Mexican society has traditionally expected the family to care for its older people but the current situation is being strained by demographic, social and economic changes. This research note outlines the situation and provides some basic information on current caretakers using data from the Mexican National Time Use Survey of 2009. The survey identifies six different caretaking tasks, three of which are performed predominantly by women. Since most health and personal care occurs within the household, the physical and psychological burdens, as well as opportunity costs involved, are seldom recognised by health and social development ministries. This remains a main challenge to be addressed in order to develop optimal targeted support for older adults and their caregivers.

INTRODUCTION

The traditional multigenerational family has been the major source of care for older Mexicans as caring for vulnerable family members has been an expected domestic function. However, this has also been predicated on a view of women that downplays the importance of their education or involvement in arenas outside the home, whether for employment, participation in the political sphere, or something else. In addition, demographic, social, and economic forces have been changing the composition and size of households and challenge the continued ability of the family household to support and care for older people, particularly unmarried older women without any children and with few social resources.

This note outlines the current health and social care situation of older people in Mexico followed by some of the demographic, social and economic changes that are straining traditional arrangements. It uses national survey data collected in 2009 to empirically show who, at that
time and on the national level, was providing care by type of care and average time spent providing that care. It shows which tasks were performed predominantly by women and which tasks were engaged in more similarly by both men and women. It notes some important age, civil status, and socioeconomic dimensions to providing care to older household members. While this only scratches the surface of what we need to know if we are to generate national policy that responds to the future needs and reality of an older Mexican population, it provides a baseline for future work.

BACKGROUND

Social Security: Pensions and access to health care services in Mexico: Health services, pensions, and retirement benefits with the Social Security system are all tied to past participation in formal employment in Mexico, while a large per centage of the economically active population works in the informal sector. According to the National Employment and Social Security Survey of 2009 (ENESS for its acronym in Spanish), only 25 per cent of adults 60 years and older received a pension; and it was almost double for men (34.6) than for women (17.6) (INEGI, 2012a).

Those that are not eligible for health care through a social security institution have access to health care provided by the Ministry of Health or, if they can afford it, to private services through direct out-of-pocket payments. While universal health care strategies started in earnest in the early 2000s, (mainly with the Seguro Popular de Salud), private, out-of-pocket expenditure still represented 47.3 per cent of Mexico’s health care expenditures in 2010 (OECD, 2013b). According to the National Demographic Dynamics Survey of 2009, approximately 30 per cent of adults 60 years and older reported having no health insurance at all.

Long-term care, that is, care needing someone else’s help in performing daily activities for a prolonged period of time (WHO, 2002a), is practically non-existent in Mexico outside of informal care provided by family, friends and neighbours. Most for profit long-term care institutions are very expensive and only accessible to a minority of older adults. Studies in other countries have estimated that between 80 and 90 per cent of the health care needed by older people is provided informally (Grunfeld et al., 2004; Pickard, 2001), and this is also the case in Mexico.

Population aging: demographic and epidemiological transitions, and their effect on household composition: According to the 2010 Population Census, 9.5 per cent of the total population in Mexico
is 60 years and older. Currently, 26 per cent of Mexican households have at least one adult 60 years or older. These older Mexicans live primarily in urban areas, are married or have a partner, and have little or no formal education (Hernández López et al., 2013). The Mexican National Population Council (Conapo) estimates that the majority of the population aged 60 years and older in Mexico lives with their children or other close relatives (Zúñiga and García, 2008), and most are independent and highly functional. However, the proportion of Mexico’s population 60 years and older is expected to grow to about 32 per cent by 2050 (Hernández López et al. 2013), and more of them will be 80+ years of age. While there is no consensus as to what this means in terms of the health and morbidity profile they will have (see e.g. Fries, 1983; Olshansky et al., 1991) and the care and support they will need, it is generally agreed that as the number of years lived increases, the number of oldest old increases, and with it the need of an older population for financial support, and health or personal care. As a group, people 80+ years of age have many limitations that require intensive care (Lopez Ortega, 2012).

While population aging is a result of huge reductions in both mortality and fertility, perhaps as important for the health of older people is that they experienced but survived many of the childhood diseases that killed earlier generations. Thus, instead of communicable diseases, major causes of death are now such non-communicable diseases as such as cancers and heart attacks. Urban living is also associated with an increased risk of obesity and diabetes, poor diet, and an overuse of tobacco and alcohol. There has been a re-emergence of such diseases as tuberculosis, dengue, malaria and cholera, particularly in economically and socially deprived areas.

A consequence of the demographic and epidemiologic transitions tightly related to the burden of personal care and economic support is the size and composition of households. The proportion of households that are nuclear is becoming less while unipersonal (single-person) households are becoming more common. According to data from the National Demographic Dynamics Surveys, nuclear households decreased from 68.3 per cent to 63.0 per cent of all households between 1992 and 2009 while unipersonal (single-person) households grew from 5.5 per cent to 9.8 per cent. More relevantly perhaps, using Population Census data, Wong et al. (2014) found that between the year 2000 and 2010 among households with members 60-64 years of age, the proportion of extended households decreased from 42.8 per cent to 40.9 per cent. Among
households with members 84 years and older, the proportion dropped from 59.8 per cent to 52.6 per cent. At the same time, the proportion of households with members 60-64 that had only one person increased from 6.1 per cent 7.4 per cent and the proportion of households with members 85 years and older that had only one person increased from 7.4 to 15 per cent. The authors note that old people in general but the oldest old especially, are increasingly living without care and support.

**Economic context and women’s labour force participation:** As with most Latin American countries Mexico, since the 1980s, has experienced major macroeconomic adjustments and restructuring focused on the strict control of public finances and inflation. These adjustments have favoured neoliberal economic policies of foreign investment and international trade and a diminishing role of the State in the economy (García & Oliveira, 2001). These policies have brought about economic growth, but not parallel economic development. To the contrary, they have generated increasing inequalities throughout the social and economic spheres. In particular, macroeconomic policies have not been able to incorporate the increasing working age population into the labour market, especially women. This, along with a gradual dismantling of social security systems, has generated an expansion of informal employment, an increase in social and economic inequalities, and increasing poverty (CEPAL, 2004).

Difficult economic conditions resulting from the economic crises in the 1980s and 1990s, international migration, and increasing separation and divorce rates, have increasingly pushed households into needing women’s labour force participation. Economic need along with other forces have resulted in the long term transformations of increased educational achievement, cultural changes in women’s roles, decreased fertility, and less time dedicated to childrearing (García, 1999; García and Oliveira, 2001).

While women’s labour force participation has grown steadily in the past 4 decades, Mexico still lags behind many Latin American countries, and is only above Turkey within OECD countries, with a female labour force participation rate of 47 per cent in 2012 (OECD, 2013). The gender gap in labour force participation is around 32 per centage points (INEGI, c2013). In addition, other persistent disparities have their base on prevailing gender and socioeconomic disparities, as well as on the macroeconomic and policy conditions. In addition to changing traditional family arrangements and socioeconomic conditions, these disparities leave
women few options to cope and reconcile work and family life, placing unequal burdens of care on them.

PROVIDERS OF INFORMAL CARE TO OLDER MEXICANS: A FIRST LOOK

Data. This note reports basic findings from the 2009 Time Use SturveyENUT of Mexico’s national statistical office INEGI (Encuesta Nacional sobre Uso del Tiempo of the Instituto Nacional de Estadística y Geografía). ENUT was a probabilistic national survey of individuals 12 years and older designed to capture the time people spent in different activities in and outside the household (INEGI, c2012b). Sampling 17,000 households, it identified 60 (or the weighted figure of 110,174) of Mexicans 12 years and older who provided informal care for a person 60 years or older in need of help performing their daily activities, because of temporary illness, a chronic disease, or disability. Activities were categorized as:

1. Preparing food for or feeding the person;
2. Helping the person with personal care;
3. Performing health care activities;
4. Taking or accompanying the person to a medical visit;
5. Performing or providing a special therapy;
6. Looking after or supervising the person while doing other activities.

The time spent on each activity was recorded. In addition, a seventh variable summed all six activities and the time allocated to all of them.

General results: At any point in time informal care givers provided an average of 6.6 hours per week (standard deviation of 8.4) for household members 60 years and older who needed help. The activity that used most time was #6—looking after or supervising the person while doing other activities—for an average of 17.4 hours per week. The next very time-consuming activity was performing or providing a special therapy at an average of 14.1 hours per week. The activity requiring the least time on average was taking or accompanying the person to a medical visit at an average of 2.2 hours per week.

This general picture is altered significantly when we also consider the caregiver’s gender. Women comprise 63 per cent of the caregivers and are the main caregivers for everything except taking or accompanying the elder to a medical visit. They are most dominant on activities that
Table 1
Number of Persons and Time Spent on Informal Care for Older Adults who Need Help, by Type of Activity and Gender of the Caregiver During Study Week. Mexico, Enut 2009

<table>
<thead>
<tr>
<th>Activity</th>
<th>Total</th>
<th>Women</th>
<th>Men</th>
<th>Female/Male</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>hours/week</td>
<td>total hours</td>
<td>hours/week</td>
<td>total hours</td>
</tr>
<tr>
<td>Provide special therapies</td>
<td>2</td>
<td>11.1</td>
<td>22.2</td>
<td>1</td>
<td>21</td>
</tr>
<tr>
<td>Take/accompany to physician visit</td>
<td>20</td>
<td>2.3</td>
<td>46.1</td>
<td>9</td>
<td>1.7</td>
</tr>
<tr>
<td>Personal care</td>
<td>10</td>
<td>6.3</td>
<td>63.1</td>
<td>7</td>
<td>5.5</td>
</tr>
<tr>
<td>Preparing meals/feeding</td>
<td>26</td>
<td>3.4</td>
<td>85.2</td>
<td>17</td>
<td>3</td>
</tr>
<tr>
<td>Health care*</td>
<td>41</td>
<td>3.6</td>
<td>157.5</td>
<td>24</td>
<td>3.8</td>
</tr>
<tr>
<td>Keep an eye/look after</td>
<td>44</td>
<td>19.5</td>
<td>858.8</td>
<td>27</td>
<td>27.4</td>
</tr>
<tr>
<td>Total</td>
<td>143</td>
<td>1232.9</td>
<td>85</td>
<td>956.8</td>
<td>58</td>
</tr>
</tbody>
</table>

* Administering medicines, monitoring, keeping an eye of symptoms; N.S. Not significant; Total number of persons higher than total number of carers due to people undertaking more than one activity.

Source: Own calculations based on ENUT 2009 data.
take the most time such as keeping an eye on the elder or providing special therapies. When subjected to a “difference of means” t-test, the gender difference in time spent was found statistically significant at a probability of less than 0.001 for those two activities and also for preparing meals or feeding. The difference was not significant for helping with personal care or health care, or with taking/accompanying the person to a medical visit.

In the sample of informal caregivers, 77.6 per cent reported being married, 9.0 per cent were single, divorced or separated, and 13.4 per cent were widowed. Again, the gender differences were striking. Ninety seven per cent of the men were married while only three per cent were single, divorced or separated. None were reported widowed. On the other hand, only two-thirds of the women were married while another 21.5

### Table 2

Percentile Distribution of Caregivers During Study Week by Selected Demographic and Socioeconomic Characteristics, Total, Male and Female

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age Group</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12-19</td>
<td>12.0</td>
<td>14.4</td>
<td>11.2</td>
</tr>
<tr>
<td>20-39</td>
<td>48.0</td>
<td>46.1</td>
<td>51.1</td>
</tr>
<tr>
<td>40-59</td>
<td>29.0</td>
<td>28.1</td>
<td>28.2</td>
</tr>
<tr>
<td>60+</td>
<td>11.0</td>
<td>11.4</td>
<td>9.5</td>
</tr>
<tr>
<td><strong>Civil Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently married/with partner</td>
<td>77.6</td>
<td>97.0</td>
<td>66.1</td>
</tr>
<tr>
<td>Single, Separated, Divorced</td>
<td>9.0</td>
<td>3.0</td>
<td>21.5</td>
</tr>
<tr>
<td>Widowed</td>
<td>13.4</td>
<td>-</td>
<td>12.4</td>
</tr>
<tr>
<td><strong>Educational attainment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No formal schooling</td>
<td>5.1</td>
<td>5.1</td>
<td>6.0</td>
</tr>
<tr>
<td>Completed primary</td>
<td>30.6</td>
<td>28.8</td>
<td>31.3</td>
</tr>
<tr>
<td>Completed high school</td>
<td>52.0</td>
<td>52.2</td>
<td>53.1</td>
</tr>
<tr>
<td>Higher</td>
<td>11.6</td>
<td>13.8</td>
<td>9.6</td>
</tr>
<tr>
<td><strong>Income level (quartiles)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>q1</td>
<td>43.0</td>
<td>21.8</td>
<td>53.5</td>
</tr>
<tr>
<td>q2</td>
<td>20.1</td>
<td>17.7</td>
<td>21.3</td>
</tr>
<tr>
<td>q3</td>
<td>17.3</td>
<td>26.2</td>
<td>13.3</td>
</tr>
<tr>
<td>q4</td>
<td>19.6</td>
<td>34.3</td>
<td>11.8</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>n</td>
<td>60</td>
<td>24</td>
<td>36</td>
</tr>
</tbody>
</table>
per cent were single, divorced or separated and only a little more than a
tenth were widowed. It was the single/divorced/separated women who
did the most caring – spending an average of 12 hours per week, compared
to six and four hours per week on average for married and widowed
women respectively.

Interestingly, while it is common for women to survive their spouse
or partner, the high prevalence of widowed women undertaking informal
care for other older adults was less expected and future analyses should
go in more detail to disentangle all the family relationships among
household members to see who these women are taking care of. Going
into more detail could also permit one to explore other care responsibilities
that these care givers may have, in particular those that are married and
with children.

Roughly half of the caretakers were between 20 and 39 years of age,
a time of life when they may be caring for their own dependent children
even as they were caring for elderly parents, parents in-law, or even
grandparents, in the context of an extended multigenerational family
household. Another 28 per cent were 40-59 years of age, in what some
people refer to as a “sandwich generation” in which middle aged
individuals are still taking care of and responsible for their children as
well as their elderly parents (Montes de Oca, 1999). Interestingly, only
an eighth or so of the caretakers were youths under the age of 20 (12-19),
and only another tenth or so were themselves 60 years of age or older.
This latter group presumably would include spouses of the older people
in need of care.

Looking at the educational attainment of caregivers shows that a
little more than half the caretakers had completed high school, almost
another third had completed primary school, about a tenth had some
tertiary education or more and only six per cent or less had no formal
education at all. There was no noteworthy difference by gender.

DISCUSSION

This study advances the way informal care to older adults has been studied
by using nationally representative data on time use by individuals 12
years and older in Mexico. Only a beginning, we still found such clear
evidence of a sexual division of non-remunerated work in the total number
of persons taking up informal care, the type of activity performed and in
total time spent caringsuch that findings are worth reporting. Consistent
with previous studies in Mexico (Nigenda et al., 2007; Robles Silva, 2001,
our nation-level results show the extension of domestic tasks and the burden that households bear in terms of care for older adults. In addition, the study reiterates how within households, it is women who assume most of the responsibilities associated to providing such informal care. This is true regarding the percentage of women who provide this care compared to that of men, as well as in the average number of hours of time spent undertaking these activities. These results are also consistent with studies in other countries (Tomassini et al., 2004; Pickard et al., 2000).

Further research is necessary for good policy development. Additionally probing ENUT 2009 in more detail and with multivariate models could be a start. And while no longitudinal data on care or time use is currently available in Mexico, the continuation of the National Time Use Surveys could continue to provide pictures of how informal care is changing along with our changing social and economic context.

Second, larger scale qualitative studies, ideally with regional and/or national representation are needed in order to investigate perceptions around informal care such as people’s willingness to accept formal services or what the gender and background of a caregiver might be. Finally, studies need to explore the impact of recent government strategies such as the universal non-contributory pension for individuals 60 years and older.

That is, by the end of his first year in the administration, President Enrique Peña Nieto announced and sent to Congress an initiative to create a universal pension for older adults who do not have access to social security or state level non-contributory pensions. The initiative was discussed and passed in March 2014 making it compulsory for federal government to provide an income through non-contributory pensions from age 65 to those who do not receive a pension. While some years will pass before this policy is implemented at national level, it is an example of some new strategies that federal and state level governments have introduced in order to increase overall wellbeing of different population groups, and in particular older adults.

While having a small income is beneficial, factors such as the speed of population aging in Mexico, the profound changes in family size and composition with older people increasingly living alone, the fact that at least a fourth of the elderly population is in need of support with daily activities, and economic policies that are hindering generational reciprocity, make it indispensable to think in terms of wider strategies...
that include long-term care for older adults, generating both support for informal caregivers at home, and formal home care services. Government institutions are just starting to recognise the profound changes that the ageing process and certain economic policies will have on the supply and demand of health and social care services, and there appear to be few concrete steps yet toward generating much needed programs.

One of the most important factors is for the Government to recognise the burden on families of informal care and the financial and opportunity costs incurred. Factors such as changes in geriatric training and generation of new health professionals and personal aides needed for older adults care should be considered. In addition, changes in employment legislation allowing flexible work schedules, as well as changes in cultural values towards childbearing, childcare and care to older adults would be very helpful.

Day centres and home-based care that could release informal carers from at least some of the burden they face could help. Inadequately supporting the caring activities of families removes the effective choice for carers and elderly people, increasing the likelihood of tension between relatives and breakdown on the part of the carers (Quareshi and Walker, 1986).

The challenge is to think in terms of a model that fits Mexico and its distinctive qualities. For instance, while older adults often seem to state that the provision of care is the responsibility of daughters, younger cohorts are more inclined to think that all children have to share the responsibility, regardless of gender. They expect daughters as well as sons to acquire education and employment outside the home. It only makes sense that they expect both sons and daughters to shoulder caretaking responsibilities as well, and that this should be considered when planning future strategies to support informal care givers in the household.

Acknowledgements

The research for this study was funded by the Mexican National Council of Science and Technology, CONACYT and the National Institute of Statistics and Geography, INEGI through grant 186319. Susan De Vos made valuable comments and suggestions on earlier drafts of this Note.

References


