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AGEING IN THE CARIBBEAN: IMPLICATIONS OF A CHANGING POPULATION

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The analysis and recommendations presented in this paper are drawn from the publication "Ageing in the Caribbean and the human rights of older persons: Twin imperatives for action", ECLAC Studies and Perspectives Series, The Caribbean, No.45, LC/L.4130, LC/CAR/L.481, 2016 and additionally the conclusions of the Caribbean Conference on Ageing, Elder Abuse and the Rights of Older Persons held in Roseau, Dominica, 30 November - 1 December 2015.

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EXECUTIVE SUMMARY

Over the next twenty years, the Caribbean will see a rapid and dramatic ageing of its population. Over this period, the number of persons aged 60 and over will increase from 1.2 million (14 per cent of the population) to 2 million (22 per cent). The number aged 70 and over will increase from 0.53 million (6 per cent) to 1.05 million (12 per cent).[1] The population will continue to age for the remainder of the century albeit at a somewhat slower rate. All Caribbean countries and territories will see significant increases in the proportion of older persons in their respective populations.

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 the risks associated with ageing which include loss of income, ill health, disability, loss of independence, loneliness and elder abuse. 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 provision of pensions, health and social care services for a growing number of older persons will have major implications for public expenditure. There is a need to plan for increases in public expenditure on pensions, health and social care services as a percentage of GDP and to take measures which will help to control future costs. Projections suggest significant increases in future pension costs and even greater costs to fund health services. These increased health costs will be driven by the need to treat growing numbers of patients with non-communicable diseases (NCDs) such as cancer, cardiovascular diseases, neurological diseases and diabetes. Many NCDs are linked to unhealthy lifestyles so health policy must target reductions in risk factors such as obesity, both for the long term benefit to public health and to control costs.

Caribbean governments recognise that population ageing is an issue of growing concern.[2] Many have adopted, 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 their equivalent). Many countries have also created national councils on ageing which provide advice to governments and act as advocates for older persons. 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.

The recent approval of the Inter-American Convention on Protecting the Human Rights of Older Persons 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 provides a clear and comprehensive statement of protected human rights and the obligations of states in this regard. Protection and promotion of the human rights of older persons are central to international efforts to address population ageing and should inform national policies and programmes for older persons. The signature and ratification of this

[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.

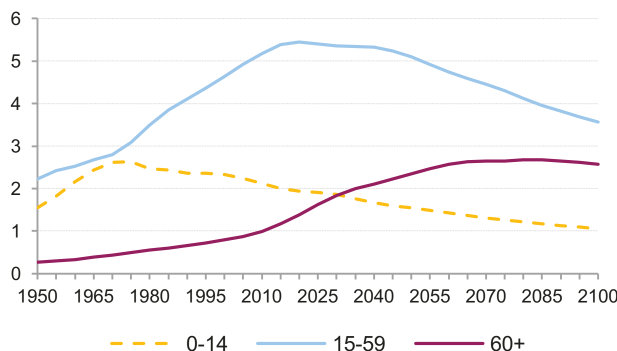
[2] In 2013, based on national responses to the United Nations Inquiry among Governments on Population and Development, 12 out of 13 Caribbean governments identified population ageing as a major concern (up from 9 out of 13 in both 2005 and 2009).

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.

I. POPULATION AGEING IN THE CARIBBEAN

The Caribbean has achieved a significant gain in life expectancy over the last one and a quarter centuries. Life expectancy at birth almost doubled between 1890 and 2015, increasing from an estimated 38 years in 1890 to 73 years in 2015. It is projected to further increase to 78 years in 2050 and 85 years in 2100. As populations live longer, fertility has declined, with total fertility falling to around the natural replacement rate. The total fertility rate in the Caribbean (the average number of children per woman) was 5.0 in 1950, 2.3 in 2000, 2.0 in 2015 and is expected to fall to 1.8 by 2050.[3] The outcome of an increasing longevity and falling fertility is an ageing population, that is, a gradual increase in the proportion of older persons in the population. Population ageing is a consequence of advances in human development and should be viewed in a positive light.

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



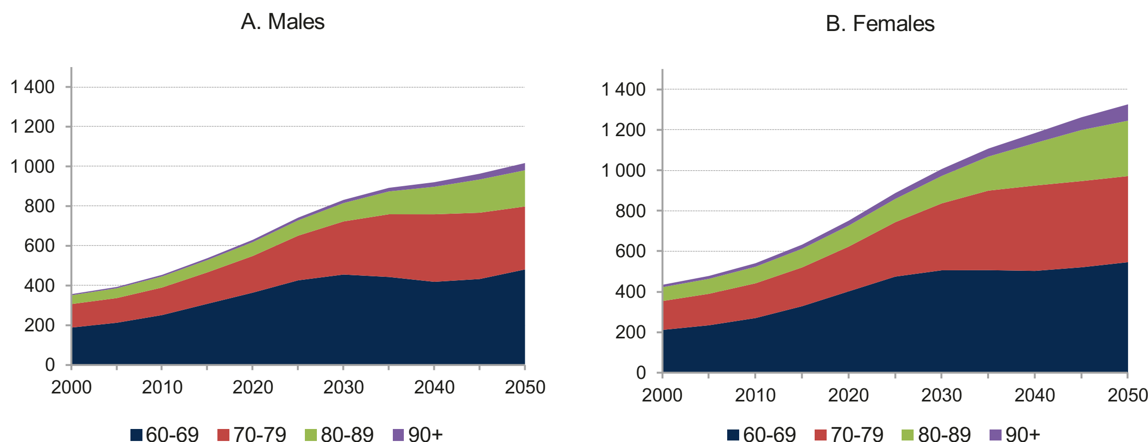
Source: United Nations, Department of Economic and Social Affairs, Population Division (2015). World Population Prospects: The 2015 Revision, DVD Edition.

The scale and implications of the population changes which will take place have not been fully appreciated by the wider public in general and policymakers in particular. The number of children aged under 15 years in the Caribbean has been falling since the early 1970s and it will continue to decline throughout the twenty-first century (Figure 1). The number of working aged adults (15-59) increased significantly throughout the second half of the twentieth century but that increase has now levelled off and it is projected that the size of this age group 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. As a consequence of these trends, older persons represent an increasing proportion of the population. Between 1970 and 2015, the proportion of children (0-14) decreased from 45 to 23 per cent, while that of the working age (15-59) and older persons (60+) increased from 48 to 63 per cent and from 7 to 14 per cent, respectively. In 2050 these proportions are projected to be 17 per cent for children; 57 per cent for working age; and 26 per cent for older persons, and these trends will continue beyond 2050.

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

Among persons aged 60 and over, it is the older age groups which will grow most quickly (Figure 2). Between 2015 and 2050, the number of persons aged 60-69 is expected to grow by 61 per cent in comparison to growth rates of 112 per cent for 70-79 year olds, 196 per cent for 80-89 year olds,and 293 per cent for persons aged 90 years and over. Across age groups, older women will be greater in number than older men. This is due to the longer life expectancy of women.

Figure 2
Older persons in the Caribbean by sex and age, 2000-2050
(Thousands)



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

A common way of analysing population ageing is with reference to dependency ratios which measure the number of children and older persons per hundred of persons of working age. Since the 1970s, child dependency ratios have been falling and during this time, old age dependency ratios were increasing but slowly and from a low level (Figure 3). The total dependency ratio was therefore in decline, from 98 in 1970 to 49 in 2015. From 2015 onwards, child dependency will continue to decline while old age dependency will start to increase more rapidly. As a result, from now 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.

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. Old age dependency ratios in 2015 were 11 in Latin America, 14 in the Caribbean and 22 in North America (Figure 4). 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.

Figure 3
Child, old age and total dependency rates for the Caribbean, 1950-2100
(Number of persons per hundred people aged 15-64 years)

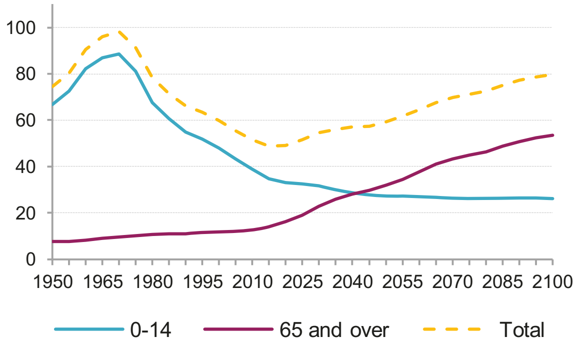
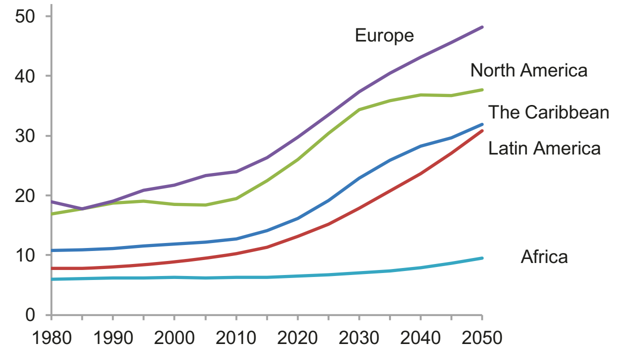
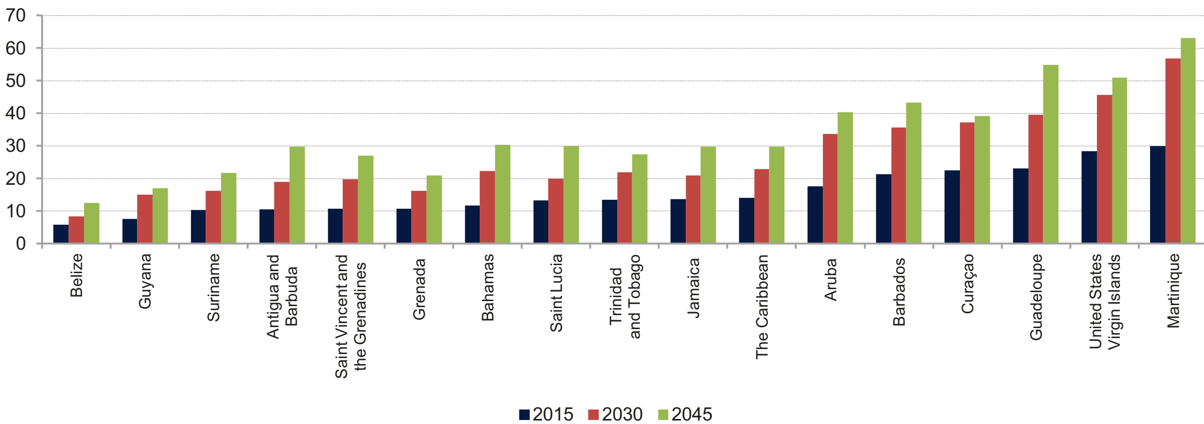


Figure 4
Old age dependency ratio by region, 1980-2050
(Number of persons aged 65 and over per hundred persons aged between 15 and 64 years)



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.

Figure 5
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.

Ageing affects all countries and overseas territories within the Caribbean although the process is more advanced in some countries than others. In territories such as Aruba, Curaçao, Guadeloupe, Martinique and the United States Virgin Islands, which are classified by the World Bank as 'high income

economies',[4] the ageing process is more advanced (Figure 5). In these territories, the dependency ratios ranged from 18 in Aruba to 30 in Martinique in 2015. In other countries, such as Antigua and Barbuda, Barbados and Trinidad and Tobago, that are also classified as high income, ageing is moderately advanced with dependency ratios similar to the regional average of 14. 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). However, irrespective of the stage of their demographic transition, most Caribbean countries will see their old age dependency ratio double over the next thirty years with important implications for public policy and household structures.

II. AGEING, WORK AND PENSIONS

The demographic trends in the Caribbean will have a major impact on the workplace, particularly on pension systems: on the management of national insurance schemes, the funding of public sector pensions, and non-contributory pensions.

Caribbean national insurance (social security) schemes are pay-as-you-go schemes. These schemes depend on current workers to fund today's pensioners, albeit with funds of accumulated reserves built up during the years before maturity when contributors vastly outnumber pensioners. As the number of pensioners increases, all national insurance schemes will need to adjust contribution rates, retirement ages, and/or entitlements in order for them to be sustainable. Public sector pension schemes for government employees are often separate from the national insurance scheme being funded from general government revenue (although where reforms have been introduced the tendency has been towards the introduction of employee contributions and/or closer integration with national insurance schemes). There are also non-contributory pensions, which are funded by government and generally aimed at those without contributory pensions or any other source of income.

All countries in the English-speaking Caribbean have national insurance schemes which provide old age pensions. These schemes cover between 45 and 80 per cent[5] of the working age population depending on the extent of formality or informality in each economy. Among those persons over the retirement age, contributory pensions cover between a quarter to three-quarters of the population and pay on average as pensions, about half of the final salary a pensioner earned before retirement. This is close to the average among OECD countries. However, only Bahamas, Barbados and Dominica automatically increase pensions to account for inflation and arbitrary increases have not always maintained the real value of pensions. Based on data for nine countries, the aggregate cost of national insurance old age pensions ranges from 0.5 to 2.7 per cent of GDP depending on benefit generosity and how far population ageing has advanced in the respective countries (Figure 6).

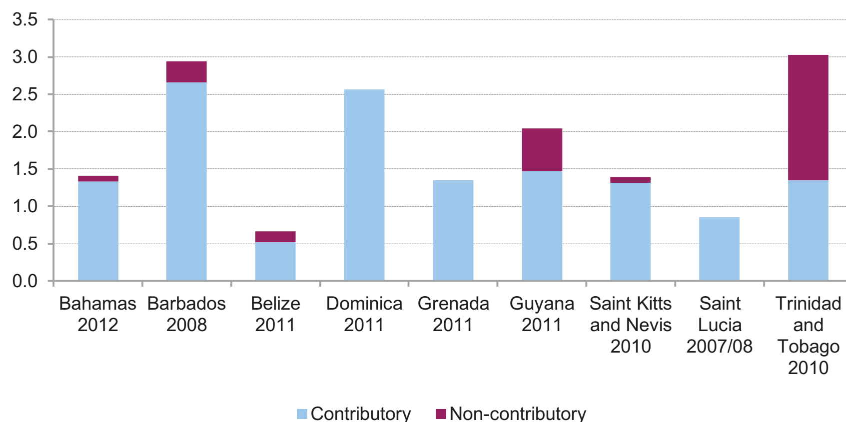
For those not receiving contributory social security or other pensions, Caribbean countries, with the exception of Dominica, Grenada and Saint Lucia, have implemented non-contributory schemes (or social pensions). These pensions are generally means tested although the pension in Guyana is universal (received by all irrespective of any other income). These pensions are funded from general government revenue and total spending on non-contributory pensions is much lower. The only exception to this is Trinidad and Tobago which spends 1.7 per cent of GDP on its non-contributory pension compared to 1.3

[4] World Bank (2014), "Income Classifications", [online], Washington, [date of reference: 5 May 2015] http://data.worldbank.org/news/2015-country-classifications.

[5] International Labour Organization (2014), "World Social Protection Report 2014/15", Geneva.

per cent on its national insurance pension. Guyana spends the next most, about 0.6 per cent of GDP on its universal pension while most other countries spend far less.

Figure 6
Expenditure on contributory national insurance old age pensions and non-contributory pensions
(Percentage 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.

Due to this lack of funding, non-contributory pensions generally fall below the poverty line and, for some countries, indigence lines (Figure 7). Only in Trinidad and Tobago does the pension exceed the national poverty line. In Barbados and the Bahamas, the non-contributory pensions are higher than the indigence line but fall short of the poverty line. In Antigua and Barbuda and Saint Kitts and Nevis, the pensions are more similar to the indigence lines while in Belize and Saint Vincent and the Grenadines, the pensions are 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.

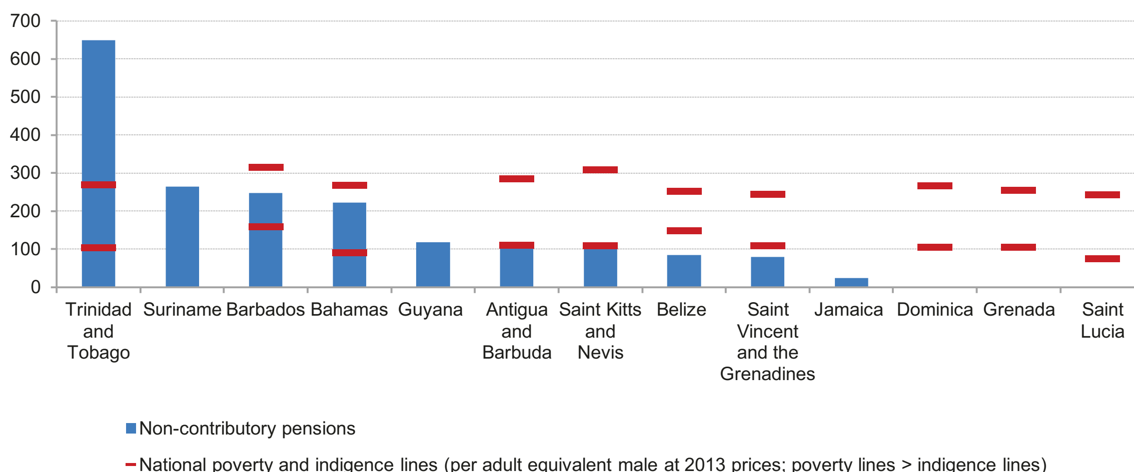
Older women are less likely than men to have income from an employment-based pension and women that do receive pensions receive less than men. While gender gaps are closing, particularly in labour market participation, ongoing inequalities in participation, the gender pay gap, and interrupted contribution records all contribute to the perpetuation of pension inequality.

Older persons who have either no pension income or an inadequate pension income are at risk of poverty and even destitution. Some continue working into old age, for example in Jamaica and Belize 40 per cent of men aged 65 and over are labour market participants although in other countries the rate is much lower; between 12 and 14 per cent in Barbados, Suriname and Trinidad and Tobago. Others may be able to depend on family support. Those less fortunate live in poverty and may suffer from hunger, ill-health and isolation.

The imminent demographic change only heightens the need for policymakers to address the inadequacies in pension systems. Projections based on the National Transfer Accounts framework suggest that, over the period 2005 to 2050, the cost of providing public pensions could increase by around 1.5 per cent of GDP. 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 pensions rise by an average of

1.5 (Latin America) and 2.3 (EU-15) percentage shares of GDP.[6] So for example, a country in which total public spending on pensions was 3 per cent of GDP in 2005 would, it is projected, be spending around 4.5 per cent of GDP on pensions by 2050.

Figure 7
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.
Note: Poverty lines for Suriname, Guyana and Jamaica not available.

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, namely 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 receive some form of pension. The level of the pensions should then be increased so that they surpass the poverty line. In parallel, there is clearly a need to continue to try and widen the coverage of contributory national insurance.

To promote efforts in this direction the United Nations introduced the Social Protection Floor (SPF) 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 Caribbean countries, statutory retirement ages are still 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. Retirement ages in the public sector can be even lower. In the context of increasing life expectancy and increasing pension costs, measures should be taken to encourage older persons to remain

[6] 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.

in the workforce if they wish. Reconsideration of mandatory retirement ages, more flexible working arrangements, educational campaigns, pension reform, and training could all play a role in this area. 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.[7]

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.

III. HEALTH POLICY FOR AN AGEING POPULATION

Population ageing will also change the morbidity profile of the population. More older persons will mean more people suffering from non-communicable diseases (NCDs) such as cardiovascular disease, cancer, type 2 diabetes, hypertension, Alzheimer's and osteoporosis. NCDs not only shorten lives but also affect the quality of life of suffers and their families. NCDs can lead to disability, for example diabetes can lead to amputations or blindness; and cardiovascular diseases, such as heart attacks and strokes, can lead to mobility or speech impairments.

In addition to the human costs, 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 productively 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.[8] Middle and upper-middle income countries, such as those in the Caribbean, are projected to bear an increasing share of 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.[9]

These trends 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.[6] In OECD countries, where medium- and high-technology health services are more widely available, the differential is even greater, five or six times.[10]

Population ageing will mean that services for older persons will account for an increasing share of the public health budget. An analysis of heath 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

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[7] 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.

[8] Gaziano, A.B. and others (2011), "The global economic burden of noncommunicable diseases", Geneva, Switzerland, World Economic Forum.

[9] Abdulkadri, Abdullahi O., 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.

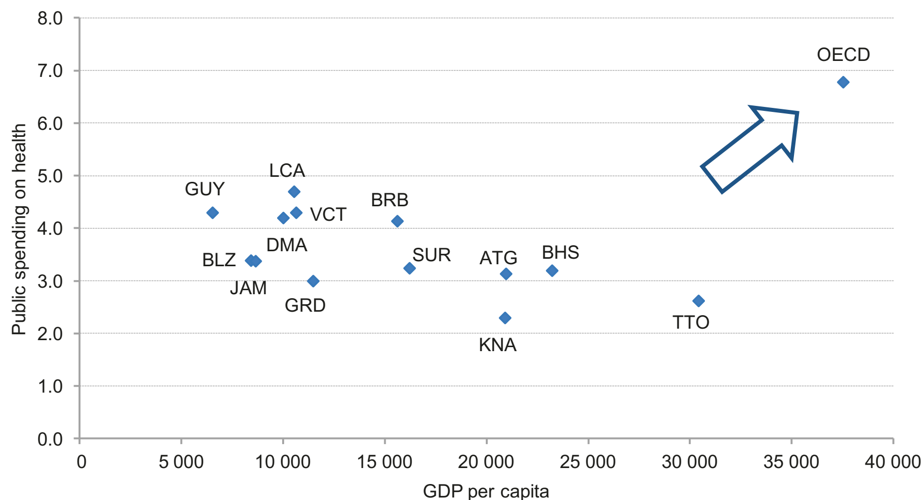
[10] OECD (Organisation for Economic Co-operation and Development) (2013), "Public spending on health and long-term care: a new set of projections", OECD Economic Policy Papers, No. 6, Paris, France, June.

persons aged 65 and over. It was projected that, after 2030, more than half of expenditure will be directed at this age group.[10]

Projections suggest that the cost of providing public health care services for an ageing population will be even greater than the cost of providing pensions.[6] It is projected that population change and economic growth will see spending on public health care services rise by an average of 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.

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. Caribbean countries continue to have two-tier health systems. On average, 59 per cent of total health expenditure is public and 41 per cent is private, three-quarters of which is out-of-pocket expenditure. Public health systems provide free primary care for older people and certain medications are available free of charge. However, there are 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.

Figure 8
Public health spending and GDP per capita, 2013
(Spending as a percentage of GDP and GDP per capita in international dollars, PPP)

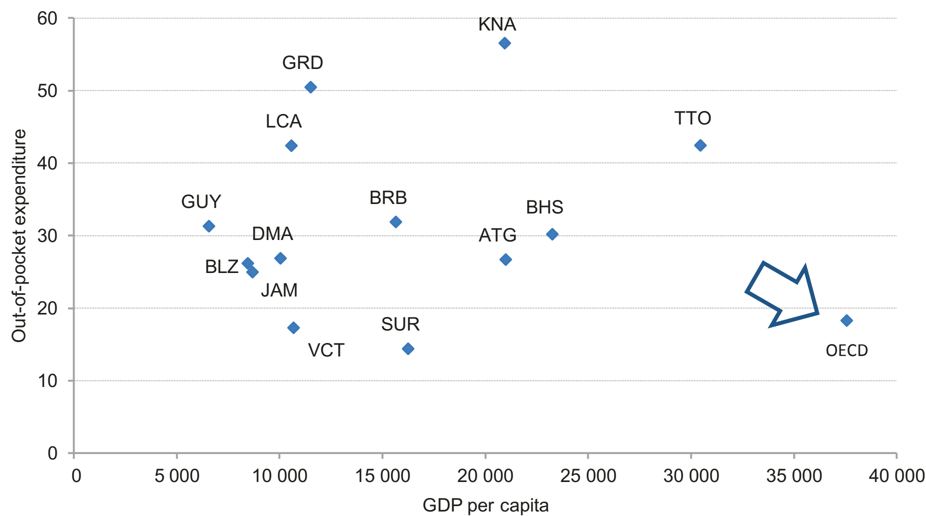


Source: National Health Accounts of the World Health Organization (WHO); Figure adapted and updated from 'Health Care Expenditure and Financing in Latin America and the Caribbean [Fact sheet] - December 2012' of the Pan American Health Organization (PAHO).
Note: The OECD average is the average of the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

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 8). Higher income Caribbean countries in particular, especially the Bahamas and Trinidad and Tobago, with GDP per capita quite close to that of at least some OECD countries, should strive to allocate a higher proportion of national income to public health services.

Figure 9
Out-of-pocket expenditure on health and GDP per capita, 2013
(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).

The 41 per cent of total health spending that is private (on average) is made up of 32 per cent out-of-pocket expenditure and 9 per cent 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. In the Caribbean, there tends to be a higher proportion of out-of-pocket expenditure in the higher income countries where the population has more disposable income. 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 9).

In addition to increasing the demand for health care services, ageing populations will require a different kind of health care, with prevention and treatment of non-communicable diseases, geriatric medicine, age-friendly services and palliative care all becoming increasingly important. A large percentage of deaths from NCDs are preventable and common, preventable risk factors underlie most NCDs. These risk factors include unhealthy eating habits, physical inactivity, obesity, tobacco and alcohol use and inadequate utilization of preventive health services.[11] Among these risk factors, obesity

[11] PAHO (Pan American Health Organization) and CARICOM (Caribbean Community Secretariat) (2006) "Report of the Caribbean Commission on health and development".

and lack of physical activity are clearly becoming more common in the Caribbean.[1211] Evidence in respect of tobacco and alcohol abuse is less clear.

To control the epidemic of non-communicable diseases, measures must be taken to reduce the risk factors such as smoke-free public places, regulation of food and cigarette labelling and advertising, provision of recreational facilities, health promotion and public education. Comprehensive and integrated treatment of NCDs should be underpinned by health information systems and evidence-based guidelines; it should include screening and health promotion; and there should sharing of tertiary treatment services.[13]

The evolving demands placed on health services will have implications for academic and in-service training of health professionals with a greater need for more geriatric specialists. Geriatric medicine differs from adult medicine due to the age-related functional decline of physiological systems. This 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. Primary health care centres need to adopt a preventative approach to these conditions, carry out screening, and implement protocols for their management.[14] In addition to the clinical treatment of older persons, the manner and location in which care is delivered is also important. For example, some older persons may need help to get to a health centre or hospital; they may have difficulties communicating or remembering instructions; and carers may need to be involved in the treatment of older patients.

IV. SOCIAL CARE SERVICES TO SUPPORT INDEPENDENT LIVING

Both globally and in the Caribbean, there is a trend towards older persons living in single generation households. Where older persons need either financial support or care, it cannot be assumed that family members will provide this. States need to support older persons in living independently through provision of services such as home help, 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 those, typically over 80 years old, who need help to continue living independently. These services include help with bathing, cleaning, cooking, shopping and companionship. In this way, older persons can continue living in their own homes, which is normally the best option to maintain an autonomous and independent life. In addition, home care is much more cost-effective than full residential care. In some countries (for example in Barbados and Saint Kitts and Nevis) basic nursing care is provided in the home. This can include dressing wounds and checking blood pressure and glucose levels. Advice on nutrition, self care, hygiene and other health issues can also be addressed. Caregivers are also trained to detect and report illnesses, cases of neglect, abuse or malnutrition.

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.

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[12] (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.

[13] Strategic Plan of Action for the Prevention and Control of Non-Communicable Diseases for countries of the Caribbean Community 2011-2015.

[14] Eldemire-Shearer, Denise (2011), "Age Friendly Primary Health Care Clinical Toolkit", Jamaica, Mona Ageing and Wellness Centre, January.

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.

These services are crucial to maintaining the independence, autonomy and dignity of frail older persons and countries should provide such services to all who need them. 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.[15] 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.

For older persons who are unable to live independently, there are public and private long-stay institutions. 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 1). 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.

Many countries have recognized the need to either pass legislation or put in place stronger enforcement mechanisms. There should be periodic inspections of residential homes with publication of key findings. 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. 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.

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 persons, and with easy access to a range of health, social and commercial services.

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[15] Cloos, Patrick and others (2009), "'Active ageing': a qualitative study in six Caribbean countries", Ageing & Society, vol. 30, 2010, Cambridge University Press (2009).

Residents have their own rooms or living space with central dining spaces and communal areas for social interaction. At present, there are relatively few assisted living facilities in the Caribbean.

Table 1
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.

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".[16] Equal participation in work, education, cultural and public life are basic human rights.

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.[17] 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.

For many older persons, the absence of accessible transport services is a huge barrier to greater social participation. Older persons should be eligible for reduced fares on buses and there should be specialised accessible transport services, like Trinidad's 'Elderly and Differently-abled Mobile (ELDAMO) Transport Shuttle' for those that need it.

[16] WHO (World Health Organization) (2002), Active Ageing: A Policy Framework (WHO/NMH/NPH/02.8), Geneva, Switzerland.

[17] 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.

V. ELDER ABUSE

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 includes physical, sexual, psychological, emotional, financial and material abuse, abandonment, neglect, and serious loss of dignity and respect. Such treatment constitutes a violation of human rights.

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.[18] 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 or are reported in the Caribbean media.

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.

Some developed countries have legislated against elder abuse and implemented preventative measures to protect older persons. In the Caribbean, there is very little legislation of this kind and elder abuse can only be dealt with under more general laws such as assault, sexual assault, domestic violence, theft, robbery, breaking and entering, and fraud. 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.

Public awareness campaigns have an important role to play in targeting the discriminatory attitudes that underlie elder abuse. 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 help lines for older persons offer an invaluable first point of contact for victims to access counselling and advice.

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[18] WHO (World Health Organization) (2014), “Elder abuse - Fact sheet N°357” Geneva, Switzerland, Updated December 2014.

VI. CONCLUSION

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 that was on the horizon but not as an immediately pressing priority. This is no longer the case. Within two decades, the Caribbean population will have changed significantly.

The provision of pensions, health and social care services for an increasing number of older persons 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 pensions, 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. At present, with a number of Caribbean countries struggling to grow their economy amidst a public debt burden, social spending has been severely constrained. However, population ageing demands greater investments in pensions schemes, health and social services in order to sustain a minimum standard of living and acceptable quality of life for a growing proportion of the population. Therefore, there must be a renegotiated settlement of intergenerational transfers between the generations, based on principles of inter-generational solidarity and sharing the costs of providing protection against the risks associated with ageing.

Equally important, 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 that disregard the contribution of older persons are wasting a valuable human resource. The human rights of older persons, and the rights-based approach increasingly adopted by the international community in its efforts to address population ageing, are fundamental to realising this transformation, emphasizing as they do freedoms to be enjoyed by all on the basis of equality and non-discrimination.