sex (1a) and age group (1b).



Source: COVID-19 México. Información general: Available at: <https://coronavirus.qob.mx/datos/#DOView> Note: Date of data: 8 June 2020

There is a wide difference between states in the total number of cases detected. The north-western states, Mexico City and surrounding states, Veracruz and Quintana Roo, present the largest number of cases (Map 1).

Map 1. Confirmed cases of COVID-19 by Federal Entity (state)*



Source: COVID-19 México. Información general: Available at: <https://coronavirus.gob.mx/datos/#DOView>

*Darker shades represent higher number of cases. Note: Date of data: 8 June 2020

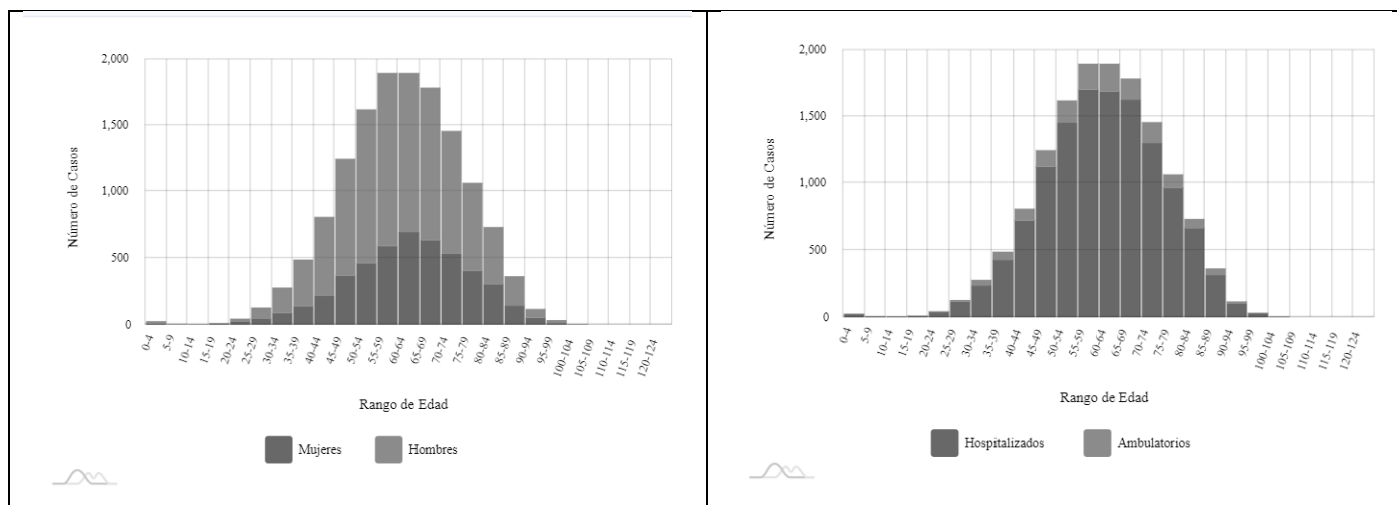
The period from mid-May to the generation of this report (8 June 2020) has seen the highest number of deaths. During this period the number of deaths more than doubled. Most deaths occurred in hospitals (89.6%)¹.

Regarding deaths from COVID-19 by age group (by 8 June 2020), slightly over half of all deaths have occurred among people aged 60 years and older. The estimated fatality rate for people of this group was 13.3 per 100 cases. In comparison, the mortality rate for those 25 and 59 years old was 4.8.

Among people aged 60 years and over who have been infected, more than half have required hospitalization. Following the patterns of confirmed cases, most deaths have been among men (66.4%) (Figure 2). In addition, comorbidities have been associated with all deaths. In 37.2% cases individuals had diabetes, in 42.1% they had hypertension, in 26% they presented with obesity and in 9.2% they were current smokers. As with the number of confirmed cases, most deaths have occurred in Mexico City, the State of Mexico and the state of Baja California (border with the U.S.)¹.

All numbers are constantly updated, disseminated through a daily press conference of the Epidemiology undersecretary and published on the official government's COVID-19 webpage (<https://coronavirus.gob.mx/datos/#DOView>).

Figure 2. COVID-19 deaths by sex (2a) and age group (2b).



Source: COVID-19 México. Información general: Available at: <https://coronavirus.gob.mx/datos/#DOView> Note: Date of data: 8 June 2020

3. Impact of COVID19 on long-term care users and staff so far

Lack of national care standards, regulations and evaluation of long-term care institutions, as well as the absence of a national public registry of all long-term care (LTC) institutions has generated a vacuum regarding their conditions during the COVID-19 pandemic.

3.1. Number of positive cases in population and deaths

The absence of a national registry and a unique institution that regulates and evaluates LTC institutions translates into the absence of a clear surveillance system of cases (or any other characteristic) and deaths of COVID-19 in these settings. As a consequence, official information about rates of infection, total number of cases (residents and staff) or mortality in LTC facilities is not readily available.

Unfortunately, cases of group contagions in at least 5 states have been reported in the news and this has increasingly received more attention.

As in many countries, a large percentage of older adults living in LTC institutions are in the oldest age group (80 years and older) and live with two or more chronic diseases. This makes them a highly vulnerable group. In addition, the conditions of a large percentage of the known/identified institutions are characterised by large bedrooms shared by multiple residents, a low resident to staff ratio and low staff qualifications. These circumstances put older people in institutional care setting at an even larger risk.

3.2. Population level measures to contain spread of COVID-19

Until 23 March 2020 there were no clear strategies available. Some message were even contradictory. Then the General Health Council published an agreement in the Official Journal of the Federation in which it recognized the COVID-19 epidemic in Mexico as a severe disease that requires priority attention and established preparatory and responsive policies.

These include, the development of plans for hospital reconversion and an immediate expansion of capacity to guarantee the timely care of COVID-19 cases that require hospitalization. This was followed by a presidential decree, which established mandatory safe distancing and a first lockdown period until 17 April. Emphasis was made on vulnerable groups (older persons, pregnant women, immunosuppressed individuals, those with asthma and know pulmonary deficiency). All efforts were focused on preventing large scale need for hospitalisation and critical care.

As the cases have been increasing, the safe distancing and lockdown measure have been pushed forward from 17 to 30 April, then to 30 May and currently to 15 June.

4. Brief background to the long-term care system

Mexico does not have a formal publicly funded long-term care system or public services that provide LTC care. Strategies to support people with disabilities are scarce. Another consequence of the lack of national long-term care policies is the absence of a compulsory registry for all long-term care institutions, regardless of their nature and funding mechanism. National care and quality standards as well as appropriate quality evaluation standards and mechanisms are also absent.

There are no specific laws that guarantee the right to care, regardless of the age group or condition for which care is required, or that require health and social security institutions to provide care. Thus, there is a clear absence of public programmes aimed at providing LTC care services.

Strategies to address aging and disability have been developed, however, they have focused on improving the economic well-being of these population groups, encourage their participation and incorporation to society, but do not include the provision of care and support in their objectives⁷. Thus, it can be said that there are no specific public policies that address LTC care in Mexico.

While it is estimated that there are approximately 90 publicly funded LTC institutions for older adults, the vast majority of health and personal care is provided by unpaid family carers, with little support or training. On the other hand, there is a growing private market for residential long-term care. Huge difference in funding mechanisms and resources, especially between not for-profit and for-profit institutions lead to differences in terms of infrastructure, human resources, service provision and fees⁷. Given the lack of compulsory registration mechanism, there is no conclusive data at national level on the total number of people living in residential care settings. In 2015 a first effort was undertaken by the National Institute of Statistics (INEGI) and the National System for the Development of the Family (DIF) to generate a Census among Social Assistance Housings (CAAS)⁸. Of the total 4,700 residential settings included in the CAAS 1,020 (22.6%) were care homes for older adults and a total of 22,611 older persons (identified as resident users) were living in these institutions at the time⁸.

5. Long-term care policy and practice measures

5.1. Whole sector measures

The National Institute of Geriatrics (INGER) generated and published a special copy of the INGER bulletin on [COVID-19 and older persons](#), as well as related informational materials when the distancing measures were introduced.

The lack of direct policies, regulatory measures and compulsory minimum standards of care have created a vacuum in terms of responsibility. It had become unclear which institution at the federal or local level was responsible for producing and disseminating recommendations for LTC institutions with respect to the Covid-19 pandemic.

By the end of March 2020 INGER identified this vacuum and generated a guide for the prevention of COVID-19 in LTC institutions for older adults ([Guía para prevención de enfermedad por coronavirus 2019 en residencias de personas mayores](#)) and produced a position paper on hospitalization and admission to critical care units for older people during the COVID-19 pandemic. Some of the latter recommendations could also be applied to LTC settings.

A month later, the National Institute for Older Adults (INAPAM) also issued guidance around care and prevention of COVID-19 in LTC institutions for older adults.

As part of its continuing work on COVID-19 and older persons, INGER began a telephone survey at the end of March with LTC institutions across the country to establish a situational overview of their capacity to prepare for and respond to the COVID-19 epidemic. The survey is still ongoing and results are expected soon.

5.2. Care coordination issues

5.2.1. Hospital discharges

While general guidelines have been issued regarding safety measures, there are no specific guidelines regarding hospital discharges to the community or to residential care homes. While by regulation all hospitals are required to explain (and give printed instructions) on specific post-discharge indications and treatments to be followed at home, we don't expect this to be COVID-19 specific at the moment but related to general recovery from infectious diseases and follow-up of any previous comorbidities.

5.3. Care homes (including supported living, residential and nursing homes, skilled nursing facilities)

5.3.1. Prevention of COVID19 infections

General recommendations to prevent infections include (INGER 2020): 1. Restrict all visits for as long as the safe distancing strategy is in place. There can be exceptions for special situations or conditions. Visits are allowed in special or extraordinary situations such as interventions to follow-up on advance directives and if the resident receives end-of-life care; 2. At the entrance, tight washing-disinfection measures are in place (gel based alcohol at 70%) and visitors have to adhere to these; 3. Signs at the entrance indicate that people should not visit the care setting if they experience any symptoms of respiratory infection or had

contact with someone with COVID-19 in the previous two weeks; 4. Sick leave policies should ensure that staff is allowed to stay at home if they develop any symptoms of respiratory infection; 5. all older adults living in the facility should be assessed for symptoms of respiratory infection; 6. Appropriate infection prevention practices for residents should be implemented.

5.3.2. Controlling spread once infection is suspected or has entered a facility

INAPAM (2020) recommends that if any resident is diagnosed with COVID-19 and receives outpatient treatment, they should be assigned an isolated room and toilet facilities. In addition, the following recommendations have been made: residents should closely following instructions from health personnel, rest, adhere to safe distancing measures (at least 2 meters) including no hand or kiss greetings, constant washing of hands, stay inside their room, eat healthily, wear a mask or face covering –when tolerable– and change it every four hours. Only one member of staff should be in charge of providing care to the affected resident and they must wear personal protective equipment (PPE) when they are in contact. Clothes and sheets must be washed with hot water.

5.3.3. Managing staff availability and wellbeing

While staff with suspected cases of COVID-19 should be granted sick leave. However, many workers do not receive full benefits from their employers and therefore, these may not be granted by law to a large percentage of care homes staff. This is a major challenge as it not only puts residents and the rest of the staff in danger, but also health and wellbeing of those affected. In his daily COVID-19 press conference, undersecretary López Gatell announced that a total of 271 deaths had been registered among health personnel. Unfortunately, given the lack of mandatory registration and the absence of a national LTC system, we will not have specific figures on the number of care workers that have been infected or the number of deaths.

With respect to their mental wellbeing, the Ministry of Health, through their Psychiatric Care Services (Servicios de Atención Psiquiátrica) generated a mental health support campaign that includes materials, webinars, an online rapid assessment tool, and a direct telephone line to evaluate and support people who feel their mental health is being affected. For both the online rapid assessment and the phone line, mechanisms are in place to identify needs, provide recommendations (support strategies) or referral to specific channels that can support them. The strategy also includes a specific campaign to support all health care workers with the slogan “Let’s care for those who care for us”.

5.4. Impact on specific vulnerable population groups

While some research and outreach information on clinical and health care aspects of COVID-19 and its impact, such as the impact on respiratory health after the illness, have been published continuously, little is known on the direct impact on specific groups such as unpaid carers, people with intellectual disabilities or people with dementia. Even before the pandemic specific programs that cater to the needs of these groups have been absent. So far no specific measures have been put forward to support them during the COVID-19 pandemic.

Nonetheless, it is highly likely that these and other vulnerable groups are experiencing negative consequences, such as increased responsibility for unpaid carers or stress and anxiety experienced by people with dementia who may find it difficult to understand and adhere to isolation and safety measures.

In addition, the negative economic impact of the pandemic is hitting already disadvantaged groups hardest. A large percentage of the population does not have the “fortune” of a formal, stable employment that guarantees their salary and therefore can afford to stay home. People who are part of the informal workforce have to continue to go out, use public transport, and be exposed to many of the risk factors, while trying to find subsistence for them and their families.

6. Lessons learnt so far

- The evident pressure on the health care system in times of crisis highlights the urgent need for a universal health care system that is adequately funded and equipped, both in terms of infrastructure and human resources.
- Inequalities in access to timely care: from the moment a person suspects being infected to the point of acute care in an intensive care unit, inequalities have been more present than ever and this too calls for an urgent need of equal access to care for all citizens irrespective of their employment status or socioeconomic condition.
- The absence of a formal publicly funded LTC system and of a national compulsory register/qualification system for all care homes not only generates an absence of timely information and procedures, it also prevents obtaining adequate information of the characteristics, cases and measures inside the institutions. It is clear that adequate systems that oblige home care services to gather and report specific information is also urgently needed.
- There is a great need to recognise and implement support strategies for particularly vulnerable groups in this crisis situations, such as for unpaid family carers, persons living with dementia and persons living with disabilities.

6.1. Short-term calls for action

- The generation of compulsory norms for care quality and safety standards as well as an evaluation system.
- The extension of health information systems so they include long-term care institutions.
- The generation of a national registry of all public, private and non-profit institutions that cater to older adults and people with disabilities. This would allow the implementation of the norms and standards of care and evaluation at a national level.

6.2. Longer term policy implications

- The monitoring and evaluation of long-term care settings in line with the generation of national compulsory standards of care and regulations.
- The lockdown has exacerbated the already difficult conditions of unpaid family carers who care without much knowledge and support for their family members with care

needs. Publicly funded support strategies for people with care needs that include support from their primary carers are urgently needed.

- A national community based long-term care system that includes all existing institutions and all those created in the future as well as support strategies for people cared for at home (for people receiving and providing care) need to be established. This could be part of a broader plan to develop a social care (personal care) system.

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