

ISSN 1727-9917

SERIES

**STUDIES AND
PERSPECTIVES**

**ECLAC SUBREGIONAL
HEADQUARTERS
FOR THE CARIBBEAN**

Ageing in the Caribbean and the human rights of older persons

Twin imperatives for action

Francis Jones



UNITED NATIONS

ECLAC

STUDIES
AND
PERSPECTIVES

Ageing in the Caribbean and the human rights of older persons

Twin imperatives for action

Francis Jones



UNITED NATIONS



This document has been prepared by Francis Jones, Population Affairs Officer in the Statistics and Social Development Unit, ECLAC subregional headquarters for the Caribbean. Inputs were prepared by Candice Gonzales, also of the Statistics and Social Development Unit. Substantive comments on chapter II were provided by Javier Vasquez, Advisor on Human Rights, Pan American Health Organization/World Health Organization. The study also benefited from comments received from: Sandra Huenchuan and Tim Miller of the Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC; Jeff James, Regional Representative of HelpAge International; Abdullahi Abdulkadri, Chief of the Statistics and Social Development Unit; and Dillon Alleyne, Johann Brathwaite and Alexander Voccia, also of the ECLAC subregional headquarters for the Caribbean.

The views expressed in this document, which has been reproduced without formal editing, are those of the author and do not necessarily reflect the views of the Organization.

United Nations publication

ISSN 1727-9917

LC/L.4130

LC/CAR/L.481

Copyright © United Nations, January 2016. All rights reserved.

Printed at United Nations, Santiago, Chile

S.15-01220

Member States and their governmental institutions may reproduce this work without prior authorization, but are requested to mention the source and inform the United Nations of such reproduction.

Contents

Abstract	5
Introduction	7
I. Population ageing in the Caribbean	11
A. The demographic transition: why the population is ageing.....	12
B. Ageing in the Caribbean: regional and national trends	16
II. The human rights of older persons in international law	21
A. The rights of older persons in the United Nations human rights system.....	22
B. The rights of older persons in the inter-American human rights system.....	25
C. Other non-binding agreements on ageing and older persons	28
D. The rights of older persons in national constitutions, laws and policies	29
III. Ensuring economic security for older persons	31
A. Poverty among older persons	31
B. Older persons in the labour force	33
C. Caribbean pension systems	34
D. Other forms of income support for older persons	39
IV. Health service provision for an ageing population	41
A. Ageing, non-communicable diseases and disability.....	41
B. Health systems, funding and equitable access to services.....	45
C. Health care services for older persons including palliative care	48
V. Enabling and supportive environments for older persons	51
A. Social care services to support independence, health and well-being.....	51
B. Facilitating greater social participation by older persons.....	54
C. Older persons in disaster risk management.....	56
D. Protection against abuse, exploitation and discrimination	57
VI. Conclusions	61
Bibliography	65

Studies and Perspectives Series: issues published 68**Tables**

TABLE 1	CARIBBEAN: SELECTED INDICATORS OF THE DEMOGRAPHIC AGEING PROCESS, 2015	19
TABLE 2	COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS: SELECTED CONTENT FROM GENERAL COMMENT No. 6 ON THE ECONOMIC, SOCIAL AND CULTURAL RIGHTS OF OLDER PERSONS, 1995	24
TABLE 3	A SUMMARY OF PROTECTED RIGHTS IN THE INTER-AMERICAN CONVENTION ON PROTECTING THE HUMAN RIGHTS OF OLDER PERSONS.....	26
TABLE 4	A SUMMARY OF THE UNITED NATIONS PRINCIPLES FOR OLDER PERSONS	29
TABLE 5	POVERTY RATE BY AGE	32
TABLE 6	PENSION SYSTEMS FOR WORKERS IN THE FORMAL AND INFORMAL SECTOR	35
TABLE 7	DISABILITY-ADJUSTED LIFE YEARS BY CAUSE, 2012.....	43
TABLE 8	UTILIZATION OF HEALTH CARE SERVICES BY AGE AND EXPENDITURE QUINTILE.....	46
TABLE 9	LEVEL OF PALLIATIVE CARE DEVELOPMENT, 2011	50
TABLE 10	HOME CARE PROGRAMMES FOR FRAIL OLDER PERSONS, 2012	52
TABLE 11	REGULATION OF RESIDENTIAL CARE HOMES FOR OLDER PERSONS, 2012.....	53

Figures

FIGURE 1	THE CARIBBEAN POPULATION BY AGE.....	11
FIGURE 2	THE CARIBBEAN: PHASES OF THE DEMOGRAPHIC TRANSITION.....	13
FIGURE 3	CARIBBEAN POPULATION BY AGE AND SEX, SELECTED YEARS, 1990-2060.....	14
FIGURE 4	SURVIVAL CURVES FOR THE CARIBBEAN POPULATION (BOTH SEXES), SELECTED YEARS, 1890-2100.....	15
FIGURE 5	CHILD, OLD AGE AND TOTAL DEPENDENCY RATES FOR THE CARIBBEAN	16
FIGURE 6	OLD AGE DEPENDENCY RATIO BY REGION, 2000-2050.....	17
FIGURE 7	OLD AGE DEPENDENCY RATIO BY COUNTRY, 2015, 2030 AND 2045	17
FIGURE 8	OLDER PERSONS IN THE CARIBBEAN BY SEX AND AGE, 2000-2050.....	18
FIGURE 9	LABOUR FORCE PARTICIPATION OF PERSONS AGED 65 AND OVER BY SEX, 2013	33
FIGURE 10	EFFECTIVE COVERAGE OF CONTRIBUTORY OLD AGE PENSIONS VERSUS THE LABOUR FORCE PARTICIPATION RATE FOR PERSONS AGED 65 AND OVER.....	34
FIGURE 11	PERSONS OVER RETIREMENT AGE WHO RECEIVE A CONTRIBUTORY SOCIAL SECURITY PENSION	36
FIGURE 12	CONTRIBUTORY OLD AGE SOCIAL SECURITY PENSION COVERAGE BY SEX.....	37
FIGURE 13	EXPENDITURE ON CONTRIBUTORY AND NON-CONTRIBUTORY PENSIONS	38
FIGURE 14	NON-CONTRIBUTORY PENSIONS AND NATIONAL POVERTY AND INDIGENCE LINES, 2013	38
FIGURE 15	DEATHS DUE TO NON-COMMUNICABLE DISEASES (NCD) AND POPULATION AGED 60 AND OVER, AROUND 2010	42
FIGURE 16	PREVALENCE OF DISABILITY IN THE CARIBBEAN BY TYPE, SEX AND AGE, 2000s.....	44
FIGURE 17	PUBLIC HEALTH SPENDING AND GDP PER CAPITA, 2012.....	47
FIGURE 18	OUT-OF-POCKET EXPENDITURE ON HEALTH AND GDP PER CAPITA, 2012	48

Abstract

This study addresses the ageing of the Caribbean population and the situation with respect to the human rights of older persons. It considers the implications for public policy of these ‘twin imperatives for action’. The first chapter describes and explains the changing age structure of the Caribbean population. Important features of the ageing dynamic, such as differential regional and national trends and the growing number of ‘older old’ persons, are also analysed. The study then describes the progress that has been made in advancing and clarifying the human rights of older persons in international law. The core of the study then consists of an assessment of the current situation of older persons in the Caribbean and the extent to which their human rights are realised in practice. The thematic areas of economic security, health, and enabling environments – which roughly correspond to the three priority areas of the Madrid International Plan of Action on Ageing – are each addressed in individual chapters. These chapters evaluate national policies and programmes for older persons and make public policy recommendations intended to protect and fulfil the human rights of older persons. The report concludes by summarising the priorities for future action both through the establishment of new international human rights instruments as well as national policies and programmes.

Introduction

Over the next twenty years, the Caribbean¹ will see a rapid and dramatic ageing of its population. Over this period, the number of older persons will double: the number of persons aged 60 and over will increase from 1.1 million (or 13 per cent of the population) in 2015 to 2 million (or 22 per cent) in 2035. The number of people aged 70 and over will increase from 500,000 (or 6 per cent) to 1 million (or 11 per cent). The population will continue to age after 2035 albeit at a slowly diminishing rate. Over the next twenty years and beyond, all Caribbean countries and territories will see rapid ageing and significant increases in the proportion of older persons in their respective populations.

At present, Caribbean pension systems, health and social care services are unable to meet the needs of the current generation of older persons. With a rapid increase in the number of older persons on the horizon, there is an urgent need for governments to strengthen social protection against a wide range of risks associated with ageing, including loss of income, ill health, disability, loss of independence and isolation, which are risks faced by all. At the same time, ageing demands a transformation of the role of older people in society. With older persons making up such a substantial proportion of the population, societies must embrace the contribution that older people can make to economic, social and family life.

The international community has sought to address population ageing through coordinated efforts to improve policies and programmes for older persons. By the time of the Second World Assembly on Ageing held in Madrid in 2002 it was widely recognised that population ageing had become a pressing issue for many developing countries, in addition to being an on-going challenge for developed countries. The Madrid Plan of Action set out a framework which has been further elaborated in regional and sub regional fora. Since the Madrid Assembly, there have been three Regional Intergovernmental Conferences on Ageing in Latin America and the Caribbean, the most recent in 2012.

Caribbean governments recognise that population ageing is an issue of growing concern. In 2013, based on national responses to the United Nations Inquiry among Governments on Population and

¹ Here the Caribbean refers to Anguilla, Antigua and Barbuda, Aruba, Bahamas, Barbados, Belize, British Virgin Islands, Cayman Islands, Curaçao, Dominica, Grenada, Guadeloupe, Guyana, Jamaica, Martinique, Montserrat, St. Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Sint Maarten, Suriname, Trinidad and Tobago, Turks and Caicos Islands, and the United States Virgin Islands.

Development, 12 out of 13 Caribbean governments identified population ageing as a major concern (up from 9 out of 13 in both 2005 and 2009). Many have adopted,² or are developing, national policies on ageing. These policies set out strategic priorities and goals, and provide a framework for the development of programmes aimed at older persons. The primary responsibility for coordinating the implementation of these policies lies with ministries of social development (or similar). Many countries have also created national councils on ageing which provide advice to governments and act as advocates for older persons.³ Some of these national councils deliver programmes and services for older persons albeit on a relatively small scale.

While these international agreements and national policies have provided the impetus for the development of programmes and other actions on behalf of older persons, reviews have shown that implementation has lagged in many countries, with significant gaps between policy and practice as a result of insufficient funds and lack of human and political resources.⁴ There are certainly many commonalities between the challenges faced by Caribbean governments in respect of population ageing and the rights of older persons, and those faced by governments in Latin America and elsewhere. However, there are also a number of issues which are specific to the Caribbean situation which need to be taken into account.

The economies of the Caribbean subregion are only slowly recovering after being severely affected by the global economic crisis. The Caribbean economy experienced negative growth in per capita GDP between 2009 and 2011 with a very weak recovery in 2012 and 2013 (ECLAC, 2014). This has worsened the fiscal situation of the countries leaving them with debts among the highest in the world surpassing 70 per cent of GDP in 9 of the 13 countries of the subregion (IMF, 2014) and with repayment of debt corresponding to 23 per cent of government revenue on average. This context makes it more difficult to increase social spending in the short term.

Due to their small size, public institutions of Caribbean countries and territories have limited capacity to develop new policies, laws and social programmes for older persons, especially in the eastern Caribbean islands. The difficulty of achieving economies of scale also results in higher administrative costs associated with the operation of social programmes, thus reducing their efficiency.

The countries of the subregion have high net emigration flows, in some cases among the highest rates in the world, which also impacts the technical capacity of their institutions. In addition, emigration accelerates, to some extent, the process of population ageing and affects the family support structures that provide care for older persons.

Entire Caribbean populations are under threat from climate change and the risk of natural disasters with older citizens among the most vulnerable. Most of the subregion is threatened by hurricanes and tropical storms which also cause flooding. Climate change is projected to make these events even more extreme. It is therefore important that disaster risk management and climate change mitigation policies take proper account of older persons.

The human rights of older persons have also become a subject of increasing concern to the international community, with important implications for public policy. International treaties oblige states to respect the human rights of older persons and provide protection against human rights violations such as age discrimination and prejudice in attitudes, practices, or laws which prevent older persons from participating fully in society. States must also take positive action to facilitate their enjoyment of basic human rights. This should include access to mechanisms enabling older persons to seek redress when their human rights are infringed or not fulfilled.

² National policies have been adopted in Jamaica, 1997; Dominica, 1999; Belize, 2002; Trinidad and Tobago, 2007; Grenada, 2009; Antigua and Barbuda, 2013; and Barbados 2013.

³ For example Belize in 2003; Dominica in 1993; Saint Lucia in 1995; and Jamaica (The National Council for Senior Citizens) established in 1976.

⁴ See the national reports prepared for the Third Regional Intergovernmental Conference on Ageing in Latin America and the Caribbean held in 2012, and Follow-up to the International Year of Older Persons: Second World Assembly on Ageing, Report of the Secretary-General (A/68/167), 19 July 2013, at para 12.

Over time, international efforts to address population ageing have gradually focused more on the human rights of older persons. The Madrid International Plan of Action on Ageing (2002) described ‘the full realization of all human rights and fundamental freedoms of all older persons’ as a ‘central theme running through the Plan’. The Brasilia Declaration (ECLAC, 2008) and then the San Jose Charter on the Rights of Older Persons in Latin America and the Caribbean (ECLAC, 2012), from the second and third regional conferences on ageing, incorporated commitments to promote and protect the human rights and fundamental freedoms of older persons. The Pan American Health Organization (PAHO) Plan of Action on the Health of Older Persons, including Active and Healthy Aging (2009) was also based on human rights instruments and informed the drafting of the Inter-American Convention on Protecting the Human Rights of Older Persons.

United Nations treaties have established various human rights which have a particular relevance for older persons, including the right to social security, to an adequate standard of living, and to the highest attainable standard of health. Some of the bodies monitoring the core United Nations human rights instruments have addressed the rights of older persons directly, by clarifying how the rights contained in existing treaties should be interpreted for older persons. However, unlike the human rights of women, children or persons with disabilities, there is no United Nations treaty which explicitly addresses the rights of older persons and defines how universal human rights should be interpreted for this age group. In the absence of a comprehensive universal treaty, the human rights of older persons remain partially specified and, resting as they do on a complex patchwork of different treaties and decisions, there remains a lack of clarity concerning the universal human rights of older persons.

Efforts continue to further advance, clarify and protect the human rights of older persons. In 2012, member States of ECLAC agreed the San Jose Charter on the Rights of Older Persons in Latin America and the Caribbean, in which representatives of member States expressed support for an international convention on the rights of older persons, and undertook to strengthen actions designed to increase the protection of human rights at the national level. The United Nations Open-ended Working Group on Ageing continues its work to strengthen the protection of the human rights of older persons through existing mechanisms, but to date there has been insufficient support among member States for the negotiation of a new United Nations convention on the rights of older persons.

While there remains a lack of clarity concerning universally applicable human rights for older persons, in the Americas there is now a treaty which does specifically address the human rights of older persons: the Inter-American Convention on Protecting the Human Rights of Older Persons. The convention was adopted by the member States of the Organization of American States (OAS) in June 2015 after four years of negotiations. This makes the Americas the first region in the world to have an instrument for the promotion and protection of the human rights of older persons. The Convention will enter into force when at least two signatory countries have ratified it. This will be an important step which strengthens the legal obligations upon member States to respect, protect and promote the human rights of older persons. The convention will have important implications for public policy for older persons in Caribbean States, all of which are members of the OAS.

The human rights of older persons are generally regarded as being applicable to persons aged 60 or older. In the Inter-American Convention, older persons are those “aged 60 or older, except where legislation has determined a minimum age that is lesser or greater, provided that it is not over 65 years.” The age at which persons become older persons in human rights law is not necessarily the same as, for example a state retirement age. Whatever minimum age is used, it should be emphasised that older persons are not a homogenous group and public policy needs to account for the fact that ageing affects people in different ways at different times of their lives.

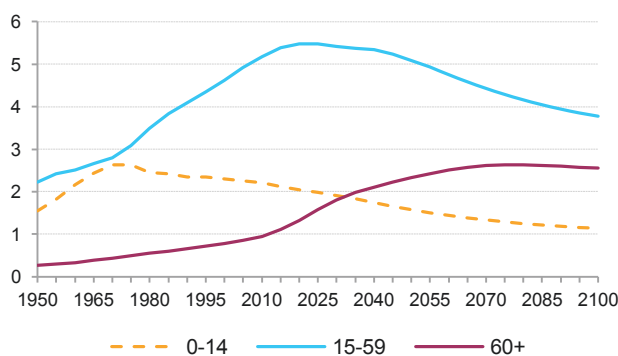
Population ageing is a worldwide demographic trend which, as the Madrid Plan makes clear, demands action for older persons in many spheres. Human rights are a guide and a framework for those actions. At the same time, fundamental human rights are an important end in themselves, and protection of the rights of older persons should be a matter of the upmost concern irrespective any demographic considerations. It is in this sense that ageing and human rights are described as ‘twin imperatives’ for action.

I. Population ageing in the Caribbean

Many people are familiar with the notion that populations are ageing. This is often attributed to the fact that ‘we’re living longer’. While this is true, and longer life expectancy is certainly one of the fundamental causes of population ageing, it is far from the whole story. Changes in age-specific mortality rates, fertility patterns and international migration also impact population ageing to different degrees. Aside from the causes of population ageing, the sheer scale of the change in population structure which is taking place is not widely appreciated among the wider public in general and policymakers in particular.

The number of children aged under 15 years of age in the Caribbean reached a peak in the early 1970s. It has declined since then and will continue to decline throughout the twenty-first century (Figure 1).

Figure 1
The Caribbean population by age
(Millions of persons)



Source: United Nations, Department of Economic and Social Affairs, Population Division (2013). World Population Prospects: The 2012 Revision, DVD Edition.

The number of working aged adults (15-59) increased significantly throughout the second half of the twentieth century. This increase has now levelled off and it is projected that the number of working age persons (15-59) will start to fall from around 2040. In contrast, the number of persons aged 60, which also increased throughout the late twentieth century, will continue to increase over the coming decades. That increase will be particularly rapid over the next twenty years.

Population ageing really refers to the changes in the *relative* age structure of the population, that is, the proportions of young, working age and older persons. Since about 1970, children have made up a decreasing proportion of the total population while older persons have made up a growing proportion of the population. In 1970, the proportions of children (0-14), working age (15-59) and older persons (60+) were: 45 per cent; 48 per cent and 7 per cent. Today the corresponding proportions are: 25 per cent; 63 per cent and 13 per cent. In 2050 these proportions are projected to be 18 per cent; 57 per cent; and 26 per cent and this trend will continue beyond 2050.

A. The demographic transition: why the population is ageing

The phenomenon of ageing populations arises as a result of what is called the demographic transition. This is the name given to the demographic changes that accompany the transition from pre-industrial societies to modern industrial/post-industrial societies. These include changes in birth rates, death rates, population growth, and population age structures. All countries are affected by these changes although developed and developing countries can be at very different stages of the process. Figure 2 illustrates how the Caribbean population has changed very much in accordance with this demographic transition model. It uses data and projections for the Caribbean over the period 1800 to 2100 to illustrate the stages of the transition; the evolution of the key population variables; and their effect on the age structure of the population (or the population pyramid).

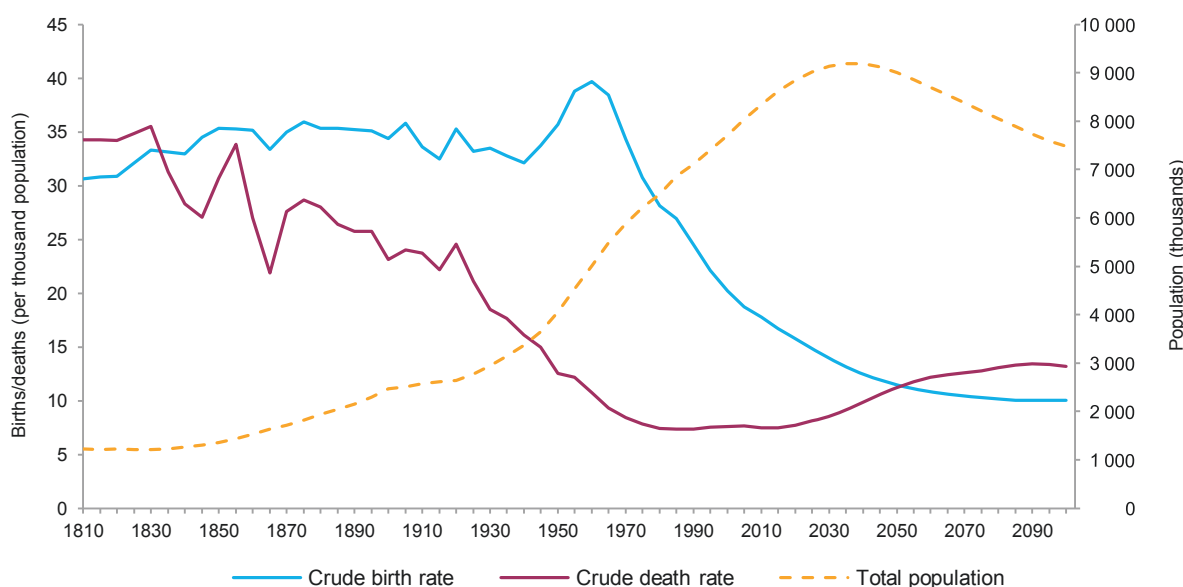
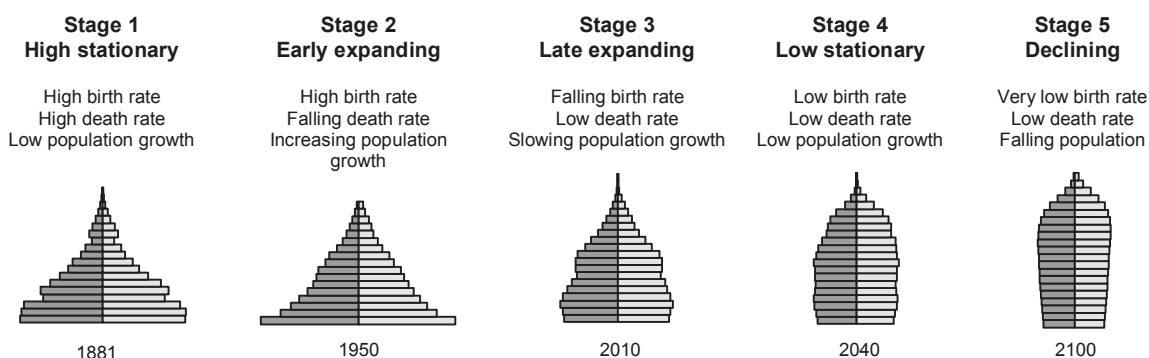
The standard model of the demographic transition consists of four stages (although a possible fifth stage has been postulated). The first stage characterises the situation in pre-industrial societies where birth rates are high, death rates are high and population growth is low. This stage is sometimes referred to as ‘high stationary’. Birth and death rates are roughly in balance and so the size and age structure of the population is relatively stable (or stationary). Populations in such societies were very young: the population pyramid was wide at the bottom but much narrower for older age groups. This was the situation in the Caribbean during the first half of the nineteenth century.

In the second or ‘early expanding’ stage, the death rate, and child mortality in particular, starts to fall mainly due to improved food supply and public health (water, sanitation, hygiene etc). This leads to increasingly rapid population growth. More people survive until their reproductive years, so the population pyramid starts to ‘fill out’ from the bottom upwards. In the Caribbean, this second stage started during the second half of the nineteenth century and continued until around the 1960s.

In the third or ‘late expanding’ stage, the death rate continues to fall, albeit more slowly, and the birth rate also starts to fall rapidly due to changing behaviour and the availability of contraception. This has the effect of slowing the rate of population growth. The population pyramid starts to narrow at the bottom and continues to widen for older age groups. The Caribbean is currently passing through this third stage and it is projected that this will continue until around the 2030s.

In the fourth stage, ‘low stationary’, which is characteristic of modern industrial/post industrial societies, the birth rate comes roughly into line with the death rate bringing to an end the era of population growth, thereby completing the demographic transition. Once the Caribbean reaches this stage, around the 2030s, it may remain at this stage with low population growth, although projections suggest it may indeed move to the proposed fifth stage of ‘declining’. This would see the birth rate lower than the death rate and therefore a declining population. It should be noted that the projected increases in the crude death rate over the coming decades are due precisely to the ageing of the population -the fact that there are a greater number of older people in the population- not a worsening of life expectancy.

Figure 2
The Caribbean: phases of the demographic transition

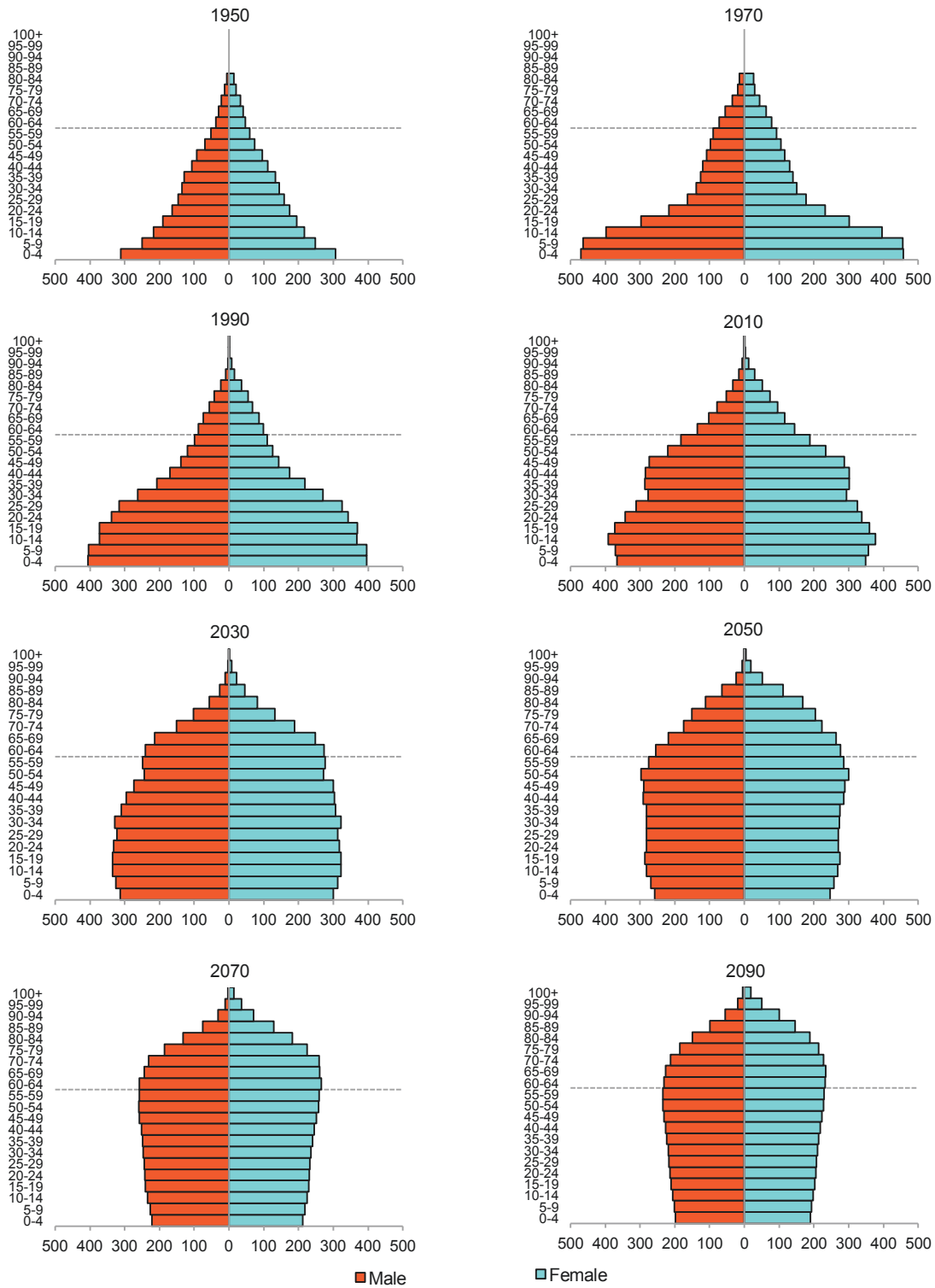


Source: The Economic History of the Caribbean Since the Napoleonic Wars, Victor Bulmer-Thomas, Cambridge University Press (2012); United Nations, Department of Economic and Social Affairs, Population Division (2013). World Population Prospects: The 2012 Revision, DVD Edition.

Note: The population pyramid for 1881 is based on data for Jamaica only.

The changing age structure of the Caribbean population over the period 1950 to 2100 is shown in more detail in Figure 3. In 1950, the population pyramid was almost literally the shape of a pyramid but by around 2030 or 2050 it will become dome-shaped. Over time, there is an increasing proportion of the population aged 60 and over. Figures 2 and 3 also illustrate why population ageing will be particularly rapid over the next couple of decades. Numerous Caribbean countries experienced ‘baby booms’ around the 1960s with a rapid increase and then subsequent fall in the crude birth rate (Figure 2). This increase was likely connected to improved living conditions (reflected in the falling death rate in the immediately preceding period) leading to an increased number of women reaching fertile age in good health. After the 1960s other factors then combined to reduce the birth rate. The effect of this ‘baby boom’ on the population pyramid is made very clear by comparison of the pyramids for 1950 and 1970 (Figure 3). The base of the pyramid substantially widened over this period reflecting the fact that this ‘baby boom’ cohort was substantially larger than either the previous or subsequent generations. This generation is now aged between 45 and 65 and will be retiring over the next twenty years, and this, coupled with the reduced birth rate, will substantially increase the proportion of older persons in the population.

Figure 3
Caribbean population by age and sex, selected years, 1990-2060
(Thousands)

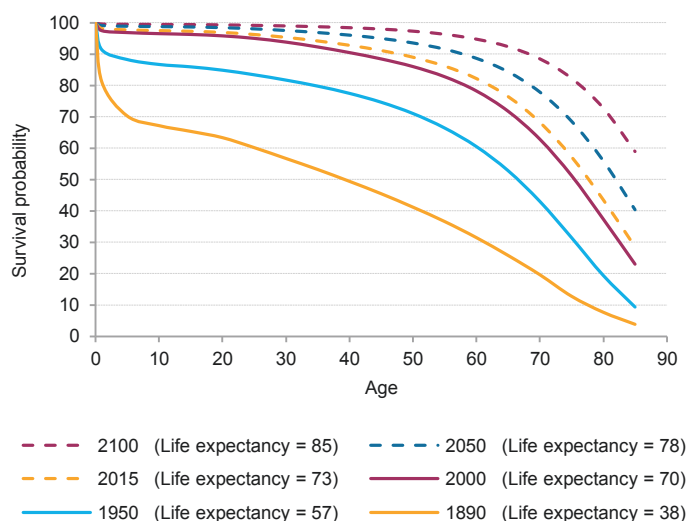


Source: United Nations, Department of Economic and Social Affairs, Population Division (2013). World Population Prospects: The 2012 Revision, DVD Edition.

In addition to the crude birth and death rates, the changing pattern of age-specific death rates also plays an important role in determining the age structure of the population. A smaller proportion of people are dying in childhood, during working age, and even in ‘young old age’ so life expectancy is increasing. These changes are analysed here using survival probabilities which are calculated from age-specific death rates and indicate the chance of an average individual surviving from birth to any given age. Survival probabilities illustrate the impact of changing age-specific death rates on the age structure of the population and show why the population pyramid is becoming dome-shaped. They are more revealing than life expectancies since they indicate the distribution of years lived, not just an average.

Survival probabilities estimated for the Caribbean changed dramatically during the twentieth century and are projected to continue evolving throughout this century (Figure 4). In 1890, around one third of Caribbean children died before their fifth birthday, many before their first birthday. Death during the remainder of childhood or working age was not uncommon either. For example, around two-thirds of people died before their 60th birthday. This explains why the population pyramid, in the early stages of the demographic transition, has its characteristic pyramid shape. During the twentieth century, the proportion of children dying before their fifth birthday fell significantly while the proportion of people dying later in childhood or during working age also declined. Today, over three quarters of people live to at least 65. By 2050, it is projected that three quarters will live to over the age of 70. It is this dramatic reduction in the proportion of persons dying before old age which explains why the population pyramid becomes dome-shaped.

Figure 4
Survival curves for the Caribbean population (both sexes),
selected years, 1890-2100
(Survival probability by age in years)



Source: United Nations, Department of Economic and Social Affairs, Population Division (2013). World Population Prospects: The 2012 Revision, DVD Edition.

Note: These curves are based on period rather than cohort life tables and therefore indicate the survival probabilities from birth to any given age for a hypothetical individual having the age specific survival probabilities estimated for each of the years indicated above. The estimates for 1890 are based on data for Jamaica only.

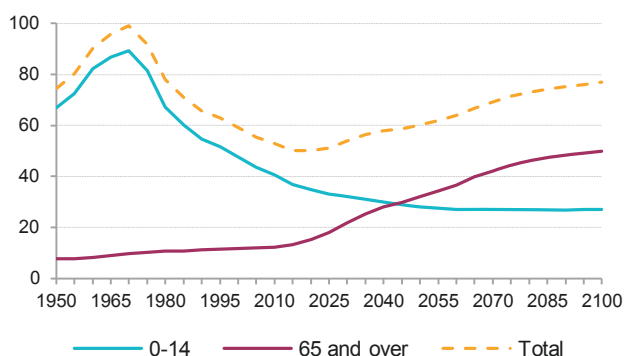
These changes in survival probabilities are reflected in increased life expectancy. In the Caribbean, life expectancy at birth increased from an estimated 38 years in 1890, to 73 years in 2015. It is projected to be 78 years in 2050 and 85 years in 2100. As mentioned at the start of this chapter, this increase in life expectancy is an important driver of population ageing. However, as has been shown, declining fertility is also a hugely important determinant of the age structure of the population.

B. Ageing in the Caribbean: regional and national trends

A common way of analysing population ageing is with reference to dependency ratios which compare the number of children and older persons with the number of persons of working age. The rationale for this is that children and older persons depend to a large degree on economic support provided by the working age population (sometimes referred to as intergenerational transfers). Population ageing causes significant shifts in these dependency ratios with major implications for public policy. In the analysis that follows, dependency ratios have been calculated based on the following age groups: children, 0 to 14 years; working age adults, 15 to 64; and older persons, 65 years and over.

Since the 1970s, child dependency ratios⁵ have been falling due to the declining fertility rates (Figure 5). During this time, old age dependency ratios were increasing but slowly and from a low level. The total dependency ratio was therefore in decline, from 89 in 1970 to 37 in 2015. From 2015 onwards, the child dependency rate will continue to decline while the old age dependency rate will start to increase more rapidly. As a result, from 2020 onwards, the total dependency ratio will start to increase again. This current period during which the total dependency ratio is low is referred to as the demographic window. It is argued that this is a propitious period for economic growth although the evidence for this is rather mixed and inconclusive.

Figure 5
Child, old age and total dependency rates for the Caribbean
(Number of persons per hundred people aged 15-64 years)

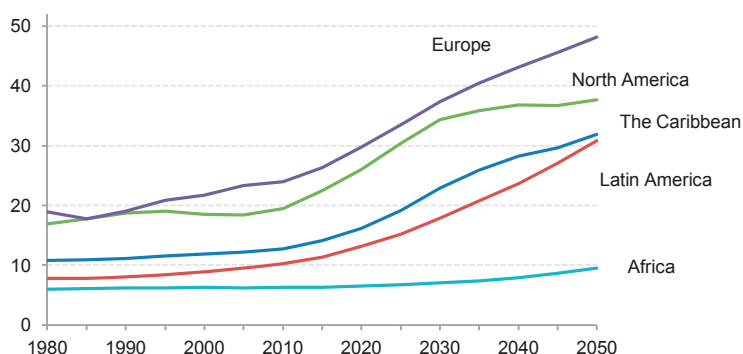


Source: United Nations, Department of Economic and Social Affairs, Population Division (2013). World Population Prospects: The 2012 Revision, DVD Edition.

Population ageing is a global phenomenon. Higher income regions and countries are generally at a more advanced stage in the process, however many middle and lower income countries are now starting to see increasingly rapid population ageing. In comparison to other regions of the hemisphere, the ageing process is a little more advanced in the Caribbean than in Latin America but far less advanced than in North America. Dependency ratios in 2015 were 11 in Latin America, 14 in the Caribbean and 22 in North America (Figure 6). However, each of those regions is at a turning point and the ageing of their populations will be much more rapid over the coming decades compared with recent history. By 2040, dependency rates will be 24 in Latin America, 28 in the Caribbean and 37 in North America, so in both the Caribbean and Latin America the rates will have doubled in a period of only twenty five years. Beyond 2040, the populations of these regions are projected to continue ageing for the rest of the century.

⁵ The child dependency ratio expresses the number of persons (aged 0-14) as a percentage of the working age population (aged 15-64); the old age dependency ratio is the number of older persons (aged 65 and over) as a percentage of the working age population; and the total dependency ratio is the sum of the child dependency ratio and the old age dependency ratio.

Figure 6
Old age dependency ratio by region, 2000-2050
(Number of persons aged 65 and over per hundred persons aged between 15 and 64 years)

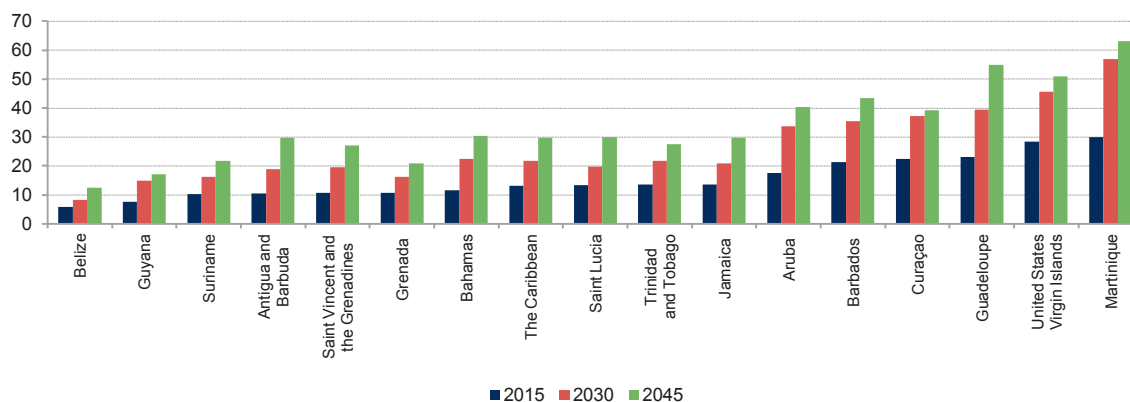


Source: United Nations, Department of Economic and Social Affairs, Population Division (2015). World Population Prospects: The 2015 Revision, DVD Edition.

Note: Latin America includes Cuba, Haiti, the Dominican Republic and Puerto Rico.

Ageing affects all countries and overseas territories within the Caribbean although the process is more advanced in some countries than others. In the territories such as Aruba, Curaçao, Guadeloupe, Martinique and the United States Virgin Islands, which are classified by the World Bank as ‘high income economies’ (World Bank, 2014), the ageing process is more advanced (Figure 7). In these territories, the dependency ratios (persons 65+/ persons 15-64) ranged from 18 in Aruba to 30 in Martinique in 2015. In countries that are also classified as high income, such as Antigua and Barbuda, Barbados and Trinidad and Tobago, ageing is moderately advanced with dependency ratios similar to the regional average of 13. In middle-income countries including Guyana, Belize, Suriname and Jamaica, ageing is less well advanced with dependency ratios generally below the regional average, the lowest being in Guyana (8) and Belize (6). Although Caribbean countries are currently found at different stages of the ageing process, all will see rapid population ageing over the coming decades. In most Caribbean countries and territories, over the next thirty years dependency ratios will more than double with important implications for public policy.

Figure 7
Old age dependency ratio by country, 2015, 2030 and 2045
(Number of persons aged 65 and over per hundred persons aged between 15 and 64 years)

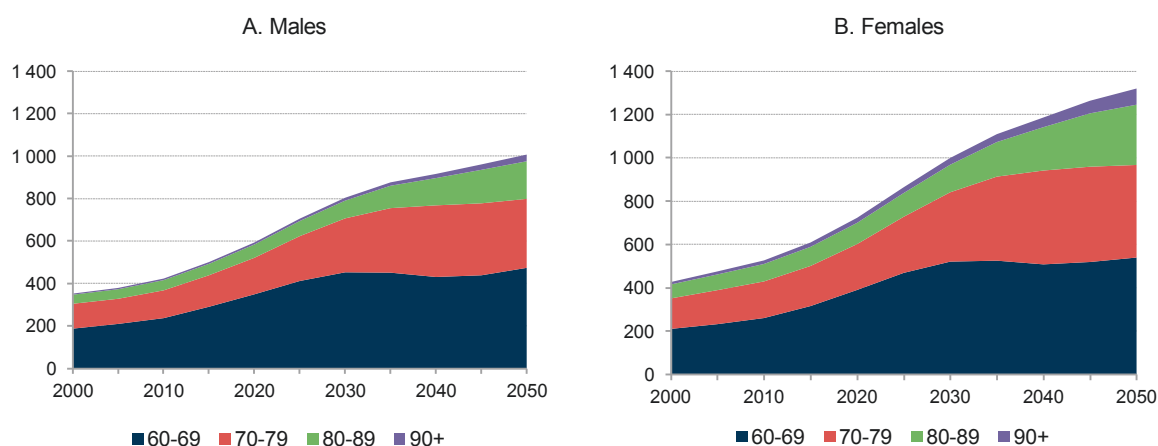


Source: United Nations, Department of Economic and Social Affairs, Population Division (2015). World Population Prospects: The 2015 Revision, DVD Edition.

While the changes to fertility and mortality rates described above are the fundamental cause of population ageing, international migration also has an impact on the age structure of the population and the speed at which it is changing. Generally speaking, an increased net outflow of migrants will contribute to more rapid ageing of the population because migrants tend to be of working age and so an outflow of migrants reduces the number of people of working age relative to the number of older persons. If there is an increased net inflow of migrants, this will slow population ageing for the opposite reason. In the majority of Caribbean countries, there has been net outward migration which leads to faster population ageing in these countries. On average, net migration accounts for about twenty per cent of the increase in the dependency ratios shown in Figure 7.

The population aged 60 and over will not only grow in number, but there will also be more persons who are aged 70 and over, 80 and over, and 90 and over (Figure 8). The increase in persons aged 80 and over, and 90 and over will be most rapid from 2035 to 2055 (as the ‘baby boom’ generation reaches these ages). Among males aged 60 and over in 2015, 58 per cent are aged 60-69; 29 per cent are aged 70-79; 11 per cent are aged 80-89; and just 2 per cent are aged 90 and over. However, while the number of persons aged 60-69 is expected to grow by 63 per cent between 2015 and 2050, the number of persons aged 70-79 is expected to grow by 120 per cent; the number of 80-89 year olds by 230 per cent; and the number of persons aged 90 and over by 280 per cent. So the number of people in the oldest age groups will be increasing more rapidly than the number of younger old.

Figure 8
Older persons in the Caribbean by sex and age, 2000-2050
(Thousands)



Source: United Nations, Department of Economic and Social Affairs, Population Division (2013). World Population Prospects: The 2012 Revision, DVD Edition.

Among women, the pattern is similar. Of course, there are a greater number of older women than older men due to the longer life expectancy of women. In 2015, there were 500,000 men and 610,000 women aged over 60 in the Caribbean although the gender differential is more pronounced among the oldest old. In the 60-69 age group, women outnumber men by 10 to 9; in the 70-79 age group the ratio is 5 to 4; in the 80-89 age group it is 8 to 5, while in the 90+ age group the ratio is 7 to 3. These ratios are not expected to change very much over time.

Table 1 provides various indicators of the current situation in each country in respect of the population ageing process. The table is ordered using an index of ageing which is defined as the number of persons aged 60 years and over divided by the number of persons aged 0 to 14 years (the old age dependency ratio could also have been used to order the countries with very similar results).

Table 1
Caribbean: selected indicators of the demographic ageing process, 2015

Country or territory	Ageing index ^a	Total fertility rate ^b	Life expectancy at 60 years ^c	Population aged 60 and over ^d (percentages)	Population aged 80 and over ^e (percentages)	Total dependency ratio ^f	Old-age dependency ratio ^g	Elderly parent support ratio ^h
Guyana	16.5	2.6	16.6	5.7	0.5	67.2	9.5	4.7
Belize	18.4	2.7	21.5	6.0	0.9	63.6	9.9	10.6
Grenada	38.1	2.2	18.5	10.1	1.7	57.8	15.9	14.2
Suriname	38.4	2.3	18.5	10.1	1.3	57.7	16.0	9.1
Saint Vincent and the Grenadines	44.4	2.0	19.7	10.9	1.6	54.9	16.9	10.3
Antigua and Barbuda	44.5	2.1	21.5	10.8	1.6	53.7	16.5	10.7
Jamaica	45.3	2.3	21.3	11.8	2.1	60.8	19.0	15.1
Cayman Islands	47.3	..	..	8.6	1.2	36.4	11.7	7.9
Saint Lucia	54.1	1.9	21.0	12.5	2.3	55.4	19.5	15.7
Bahamas	60.2	1.9	22.3	12.6	1.5	50.2	18.9	9.1
Trinidad and Tobago	69.6	1.8	17.8	14.5	1.6	54.5	22.4	9.1
Barbados	90.9	1.8	19.5	17.0	2.4	55.4	26.4	11.6
Guadeloupe	93.0	2.1	24.8	19.5	3.9	67.7	32.6	20.1
Montserrat	99.5	..	..	19.6	..	64.9	32.4	..
Aruba	100.7	1.7	19.9	18.5	2.0	58.2	29.2	8.8
Puerto Rico	103.9	1.6	23.5	19.6	3.7	62.6	31.9	21.8
Curaçao	110.4	1.9	22.1	21.1	3.1	67.0	35.2	14.3
United States Virgin Islands	114.9	2.5	23.2	23.9	3.0	81.0	43.3	14.6
Martinique	130.5	1.8	24.8	23.3	4.8	70.0	39.6	22.1

Source: United Nations, Department of Economic and Social Affairs, Population Division (2013). World Population Prospects: The 2012 Revision, DVD Edition. Estimates for Cayman Islands and Montserrat are from the 2010 and 2011 censuses respectively (adapted and updated from Huenchuan (2013), "Ageing, solidarity and social protection in Latin America and the Caribbean: time for progress towards equality").

^a Ageing index = (number of persons aged 60 years and over / number of persons aged 0 to 14 years) x 100.

^b Total fertility rate = average number of children per woman, assuming she were to experience the current age-specific fertility rates throughout her reproductive life and that she survives from birth through to the end of her reproductive life.

^c Life expectancy at age 60 = average number of additional years a person of 60 years can expect to live.

^d Population aged 60 years and over = (number of persons aged 60 years and over / total population) x 100.

^e Population aged 80 years and over = (number of persons aged 80 years and over / total population) x 100.

^f Total dependency ratio = ((number of persons aged 0 to 14 years + persons aged 60 or over) / number of persons aged 15 to 59 years) x 100.

^g Old-age dependency ratio = (number of persons aged 60 years and over / number of persons aged 15 to 59 years) x 100.

^h Elderly parent support ratio = (number of persons aged 80 years and over / number of persons aged 50 to 64 years) x 100.

Statistics for Guyana, where ageing is least advanced, are shown in the first row of the table and statistics for Martinique, where ageing is most advanced, are shown in the final row. These figures illustrate how, for example, the countries or territories where ageing is most advanced are generally those where fertility rates have fallen the most and life expectancy has increased the most. The countries where ageing is least advanced are those where the fertility rates are still a little higher and life expectancy is not as high.

Of course, the population ageing process will not take place in exactly the same way in each country and territory due to differences in national patterns of fertility, mortality and international migration. As has been mentioned, population ageing has advanced further in some countries than others. However, it is worth emphasising that although countries might currently be at different stages of the process, the population ageing process itself is fundamentally a common process which all countries and territories are passing through.

II. The human rights of older persons in international law

The human rights of older persons have become a subject of increasing concern to the international community in recent years. At present, in the United Nations human rights system, there is no single human rights treaty which specifically addresses the rights of older persons in the same way as exists, for example, in the case of children, persons with disabilities and women. In the absence of such a treaty, the human rights of older persons rest on a complex patchwork of treaties which either directly address in some way the rights of this age group, or otherwise establish rights which have a particular relevance for older persons. Various decisions of charter and treaty monitoring bodies have further clarified these rights. In the Inter-American human rights system meanwhile, there is now a unifying treaty addressing the rights of older persons. The recently approved Inter-American Convention on Protecting the Human Rights of Older Persons now provides a clear statement of protected rights and the obligations of states to respect, promote and ensure those rights. This treaty, once it enters into force, will apply to all Caribbean States as members of the OAS.

It is important to emphasise that the human rights of older persons (or any other subgroup) are, at root, the same fundamental human rights enjoyed by all people irrespective of age, nationality, sex, ethnic origin, religion, language, or any other status. This principle of the universality of human rights was established in the Universal Declaration of Human Rights in 1948. Nevertheless, certain groups remain more vulnerable to rights violations of different kinds and find it more difficult to realise their rights, therefore additional protections and measures are necessary for these groups to fully enjoy their basic human rights. In the case of women, children, persons with disabilities, and migrant workers and their families, the need to strengthen protection for their fundamental human rights led to the creation of specific conventions, within the United Nations human rights system, namely: the Convention on the Elimination of All Forms of Discrimination against Women; the Convention on the Rights of the Child; the Convention on the Rights of Persons with Disabilities; and the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families.

Such agreements define in greater detail how fundamental human rights should be interpreted for these subgroups: what specific rights must be protected and fulfilled in order that these subgroups can fully enjoy their basic human rights; and what actions are necessary to make this happen. The rights of

older persons, or women, or children, should not therefore be understood as either new rights or special rights, but rather as an interpretation and application of existing human rights for these groups. The treaties mentioned above clarify and systematize the minimum rights of these groups and specify measures which must be taken to protect and promote those rights. States which become parties to treaties assume legally binding obligations: to respect and refrain from interfering with the enjoyment of human rights; to protect individuals and groups against human rights abuses; and to commit to take positive action to facilitate the enjoyment of rights. Where human rights are addressed in regional human rights treaties or in national constitutions and laws, similar principles apply.

The human rights of older persons have been an issue of concern to the international community for some time and have received growing attention, particularly in recent years. The rights of older persons have been addressed, to varying degrees, in a wide range of treaties, laws and agreements of differing legal status and scope. These include United Nations human rights instruments; other international agreements of universal scope; inter-American human rights standards; other international and regional policies; as well as national constitutions and laws. Despite this, there has been insufficient consensus to enable the establishment of a human rights instrument specifically addressing the rights of older persons.

While this patchwork of treaties, laws and agreements is evidence of widespread recognition of the importance of the human rights of older persons, the absence of a single unifying convention leads to a lack of clarity concerning what exactly the rights of older persons are. This lack of clarity undermines the efforts of duty-bearers, and particularly States, that are ultimately responsible for adopting legislative measures and policies to promote and protect the rights of older persons. It also affects rights holders and other stakeholders, inasmuch as they play a substantive role in promoting the protection of and respect for those rights (ECLAC, 2010).

This chapter describes the human rights of older persons such as they currently exist in international law. It does this through reference to the individual treaties, the decisions of treaty monitoring bodies and other relevant resolutions or policies which have addressed the issue. These include United Nations human rights instruments, inter-American human rights standards, other international agreements, as well as national constitutions and laws.

A. The rights of older persons in the United Nations human rights system

The treaties of the United Nations Human Rights System, and the universal rights they establish, form the basis of international human rights law. Caribbean countries have been active participants in the negotiation of these treaties, having signed and ratified a number of them, and having reported on their implementation. Caribbean governments maintain that they are in the mainstream as regards international human rights law in that they seek to apply the norms recognised in United Nations human rights instruments (Vasciannie, 2010).

The treaties making up the International Bill of Human Rights,⁶ while not addressing the rights of older persons directly, established a number of human rights which are of particular relevance to older persons. These include, from the International Covenant on Civil and Political Rights (ICCPR) (1966):

- the right to life (article 6);
- that no one shall be subjected to cruel, inhuman or degrading treatment (article 7);
- the right to liberty and security of person (article 9);
- the right to choose one's residence (article 12);

⁶ The International Bill of Human Rights is made up of the Universal Declaration of Human Rights (1948); the International Covenant on Economic, Social and Cultural Rights (1966); the International Covenant on Civil and Political Rights (1966); and the two Optional Protocols to the International Covenant on Civil and Political Rights.

- the right to privacy (article 17);
- the right to take part in the conduct of public affairs (article 25);
- the right to equal protection of the law (article 26).

and, from the International Covenant on Economic, Social, and Cultural Rights (ICESCR) (1966), the following rights:

- the right of self-determination (article 1);
- the right to work (article 6);
- the right of everyone to social security, including social insurance (article 9);
- the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions (article 11);
- the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (article 12);
- the right to education (article 13); and
- the right to take part in cultural life and to enjoy the benefits of scientific progress and its application (article 15).

These are human rights which are obviously important for people of all ages. However, older persons are particularly vulnerable to rights violations in these areas because of the way that old age is associated with, for example, loss of independence and autonomy, isolation, withdrawal from the labour market, reduction or loss of income and ill health. It is for this reason that additional human rights instruments are necessary to clarify how these (and other) fundamental human rights are to be interpreted for older people, and the responsibilities of states to respect, promote and protect the rights of this group.

Other United Nations human rights conventions have also explicitly prohibited discrimination on the grounds of age in certain circumstances. The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990), in its first article, states that it applies to all migrant workers and members of their families irrespective of age (among other statuses). The Convention on the Rights of Persons with Disabilities (2006) commits States parties to combat age-based stereotypes, prejudices and harmful practices towards persons with disabilities (PWD). It also commits States to ensure effective access to justice for PWD of all ages; and to take all measures to prevent exploitation, violence and abuse of PWD of all ages.

While these protections afforded to the rights of older persons in the core United Nations human rights instruments are limited, they have been expanded upon by the progressive interpretation of those conventions by the treaty monitoring bodies (ECLAC, 2010). Each of the treaty bodies publishes its interpretation of the provisions of its respective human rights treaty in the form of “general comments” or “general recommendations”. In 1995, the Committee on Economic, Social and Cultural Rights (CESCR) adopted General comment No. 6 on the economic, social, and cultural rights of older persons, in which it specified the obligations that correspond to States that are parties to this treaty (United Nations, 1995) (see Table 2).

The committee has further expanded on the content of those rights in its General Comments relating to education (United Nations, 1999), health (United Nations, 2000), and social security (United Nations, 2008). General comment No. 14 of CESCR elaborates on substantive issues arising from the implementation of the right to health and addresses particular issues related to older persons, including “preventive, curative and rehabilitative health treatment...maintaining the functionality and autonomy of older persons...[and] attention and care for chronically and terminally ill persons, sparing them avoidable pain and enabling them to die with dignity.”

Table 2
Committee on Economic, Social and Cultural Rights: selected content from General Comment No. 6
on the Economic, Social and Cultural Rights of Older Persons, 1995

Article of the International Covenant on Economic, Social and Cultural Rights (ICESCR)	Interpretation of the Committee on Economic, Social and Cultural Rights (CESCR)
Article 3: Equal rights of men and women	States parties should pay particular attention to older women and should institute non-contributory old-age benefits or other assistance for all persons, regardless of their sex, who find themselves without resources.
Articles 6 to 8: Rights relating to work	States parties must take measures to prevent discrimination on grounds of age in employment and occupation; ensure that older workers enjoy safe working conditions until their retirement and promote the employment of older workers in circumstances in which the best use can be made of their experience and know-how; implement retirement preparation programmes.
Article 9: Right to social security	States parties must take appropriate measures to establish general regimes of compulsory old-age insurance; establish retirement age so that it is flexible; provide non-contributory old-age benefits and other assistance for all older persons, who, when reaching the age prescribed in national legislation, have not completed a qualifying period of contribution and are not entitled to an old-age pension or other social security benefit or assistance and have no other source of income.
Article 10: Protection of the family	Governments and non-governmental organizations should establish social services to support the whole family when there are elderly people at home and implement measures especially for low-income families who wish to keep elderly people at home.
Article 11: Right to an adequate standard of living	Older persons should have access to adequate food, shelter, health care among other things. National policies should help elderly persons to continue to live in their own homes, through the improvement and adaption of those homes.
Article 12: Right to physical and mental health	States parties should seek to maintain health into old age through investments during the entire life span.
Articles 13 to 15: Right to education and culture	This right must be approached from two different and complementary points of view: (a) the right of elderly persons to benefit from educational programmes; and (b) making the know-how and experience of elderly persons available to younger generations.

Source: "The economic, social and cultural rights of older persons", General Comment No. 6 (E/C.12/1995/16/Rev.1), Geneva, Committee on Economic, Social and Cultural Rights, 1995 and Huenchuan (2013b), "Perspectivas globales sobre la protección de los derechos humanos de las personas mayores", 2007-2013.

In October 2010, the Committee on the Elimination of Discrimination against Women (CEDAW) adopted General Recommendation No. 27 on older women and the protection of their human rights. It addresses the multiple forms of discrimination that women face as they age; outlines the content of the obligations assumed by States as parties to the Convention from the perspective of older women's rights; and provides guidance to States parties on the inclusion of older women's situation in the reporting process on the Convention. CEDAW has devoted particular attention to the situation of older women in its concluding observations on individual State parties, including issues such as violence against women; education and illiteracy; and access to social benefits.

In addition to the standards progressively developed by these United Nations Treaty-based bodies, the rights of older persons have also been addressed by the Human Rights Council, the inter-governmental body within the United Nations system responsible for the promotion and protection of all human rights around the globe. The Human Rights Council has Special Procedures through which independent human rights experts are mandated to report and advise on human rights from a thematic or country-specific perspective.

In May 2014, the Human Rights Council appointed an Independent Expert on the enjoyment of all human rights by older persons. In its resolution 24/20, the Council established the mandate of the Independent Expert, to assess the implementation of existing international instruments with regard to older persons while identifying both best practices in the implementation of existing law related to the promotion and protection of the rights of older persons and gaps in the implementation of existing law.

In her first annual report (United Nations, 2014), the Independent Expert described some of the problems arising from the absence of a comprehensive international legal instrument to promote and protect the rights of older persons: that existing arrangements ‘do not cohere, let alone conceptualize, regulatory principles to guide public action and policies of Governments’; ‘general human rights standards do not consider the recognition of third-generation specific rights in favour of elderly adults’; ‘it is difficult to clarify the obligations of States with respect to older persons’; and ‘procedures for monitoring human rights treaties generally ignore older persons’.

The rights of older persons have also been addressed under several other different thematic mandates. In 2011, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health presented a thematic study on the exercise of the right to health of older persons. The report addressed specific issues and concerns and stressed that the right-to-health approach was indispensable for the design, implementation, monitoring and evaluation of health-related policies and programmes for older persons.

In 2010, the Independent Expert on the question of human rights and extreme poverty presented a report to the Human Rights Council on the role that non-contributory pensions (also referred to as social pensions) play in reducing extreme poverty and contributing to the realization of human rights of older persons. The report called for universal access to social security based on recognition of the human right to social security in domestic law. It made recommendations for non-contributory pensions to be designed in accordance with basic human rights standards. The Human Rights Committee also has a complaints procedure and has developed the principle of non-discrimination by reason of age in a number of cases which it has examined.

B. The rights of older persons in the inter-American human rights system

The Organisation of American States’ (OAS) Inter-American human rights system is the regional forum for promotion and protection of human rights. The human rights instruments of the inter-American system are applicable to Caribbean States (all of which are members of the OAS) through the OAS Charter. Its two most fundamental instruments are the American Declaration on the Rights and Duties of Man (1948) and the American Convention on Human Rights (1969). Similar to the International Bill of Human Rights, these instruments establish human rights for persons of all ages, some having particular relevance for older persons, but without making any explicit reference to the rights of older persons.

The first explicit recognition of the human rights of older persons in the inter-American system came with the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (1988), the “Protocol of San Salvador”. Article 17 establishes the right to special protection in old age and obliges States Parties to take progressively the necessary steps to make this human right a reality. In particular it obliges states to provide facilities, as well as food and specialized medical care, for elderly individuals who lack them and are unable to provide them for themselves; to give the elderly the opportunity to engage in a productive activity; and to foster the establishment of social organizations aimed at improving the quality of life for the elderly. Other instruments of the inter-American system have also identified older persons as a group requiring special protection, for example the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women, the “Convention of Belem do Pará”.

The first steps towards the creation of an inter-American convention on the rights of older persons came with the adoption of the Declaration of Commitment of Port of Spain at the Fifth Summit of the Americas in April 2009, when governments pledged to promote an examination of the feasibility of

developing such a treaty. Following four years of negotiations coordinated by an OAS Working Group, the Inter-American Convention on Protecting the Human Rights of Older Persons was finally approved by the member States of the OAS in June 2015. The Convention will enter into force when at least two signatory countries have ratified it.

This convention is the first human rights convention specifically addressing the human rights of older persons. As such, it is the most well developed standard on the human rights of older persons and represents a major step forward in the advancing, clarifying and unifying conceptual and normative standards with respect to the human rights of older persons (Table 3).

Table 3
A summary of protected rights in the Inter-American Convention on Protecting the Human Rights of Older Persons

Article	Protected Rights
Article 5: Equality and non-discrimination for reasons of age	Prohibits discrimination based on the age of older persons
Article 6: Right to life and dignity in old age	Enjoyment of the right of life and the right to live with dignity in old age until the end of their life and on an equal basis with other segments of the population
Article 7: Right to independence and autonomy	The right of older persons to make decisions, to determine their life plans, to lead an autonomous and independent life
Article 8: Right to participation and community integration	The right to active, productive, full, and effective participation in the family, community, and society
Article 9: Right to safety and a life free of violence of any kind	The right to safety and a life without violence of any kind, to be treated with dignity, and to be respected and appreciated
Article 10: Right not to be subjected to torture or cruel, inhuman, or degrading treatment or punishment	The right not to be subjected to torture or cruel, inhuman, or degrading treatment or punishment
Article 11: Right to give free and informed consent on health matters	The inalienable right to express their free and informed consent on health matters
Article 12: Rights of older persons receiving long-term care	The right to a comprehensive system of care that protects and promotes their health, provides social services coverage, food and nutrition security, water, clothing, and housing, and promotes the ability of older persons to stay in their own home and maintain their independence and autonomy, should they so decide
Article 13: Right to personal liberty	The right to personal liberty and safety
Article 14: Right to freedom of expression and opinion, and access to information	The right to freedom of expression and opinion, and access to information
Article 15: Right to nationality and freedom of movement	The right to freedom of movement, to choose their residence
Article 16: Right to privacy and intimacy	Older persons are entitled to privacy and intimacy, and neither their private life, family, home, household unit, nor any other environment in which they function, nor their correspondence, nor any other communications shall be the subject of arbitrary or illegal intrusion. Older persons have the right not to have their dignity, honor, and reputation attacked. They are also entitled to privacy in their personal hygiene and other activities, regardless of their environment.
Article 17: Right to social security	The right to social security to protect them so that they can live in dignity
Article 18: Right to work	The right to dignified and decent work and to equal opportunity
Article 19: Right to health	The right to physical and mental health
Article 20: Right to education	The right to education, on an equal basis with other sectors of the population

Table 3 (concluded)

Article 21: Right to culture	The right to their cultural identity, to participate in the cultural and artistic life of the community, to enjoy the benefits of scientific and technological progress
Article 22: Right to recreation, leisure, and sports	Older persons are entitled to recreation, physical activity, leisure, and sports
Article 23: Right to property	The right to the use and enjoyment of their property and not to be deprived of said property on the grounds of age
Article 24: Right to housing	The right to decent and adequate housing and to live in safe, healthy, and accessible environments that can be adapted to their preferences and needs
Article 25: Right to a healthy environment	The right to live in a healthy environment with access to basic public services
Article 26: Right to accessibility and personal mobility	The right to accessibility to the physical, social, economic, and cultural environment, as well as to personal mobility
Article 27: Political rights	The right to participate in political and public life, to vote freely and to be elected
Article 28: Freedom of association and assembly	The right to assemble peacefully and to freely form their own groups and associations
Article 29: Situations of risk and humanitarian emergencies	States Parties shall adopt all necessary specific measures to ensure the safety and rights of older persons in situations of risk, including situations of armed conflict, humanitarian emergencies, and disasters
Article 30: Equal recognition before the law	The right to recognition as persons before the law.
Article 31: Access to justice	The right to a hearing by a competent, independent, and impartial tribunal in the substantiation of any accusation of a criminal nature made against them or for the determination of their rights and obligations of a civil, labor, fiscal, or any other nature

Source: Inter-American Convention on Protecting the Human Rights of Older Persons, Organization of American States (OAS, 2015).

It should be acknowledged that many of the instruments of the Inter-American Human Rights System have not been signed or ratified (or acceded to) by the states of the English and Dutch-speaking Caribbean. For example, the American Convention on Human Rights, has been ratified (or acceded to) by only Barbados, Dominica, Grenada, Jamaica and Suriname and the additional protocol addressing Economic, Social and Cultural Rights has been ratified only by Suriname⁷. Conventions on the death penalty, forced disappearance of persons, and persons with disabilities have not been ratified by any Caribbean country. The jurisdiction of the Inter-American Court of Human Rights is recognised only by Barbados. The notable exception to this pattern is the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women or "Convention of Belém do Pará" which has been ratified by all Caribbean countries.

Whether a State has ratified the American Convention on Human Rights, and whether it recognises the Inter-American Court, determines the judicial or quasi-judicial procedures which can be used to process individual cases of alleged human rights violations against that State. This determines, to some extent, the level and strength of protection afforded to human rights. Nevertheless, according to the rules of procedure of the Inter-American Commission on Human Rights, any person or group of persons can present an individual petition alleging violations of human rights (including violations of human rights of older persons) against any Member State of the OAS (including English and Dutch speaking Caribbean countries) before the Inter-American Commission on Human Rights through the "American Declaration on the Rights and Duties of Man". The State may be alleged to have violated human rights

⁷ Trinidad and Tobago acceded to the American Convention on Human Rights but subsequently denounced it.

by action, acquiescence (tacit consent) or omission (failure to act). In the event of a petition alleging violations of the human rights of older persons being brought before the Commission, in principle, the Commission would use the highest relevant standard which would be the Convention on Protecting the Human Rights of Older Persons, as has been the practice, for example, when the Commission has applied the Inter-American Convention on the Elimination of All Forms of Discrimination Against Persons With Disability, on petitions and precautionary measures which have involved persons with disability. Therefore, once the convention enters into force, this convention could be used to interpret the American Declaration on the Rights and Duties of Man which is binding on all OAS Member States and the American Convention on Human Rights, irrespective of whether the Convention on Protecting the Human Rights of Older Persons had been signed or ratified. In this way, and through the mechanisms of protection of the Inter-American Human Rights System, the new Convention could be applicable to all Caribbean States.

C. Other non-binding agreements on ageing and older persons

There are also non-binding United Nations Resolutions and other agreements endorsed by the General Assembly which have contributed in important ways to the development of understanding of the rights of older persons. Often referred to as “soft law,” these agreements clearly have a legal status different from treaties. However, this does not mean that they lack judicial relevance. Having been adopted by the highest representative body of the United Nations, with the intent of expressing the common concerns, commitments, and aspirations of the international community regarding the rights of older persons, these instruments should be seen as authoritative reflections of an emerging normative consensus on the minimum contents of those rights under international law. (ECLAC, 2010).

While many resolutions have addressed the situation of older persons, the adoption in 1991 of the United Nations Principles for Older Persons (United Nations, 1991) was an important step forward in that it clearly signalled the emergence of a rights perspective to ageing issues on the United Nations agenda. The Principles, which were adopted pursuant to the 1982 Vienna International Plan of Action on Ageing,⁸ affirm a number of rights and State measures under the headings of “independence,” “participation,” “care,” and “self-fulfilment” and “dignity” (see Table 4). They constitute the most important expression at the United Nations level so far on the minimum contents of the rights of older persons. (ECLAC, 2010).

There have been two World Assemblies on Ageing through which Member States have coordinated action to address population ageing, the first in Vienna, Austria, in 1982, and the second twenty years later in Madrid in 2002. Whereas the first Assembly in Vienna focused primarily on the situation in developed countries, by the time of the Madrid Assembly it was clear that population ageing had become an equally pressing issue for developing countries and the Madrid Political Declaration and International Plan of Action on Ageing paid particular attention to the situation of older persons in developing countries.

The stated aim of the Madrid International Plan of Action is to ensure that persons everywhere are able to age with security and dignity and *to continue to participate in their societies as citizens with full rights*. It sets out objectives and actions under three broad headings: older persons and development; advancing health and well-being into old age; ensuring enabling and supportive environments. The full realization of all human rights and fundamental freedoms is one of the central themes running through the Plan of Action.

In the Latin American and Caribbean Region there have been three Regional Inter-governmental Conferences on Ageing in follow up to the Madrid Plan of Action. The most recent, held in 2012, concluded with the adoption of the San Jose Charter on the Rights of Older Persons in Latin America and the Caribbean. The Charter expressed support for the work of the United Nations Open-ended Working

⁸ Adopted by the World Assembly on Ageing, held in Vienna, 26 July-6 August 1982.

Group on Ageing and urged it to consider the feasibility of an international convention on the rights of older persons.

Table 4
A summary of the United Nations Principles for Older Persons

Principle	Recommendations
Independence	Older persons should have access to adequate food, water, shelter, clothing and health care. Older persons should have the opportunity to work. Older persons should have access to appropriate educational and training programmes.
Participation	Older persons should remain integrated in society, participate actively in the formulation and implementation of policies that directly affect their well-being and share their knowledge and skills with younger generations. Older persons should be able to form movements or associations of older persons.
Care	Older persons should benefit from family and community care, protection, and have access to health care. Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility.
Self-fulfilment	Older persons should have access to the educational, cultural, spiritual and recreational resources of society.
Dignity	Older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse. They should be treated fairly regardless of age, gender, racial or ethnic background, disability or other status, and be valued independently of their economic contribution.

Source: United Nations, Resolution 46/91, "Implementation of the International Plan of Action on Ageing and related activities", 16 December 1991.

In the San Jose Charter, the government representatives committed to strengthening actions designed to increase the protection of human rights at the national level. This included the enactment of special laws for the protection of such rights or updating existing laws, including institutional and civic measures which guarantee their full implementation. It also involves creating mechanisms to ensure the enforcement of laws, the strengthening of public institutions, and participation of older persons.

Also relevant are the policies on active ageing launched in 2002 by the World Health Organization and Pan-American Health Organization, which are based on the basic human rights principles enshrined in the United Nations 1991 Principles for Older Persons (WHO, PAHO 2002). Also in 2002, WHO promoted the adoption of the Toronto Declaration on Global Prevention of Elder Abuse (WHO, 2002) and in 2009 this theme was also included in the PAHO Plan of action on the health of older persons, including active and healthy aging (PAHO, 2009) which is rooted in human rights instruments and includes an annex that explains the universal and regional human rights norms and standards applicable to older persons. All of these policies and instruments have contributed to advancing and developing an emerging international consensus regarding the human rights of older persons and will be useful instruments in developing a future international convention.

D. The rights of older persons in national constitutions, laws and policies

International human rights treaties, and the decisions of the corresponding treaty bodies, are the primary frame of reference in relation to human rights. Where human rights have been incorporated into domestic law, international treaties have generally been the primary source of law. Regarding the relationship between international and domestic law, Caribbean countries have dualist legal systems where domestic legislation needs to be passed in order to incorporate international treaties into domestic law (even though in practice this often does not happen). International law is regarded as being on a

separate plane from domestic law, albeit international law informs domestic legal processes. The exact nature of this relationship between international and domestic law continues to be a matter of some legal deliberation. This situation contrasts somewhat with that in Latin America, where in most cases there are clear mechanisms for the incorporation of international treaties in domestic law (Huenchuan, 2010).

National Constitutions in Commonwealth Caribbean countries provide protections for some basic civil and political rights. Constitutions in these countries were based on the ‘Westminster Export-Model Constitution’ which incorporated fundamental human rights from the European Convention for the Protection of Human Rights and Fundamental Freedoms (1950). These rights include, among others, freedom of expression; the right to a fair trial; and freedom from inhuman or degrading punishment or treatment. However, Caribbean constitutions do not contain any protections for economic, social, and cultural rights or the rights of older persons. Furthermore, there are no Caribbean equivalents of the laws for older persons, common in Latin America, which establish rights for older persons in national law. Examples include the Law on the Rights of Older Persons of Mexico (2002) or the Older Persons Law of Peru (2006).

In some Caribbean States, there have been steps toward wide-ranging legislation aimed at addressing the needs and rights of older persons. In Barbados, a White Paper on Ageing received parliamentary approval in 2013 representing a step towards a proposed Elder Affairs Act. In the Bahamas, efforts are being made to draft legislation for older persons and something similar is planned in Trinidad and Tobago. In Caribbean countries there are examples of legislation addressing specific issues relevant to older persons which, although not explicitly referring to human rights, contribute to the protection and promotion of the rights of older persons, and compliance with treaty obligations. Examples would include legislation governing the provision of pensions, health services and the regulation of social care services such as long-stay institutions.

Domestic law can create and govern institutions and programmes for older persons as well as provide legal protection and enforcement mechanisms to protect the rights of older persons. It can more directly influence the lives of older persons compared with international law which is more remote and less directly enforceable. Therefore national legislation, drafted with careful regard to treaty and other international commitments, has a critical role to play in protecting and fulfilling the human rights of older persons. These tentative steps, taken by a small number of countries, need to be pursued more widely. However, it is open to debate whether in individual countries it is more effective to implement wide-ranging legislation for older persons or legislation addressing more specific issues, such as employment, public health or regulation of social care services.

III. Ensuring economic security for older persons

Economic security in old age is a matter of concern both for older persons and those of working age. Older persons generally rely on three main sources of income or in-kind support for economic security: pensions, employment and their families. The relative importance of these three sources varies from country to country depending on the level of economic development, and the characteristics of the labour markets and pensions systems. However, many older persons have either no independent source of income, or an inadequate income. Rights related to social security and an adequate standard of living have yet to be fully realized for a significant proportion of older people.

A. Poverty among older persons

Poverty statistics show that there are still many older persons living below national poverty lines. Based on data for ten countries, the average poverty rate among persons aged over 65 was 17 per cent although the rates varied from 7 per cent in Trinidad and Tobago to 34 per cent in Belize (Table 5). In general, poverty rates among older persons tend not to be very different to those for older working aged adults (45 to 64 years) and younger working age adults (25 to 44 years). The highest poverty rates are among children and young people.⁹ Where older persons are living in multigenerational households their income and wellbeing is likely to be determined by arrangements for income sharing within the household which is not captured by these statistics based on household expenditures. Nevertheless, the statistics indicate that there is a problem of poverty among older persons just as there is among other age groups.

The monetary value of the poverty lines helps to put these figures into perspective. In most countries, the poverty lines would equate to around 300 US dollars per month for an adult male in today's prices. So, in addition to those older persons living beneath the poverty line, there are many more living just above the poverty line, surviving on little more than 300 US dollars per month, who could hardly be described as economically secure.

⁹ Poverty rates among children and young people are higher because children require additional resources; they have to be cared for and so reduce the earning capacity of the adults in the household; and because there tend to be more children in poor households.

Older people find themselves in poverty when they have either no pension income or an inadequate pension income; when they no longer have the opportunity, the capability, or the desire to work; and when their families are not able to provide sufficient support to compensate for this lack of an independent income. Rates of poverty among those aged 65 and over are lowest in those countries such as Trinidad and Tobago, the Bahamas and Saint Kitts and Nevis where the social security coverage is higher and where a majority of older persons receive a contributory old age pension. Poverty among older persons is much higher in countries such as Belize, Dominica, Jamaica and Saint Lucia, where fewer people are entitled to contributory old age pensions.

Table 5
Poverty rate by age
(Percentages)

Country	0-14	15-24	25-44	45-64	65+	All persons	Poverty line (dollars per adult male per year)	Year
Antigua and Barbuda	24.6	21.6	14.0	15.3	15.2	18.4	2 366	2005-2006
Belize	50.0	43.0	35.0	31.0	34.0	41.3	1 715	2009
Bahamas ^a	13.9	9.1	4.9	3.5	6.3	9.3	2 863	2001
Dominica	38.7	29.1	27.2	21.2	23.0	28.8	2 307	2008-2009
Grenada	50.8	47.7	33.0	24.8	13.3	37.7	2 164	2007-2008
Jamaica	20.2	18.6	11.9	14.0	18.7	16.5	...	2009
Saint Kitts and Nevis	31.3	28.0	17.6	10.9	10.6	21.8	2 714	2007
Saint Lucia	36.9	32.5	25.0	21.3	19.1	28.8	1 905	2005-2006
Saint Vincent and the Grenadines	38.1	36.1	28.0	21.7	18.8	30.2	2 046	2007-2008
Trinidad and Tobago	23.0	22.1	15.6	11.5	6.7	16.7	...	2005
Average (simple)	32.8	28.8	21.2	17.5	16.6	25.0	...	...
Average (population weighted)	24.1	21.9	15.1	14.3	15.6	18.8	...	...

Source: Country poverty assessments and ECLAC calculations based on Surveys of Living Conditions.

^a Figures correspond to the following age groups: 5-14, 15-19, 35-54, 55-64, 65+.

Some common problems faced by older persons living in poverty have emerged from the participatory poverty assessments carried out as part of the country poverty assessment programme coordinated by the Caribbean Development Bank. Among older persons living in poverty, hunger was a frequently cited complaint as was the inability to maintain and repair their homes or afford medical expenses. Loneliness and having no-one to help them were also common complaints.

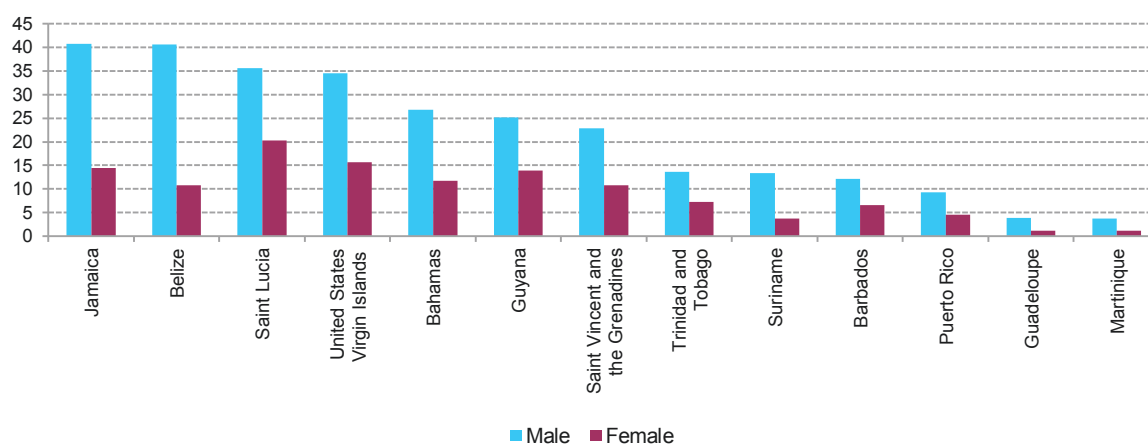
An inability to meet the costs of home maintenance and repair can leave older persons living in substandard or unsafe conditions with serious long term consequences for health and wellbeing. For example, a study in Belize showed that approximately 25 per cent of older persons reported that their houses were in poor condition while 66 per cent reported that their houses needed minor to major repairs (National Council on Ageing, 2010).

Some older persons who were classified as poor blamed their situation on no longer being able to work, which could have been due to age, ill-health, disability or simply a lack of appropriate employment opportunities. Others cited the inability to access social security benefits as a major reason for their situation, or reported that the benefits that they were receiving were insufficient to provide an adequate standard of living.

B. Older persons in the labour force

Across the Caribbean, many persons aged 65 and over continue in some form of paid work. For example, in Jamaica and Belize 40 per cent of men aged 65 and over are labour market participants (Figure 9). In other countries the rate is much lower, between 12 and 14 per cent in Barbados, Suriname and Trinidad and Tobago. Labour force participation rates for older men are around double the rates for older women. This gender gap in labour force participation among over 65s is larger than for younger age groups. This is likely to be due, at least in part, to the fact that for this generation, women would have been less likely than men to have been labour market participants even when they were of working age. Female labour market participation rates have increased significantly in the last twenty years, and so it is likely that the gender disparity in participation rates among over 65s will reduce as today's working age population grows older.

Figure 9
Labour force participation of persons aged 65 and over by sex, 2013
(Percentages)



Source: ILO Estimates, Key Indicators of the Labour Market (KILM), International Labour Organization (ILO).

The propensity of older persons to remain in the labour force is closely related to the coverage and level of social security in each country. In countries where the effective coverage rate of the contributory social security pension is relatively high, for example Bahamas, Guyana and Barbados, labour market participation among older persons is lower (Figure 10). Where there are fewer older persons receiving a contributory old age pension, for example in Belize, Jamaica and Saint Lucia, older persons are more likely to remain in work. This suggests that many persons aged 65 and over only remain in the labour market because they do not have adequate pensions which would enable them to retire.

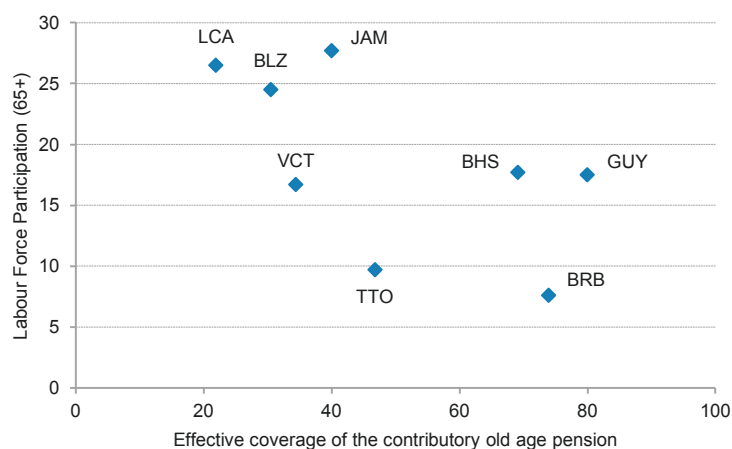
Among older persons who do work, they are more likely to be self-employed compared with working age adults. Of these self-employed older persons, the majority are own account workers meaning that they do not employ anybody else. Many older persons who are own account workers are engaged in informal activities of various kinds, including for example sales of agricultural or other products. In some cases, this is likely to reflect a preference of some older persons to work on a self-employed basis but it also reflects the fact that older persons find it more difficult to obtain work as paid employees.

In some Caribbean countries, statutory retirement ages tend to be quite low: 60 in Antigua and Barbuda, Grenada, Guyana and Saint Vincent and the Grenadines and 62 in Saint Kitts and Nevis and Saint Lucia; 65 in Bahamas, Belize, Jamaica and Trinidad and Tobago; and 66.5 in Barbados. Often retirement ages in the public sector are lower. Where retirement ages are compulsory, they restrict access to employment and also contribute to the perception that older persons have no role in the workplace. Employers should provide workers with flexibility concerning the age at which they choose to retire so

that, if they want, they can continue working without any adverse impact on their pension entitlement. The Human Rights Committee has found that age ceilings within the framework of the right to work can be permitted if “objective and reasonable” (United Nations, 2003) but, as far as possible, measures should be taken to prevent discrimination on grounds of age in employment and occupation.

Measures should also be taken to make it easier for older people to work if they wish. Relatively few governments have implemented policies or programmes to encourage older persons to remain in, or re-enter, the workplace. Educational campaigns, pension reform, reconsideration of mandatory retirement ages, more flexible working arrangements, and training could all play a role in this area.

Figure 10
Effective coverage of contributory old age pensions versus the labour force participation rate for persons aged 65 and over
(Percentages)



Source: United Nations Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of information published by departments of social security (figures for Jamaica and Saint Vincent and the Grenadines are from the International Labour Organization database social security expenditures); population estimates from the United Nations Department of Economic and Social Affairs; and estimates of labour force participation from Key Indicators of the Labour Market (KILM), International Labour Organization (ILO).

Note: BHS (Bahamas, 2012); BRB (Barbados, 2008); BLZ (Belize, 2011); GUY (Guyana, 2011); JAM (Jamaica, 2003); LCA (Saint Lucia, 2007/08); VCT (Saint Vincent and the Grenadines, 2006); TTO (Trinidad and Tobago, 2010).

The Independent Expert on the enjoyment of all human rights by older persons has argued that the right of older persons to work and to have access to income-generating activities also includes equal treatment and opportunities in salaries, working conditions, vocational guidance and training, and job placement. It also requires the establishment of employment policies that promote the participation or return to the labour market of elderly workers, as well as legal reforms and economic incentives that allow the employment of older persons after retirement age, according to their ability, experience and preferences, including such measures as the gradual reduction of working hours, part-time work and flexible schedules, and the dissemination of information on the rights and benefits of retirement (United Nations, 2014).

C. Caribbean pension systems

Pensions are fundamental to the economic security of older persons and should be sufficient to maintain an adequate standard of living and provide older persons with independence, autonomy and dignity. Many older persons receive contributory social security/national insurance pensions. A rather smaller proportion receives an occupational pension from a former employer (which may be public, private or overseas). There are also non-contributory pensions aimed primarily at those with no other source of

income. According to their circumstances, some people will receive income from one or more of these sources while others do not receive any form of pension.

All countries in the English-speaking Caribbean have social security systems (referred to in some countries as national insurance schemes) of broadly similar design. Social security schemes cover people in formal employment only, excluding many who work in more informal jobs and many self-employed. This creates a great divide between those who worked in the formal sector and those in the informal sector, in respect of their entitlement to pensions (Table 6). Those who worked in the formal sector (assuming they have substantial contribution records) will have a contributory social security pension or, in the case of public sector workers, a government pension (which may be contributory or non-contributory). Some people working for large companies may have a company pension and some may have private pensions and savings. In contrast, those who worked in the informal sector will, at best, only be eligible for a non-contributory pension or some form of social assistance which in most cases provides a very low level of income.

Table 6
Pension systems for workers in the formal and informal sector

Formal sector workers		Informal sector workers	
Level 1: Contributory social security pensions (or public sector pensions)	Provide decent replacement rates to those with good contribution records (assuming they are increased to reflect inflation)	Level 1: Non-contributory pensions	Generally offering very low incomes; eligibility criteria can sometimes be very strict and even arbitrary
Level 2: Occupational pensions from private employers	Relatively few schemes generally limited to large companies		
Level 3: Voluntary private pensions and savings	A limited selection of savings and investment products on the market		

Source: United Nations Economic Commission for Latin America and the Caribbean (ECLAC).

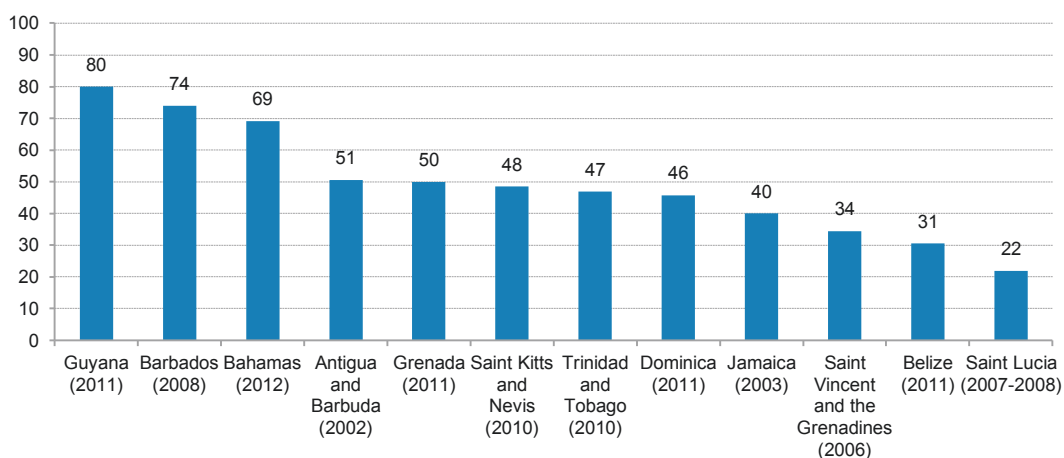
The coverage of social security systems varies significantly from country to country according to the extent of formality or informality in each economy. As a result, the effective coverage of contributory old age pension schemes (the percentage of persons over retirement age who are in receipt of old age pensions) also varies from country to country. For example, based on the most recently published data, in the Bahamas, Barbados and Guyana, at least two thirds of persons over the state retirement age receive a contributory old age pension (Figure 11). In contrast, in Belize, Saint Lucia and Saint Vincent and the Grenadines, a third or fewer of older persons receive social security pensions. It is important to remember that these figures refer only to the main national social security pension and therefore some of those not receiving social security pensions could have other pension income, for example pensions from former employers including public sector pensions which in some cases are administered separately.

The replacement rates¹⁰ offered by social security pensions are reasonable by international standards, usually about half of final salary which is close to the average of OECD countries. However, relatively few countries automatically increase pensions to account for inflation. Indexation is of critical importance because it ensures that pensions will not lose purchasing power over time. Indexation depends on having a robust and reliable Consumer Price Index which may explain why many countries do not operate on this basis. The Bahamas, Barbados and Dominica are the countries which have introduced indexation based on the Consumer Price Index for social security pensions (with some slight variations in methodology). In many other countries pension increases have been dependent on political decisions and so often the real value of pensions has been eroded.

¹⁰ The percentage of a worker's pre-retirement income that is paid out by a pension program upon retirement.

Not all people who are entitled to a contributory pension will have made sufficient contributions to receive a full pension. This could be, for example, because they moved between formal and informal sectors, or because they stopped working to care for their children or other relatives. In particular, women's lower level of participation in the labour market has important consequences for their economic security in retirement. Older women are less likely than men to have income from a contributory social security pension and not only are women less likely to have such a pension, but what income they do have from this source will tend to be lower than that received by men (Figure 12). In addition to labour market participation, the lower salaries paid to female workers would also contribute to the lower pensions received by women. Together these factors mean that older women are less likely to have an adequate independent income.

Figure 11
Persons over retirement age who receive a contributory social security pension
(Percentages)



Source: United Nations Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of information published by departments for social security and population estimates from the Department of Economic and Social Affairs, United Nations; figures for Jamaica and Saint Vincent and the Grenadines are from the International Labour Organization, database on social security expenditures.

The gender disparities in the pension entitlements of today's pensioners are due to their different interactions with the labour market during their working lives. Among the working age population, employment rates for women in the Caribbean are much higher than they were twenty or thirty years ago although they still remain lower than the rates for men. However, among countries for which data was available, and with the exception of Belize, social security coverage among women was not significantly lower than that for men. This would suggest that, in the long term, gender disparities in the pension receipt among older persons will decline.

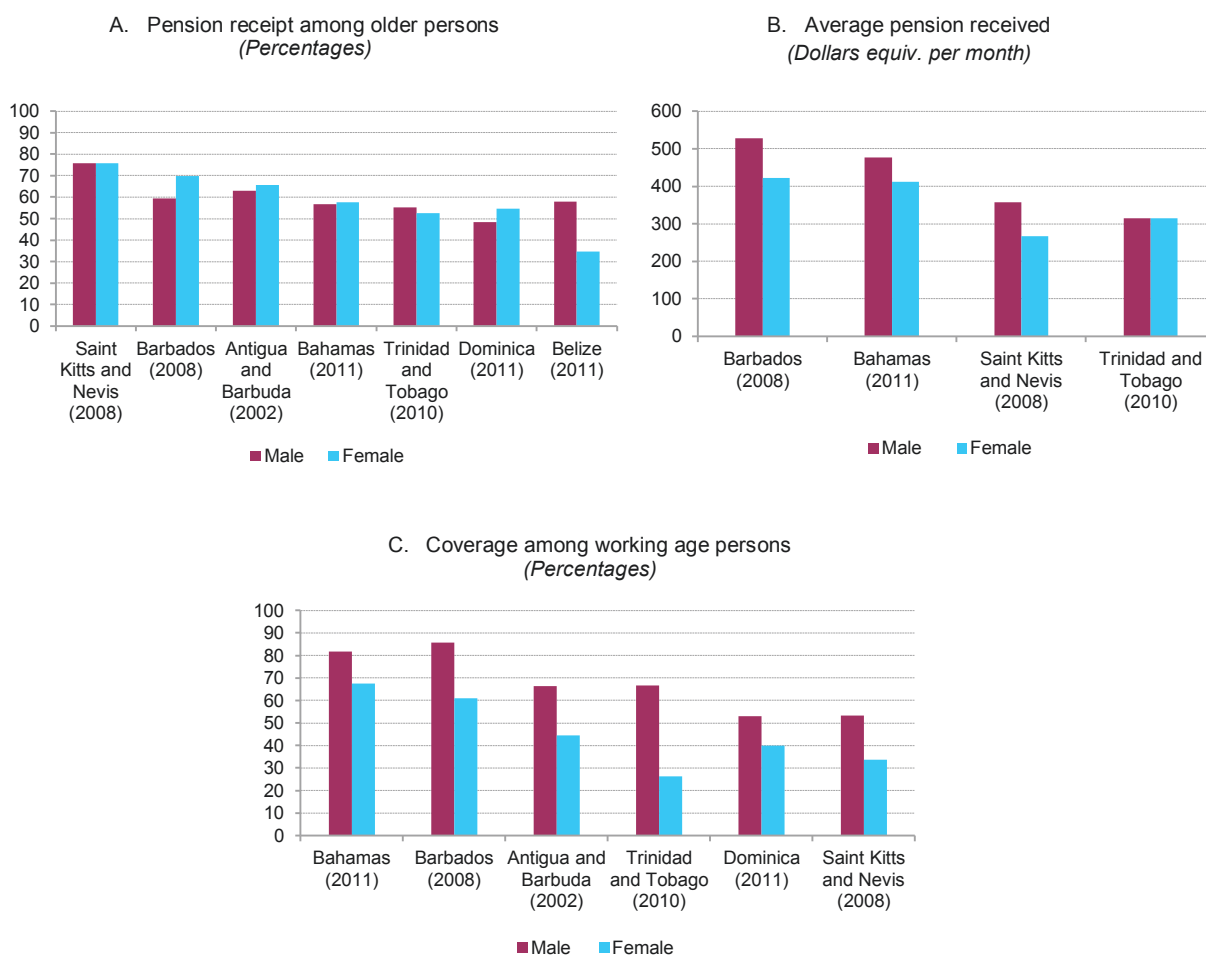
For those not receiving contributory social security pensions, they may be eligible for non-contributory pensions (also referred to as social pensions). These are of critical importance because it is the non-contributory pension that should guarantee everyone a minimum income in old age. Some Caribbean countries have had non-contributory pension schemes for many years; some have introduced them much more recently, while others still have no non-contributory pension. For example, an old age pension was introduced in Barbados in 1938, while schemes were introduced in Belize in 2003 and Saint Vincent and the Grenadines in 2009. All Caribbean countries have implemented schemes with the exception of Dominica, Grenada and Saint Lucia.

Broadly speaking there are three different types of non-contributory pension. First, there are universal pensions which are granted to all, irrespective of any other pension or income that people may have; the only criteria are age, history of residence and citizenship. Only two countries in the Caribbean have universal pensions, Suriname and Guyana. Secondly, there are pensions which are awarded to those who have no other pension (but irrespective of any income from other sources). The idea is to ensure that every older person receives a pension of some form and normally a guaranteed minimum pension income. The non-contributory pension in Barbados is like this. The third and most common type of

social pension are those which are means-tested. They are intended to provide an income for those older persons with no other source of income.

While most countries have a non-contributory pension scheme, generally they are not well-funded. Figure 13 shows spending on contributory social security pensions and non-contributory pensions as a percentage of GDP in nine countries. It is clear that spending on social pensions is well below that on contributory pensions. The only exception to this is Trinidad and Tobago which spends 1.7 per cent of GDP on its social pension (the old age pension) compared to 1.3 per cent on its social security (national insurance) pension. Among these countries, Guyana spends the next most, about 0.6 per cent of GDP on its universal pension while most other countries spend far less. In Suriname (not shown in Figure 13), there is a hybrid scheme, the state old age pension scheme, which is contributory for formal sector workers but is awarded universally and so is effectively a non-contributory pension for informal sector workers. Spending on this pension scheme is about 1.6 per cent of GDP.

Figure 12
Contributory old age social security pension coverage by sex



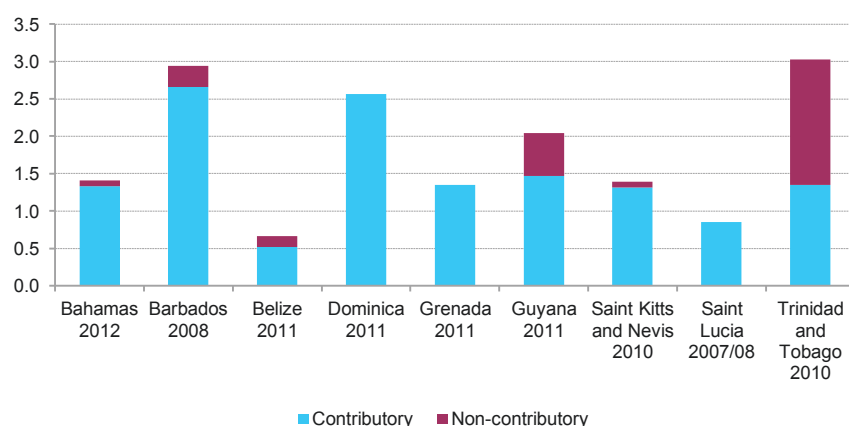
Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of data published by departments of social security.

This lack of funding for social pensions is reflected in their low level compared with poverty and indigence lines (Figure 14). Only in Trinidad and Tobago, where the non-contributory pension is well funded, does the pension exceed the national poverty line. In Barbados, the Bahamas, and Suriname the pensions are close to the poverty lines without surpassing them; in Guyana, Antigua and Barbuda, Saint Kitts and Nevis,

Belize, and Saint Vincent and the Grenadines the pensions are more similar to the indigence lines and in Jamaica it is lower still. Dominica, Grenada and Saint Lucia do not have non-contributory pension schemes. As a result, many older adults who depend on these pensions do not have adequate income.

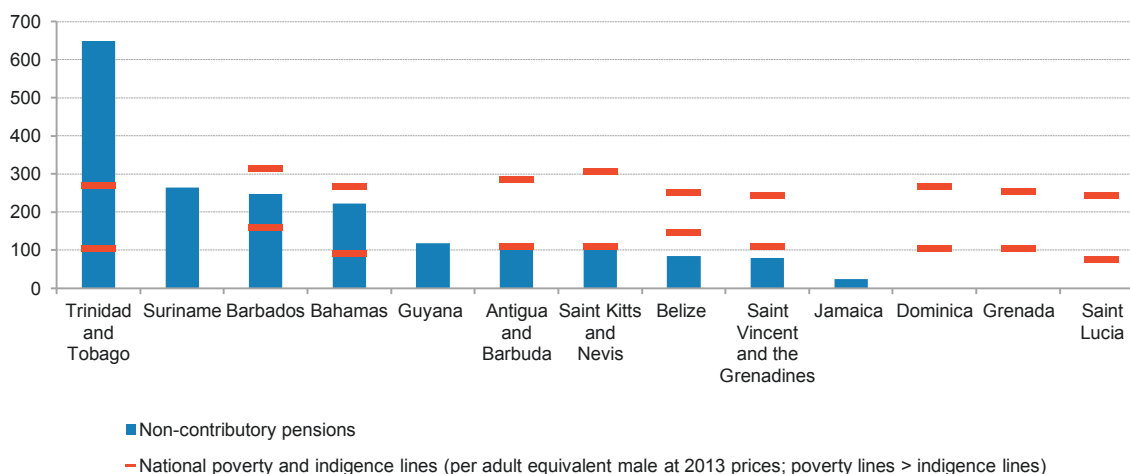
For older persons to have a secure income which is adequate to live on, the first step must be to ensure that all older persons have a pension whether it is contributory or non-contributory, that is, universal pension coverage. This will require the introduction of non-contributory pensions in those countries which have yet to introduce one, Dominica, Grenada and St. Lucia. In some of the countries where non-contributory pensions have been introduced, eligibility criteria will need to be relaxed to ensure that all older persons have some form of pension. The level of the pensions should then be increased so that it surpasses the poverty line.

Figure 13
Expenditure on contributory and non-contributory pensions
(Percent of GDP)



Source: United Nations Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of information published by departments of social security.

Figure 14
Non-contributory pensions and national poverty and indigence lines, 2013
(Current international dollars (PPP) per month)



Source: United Nations Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of information published by departments of social security, country poverty assessments, and results of the International Comparison Program, Round 2011.

Pension reforms require careful analysis of the impacts within and between generations and considering the pension system as a whole including social security, public sector, private and non-contributory elements. What matters is whether the overall pension system provides universal coverage and a decent income for all seniors. Social pensions should be designed to guarantee everyone's right to social security in old age, and in a way that strengthens solidarity between generations (and within the same generation) without undermining existing systems based on the contributory principle. Although few countries have introduced a universal pension, they have some significant advantages over pensions which are awarded according to income tests. Universal pensions are easy and inexpensive to administer because they do not require complex tests; they do not discourage other saving; and they strengthen social solidarity because everyone, or at least the vast majority, receives them.

In countries where there are still substantial gender inequalities in the level of labour market participation, governments should seek to increase female participation. Gender equality legislation can be used to address issues such as equal pay and protection for pregnant workers. The workplace should also be made more family friendly, and policies should promote co-responsibility between men and women for parenthood and other care responsibilities. Women's pension insecurity can also be addressed by providing some form of pension credit to those carrying out unpaid work as carers.

There is clearly a need in many countries to widen social security coverage by expanding the numbers of contributors and increasing the value of non-contributory pensions. To promote efforts in this direction the United Nations initiated the Social Protection Floor Initiative in 2009. It is envisaged that countries should seek to provide a minimal level of social protection which would be universally available, and then over time, increase the level of protection offered to align with internationally agreed minimum standards embodied in ILO conventions. Within the SPF initiative, there is an emphasis on individual country level solutions rather than top down solutions.

In some countries the state retirement age is still 60, in others 62 or 65, while in Barbados the retirement age is in the process of being raised to 67. In some cases retirement ages for civil servants are as low as 55. A number of countries are increasing retirement ages, both for civil servants and other workers, or are introducing more flexible arrangements for either early or late retirement. In the context of increasing life expectancy, policy changes relating to retirement ages are an important aspect of the policy response to ageing populations.

D. Other forms of income support for older persons

Some older persons depend on transfers from family members, remittances from family members overseas or in-kind support. While this is surely welcome, financial dependence on children or other family members can be a source of discomfort or conflict and undermines the independence of older persons. Moreover, older people have a right to old age benefits irrespective of any support they receive from their family. So the availability of family support does not absolve governments from the responsibility of ensuring that older persons have an independent income. It should also be remembered that in multigenerational households, older persons themselves may also be providers of financial support to other members of their household.

Where older persons do not have any form of pension, they may receive some form of public assistance. Many countries still have some form of public assistance programme through which benefits are disbursed to individuals and families facing severe hardships. Public assistance programmes are intended to provide welfare of last resort. They do not provide pensions where there is an explicit right to a certain income for those who meet objective eligibility criteria. Rather, public assistance programs have a fixed budget that is not related to the needs of the population and this budget is disbursed using criteria which may be more or less objective. While these schemes target the poorest and most needy they tend not to reach everyone who is in need of assistance.

In several states there are either subsidies, rebates or free provision of particular utility services. In Antigua and Barbuda, a Senior Citizens Utilities Subsidy Programme was started in 2008 which provides a monthly subsidy of EC\$100 for utility bills and is available to all pensioners registered with

the Antigua and Barbuda Social Security Board. Guyana introduced a universal government funded water subsidy to assist senior citizens with payment of their water bills. The Government of Saint Vincent and the Grenadines also provides a means tested water rebate to some elderly home owners. In Suriname, elderly homeowners receive their electricity supply free of charge on condition that their usage does not exceed a certain maximum level. There is also a Public Assistance Programme for Older Persons in Trinidad and Tobago which grants discounts on water and electricity and social welfare grants for things like glasses and hearing aids, house repairs, and burial costs.

IV. Health service provision for an ageing population

Population ageing has huge implications for the morbidity profile of the population and by extension for health policy and the provision of health services. As the population ages, there will be more people suffering from diseases such as cardiovascular disease, cancer, type 2 diabetes, hypertension, Alzheimer's and osteoporosis. These are chronic conditions which, in addition to impacting people's well-being, place a huge burden on health care services and undermine the productivity of the workforce. In adapting health services to meet this evolving demand, the right-to-health approach, and the principle of equitable access, should serve as a guide.

A. Ageing, non-communicable diseases and disability

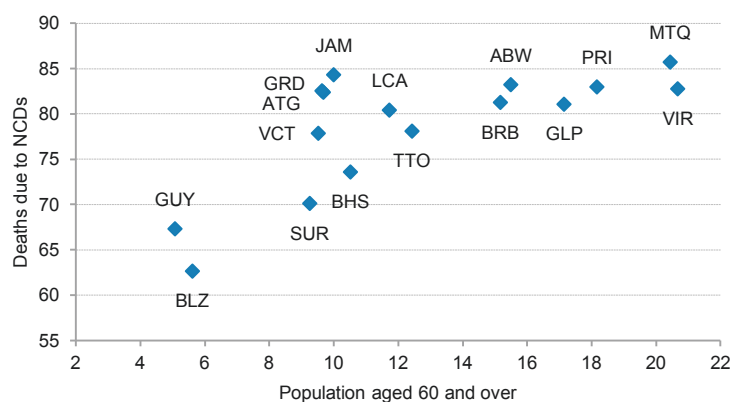
In addition to changing the age structure of the population, the demographic transition is accompanied by an epidemiological transition whereby chronic and degenerative diseases, as opposed to communicable diseases, become the most common causes of death. In the nineteenth century and early part of the twentieth century, communicable diseases killed a substantial proportion of the population: diseases such as small pox, cholera, tuberculosis, typhoid, malaria, yellow fever, as well as childhood diseases such as chicken pox, measles and whooping cough. Over time, improvements in public health and medicine reduced the incidence of communicable diseases so that many more people lived until old age. An inevitable consequence of this has been that a correspondingly higher proportion of people now die from chronic non-communicable diseases. Both the fall in the crude death rate of the population and the evolution of survival probabilities described in chapter one were due to this epidemiological transition.

In the Caribbean, deaths due to communicable diseases have been at a relatively low level, at least in historical terms, for some time (the one exception to this is death due to HIV/AIDS). However, over the coming decades countries will see an increase in the number and proportion of people suffering from non-communicable diseases due, in significant part, to the changing age structure of the population. In Latin America and the Caribbean, in 2000, deaths from non-communicable diseases were estimated to account for 67 per cent of all deaths with communicable, maternal, perinatal and nutritional conditions,

and injuries accounting for the remainder. By 2015, this figure had increased to 75 per cent and by 2030 it is projected to have increased to 79 per cent of all deaths (WHO, 2013). This is primarily due to the changing age structure of the population.

Among Caribbean countries, in those where population ageing is more advanced, non-communicable diseases (NCDs) account for a larger proportion of deaths (Figure 15). For example, in territories such as the United States Virgin Islands and Martinique where around 20 per cent of the population are aged over 60, 80 per cent of deaths are due to NCDs. In contrast, in Guyana and Belize where only around 5 per cent of the population are aged over 60, NCDs account for between 60 and 70 per cent of deaths. With the ageing of the population, all Caribbean countries and territories can expect the proportion of deaths due to NCDs to increase to 85 per cent or more of total deaths.

Figure 15
Deaths due to non-communicable diseases (NCD)
and population aged 60 and over, around 2010
(Percentages)



Source: Regional Mortality Database, Pan American Health Organization (PAHO).

The burden of disease is commonly measured using the Disability-Adjusted Life Year or DALY. One DALY can be thought of as one lost year of "healthy" life. The sum of these DALYs across the population is a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability. So the DALY is a measure of the impact of disease on the wellbeing of the population.

The disease burden due to NCDs in the Caribbean is higher than in Latin America but lower than in developed countries (Table 7). This is to be expected given the relative stage of advancement of population ageing in those regions. The burden of diabetes mellitus, measured by DALYs per 1,000 persons, is particularly high – higher than in either Latin American or developed countries. The burden of communicable diseases is also higher in the Caribbean which is principally due to higher rates of prevalence of HIV/AIDS. In addition, the burden due to injuries is also higher in the Caribbean which is due to the high level of interpersonal violence.

Many NCDs can lead to disabilities. For example, diabetes can damage the retina, leading to blindness, or cause nerve damage and poor circulation leading to chronic ulcerations and the amputation of limbs. Cardiovascular diseases, such as heart attacks and strokes, can lead to mobility or speech impairments. Persons with disabilities may also be vulnerable to NCDs, for example persons with mobility impairments are less likely to be physically active, a risk factor for NCDs.

Table 7
Disability-adjusted life years by cause, 2012
(DALYs per 1,000 population)

	Communicable diseases ^a	Non-communicable diseases					Total Non-communicable diseases	Injuries	All causes
		Malignant neoplasms	Diabetes mellitus	Mental and behavioural disorders	Cardiovascular diseases	Other			
All Persons									
The Bahamas	78	28	13	36	40	73	190	36	304
Barbados	40	45	20	35	38	89	227	33	300
Belize	61	12	14	32	23	69	149	47	257
Guyana	109	24	27	35	77	88	250	79	437
Jamaica	70	31	20	31	49	78	209	44	323
Suriname	60	19	13	32	33	76	173	51	284
Trinidad and Tobago	51	40	41	36	71	100	287	69	406
Caribbean ^b	67	28	21	34	47	82	212	51	330
LAC ^c	52	27	12	32	39	83	193	44	289
Developed countries	21	54	8	38	76	93	269	32	322
Males									
The Bahamas	82	28	14	36	48	72	198	50	330
Barbados	46	46	19	34	44	89	232	48	326
Belize	68	15	10	34	22	67	148	73	289
Guyana	118	18	23	36	83	90	249	115	482
Jamaica	79	34	18	31	52	79	215	64	357
Suriname	66	20	15	32	34	71	172	76	314
Trinidad and Tobago	51	41	46	35	85	103	309	107	467
Caribbean ^b	73	29	21	34	53	81	218	76	366
LAC ^c	59	27	12	33	44	82	198	72	329
Developed countries	25	63	8	41	86	90	288	46	359
Females									
The Bahamas	74	28	12	37	33	73	183	23	280
Barbados	34	45	20	36	33	88	222	19	274
Belize	55	10	17	30	23	70	150	20	225
Guyana	99	29	30	34	71	86	250	42	391
Jamaica	62	28	23	31	45	76	203	24	289
Suriname	54	17	12	32	32	82	175	27	255
Trinidad and Tobago	50	39	36	37	56	97	265	32	346
Caribbean ^b	61	28	21	34	42	82	207	27	294
LAC ^c	45	27	13	31	34	83	188	17	250
Developed countries	17	46	8	34	67	96	251	19	287

Source: World Health Organization.

^a Communicable, maternal, perinatal and nutritional conditions.

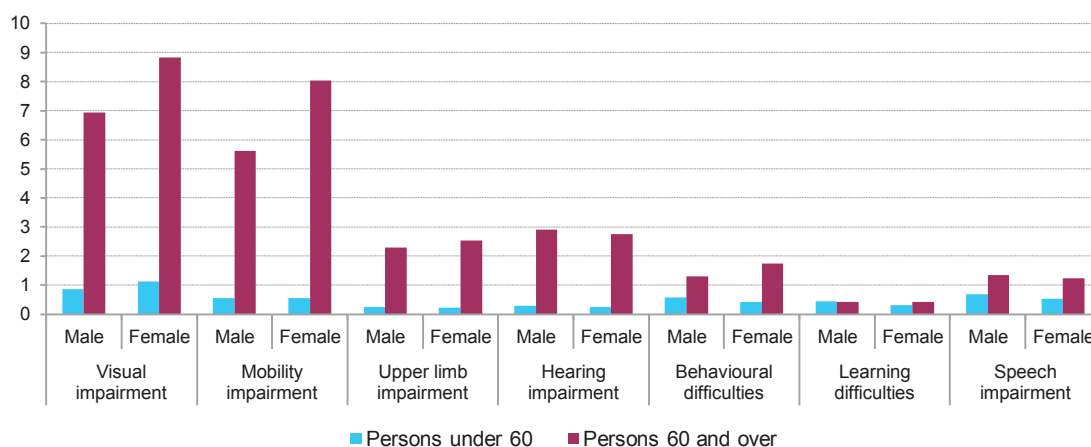
^b Average of seven countries shown.

^c Latin America and the Caribbean.

Just as population ageing will lead to an increase in the burden of NCDs, so it will lead to an increase in the number of persons with disabilities. Again, this is due to the much higher prevalence rates for disability among older persons compared with younger persons. Persons aged 60 and over are about eight times more likely to have a visual impairment than people under 60 (Figure 16). They are ten times more likely to have an upper limb impairment or a hearing impairment. Older men are ten times more likely, and older women fifteen times more likely, to have a mobility impairment compared with those under 60. Behavioural and speech impairment are also more common among the elderly due to conditions such as Alzheimer's.

Persons suffering from NCDs incur significant out-of-pocket expenses for treatment and medication. In both Jamaica and Saint Lucia, an average individual suffering from NCDs uses approximately one-third of household income on healthcare services and medicine purchases. In Saint Lucia it was found that among poorer households this proportion could rise to 48 per cent (World Bank 2011).

Figure 16
Prevalence of disability in the Caribbean by type, sex and age, 2000s
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC) on the basis of special tabulations of the following censuses: Antigua and Barbuda (2001), Aruba (2010), Bahamas (2010), Barbados (2000), Belize (2000), Bermuda (2010), Cayman Islands (2010), Grenada (2001), Montserrat (2011), Saint Vincent and the Grenadines (2001).

A large percentage of deaths from NCDs are preventable and common, preventable risk factors underlie most NCDs. The major NCDs in the Caribbean share common underlying risk factors, namely unhealthy eating habits, physical inactivity, obesity, tobacco and alcohol use and inadequate utilization of preventive health services (PAHO and CARICOM, 2006). The World Health Organization has estimated that the leading NCD risk factor globally is elevated blood pressure (to which 13 per cent of global deaths are attributed), followed by tobacco use (9 per cent), elevated blood glucose (6 per cent), physical inactivity (6 per cent), and being overweight or obese (5 per cent) (WHO, 2011). Among these risk factors, obesity and lack of physical activity are clearly becoming more common in the Caribbean (World Bank, 2011; PAHO and CARICOM, 2006). Evidence in respect of tobacco and alcohol abuse is less clear.

In addition to the human cost, non-communicable diseases exert a heavy economic cost. This includes direct costs, that is, the cost of treatment (borne by the state and/or the individual) and indirect costs, namely, the loss of productivity in the labour force. It is anticipated that the economic costs associated with non-communicable diseases will climb steadily over the next 20 years, with the rate of increase having picked up sharply by 2030 (Gaziano, A.B. and others, 2011). Middle and upper-middle

income countries, such as those in the Caribbean, are projected to bear an increasing share the cost. It was estimated that in 2001 the economic cost of diabetes and hypertension alone were of the order of several percentage points of GDP; in Jamaica 5.9 per cent of GDP, in Barbados 5.3 per cent, in the Bahamas 1.4 per cent while in Trinidad and Tobago costs were estimated at 8.0 per cent of GDP (Abdulkadri, Cunningham-Myrie and Forrester 2009).

It bears repeating that many NCDs are preventable and policy interventions which achieve reductions in the prevalence of key risk factors would result in substantial and long term public health benefits and future cost savings. The World Health Organization has proposed a range of treatments and policy interventions aimed at reducing risk factors which potentially offer significant health benefits for relatively little cost. These policies have been described as ‘best buys’ and include things like increased taxation of tobacco and alcohol, reducing salt intake, public education and immunisation against hepatitis B at birth.

In response to this threat CARICOM countries developed a Strategic Plan of Action for the Prevention and Control of Non-Communicable Diseases for countries of the Caribbean Community 2011-2015. The plan covers risk factor reduction, screening and treatment, health information systems, health promotion, advocacy and communications. Measures aimed at risk factor reduction include smoke free public places, regulation of food and cigarette labelling and advertising, provision of recreational facilities, health promotion and public education. More integrated treatment is proposed with the introduction of evidence-based guidelines, supported by training of primary health care personnel, and shared tertiary treatment services. It is planned to introduce annual reporting on NCDs.

B. Health systems, funding and equitable access to services

The trends described above have major implications for health service provision. Older persons place substantially greater demands on health care systems than working age or younger persons. For example, studies have shown that per capita health costs for persons aged 65 and over are between three and five times the cost for adolescents and young adults (Miller, Mason and Holz, 2011). In OECD countries, the differential is even greater, five or six times (OECD, 2013). The differential is greater in these countries because older adults consume medium- and high-technology health services more often than younger people and such technologies are more widely available in OECD countries. Population ageing will therefore lead to increased demand for health care services.

Projections based on the National Transfer Accounts framework suggest that the cost of providing public health care services for an ageing population will be even greater than the cost of pensions (Miller, Mason and Holz, 2011). Based on an analysis of ten Latin American countries and fifteen European Union countries (EU-15), population change and economic growth would see spending on public health care services rise by 3.4 (Latin America) and 3.2 (EU-15) percentage shares of GDP between 2005 and 2050. So for example, a country spending 3.5 per cent of GDP on public health services in 2005 would, it is projected, be spending around 7 per cent of GDP on health care by 2050. The corresponding increases in public expenditure on pensions were 1.5 (Latin America) and 2.3 (EU-15) percentage shares of GDP. It is reasonable to assume that similar increases will be required in Caribbean countries.

A consequence of these pressures is that public health care services for older persons will account for an increasing share of the public health budget. An analysis of health care expenditures in a selection of both OECD and non-OECD countries showed that, in 2010, 40 per cent of public health care expenditure was directed at persons aged 65 and over. It was projected that, after 2030, more than half of expenditure will be directed at this age group (OECD, 2013).

Based on a simple measure of the utilization of health care services in the Caribbean -persons seeking medical attention in the last month- those aged 60 and over use health care services about three times as much as the average for the population as a whole (Table 8). This appears to be true of older persons living in both high and low income households: older persons living in households in the bottom two quintiles utilize health services almost as much as older persons in the upper quintiles.

In order to improve equality of access to public health care services, most Caribbean countries have moved against levying user fees for services, either through abolition, non-increase or non-collection of fees, or extending exemptions. In recent years there have been important extensions to the free provision of care and/or medication for older people. In 2008, user fees were abolished for all persons at public health facilities in Jamaica (except the University Hospital of the West Indies). Also in 2008, the Government of Dominica instituted Universal Health Care for older persons. Those over the age of sixty receive free medical care which includes all diagnostic and other tests, hospitalization, surgical procedures, prescriptions filled at the hospital pharmacy, emergencies and casualty visits. In the Bahamas, the National Prescription Drug Plan (NPDP) was launched in 2010 for sufferers of chronic non-communicable diseases. Under this plan all recipients of the main National Insurance Board benefits aimed at older people, and all Bahamian citizens over the age of 65, get access to prescription drugs and medical supplies free of charge.

Table 8
Utilization^a of health care services by age and expenditure quintile
(Percentages)

		Expenditure quintiles					All
		Bottom	2nd	3rd	4th	Top	
Antigua and Barbuda (2005-2006)	Persons over 60	14	24	21	34	34	28
	All persons	5	6	6	10	12	8
Grenada (2008-2009)	Persons over 60	18	25	44	29	27	30
	All persons	4	8	13	13	12	10
Jamaica (2009)	Persons over 60	19	21	20	16	16	18
	All persons	6	8	8	8	9	8
Saint Lucia (2005-2006)	Persons over 60	33	29	40	30	34	33
	All persons	8	9	11	13	17	12
Saint Vincent and the Grenadines (2007-2008)	Persons over 60	28	25	29	24	31	28
	All persons	9	7	9	10	14	10

Source: Surveys of living conditions.

^a Persons seeking medical attention in the last 30 days.

Trinidad and Tobago also offers free health services at the nation's health clinics and hospitals, and selected drugs are available at no cost under the Chronic Disease Assistance Programme. Free health care is provided to persons aged over 62 in Saint Kitts and Nevis, and to persons aged 65 and over in Saint Vincent and the Grenadines.

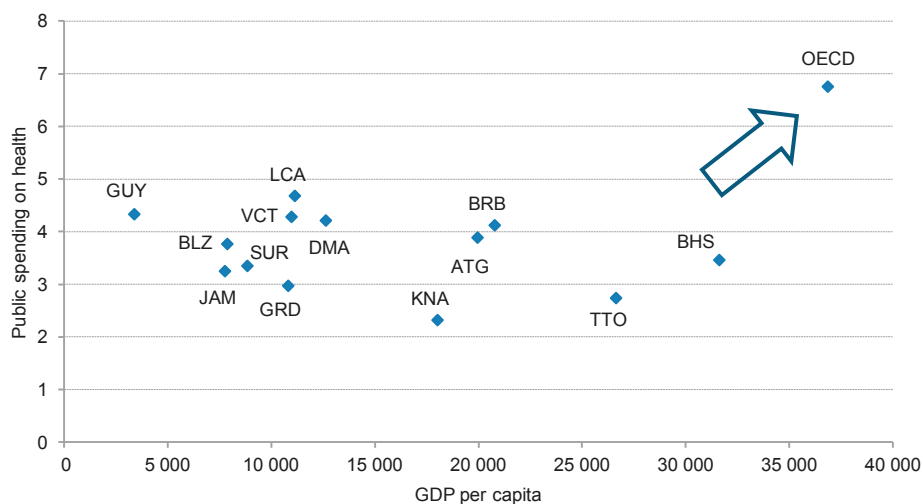
Where user fees have been removed, the effect has been to successfully widen access to services but also, with the deterrent effect of fees removed, to create an increase in demand for services. Where resources are insufficient, services and medication may be available in theory, but not in practice. Waiting times at public health facilities can become a barrier to access, while free medication at government pharmacies is not always available, in which case the elderly have no option but to purchase their medication from private pharmacies.

Caribbean countries continue to have two-tier health systems. On average, 60 per cent of total health expenditure is public and 40 per cent is private, most of which is out-of-pocket expenditure. Public health systems provide free primary care for older people (people over 60, 62 or 65 depending on the country) and certain medications are available free of charge. In addition, older persons are often exempt from hospital fees. However, there are still shortcomings with regard to the availability of secondary and tertiary care and some medications. As a result, there is widespread use of

private health services, not only by high-income households (for example, through insurance schemes or out-of-pocket expenditure), but also by low-income households (for example the purchase of medicines in private pharmacies). The ability to pay, therefore, still plays an important role in determining access to health care with obvious implications for the right to the highest attainable standard of health.

Both population ageing, and the need to improve equality of access, demand that public spending on health increase over time as a percentage of GDP. In OECD countries that have achieved universal access to health care services, public spending on health averages 6.8 percent of GDP but Caribbean governments spend between 2 and 5 per cent of GDP on health services (Figure 17). It is noticeable that public spending on health in the Caribbean remains within this range of 2 to 5 per cent irrespective of the level of GDP per capita of the country. For example, the Bahamas and Trinidad and Tobago, although their GDP per capita is much higher than other Caribbean countries, do not spend any more, proportional to their GDP, than Belize, Guyana or Jamaica – if anything they appear to spend slightly less. Of course, public budgets are subject to many demands and are currently constrained by high levels of public debt. However, higher income Caribbean countries, especially the Bahamas and Trinidad and Tobago, with GDP per capita quite close to that of at least some OECD countries, should be able to allocate a higher proportion of national income to public health services. As expenditures on public health services increase, equality of access to primary, secondary and tertiary health care services and the right to health-approach should be guiding principles.

Figure 17
Public health spending and GDP per capita, 2012
(Spending as a percentage of GDP and GDP per capita in international dollars, PPP)



Source: National Health Accounts of the World Health Organization (WHO); Figure adapted and updated from 'Health Care Expenditure and Financing in Latin America and the Caribbean [Fact sheet] - December 2012' of the Pan American Health Organization (PAHO).

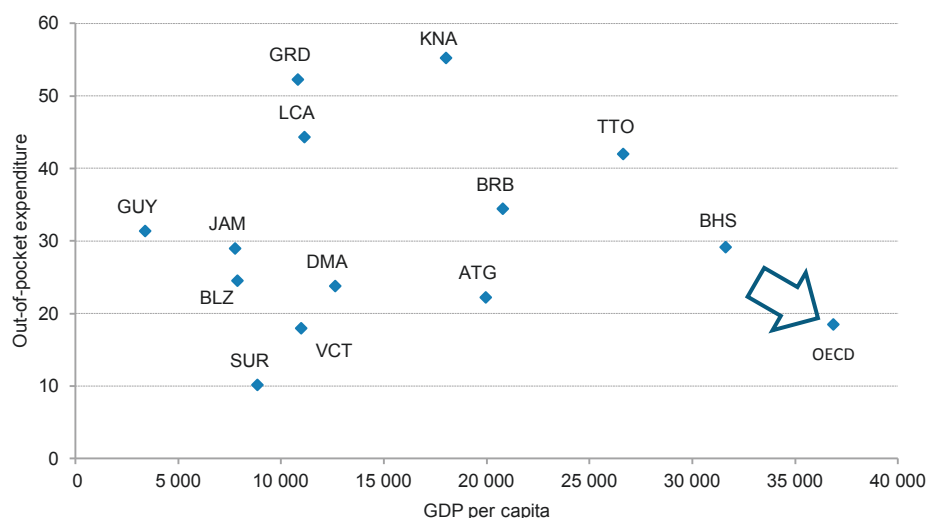
Note: The OECD average is the average of the countries of this organization which are considered to have achieved universal access to health services, that is, 32 of the 34 member countries with Mexico and the United States excluded.

The roughly 40 per cent of total health spending that is private, is mostly out-of-pocket expenditure (32 per cent) while the remainder is made up of contributions to private health insurance schemes. High out-of-pocket expenditure is indicative of deficiencies in public health services in respect of the availability and/or quality of care. It implies unequal access to services where getting treatment depends on whether someone has the resources to pay for it. Among Caribbean countries, there is substantial variation in the proportion of health spending which is accounted for by out-of-pocket expenditure but generally it is in the higher income countries where out-of-pocket expenditure is more

likely to represent a higher proportion of total health expenditure. Higher income Caribbean countries are not spending more as a proportion of GDP on public health services, but in many cases the population has greater ability to pay, out-of-pocket, for health care. In OECD countries that provide universal health coverage, out-of-pocket expenditures represent only 18 per cent of total health expenditure, substantially lower than in the Caribbean (Figure 18).

There are two main options for financing public health: a national health insurance scheme or a national health care system funded through general taxation. In the first case, defined benefits are provided to an insured population (which may or may not include all residents) funded by payroll contributions or sometimes another tax. In the second case, health care is provided universally and is funded through general taxation. In each case, care may be provided free or user fees may be charged. Proposals for National Health Insurance schemes have been considered in various countries including the Bahamas, Belize, Jamaica, Saint Lucia, Saint Vincent and the Grenadines and Trinidad and Tobago. Countries that have achieved universal health coverage have implemented many different variants of these two general models. In the Caribbean, any scheme which increases funding for public health care services is worth considering.

Figure 18
Out-of-pocket expenditure on health and GDP per capita, 2012
(Out-of-pocket expenditure as a percentage of total health expenditure and GDP per capita in international dollars, PPP)



Source: National Health Accounts of the World Health Organization (WHO); Figure adapted and updated from 'Health Care Expenditure and Financing in Latin America and the Caribbean [Fact sheet] - December 2012' of the Pan American Health Organization (PAHO).

C. Health care services for older persons including palliative care

In addition to increasing the demand for health care services, ageing populations will require a different kind of health care with geriatric medicine and age friendly services becoming increasingly important. Health service managers need to plan for the provision of services, and training of health care professionals, to meet these evolving demands.

Geriatric medicine differs from adult medicine in a number of important ways. Older bodies differ physiologically from the bodies of younger adults due to the age-related functional decline of physiological systems.

Age-related decline tends to be gradual as opposed to the impact of disease which can lead to a more abrupt functional decline. Lifestyle choices made throughout the course of life can also cause functional decline. The interplay of these factors, and the way in which they compound each other, is central to geriatric medicine. Functional decline, due to whichever cause, leaves older persons less able to prevent or recover from illnesses and more likely to suffer from serious complications. For example, pneumonia can be deadly for older persons due to their weaker immune systems, and the risk is further increased for those with existing health conditions which also affect immune health (for example long-term heart, lung and kidney diseases, diabetes and HIV). Smokers, having reduced lung capacity, would also be more vulnerable.

In addition to non-communicable diseases, age-related functional decline has in itself been identified as a leading cause of hospitalization of people and can manifest itself as the development of malnutrition, decreased functional mobility, loss of skin integrity, incontinence, falls, the development of delirium, problems with medication, poor self-care and depression (Eldemire-Shearer, 2011). Primary health care centres need to adopt a preventative approach to these conditions (preventative health care is just as effective with older persons as it is with the young). Centres need to screen for these conditions and implement protocols for their management.

Older persons may have complex needs due to multiple health conditions and, because they take more medications than younger patients, they have a higher risk of adverse reactions to medication. Diagnosis can be more difficult as symptoms either manifest themselves in different ways in older persons or are more easily confused with other conditions or age-related functional decline. Care of older persons is much more likely to involve other parties, such as family members, caregivers and social workers. Their involvement is important to ensure that older persons receive the ongoing support that they need to aid their recovery and/or rehabilitation although it also needs to be managed in a way that does not unduly compromise the privacy of the patient. Regular health checks of older persons are important to monitor, for example blood pressure, nutritional status, and the management of chronic conditions.

In addition to the clinical treatment of older persons, the manner and location in which care is delivered is also important. Physically getting to a health centre or hospital can be a major challenge for older persons and in some cases a barrier preventing access to services. Older persons may depend on their carer for transport, on some other form of accessible transport, or they may require home visits by health professionals. Where older people have impaired vision, hearing, or memory loss, extra care needs to be paid to communication, for example describing symptoms and instructions for taking medication. Appointments with older persons need to be carefully managed taking into account transport issues and there should be reminders and follow-up in the event of non-attendance. Health centres themselves should be designed to be age-friendly with ramps, handrails, clear and legible signs, accessible toilets, availability of wheelchairs, and personal assistance. (Eldemire-Shearer, 2011).

The evolving demands placed on health services will have implications for academic and in-service training of health professionals. There will be a need for more geriatric specialists and the care and treatment of older persons should be given greater weight in the training of all health service staff. The management of health and social care services more generally will create a growing demand for expertise in gerontology and gerontological nursing. PAHO is active in supporting training in these areas.

Ageing populations and the increasing proportion of people dying from non-communicable diseases will also create a growing demand for palliative care. The purpose of palliative care, in contrast to curative care, is to improve the quality of life of patients, to prevent and relieve pain and other suffering. It seeks neither to hasten nor postpone death. Patients suffering from a wide range of chronic conditions can benefit from palliative alongside curative care. However, when someone is deemed to be terminally ill, usually with less than six months to live, there is commonly a point of transition to palliative-only care. This 'end-of-life' or hospice care is to help people who are dying to have peace, comfort, and dignity. Hospice care may be provided at a hospice, at a hospital, in a care facility, or at the patient's home.

The World Health Organization has produced global and regional estimates of demand for palliative care (WHO, 2014b). The following diseases can require palliative care: Alzheimer's and other

dementias, cancer, cardiovascular diseases (excluding sudden deaths), cirrhosis of the liver, chronic obstructive pulmonary diseases, diabetes, HIV/AIDS, kidney failure, multiple sclerosis, Parkinson's disease, rheumatoid arthritis, and drug-resistant tuberculosis (TB). Estimates of demand for palliative care were based on assumptions about the proportions of those suffering from each disease that would need palliative care. They suggest that, at the very least, one third of the total number of persons that die in the Caribbean each year is in need of palliative care at the end of their lives. The majority of these people are persons aged over 60 suffering from non-communicable diseases.

The levels of national development of palliative care services have also been classified on a scale ranging from group one countries, 'no known activity'; to group 4b countries, 'advanced integration' (Table 9). States classified as 4b would be characterised by comprehensive provision of all types of palliative care by multiple service providers; broad awareness of palliative care on the part of health professionals, local communities and society in general; and unrestricted availability of morphine and all other strong pain-relieving medicines. Nine Caribbean countries or territories were classified as belonging to group 3a, which is characterised by the development of palliative care activism that is patchy in scope and not well supported; sourcing of funding that is often heavily donor dependent; limited availability of morphine; and a small number of hospice-palliative care services that are often home-based in nature and relatively limited compared with the size of the population.

Table 9
Level of palliative care development, 2011

Level of palliative care development	Countries and territories
Group 1: No known activity	Anguilla, Antigua and Barbuda, Aruba, Grenada, Martinique, Montserrat, Netherlands Antilles, Saint Kitts and Nevis, Saint Vincent and the Grenadines, Turks and Caicos Islands, US Virgin Islands.
Group 2: Capacity building	British Virgin Islands, Dominica, Suriname, The Bahamas.
Group 3a Isolated provision	Barbados, Belize, Bermuda, Cayman Islands, Guadeloupe, Guyana, Jamaica, Saint Lucia, Trinidad and Tobago.
Group 3b Generalised provision	
Group 4a Preliminary integration	Puerto Rico.
Group 4b Advanced integration	

Source: Global Atlas of Palliative Care at the End of Life, Worldwide Palliative Care Alliance (WPCA) and World Health Organization (WHO), January 2014.

The limited nature of palliative care services in the Caribbean was confirmed in a recent study covering 10 of the 13 English-speaking CARICOM members. Of the islands surveyed, there were only six palliative care specialists employed for a population of 5.4 million. Annual medical use of opiates, which is considered an indicator of the state of development of palliative care services, is well below the global mean. The International Narcotics Control Board (INCB), which monitors such use, encourages Caribbean and other low- and middle-income countries to increase their use of opiates to treat pain, and to overcome both unfounded fears of addiction and overly restrictive interpretation of related laws and regulations (Macpherson and others, 2014).

V. Enabling and supportive environments for older persons

This chapter considers how public policy can create enabling and supporting environments which enhance the independence, self-reliance and autonomy of older persons, enabling them to participate fully in economic, social and cultural life.

A. Social care services to support independence, health and well-being

Some older persons live in single generation households with their spouse, or alone, while others live in multigenerational households with children or other family members. However, both globally and in the Caribbean, there is a general trend in the direction of older persons living in single generation households. This has been seen in high income countries where families have more choices concerning their living arrangements. The same is likely to apply within country. In Belize, for example, it was found that older persons among higher quintile groups were much more likely to be living independently, compared to older persons in lower quintile groups (CDB, 2010). Taking into account this general preference for independent living, and the changing age structure of the population, not only will there be increasing numbers of older persons in future, more of them will be living in single generation households.

In multigenerational households, family members can provide financial, emotional and practical support and care. However, this should not be seen as a substitute for action on the part of the state, which has a responsibility to ensure that older persons have an independent income and that social services support families living with elderly members. Where this is not the case, excessive dependence can lead to feelings of mutual resentment or even abuse. Equally, it should be noted that there are older persons living in multigenerational households who are home owners with an independent income and where other family members may be heavily dependent upon them for financial support. This introduces a different dynamic to intra-household relations and potentially creates the circumstances for financial exploitation of older persons as younger members of the household seek to appropriate the assets and/or income of older household members.

At particular risk of isolation are persons living alone. Approximately 18 per cent of persons aged 60 and over in the English-speaking Caribbean live on their own. In most parts of the world more older women live alone compared to men (mainly due to widowhood), although the English-speaking Caribbean is an exception in this regard. Among persons aged 60 and over, 20 per cent of men live alone compared to 16 per cent of women (Nam, 2009). This is because older women are more likely to live with other family members.

In order to support older persons to live independently, many Caribbean countries have developed programmes such as home help services, home nursing care, day care and activity centres, and for those older persons who are unable to live independently, long-stay institutions. Most countries have some form of scheme to provide home care services to older people (Table 10). These services include help with bathing, cleaning, cooking, shopping and companionship. In this way, older persons receive the support that they need to continue living in their own homes, which is normally the best option to maintain an autonomous and independent life. In addition, home care for persons living independently is much more cost-effective than full residential care for the individual and/or the state.

Table 10
Home care programmes for frail older persons, 2012

Country	Home Care Programmes	Beneficiaries	Population 80+	Ratio: Beneficiaries / Caregivers
Antigua and Barbuda	Government Assistance and Residential Care for the Elderly and Eligible (GRACE)	110	1 511	2.1
Bahamas	Home Care Services for Older Persons	..	4 445	..
Barbados	Home Care Programme	1 025	7 009	..
Belize	Some services provided by NGOs	..	2 615	..
Dominica	"Yes We Care" Programme	198	..	4.6
Grenada	Geriatric Caregivers Programme	160	2 040	3.9
Guyana	Home-Based Health Care Programme (only region 6)	439	4 481	..
Jamaica	A very limited programme run by the National Council on Ageing	277	53 569	69
Saint Kitts and Nevis	Home Care Programme for the Aged	352	..	11.7
St. Lucia	Private services	..	3 971	..
Saint Vincent and the Grenadines	Home Help Programme	270	1 485	3
Suriname	Private services	..	5 688	..
Trinidad and Tobago	Geriatric Adolescent Partnership Program (GAPP)	7 200	20 028	12

Source: United Nations Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of information from national reports on ageing or provided by national focal points.

In some countries (for example in Barbados and Saint Kitts and Nevis) basic nursing care is provided in the home, either as part of the home care programme or in a separate programme. This can include dressing wounds and checking blood pressure and glucose levels. In addition, advice on nutrition, sanitary standards and other health issues can be addressed. Caregivers are also trained to detect and report illnesses, cases of neglect, abuse or malnutrition.

Most of those who need home care services are aged 80 and over. In Antigua and Barbuda, Dominica, Grenada and Saint Vincent and the Grenadines caregivers usually have two to five clients, so they can spend more time with each client and provide a better service, although as a result, the service is not so widely available. In other countries, Trinidad and Tobago and Saint Kitts and Nevis, caregivers have an average of about 12 clients each, so less time is spent with each one but the service is offered to more people. Some countries are yet to develop public home care programmes for older persons: in Belize, there are NGOs providing these services in a few locations; in Jamaica there is a programme organized by the National Council for Senior Citizens although it is very limited in scope; and Saint Lucia and Suriname also lack a public programme that provides these services.

All countries should provide home care services to those who need this additional support to maintain their independence, autonomy and dignity. Even countries with well-established programmes recognize the need to improve their quality, scope and reach. A qualitative study in six Caribbean countries confirmed that there were significant problems of coverage and access to these services (Cloos and others, 2009). In several countries there are problems of recruitment and retention of workers which need to be addressed. There is also a need to strengthen the training and guidance provided to caregivers, for example to help them to identify abuse or poor health. In Barbados, in order to reach out to older persons in remote locations, a minibus was purchased to transport caregivers.

In some countries day care centres for older people enable family carers to work, or at least take a break from their duties as carers. These centres also keep older persons socially and physically active, provide a nutritious meal and sometimes offer services such as health checks. Such services provide invaluable support to carers -who in many cases are older persons themselves- and should form part of the social care programme.

For older persons who are unable to live independently there are public and private long-stay institutions. These residential care and nursing homes are generally for the care of older persons who can no longer live independently even with support. Only a small percentage of older persons live in residential homes although the percentage is increasing. Most Caribbean countries have a small number of government run residential homes which are free and care for older persons who would otherwise be destitute. Most residential homes are run as businesses although there are also some run by churches. Some of these homes receive public subsidies. The managers or owners of homes are commonly registered nurses although many of the care workers employed have little or no training. The quality of care is a real concern across the sector and problems in some institutions have included: inadequate buildings; overcrowding; inadequately trained staff; lack of equipment and problems related to nutrition and medical care; and inadequate monitoring and regulation by government.

Many countries have passed laws and regulations governing long-stay institutions, especially since 2000, although countries still to pass laws, include Antigua and Barbuda, Dominica, Guyana, Saint Kitts and Nevis, Saint Lucia and Saint Vincent and the Grenadines (Table 11). Regulations generally require the registration of residential homes, set some minimum standards and establish the right of the government to carry out inspections. However, even if the legislation is in force, not all residential and nursing homes are necessarily registered and inspection regimes may not have been implemented or may be inadequate. In Trinidad and Tobago, where there are about 85 residential homes for the elderly, the Division of Ageing is seeking to strengthen the implementation of the law that was passed in 2007 including the introduction of an inspection regime and sanctions against owners of homes which are not compliant with minimum standards.

Table 11
Regulation of residential care homes for older persons, 2012

Country	Public residential care homes	Private residential care homes	Regulations
Antigua and Barbuda	1	14	No regulation
Bahamas	5	11	Regulation (2006)
Barbados	about 60 homes		Regulations (2005)
Belize	3		Regulation (2000)
Dominica	1	6	No regulation
Grenada	3	8	Regulation (2002)
Guyana	..	..	No regulation
Jamaica	approximately 100 homes		Regulation (2004)
Saint Kitts and Nevis	3	2	No regulation
St. Lucia	1	6	No regulation
Saint Vincent and the Grenadines	1	6	No regulation
Suriname	2	about 18	Pending legislation
Trinidad and Tobago	about 85 homes		Regulation (2007)

Source: United Nations Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of information from national reports on ageing or provided by national focal points.

Many countries have recognized the need to continue efforts towards the adoption of legislation or stricter enforcement. Effective inspection regimes must be put in place and the results of inspections should be publically available. There should be a sliding scale of penalties against homeowners who do not comply with regulations, for example warnings; the suspension of new admissions until problems are resolved; suspension or cancellation of registration; and ultimately legal proceedings against those that violate the law.

In some countries, consideration is being given to the development of good practice manuals for owners and managers of homes and care workers so that not only are establishments expected to meet legal minimum requirements but to achieve continuous improvement in pursuit of excellence. The residents of residential care homes should have specific rights, for example, the right to refuse or accept medical treatment; to have privacy in treatment; to have access to a procedure for the resolution of complaints; to receive visitors; and to choose what time they go to bed.

All countries should have legislation and regulations governing nursing homes as well as enforcement mechanisms such as inspections and punishment for non-compliance. Given the ageing population, trends in living arrangements and disability, the need for nursing care is likely to increase significantly. Therefore improving the quality of both public and private sector long-stay institutions ought to be a high priority and indeed has been identified as a priority in a number of countries.

Assisted living facilities represent a compromise between the provision of care in the home and in a long-stay institution. They enable older people to live independently within a communal environment with other older people, with easy access to a range of health, social and commercial services. Residents have their own rooms or living space and central dining spaces and communal areas for interaction. At present, there are relatively few assisted living facilities in the Caribbean.

B. Facilitating greater social participation by older persons

For older persons, continuing participation in social, economic and cultural life is essential to maintain physical, mental and social wellbeing. Since the late 1990s, the World Health Organization has promoted the concept of ‘Active Ageing’ which is defined as the “process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age” (WHO, 2002). Rights to equal participation, for example in work, education, cultural and public life are well-established. Moreover, with older persons representing an increasing proportion of the population, societies should embrace the contribution that older persons can make to social, cultural and family life.

Loneliness and isolation are commonly cited problems among older persons in the Caribbean. For example, in a study of older persons in Trinidad, 33 per cent reported being lonely (Rawlins and others, 2008). Older persons reporting loneliness included those living alone but also many who lived with family members. Men were more likely to suffer from loneliness than women. Country poverty assessments have also suggested that many older persons living in poverty feel lonely and abandoned.

Social participation of older persons is related to their financial situation, health, and also location, with more opportunities for participation in urban areas (Cloos and others, 2009). This reinforces the fact that it is not enough to address individual dimensions of social exclusion, such as social participation, without also addressing, for example, economic security and health. In countries where there is no established mechanism for involvement of older persons in decision-making, governments must make this a priority. Older persons should be involved in policy development, monitoring and evaluation. Existing government-run schemes, such as community education, should also target older persons.

In several countries in the Caribbean there are national councils of older persons which are either non-governmental organisations or bodies created by governments as a mechanism through which older persons can participate in decision making. There are also associations of retired persons which represent the interests of older persons.

In Jamaica, the National Council for Senior Citizens (NCSC), which under the Ministry of Labour and Social Security oversees the implementation of the National Policy for Senior Citizens, supports and encourages the network of senior citizens clubs across the country. Senior citizens have participated in conferences on ageing at both national and regional level and the clubs have organized activities promoting social interaction between generations such as visits to schools. The Barbados Association of Retired Persons (BARP) is a well-established organization whose objectives include: enhancing the quality of life of older persons in Barbados; promoting independence, dignity and purpose in the lives of its members; representing and expressing the views of members; and changing the prevailing attitudes towards older persons. In Trinidad and Tobago, Public Forums for Older Persons and a Senior Citizens Parliament are regular events.

In some other smaller Caribbean States there are similar organizations for older people which have found it more difficult to grow and/or remain active. In Saint Vincent and the Grenadines there was a National Council of Older Persons which recommended programmes and policies to improve the well-being of the elderly. However, this is no longer functioning and so there is currently no formal mechanism for the engagement of older persons in policy making. It was reported that in Saint Kitts and Nevis participation and engagement of older persons in policy making was limited because there were no independent groups involving older people and advocating on their behalf.

Education and learning have many benefits for older adults, enabling them to develop new skills and interests; keep up with social, cultural and technological changes; and stay physically, mentally and socially active. There is also an emerging body of evidence which suggests that there are important health benefits associated with lifelong learning, including protection against cognitive decline (Swindell, 2012). In addition, education can act as a springboard to greater participation in other aspects of society, such as economic, cultural, civic or faith based-activities, and therefore promoting social participation more generally.

In 2012, the Unique Helping Hands Senior School was opened in Barbados. The school serves retired and independent persons aged 50 and over, and believes in the concept of learning through interaction. It offers programmes in areas such as information technology, arts and craft, music and foreign languages. In Jamaica and Trinidad and Tobago, there are extensive networks of activity centres for older people. For example the eleven centres in Trinidad and Tobago offer activities such as aerobics, yoga, tai chi, home gardening, field trips, art and craft, computer literacy, swimming, dance and reading/adult literacy.

For many older persons, the absence of accessible transport services is a huge barrier to greater social participation. In several countries, older persons are entitled to reduced fares on buses although the reductions are not necessarily available on privately operated bus services and may only be available in certain areas. The Bahamas, Barbados, Belize, Jamaica and Trinidad and Tobago all have at least some reduced fare scheme. In the OECS countries, buses are generally privately operated and older people have to pay the same as everyone else. Bus services also tend to be inaccessible to older persons with impaired mobility, who are likely to find it difficult walking to the bus stop and boarding the bus. In Trinidad and Tobago, to address this issue, the 'Elderly and Differently-abled Mobile (ELDAMO) Transport Shuttle' was introduced. It is operated by the Public Transport Service Corporation (PTSC) and provides a dial-a-ride, free shuttle service in Trinidad and Tobago for the two target populations. Providers of health and other services for older persons need to consider the provision of appropriate transport to ensure that older persons can access their services.

Social participation is also enhanced by positive perceptions of older persons among other population groups and therefore efforts to raise public awareness about the contribution of older people to society can contribute towards social participation of older persons.

In order to promote a positive image of older persons and promote social participation, many Caribbean countries organise events in conjunction with International Day of Older Persons on 1st October. The Jamaican National Council for Senior Citizens established a national education programme to inform the general public about the ageing process, and the beneficial role of seniors in families and communities. Activities included: seminars; publication of oral histories and personal accounts of the experiences of

older people; exhibitions to display the work of seniors at libraries and government offices; and conferences to bring together senior citizens with senior members of government. The Senior Games organized in Barbados and Saint Lucia also promote a very positive image of older people and encourage them to be physically and socially active.

Legislation to protect older persons from discrimination and abuse can also play an important role in changing perceptions of older persons. A number of countries in Latin America have enacted equal opportunities and anti-discrimination legislation to protect older persons. There has been much less progress in this area in the Caribbean.

While some countries have national policies on ageing, the rights of older people as a minority group are not generally enshrined in legislation. There is no special protection against discrimination for older people, nor any special status attached to the mistreatment of older people. An exception to this is in Trinidad and Tobago where the new Homes for Older Persons Act (2007) made elderly abuse taking place in a long-stay institution an offence punishable by law.

In Barbados, a national Anti-Elder Abuse Programme Coordinating Committee was established. Over the past five years the committee has successfully raised the level of public awareness and public debate on the issue of elder abuse and has developed the case for legislation to tackle elder abuse and discrimination. Numerous countries have identified legislation and protection of the rights of older persons as priority areas for future action.

C. Older persons in disaster risk management

The Caribbean is at risk from a diverse set of natural hazards. Most of the islands are located within the recognized hurricane belt and there is seismic activity throughout the subregion. There have been repeated losses from localised storms, flooding and landslides and half of an entire island, Montserrat, remains uninhabitable due to ongoing volcanic eruptions. Regular annual disaster losses have been estimated at US\$3 billion with significant loss to social and productive sectors (CDEMA, 2014). Climate change will add to these existing threats by intensifying extreme weather events and rising sea levels directly threaten at least 1,300 km² of land and 110,000 people in CARICOM nations (Simpson and others, 2010).

Disaster management is the systematic process of planning, organization, direction and control of all disaster related activities at all phases including mitigation, preparedness, response and recovery. The Caribbean Disaster Emergency Management Agency (CDEMA) is responsible for coordinating disaster emergency response and disaster risk management in the Caribbean. The mandate of CDEMA is to mobilise and coordinate disaster relief; promote the adoption of disaster loss reduction and mitigation policies and practices; and provide reliable and comprehensive information on disasters.

Older people are at greater risk of being impacted by natural disasters. This is because problems which are more common in old age increase vulnerability: deteriorating physical ability; decreased strength; poor physical activity tolerance; functional limitations; and decreased sensory awareness (PAHO, 2012). Past disaster and emergency events in the Caribbean region have had grave impacts on older people. After Hurricane Ivan in 2004, the OECS in collaboration with ECLAC and other UN agencies did a Macro-Socio-Economic Assessment in Grenada and it was found that of the 28 persons that died from the hurricane, 70 per cent were over 60 years old (OECS, 2004).

Substandard housing may also put older persons at greater risk. For example, in Belize 38 per cent of older persons reported that their homes were not able to withstand strong winds and 40 per cent reported that they were vulnerable to flooding (National Council on Ageing, 2010). The earthquake that struck Haiti in 2010 affected an estimated 200,000 people over 60 years old. Like everyone else, their homes were reduced to rubble, food and water became increasingly scarce, and they could no longer rely upon previously existing safety nets of community, family, health care, and other general services (HelpAge International, 2010).

The mitigation phase involves the shaping of policies and strategies that take into account the needs, capacities, specific vulnerabilities, and perspectives of all ages. As such, increasing awareness and knowledge of disasters, and how older persons experience and respond to them, are very useful in developing these plans. The effectiveness of these plans will depend on the availability of information on hazards, emergency risks, and the countermeasures to be taken. Work must also be done at the community level through municipal corporations and local NGOs who can collect information on the elderly in their community including their special needs. This information must be further shared with the disaster authorities to be incorporated into disaster planning, particularly related to shelter arrangements, food distribution, and ensuring that older persons have access to the required support. This is being done to some extent in some of the CDEMA Participating States but there is a recognised need for it to become more institutionalized.

In the preparedness phase, governments, local organizations, individuals in their communities, and other stakeholders develop plans to save lives, minimize disaster damage, and enhance disaster response operations. Preparedness measures include emergency exercises/training; warning systems; emergency communications systems; evacuation plans and training; resource inventories; emergency personnel/contact lists; mutual aid agreements; and public information/education. It is in this phase where the knowledge of older persons can be utilized as they may have lived through disasters in their local environments and can share their experiences. They also have coping skills and survival strategies that are useful for their local communities.

The focus in the response phase is on meeting the basic needs of people until more permanent and sustainable solutions can be found. During this phase, older persons may have special needs that have to be addressed. They may have more specific requirements with regard to diet or health care; they may require a greater level of assistance or environmental adaptations when housed in shelters. Older persons may have a reduced capacity to cope in the aftermath of an emergency, for example in rapidly accessing food and/or medical supplies or finding shelter. Whether or not the basic needs of older persons are met can be the difference between life and death. The World Development Report (WDR) 2007 indicates that healthcare provided in the aftermath of a disaster may not be appropriate for the medical needs of older people, for example, the need for eye clinics, physiotherapy, mobility aids and specific medication.

The recovery phase continues until all systems affected by the disaster return to normal or better. Recovery measures, both short and long term, include returning vital life-support systems to minimum operating standards; temporary housing; public information; health and safety education; reconstruction; counselling programs; and economic impact studies. Information resources and services include data collection related to rebuilding, and documentation of lessons learned. During the recovery phase of an emergency, older people can and often do experience challenges in accessing relief assistance, for example in making repairs to their homes. They are at prime risk of being excluded from support provided by governments.

Generally in the Caribbean, increasing attention is being given to the vulnerability of older persons in disasters, nevertheless there is still much more to be done to meet the needs of this growing segment of society. According to best practice guidelines produced by HelpAge International, reducing the vulnerability of older persons is not primarily about creating special services for them but rather about ensuring that they have equal access to vital services. It must also be recognized that the older population should not only be seen as victims, but their unique capacities and contributions in preparing for and responding to disaster should be recognised and utilised.

D. Protection against abuse, exploitation and discrimination

In recent years, there has been growing recognition of the problem of elder abuse. WHO defines elder abuse to be a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person. This type of violence constitutes a violation of human rights and includes physical, sexual, psychological, emotional, financial and material abuse, abandonment, neglect, and serious loss of dignity and respect (WHO, 2014).

Discriminatory attitudes towards older persons, for example the idea that physical and mental ailments (real or perceived) make them dependent and a burden, underlie elder abuse. Gender inequality and tolerant attitudes towards violence also contribute to creating the conditions in which elder abuse can take place. Older people themselves may internalise these attitudes leading to low self esteem which may prevent them from recognising that they are being abused or lead them to think that they just have to accept it. As older persons become more physically frail, they are less able to stand up to bullying and to defend themselves if they are physically attacked. A lack of understanding and empathy towards older persons who are suffering from physical or mental ailments can develop into abuse. If their sight, hearing, or memory has deteriorated, they may be more vulnerable to exploitation by others.

It is difficult to quantify the scale of the problem in the Caribbean but WHO suggests that, globally, around 10 per cent of older persons experience abuse every month (WHO, 2014). In the Caribbean there is certainly anecdotal evidence of elder abuse and some press coverage of the issue. In Saint Lucia, a protest march took place in 2014 to highlight the issue and to call for better care of the elderly. The most commonly cited form of abuse is financial, for example where older persons have their pension income taken from them or collected on their behalf but not passed on to them. Older persons may also be pressured into transferring ownership of their properties to family members. There are undoubtedly cases of physical and even sexual abuse of older persons and from time to time cases come to the attention of government authorities.

Abuse most commonly takes place where older persons are living, in their own homes, or perhaps in residential care or nursing homes. Those responsible naturally take great care to ensure that the abuse is kept behind closed doors. In many cases, and particularly where elder abuse is carried out by family members, the elderly person may have conflicted feelings towards the abuser and may not want to complain. They may feel that if they report the issue it will not be taken seriously or they may doubt the willingness or capability of the government to intervene. They may be concerned that reporting the issue will make it worse. They may simply not know what to do.

Internationally, research suggests that if older persons are victims of abuse, their son or daughter is the most likely perpetrator, followed by their spouse, another relative, a care-worker or another service user (for example a co-resident in an institution). Victims of abuse are more likely to be women than men and perpetrators are more likely to be men.

Frail older persons are often left at hospitals by relatives who are no longer willing to care for them. Hospitals find themselves diverting resources in order to provide, in effect, temporary residential care services for which they were not designed or equipped. In cases of abandonment the state has the ultimate responsibility to provide care and therefore hospitals have to liaise with social workers to find alternative accommodation for these persons.

Care workers in residential and nursing homes can also be responsible for abuse. Little information is available about the extent of this problem in the Caribbean which is probably due to the relatively small number of such institutions and the lack of rigorous inspection and monitoring. Evidence from outside the Caribbean certainly suggests that residents of long-stay institutions are at risk of abuse from care workers or fellow residents.

Abusive acts in institutions include physically restraining patients; depriving them of their dignity by for instance leaving them in soiled clothes; depriving them of choice over daily affairs; intentionally providing insufficient care, for example allowing them to develop pressure sores, over- and under-medicating or withholding medication from patients; and emotional neglect and abuse. (WHO, 2014).

For older people, the consequences of abuse can be especially serious. Older persons are more vulnerable in the face of physical violence, take longer to recover from physical injuries, and lesser injuries can lead to serious and permanent damage, or even death. Abuse can also lead to serious, sometimes long-lasting, psychological consequences, including depression and anxiety.

There are common risk factors associated with abuse: financial or other forms of dependency (either the abuser's dependency on the older person or the reverse); a history of poor family relationships; social isolation of caregivers and older persons; and lack of funds to pay for care.

In an institutional environment, risk factors include lack of training and low pay of care workers, and the absence of monitoring and inspection regimes.

Some developed countries have legislated against elder abuse and implemented preventative measures to protect older persons. However, legal definitions of elder abuse and neglect vary significantly as do the legal frameworks (Canadian Department of Justice, 2009). The United States of America has legislation specifically criminalising ‘elder abuse’. In other countries, including the United Kingdom, there is legislation addressing the wider problem of mistreatment of ‘vulnerable adults’ (with frail older persons being one category of vulnerable adult). Many developed countries have also passed non-criminal laws to address elder abuse and neglect of residents in care facilities.

In the Caribbean, there is very little legislation of this kind and elder abuse would be dealt with under more general laws such as assault, sexual assault, domestic violence, theft, robbery, breaking and entering, and fraud. In Trinidad and Tobago, legislation introducing an offence of abuse of an older person, which will cover residents of care homes, is awaiting proclamation.¹¹

Public awareness campaigns, for example those organised in connection with World Elder Abuse Awareness Day (15 June), have an important role to play in targeting the discriminatory attitudes that underlie elder abuse. Awareness campaigns should target both potential abusers and victims. They should ensure that potential victims, abusers and others can recognise abuse and are aware of the support services that are available to them if they are suffering from abuse. Confidential helplines for older persons offer an invaluable first point of contact for victims to access counselling and advice. Such helplines can be staffed by volunteers, but should be able to provide access to expert advice in areas such as finance, law and housing.

In order to protect older persons, legislation should be introduced creating a specific crime of abusing an older person (or a vulnerable adult). Legislation should establish mechanisms to identify cases of abuse or suspected abuse and provide government agencies with the authority to intervene in cases of serious abuse. There should be training and guidelines for health care workers, social workers, care workers or caregivers to help them to recognise abuse and protocols for referrals and reporting. Inter-agency cooperation is vital both to identify and prevent abuse. In suspected cases of abuse, case managers should be assigned to help victims obtain the support that they need. There have been two Caribbean Conferences on Abuse of Older Persons, the first held in Martinique in 2010 and the second in Guadeloupe in 2013, which have been valuable opportunities for discussing and comparing strategies for addressing abuse in the subregion.

In order to address financial abuse, older persons and their families should be provided with information about the risks and how they can protect themselves, for example using direct debit to pay bills, or using online banking or telephone banking services. Carers should be sensitized to warning signs of abuse, such as the sudden appearance of would-be friends, rogue traders or unusual interest in a person’s financial affairs by a relative who otherwise should have no interest in the older person’s finances. Banks also have a role to play in minimising the risk of financial abuse of older persons, for example by making their services more accessible so older people are less reliant on third parties and being alert to suspicious transactions. (UNECE, 2013).

¹¹ See the Homes for Older Persons Act No. 20 of 2007.

VI. Conclusions

Population ageing has long been recognised as a demographic trend which will shape Caribbean societies in the twenty-first century. Until now, the Caribbean population has aged relatively slowly and for many countries ageing has been seen as something on that was on the horizon but not as an immediately pressing priority. This is no longer the case. The most rapid period of population ageing will be over the next twenty years from 2015 to 2035. After this period, the population will continue to age, but the pace of demographic change will gradually slow. This means that within two decades, the Caribbean population will look very different than it does today.

With older persons making up an increasingly large proportion of the population, societies need to fundamentally reconsider the role of older persons. For older persons themselves, full and equal participation in society is essential to their physical, mental and social wellbeing. Moreover, societies will no longer be able to disregard the contribution that older people can make to economic, social, cultural and family life.

The protection and fulfilment of the human rights of older persons is a means to achieving this transformational shift. Recognition of the rights of older persons opens the space for them to participate equally, and without discrimination, in all aspects of society. Just as importantly, it also places responsibility on the state to take whatever additional measures may be necessary to ensure that these rights are fulfilled. In this way, the rights of older persons can be seen as a framework for addressing population ageing, in addition to being an important end in their own right.

As was discussed in chapter two, there are many treaties, resolutions and policies which address the human rights of older persons and there is an emerging consensus on the rights of older people. However, the absence of a unifying treaty in the United Nations human rights system contributes to a lack of clarity surrounding the content of these universal rights, which means that the obligations of States as duty bearers are unclear. It also means that in procedures for monitoring United Nations human rights treaties, older persons are marginalised. International efforts continue to further advance and clarify the rights of older persons, for example through the United Nations Open-ended Working Group on Ageing; and through the work of the Independent Expert on the enjoyment of all human rights by older persons. Caribbean countries have a role to play through participation and contribution to these international efforts to advance the human rights of older persons.

The recent approval of the Inter-American Convention on Protecting the Human Rights of Older Persons is a very important step towards unifying and clarifying the human rights of older persons. This convention makes the Americas the first region in the world to have an instrument for the promotion and protection of the human rights of older persons. It provides a clear and comprehensive statement of protected human rights and the obligations of states in this regard. The signature and ratification of this convention is an opportunity for Caribbean countries to make an explicit commitment to providing the strongest possible protection for the human rights for older persons.

Over recent years, Caribbean countries have implemented policies for older persons which have sought to address issues related to population ageing and to promote the human rights of older persons. They have created institutions, councils, and implemented national policies on ageing. They have created programmes to address the economic security of older persons, provide them with basic health care and social care services and they have sought to address issues of concern such as elder abuse. Despite these efforts, Caribbean countries still fall substantially short of meeting the commitments enshrined in international agreements such as the Madrid International Plan of Action on Ageing, and it is abundantly clear that the human rights of older persons are far from being fully realised in practice.

Notwithstanding the hugely varied situation of older persons across the Caribbean, there are inadequate protections against the risks of old age. As a result, the well-being of too many older persons is severely compromised by poverty, ill health, loss of independence, isolation and even abuse or violence.

There is an urgent need to improve pension provision for older persons to ensure, first, that all older persons have a pension income and, second, that the minimum pension income provides an adequate standard of living (for example at or above the national poverty line). To achieve this, governments should increase the currently low level of funding for non-contributory pensions. In parallel with this, ongoing efforts should be made to expand and strengthen the contributory social security system.

Governments should consider reducing barriers to employment for older persons such as compulsory retirement ages, particularly in the case of public sector retirement ages as low as 55. They should promote more flexible working arrangements so that older persons can play a continued role in the economic development of their country, contributing their skills and experience and giving them greater freedom to phase their retirement.

Population ageing combined with unhealthy lifestyles are causing a growing epidemic of non-communicable diseases. Aside from the suffering caused to individuals and families, diseases such as cardiovascular disease, cancer, diabetes, hypertension and Alzheimer's impose a heavy burden on health services and undermine the productivity of the workforce. Health services need to plan for the care and treatment of increasing numbers of older persons with these conditions, which will demand increased funding of public health services (as a percentage of GDP). With many cases of non-communicable diseases linked to unhealthy lifestyles there is a great deal of scope for the development of public policies to address the risk factors associated with non-communicable diseases thereby limiting the future incidence of NCDs. Investment in such policies could potentially result in huge savings in the long term.

Governments should develop a range of social care services for older persons and their families, which provide the support that they need to continue living as independently as possible, with dignity and with equal participation in community life. Regulation and monitoring of the quality of these services is essential, whether the provider is in the public or private sector. Organizations of older persons have a crucial role in promoting a positive image of older persons, encouraging social participation and contributing to the development of policies aimed at this age group. Governments should promote and interact with organizations of older persons.

Special provision should be made for older persons in disaster risk management plans to ensure that they have equal access to vital services and to take advantage of the contributions that older persons can make in preparing for and responding to disasters.

Programmes are needed to address the issue of elder abuse involving training and guidelines for health care workers, social workers, care workers or caregivers to help them to recognise abuse. There should be legislation addressing elder abuse and protocols for referrals and reporting.

The increasing number of older persons in the population, and provision of pensions, health and social care services, will have major implications for public expenditure. Until now, the relatively large working age population and relatively small number of older persons, has meant that funding of pension, health and social care services for older persons was relatively cheap. Public expenditure on pensions and other services will have to rise as a percentage of GDP and the future costs of health services will be even greater than the pension costs. This will demand a renegotiated settlement between the generations, which should seek to strengthen principles of inter-generational solidarity and sharing of common risks. Rising to meet these challenges will require planning and analysis, democratic consultation and debate, and commitment to action but the problems are by no means insurmountable.

Bibliography

- Abdulkadri, Abdullahi D., Colette Cunningham-Myrie and Terrence Forrester (2009), “Economic burden of diabetes and hypertension in CARICOM states”, *Social and Economic Studies*, vol. 58, Nos. 3 & 4, pp. 175-197.
- CDB (Caribbean Development Bank) and the Government of Belize (2010), “Final Report, Country Poverty Assessment, Volume 2, Supplementary Material”.
- CDEMA (Caribbean Disaster Emergency Management Agency) (2014), “Regional Comprehensive Disaster Management (CDM) Strategy and Programming Framework 2014-2024 (Draft)”, Barbados.
- Cloos, Patrick and others (2009), ““Active ageing’: a qualitative study in six Caribbean countries”, *Ageing & Society*, vol. 30, 2010, Cambridge University Press (2009).
- Canadian Department of Justice (2009), “Legal Definitions of Elder Abuse and Neglect”, Research Report, Ottawa, Ontario, May.
- ECLAC (United Nations Economic Commission for Latin America and the Caribbean) (2014) *Preliminary Overview of the Economies of Latin America and the Caribbean 2013* (LC/G.2581-P), Santiago, Chile. United Nations publication, Sales No.: S.14.II.G.2.
- _____ (2012), San Jose Charter on the Rights of Older Persons in Latin America and the Caribbean (LC/G.2537), Santiago, Chile.
- _____ (2010), “Strategy proposal, from the perspective of Latin America and the Caribbean, for advancing towards an international convention on the human rights of older persons”, document presented at the ECLAC Ad Hoc Committee on Population and Development, Santiago, Chile, May.
- _____ (2008), Brasilia Declaration (LC/G.2359), Santiago, Chile.
- Eldemire-Shearer, Denise (2011), “Age Friendly Primary Health Care Clinical Toolkit”, Jamaica, Mona Ageing and Wellness Centre, January.
- Gaziano, A.B. and others (2011), “The global economic burden of noncommunicable diseases”, Geneva, Switzerland, World Economic Forum.
- HelpAge International (2010), “Humanitarian response for older people in Haiti: three months on”.
- Huenchuan, Sandra (2013), “Ageing, solidarity and social protection in Latin America and the Caribbean: time for progress towards equality” (LC/G.2553-P), Santiago de Chile, United Nations Economic Commission for Latin America and the Caribbean.
- Huenchuan, Sandra (2013b), “Perspectivas globales sobre la protección de los derechos humanos de las personas mayores”, 2007-2013, Santiago de Chile, United Nations Economic Commission for Latin America and the Caribbean.

- Huenchuan, Sandra (ed.) (2010), *Ageing, Human Rights and Public Policies*, Santiago de Chile, United Nations Economic Commission for Latin America and the Caribbean. United Nations publication, Sales No.: E.08.II.G.94.
- Macpherson, Cheryl and others (2014), “Hospice and Palliation in the English-Speaking Caribbean”, *Cambridge Quarterly of Healthcare Ethics* 23 (3):341-348.
- Miller, Tim, Carl Mason, and Mauricio Holz (2011), “The Fiscal Impact of Demographic Change in Ten Latin American Countries”, *Population Aging: Is Latin America Ready?*, The World Bank, Washington, D.C.
- Nam, Valerie (2009), Regional special topic monograph on the elderly based on analysis of the 2000 round census data of eighteen Caribbean countries, Georgetown, Guyana, The Caribbean Community (CARICOM) Secretariat.
- National Council on Ageing (2010), “Situational Analysis of Older Persons in Belize 2010”, Belmopan City, Belize.
- OECD (Organisation for Economic Co-operation and Development) (2013), “Public spending on health and long-term care: a new set of projections”, *OECD Economic Policy Papers*, No. 6, Paris, France, June.
- Organization of Eastern Caribbean States (OECS) (2004), “Grenada: Macro-Socio-Economic Assessment of the damages caused by Hurricane Ivan”, September.
- PAHO (Pan American Health Organization) (2012) “Health care expenditure and financing in Latin America and the Caribbean”, *Fact sheet*, Washington, D.C.
- _____(2012), Pan American Health Organization (PAHO), “Older People and Disasters”, *Fact sheet*.
- _____(2009), Plan of Action on the Health of Older Persons, Including Active and Healthy Aging (CE144.R13), May.
- _____(2006), (Pan American Health Organization) and CARICOM (Caribbean Community Secretariat) “Report of the Caribbean Commission on health and development”.
- _____(2002), “Health and Aging” (CSP26/13), Washington, D.C, 10 July.
- ILO (International Labour Organization) (2009), “Ageing societies: The benefits, and the costs, of living longer”, *World of Work 67: Social security as a crisis response; Ageing societies; Extending health care*, Geneva, Switzerland, December.
- IMF (International Monetary Fund) (2014) *World Economic Outlook - Recovery Strengthens, Remains Uneven*, Washington, April.
- Rawlins, Joan and Nicole Alea (eds.), *Ageing in the Caribbean*, Trinidad and Tobago, 2014.
- Rawlins, Joan and others (2008) “The elderly in Trinidad: health, social and economic status and issues of loneliness”, *West Indian Medical Journal*, vol. 57, No. 6, pp. 589- 595.
- Simpson, M.C. and others (2010), “Quantification and Magnitude of Losses and Damages Resulting from the Impacts of Climate Change: Modelling the Transformational Impacts and Costs of Sea Level Rise in the Caribbean”, United Nations Development Programme (UNDP), Barbados.
- Swindell, Rick (2012), “Successful ageing and international approaches to later-life learning”, *Active Ageing, Active Learning. Issues and Challenges*. Gillian Boulton-Lewis and Maureen Tam (eds.), New York, Springer.
- UNECE (United Nations Economic Commission for Europe), “Policy brief - Abuse of Older Persons”, *UNECE Policy Brief on Ageing No. 14*, October 2013.
- United Nations (2014), “Report of the Independent Expert on the enjoyment of all human rights by older persons, Rosa Kornfeld-Matte” (A/HRC/27/46), July.
- _____(2008), The right to social security (article 9), General Comment, No. 19 (E/C.12/GC/19).
- _____(2003), “Communication No 983/2001: Australia. 04/28/2003. CCPR/C/77/D/983/2001. (Jurisprudence), Geneva, Human Rights Committee.
- _____(2000), The right to enjoy the highest possible level of health (article 12 of the International Covenant on Economic, Social, and Cultural Rights), General Comment, No. 14 (E/C.12/2000/4).
- _____(1999), The right to education (article 13 of the International Covenant on Economic, Social, and Cultural Rights), General Comment, No. 13 (E/C.12/1999/10).
- _____(1995), The economic, social and cultural rights of older persons, General Comment, No. 6 (E/C.12/1995/16/Rev.1), Geneva, Committee on Economic, Social and Cultural Rights.
- _____(1991), “United Nations Principles for Older Persons”, *General Assembly resolution 46/91*, December.
- Vasciannie, Stephen (2010), “Human Rights Law in the Caribbean”, [online], United Nations, <http://legal.un.org/avl/l/Vasciannie_HR.html> [date of reference: 11 May 2015].
- WHO (World Health Organization) (2014), “Elder abuse - Fact sheet N°357” Geneva, Switzerland, Updated December 2014.

- WHO and WPCA (World Health Organization and Worldwide Palliative Care Alliance) (2014), “Global Atlas of Palliative Care at the End of Life”, London, United Kingdom, January.
- WHO (World Health Organization) (2013), Global health estimates, Geneva, Switzerland, July. http://www.who.int/healthinfo/global_burden_disease/en/
- _____ (2011), “Global status report on noncommunicable diseases 2010”, Geneva, Switzerland.
- _____ (2008), Age-friendly Primary Health Care Centres Toolkit, Geneva, Switzerland, December.
- _____ (2008), “A Global Response to Elder Abuse and Neglect: Building Primary Health Care Capacity to Deal with the Problem Worldwide: Main Report”, Geneva, Switzerland.
- _____ (2002), *Active Ageing: A Policy Framework* (WHO/NMH/NPH/02.8), Geneva, Switzerland.
- _____ (2002), *The Toronto Declaration on the Global Prevention of Elder Abuse*, Geneva, Switzerland.
- World Bank (2014), “Income Classifications”, [online], Washington, [date of reference: 5 May 2015] <http://data.worldbank.org/news/2015-country-classifications>.
- _____ (2011), “The growing burden of non-communicable diseases in the eastern Caribbean”, Human development unit, Caribbean Country Management Unit, Latin America and the Caribbean Region, The World Bank.



UNITED NATIONS

ECLAC

Studies and Perspectives Series – The Caribbean**Issues published****A complete list as well as pdf files are available at****www.eclac.org/publicaciones**

45. Ageing in the Caribbean and the human rights of older persons – Twin imperative for actions, LC/L.4130, LC/CAR/L.481, 2016.
44. Towards a demand model for maritime passenger transportation in the Caribbean – A regional study of passenger ferry services, LC/L.4122, LC/CAR/L.477, 2015.
43. The Caribbean and the post-2015 development agenda, LC/L.4098, LC/CAR/L.472, 2015.
42. Caribbean synthesis review and appraisal report on the implementation of the Beijing Declaration and Platform for Action, LC/L.4087, LC/CAR/L.470, 2015.
41. An assessment of performance of CARICOM extraregional trade agreements – An initial scoping exercise, LC/L.3944/Rev.1, LC/CAR/L.455/Rev.1, 2015.
40. Caribbean Development Report – Exploring strategies for sustainable growth and development in Caribbean small island States, LC/L.3918, LC/CAR/L.451, 2014.
39. Economic Survey of the Caribbean 2014 – Reduced downside risks and better prospects for recovery, LC/L.3917, LC/CAR/L.450, 2014.
38. An assessment of mechanism to improve energy efficiency in the transport sector in Grenada, Saint Lucia, and Saint Vincent and the Grenadines, LC/L.3915, LC/CAR/L.449, 2014.
37. Regional integration in the Caribbean – The role of trade agreements and structural transformation, LC/L.3916, LC/CAR/L.448, 2014.
36. Strategies to overcome barriers to the implementation of the Barbados Programme of Action and the Mauritius Strategy in the Caribbean, LC/L. 3831, LC/CAR/L.441, 2014.
35. Foreign direct investment in the Caribbean – Trends, determinants and policies, LC/CAR/L.433, 2014.
34. Situation of unpaid work and gender in the Caribbean: The measurement of unpaid work through time use studies, LC/L.3763, LC/CAR/L.432, 2014.
33. Progress in implementation of the Mauritius Strategy: Caribbean Regional Synthesis Report, LC/L.3762, LC/CAR/L.431, 2014.
32. Information and communication technologies for disaster risk management in the Caribbean, LC/L.3759, LC/CAR/L.430, 2013.
31. Towards diversification of the tourism sector: A recreational demand study of yachting and marina services in the Caribbean, LC/L.3758, LC/CAR/L.421, 2013.

STUDIES

AND

PE

SPEC

TIVES

45

STUDIES

AND

PE

SPEC

TIVES

STUDIES AND PERSPECTIVES

E C L A C

Series

ECONOMIC COMMISSION FOR LATIN AMERICA AND THE CARIBBEAN

COMISIÓN ECONÓMICA PARA AMÉRICA LATINA Y EL CARIBE

www.eclac.org