Challenges to the autonomy and interdependent rights of older persons

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ECLAC

Fourth Regional Intergovernmental Conference on **Ageing** and the **Rights** of **Older Persons** in Latin America and the Caribbean

Asunción, 27-30 June 2017

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Alicia Bárcena
Executive Secretary

Antonio Prado
Deputy Executive Secretary

Paulo Saad
Chief, Latin American and Caribbean Demographic Centre (CELADE)-Population Division of ECLAC

Ricardo Pérez
Chief, Publications and Web Services Division

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The document was prepared by Sandra Huenchuan of the Latin American and Caribbean Demographic Centre (CELADE)-Population Division of the Economic Commission for Latin America and the Caribbean (ECLAC). Daniela González, of CELADE-Population Division of ECLAC, assisted with the work and specific inputs were received from Alejandro Morlachetti, Cecilia Gallo and María Cecilia Villarroel, consultants with the Division, and Francis Jones, of the ECLAC subregional headquarters for the Caribbean.

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Foreword

The changing age structure of the population is a phenomenon that has been clearly foreseen. Today, population ageing is an ongoing, but well-established, process, with some differences between subregions and countries.

The absolute and relative increase in the number of older persons is a global trend that is affecting the economy, development planning, social policies, families, communities, large cities and indigenous localities. Given its economic and social implications, it may be the most significant change of our times.

A good indicator of ageing is the average age of the population, which in Latin America and the Caribbean will almost double between 1950 and 2050. According to estimates by ECLAC, the greatest increases in average age will occur between 2000 and 2050, when it will jump from an average of 28 to 40 years. Likewise, the population aged 60 and over will triple in size over the same period, while the population aged 15 or younger will drop from more than 30% of the total population to less than 20%. Meanwhile, longer life expectancy, as a result of the fall in mortality rates, has expanded the proportion of older persons (aged 60 or over) from 6% in 1965 to 11.8% in 2017.

Latin America and the Caribbean is on the threshold of an unprecedented change: by 2037, older persons will outnumber those under age 15. In absolute terms, the population aged 60 and over, which currently numbers some 76 million, will grow exponentially to reach 147 million by 2037 and 264 million by 2075. Nevertheless, while the region as a whole is entering a phase of rapid ageing, half the countries —among them the poorest— are still in the earliest stages of this process.

Even as the population in Latin America and the Caribbean is ageing, its numbers are stabilizing and it will stop growing around 2060. While the projections indicate a population increase to some 730 million by 2050, it is expected to be close to 690 million people by the end of the twenty-first century. Thus, by 2100, the region's population will represent almost the same percentage of the world population as it did in the 1950s (6.8%).

These two phenomena mean that there is a pressing need to adapt to an era of demographic changes. These changes are occurring faster in the region than in Europe and against a backdrop of underdevelopment, where inequality has still not been eradicated and the institutional infrastructure for the protection and exercise of human rights is inadequate.

Planning for the future based on demographic scenarios has been a long-standing priority for ECLAC since, despite the variations, it provides a framework for taking important decisions regarding the development of peoples. Combined with other factors, particularly those arising from governments' economic and social decisions, population ageing is a key element today in identifying and pursuing the reforms needed to ensure the well-being of countries and their citizens by 2030.

For more than 15 years, ECLAC has been contending that, in addition to expanding protections for the current generation of older persons —the so-called baby boomers— steps must be taken to address the needs of the cohort that will bear the financial and social costs of the main demographic changes starting in the second half of this century.

It should be borne in mind that the issues of the adult population today will have impacts on the rest of society, particularly when resources are scarce. Unless sufficient provision is made, the budgetary and technical resources necessary to attend to ageing-related issues and older persons' needs, once they become obvious, will be made to the detriment of other social groups. From this perspective, it is imperative that efforts to address older persons' needs and interests help to build an interdependent society, a society for all.

The concept of a society for all ages, which dates back to the Programme of Action adopted at the World Summit for Social Development, held in Copenhagen in 1995, advances the idea that everyone has rights and responsibilities and has an active role to play in the community. This idea is not time-bound or geographically limited and reinforces the view that present and future generations have the right to social equality and justice.

Rapid population ageing in the region brings with it multiple challenges and calls for steps to guarantee the fair distribution of resources in order to meet the needs of all age groups. It also requires a change in attitudes, policies and practices to improve older persons' quality of life. In this context, the effective inclusion of older persons has to do with equitable access to different services and social and economic benefits, as well as the guarantee of their rights.

New opportunities must be created to promote intergenerational solidarity. Physical and symbolic barriers between children, adults and older persons must be eliminated, and contact and communication among them facilitated. In today's world, family members spend much of their time in places devoted to different age groups and, as a result, a high proportion of people could live out their final years without the support they need. Hence, it is essential to move towards more inclusive societies that provide care as well as being enabling.

The likelihood of age segregation should be minimized, while adopting policies to limit the number of people who become dependent through ill-health, by promoting healthy ageing, accident prevention and rehabilitation for any illness at any age. This also means rethinking and modifying obsolete practices and institutions, and combining forces around a strategy that empowers and motivates older persons to continue to play an active role in their families and communities, both economically and socially.

This report, prepared by the Economic Commission for Latin America and the Caribbean (ECLAC), describes the current situation of older people and their human rights and provides a framework for analysis. It will serve as the basis for the discussions at the Fourth Regional Intergovernmental Conference on Ageing and the Rights of Older Persons in Latin America and the Caribbean, to be held in Asunción from 27 to 30 June 2017. It documents the main developments, limitations and challenges with regard to the exercise of older persons' human rights in the region and in the world.

Since the last Regional Conference, held in 2012, major progress has been made. At the international level, the mandate of the United Nations Open-ended Working Group on Ageing was extended and, at its seventh session, the Working Group agreed that it would focus on defining possible content for a multilateral legal instrument. In addition, the United Nations Human Rights Council established in 2013 —and extended in 2016— the mandate of the Independent Expert on the enjoyment of all human rights by older persons.

The Americas took a historic step in support of this cohort when the Inter-American Convention on Protecting the Human Rights of Older Persons was adopted in 2015. To date, the Convention has been ratified by five countries: Argentina, Chile, Costa Rica, the Plurinational State of Bolivia and Uruguay.

The Latin American and Caribbean region has played a key role in international developments, and the commitments assumed under the San José Charter on the Rights of Older Persons in Latin America and the Caribbean paved the way for the progress made in the past five years. It has undoubtedly been an auspicious period of work for governments and civil society organizations and the progress is worth celebrating.

Countries have also made progress in different policy areas. Since 2012, a number of issues related to the protection and exercise of older persons' rights have become more visible, some of which are covered in the chapters of this document.

However, this progress is still too little.

Eliminating discrimination against older people is still an unfulfilled aim. Age-based discrimination can be seen in differentiated treatment, the denial of rights or the use of stereotypical or degrading images of this social group and of its members.

Although the international community has explicitly recognized that age discrimination must be eradicated, a socially negative image of ageing and older people persists. This is partly due to the fact that the changing age structure of the population has not been accompanied by a shift in hegemonic concepts and relations. Ageing is often associated with situations of dependency, deprivation or other socially "dysfunctional" circumstances, which can reinforce negative perceptions of older people. True though it may be that old age brings with it disadvantages or losses, focusing on these alone often masks the existence of a healthy, experienced and knowledgeable population.

Age-discriminatory attitudes and practices are not only unfair; they also represent a waste of resources. Socially constructed obstacles must be eliminated in order to guarantee full respect for the dignity and equal rights of all. The right policies and attitudes in this regard will help society to make effective use of older persons' potential.

Meanwhile, in the region —and worldwide—, families still tend to be the main source of security and protection for older persons, particularly in the absence of formal mechanisms. The State must support these roles through different mechanisms that build families' capacities to decide how to best to provide care for their older members.

Strategies are needed to rethink care as something valuable and productive, a key step in ensuring that caregivers receive the recognition they deserve and the support they need to do their work without it infringing their rights and dignity.

In short, each country of the region has its own particular concerns, but a general assessment reveals that many share similar issues. While the measures adopted to address these are country-specific, certain general guidelines should steer work in this area in the coming years. As noted in this report, it is time to put into practice the different approaches to addressing the problems that older people encounter in relation to the exercise of their rights, bearing in mind the lessons learned from experiences of other parts of the world or with respect to other social groups.

The topics covered in this document were chosen on the basis of the outcomes of the work undertaken by ECLAC in the countries of the region. It does not analyse all the issues being discussed on the regional agenda today, but covers the most pressing ones. While there is undoubtedly a long road ahead, now, unlike some years ago, a legally binding instrument exists to support governments' efforts to improve the situation of older persons.

ECLAC will continue to support the governments of Latin America and the Caribbean in establishing mechanisms to implement the Inter-American Convention on Protecting the Human Rights of Older Persons and. It will also continue —as mandated by the countries of the region— to call for a United Nations instrument that provides similar protections.

In the meantime, the Fourth Regional Intergovernmental Conference on Ageing and the Rights of Older Persons in Latin America and the Caribbean will help to elevate and broaden the scope of the regional debate to promote an interdependent society, where everyone has a place and human dignity is fully respected.

Alicia Bárcena
Executive Secretary
Economic Commission for Latin America
and the Caribbean (ECLAC)

Chapter

I

Population ageing and the status of older persons in Latin America and the Caribbean

Introduction

Since the late 1960s, most Latin American and Caribbean countries have undergone profound demographic changes, which have altered the growth and age structure of the population. One of the most significant changes is the ageing of the population, as young societies gradually become mature, then aged, societies. Thus, the region's heterogeneity also has a demographic dimension, with differences among countries and, within those countries, among areas and population groups.

This chapter identifies the demographic trends in the region, as well as the main characteristics of older persons' sociodemographic status. The information presented is taken from population projections, the 2010 census round and household surveys, among other sources.

A. The major demographic trends

1. Fertility rate declines to replacement level

The hallmark of demographic change in the second half of the twentieth century was its declining fertility rate. Between 1965 and 1970, the regional fertility rate was very high (5.5 children per woman) compared with the global figure, but has fallen to rates just below replacement level (2.05 children) for the period 2015-2020 (see table I.1).

A multitude of determining factors underlies this profound sociodemographic change. One is the relatively steady increase in per capita gross domestic product (GDP) until the early 1970s, which led to significant social changes, such as the expansion of the middle and wage-earning classes, the expansion of compulsory education and rapid urbanization. Changes to economic and social structures brought about a series of cultural shifts, which in turn led to the adoption of reproductive behaviour patterns in line with a smaller family model, facilitated by the availability of contraceptives.

Another factor in the decision to have fewer offspring has been the change in children's status in new social, economic and cultural contexts. Rising female participation in the labour market appears to have become, at least among the middle and higher strata, incompatible with a strictly domestic role. Another significant factor is the effect of lower infant mortality rates, since children's improved chances of surviving infancy could well have given reasons to avoid additional pregnancies (Villa and González, 2004).

In addition to being rapid and precipitous, the fall in fertility rates spread quickly to nearly all countries. The decline considerably lowered population growth, although this effect has since been attenuated. Conversely, the effects of the decline in fertility on the age structure of the population can still be seen and will be felt for several years to come.

The onset of the decline in fertility, the periods of most rapid change and the moment when the replacement level was reached in the various subregions and countries of the region have all been different. These differences will result in variations in the size and relative weight of the different generations in the total population in the future and, therefore, in the onset, size and duration of the demographic dividend and ageing.

On average, in the period 2015-2020 a person aged 60 has 22.4 years left to live in the region. Survival rates differ by sex: women outlive men by an average of 3.2 years.

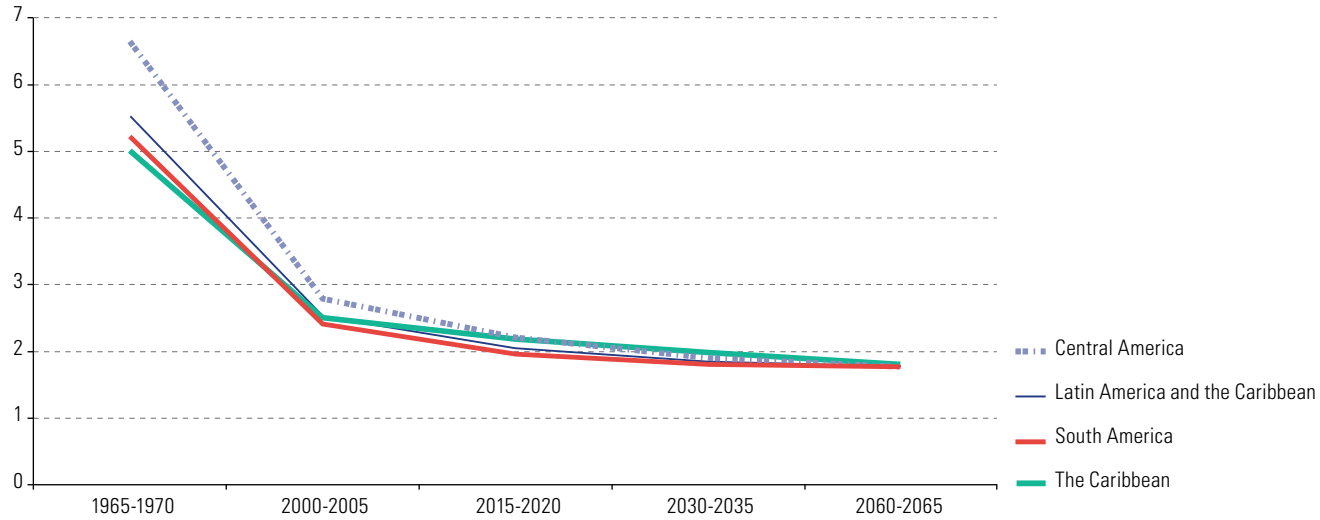
Table I.1
Latin America and the Caribbean: total fertility rate by country and subregion, 1965-2065
(Number of children per woman)

Country	1965-1970	2000- 2005	2015-2020	2030-2035	2060-2065
Latin America and the Caribbean	**5.53**	**2.52**	**2.05**	**1.85**	**1.77**
The Caribbean	**5.01**	**2.50**	**2.19**	**1.98**	**1.80**
Antigua and Barbuda	4.00	2.27	2.03	1.91	1.83
Bahamas	3.58	1.87	1.83	1.76	1.77
Barbados	3.53	1.75	1.80	1.83	1.86
Cuba	4.30	1.64	1.58	1.60	1.72
Grenada	4.80	2.43	2.08	1.85	1.75
Dominican Republic	6.65	2.83	2.38	2.03	1.78
Haiti	6.00	4.00	2.85	2.32	1.87
Jamaica	5.78	2.45	1.99	1.82	1.78
Saint Lucia	6.48	2.10	1.82	1.66	1.70
Saint Vincent and the Grenadines	6.41	2.24	1.90	1.71	1.72
Trinidad and Tobago	3.81	1.75	1.73	1.68	1.74
Central America	**6.65**	**2.79**	**2.21**	**1.90**	**1.77**
Belize	6.35	3.35	2.46	2.10	1.80
Costa Rica	5.26	2.17	1.76	1.66	1.73
El Salvador	6.36	2.62	1.87	1.69	1.69
Guatemala	6.30	4.16	3.03	2.50	2.00
Honduras	7.42	3.63	2.25	1.90	1.73
Mexico	6.75	2.63	2.14	1.82	1.73
Nicaragua	6.95	2.84	2.16	1.85	1.73
Panama	5.41	2.61	2.36	2.08	1.86
South America	**5.22**	**2.41**	**1.96**	**1.81**	**1.77**
Argentina	3.05	2.52	2.27	2.07	1.88
Bolivia (Plurinational State of)	6.41	3.82	2.83	2.39	1.96
Brazil	5.38	2.25	1.74	1.65	1.71
Chile	4.46	2.00	1.73	1.70	1.76
Colombia	6.18	2.30	1.83	1.67	1.71
Ecuador	6.40	2.88	2.44	2.12	1.82
Guyana	5.28	2.95	2.47	2.19	1.89
Paraguay	6.15	3.24	2.45	2.13	1.84
Peru	6.70	2.80	2.35	2.02	1.78
Suriname	5.94	2.71	2.28	2.00	1.81
Uruguay	2.80	2.20	1.98	1.87	1.82
Venezuela (Bolivarian Republic of)	5.90	2.72	2.28	2.00	1.80

Source: United Nations, "World Population Prospects: The 2015 Revision, Key Findings and Advance Tables", *Working Paper*, No. 241 (ESA/P/WP.241), New York, Population Division, 2015 [online] http://esa.un.org/unpd/wpp/.

Fertility began to decline relatively early in the Caribbean and South America, with rates in most countries already starting to fall by the end of the 1960s (see figure I.1 and table I.1). However, in some Central American countries, such as Belize and Guatemala, rates did not start to fall until the 1980s. In all three subregions there were some countries where fertility plummeted: Cuba and Barbados already had fertility rates below replacement level by the early 1980s, a phenomenon that spread to Antigua and Barbuda, Brazil, Chile, Colombia, Costa Rica, El Salvador, Mexico, Panama, and Trinidad and Tobago early in the twenty-first century (ECLAC, 2016).

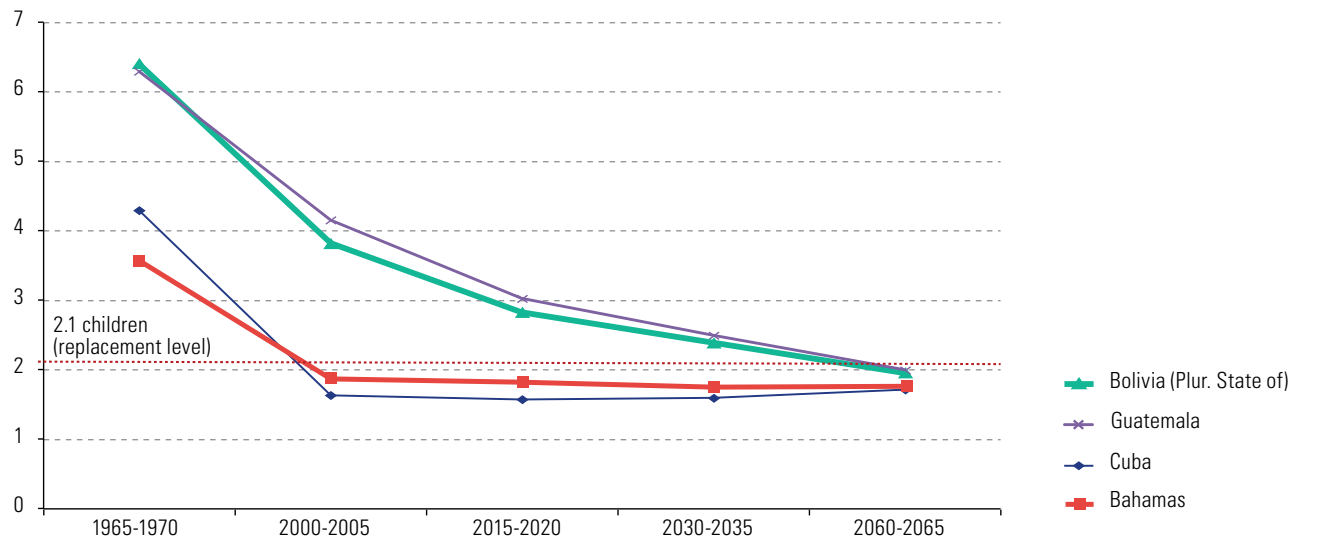
Figure I.1
Latin America and the Caribbean: total fertility rate by subregion, 1965-2065
(Number of children per woman)



Source: United Nations, "World Population Prospects: The 2015 Revision, Key Findings and Advance Tables", *Working Paper*, No. 241 (ESA/P/WP.241), New York, Population Division, 2015 [online] http://esa.un.org/unpd/wpp/.

According to population projections by the United Nations (2015b), the fertility rate is expected to stabilize, dropping below replacement level for a long time. Rapid convergence suggests that almost all countries in the region will reach this level by 2050. However, different national trends mean that it will stabilize at very different rates. Thus, two countries that are lagging behind in the demographic transition, the Plurinational State of Bolivia and Guatemala, will reach this level between 2050 and 2055 and between 2055 and 2060, respectively, or some 70 or 75 years after the Bahamas and Cuba (see figure I.2). Like the regional average, fertility rates in all countries will continue to fall below replacement level in the next 15 to 30 years, before the trend is reversed (ECLAC, 2016).

Figure I.2
Latin America and the Caribbean (selected countries): total fertility rate, 1965-2065
(Number of children per woman)



Source: United Nations, "World Population Prospects: The 2015 Revision, Key Findings and Advance Tables", *Working Paper*, No. 241 (ESA/P/WP.241), New York, Population Division, 2015 [online] http://esa.un.org/unpd/wpp/.

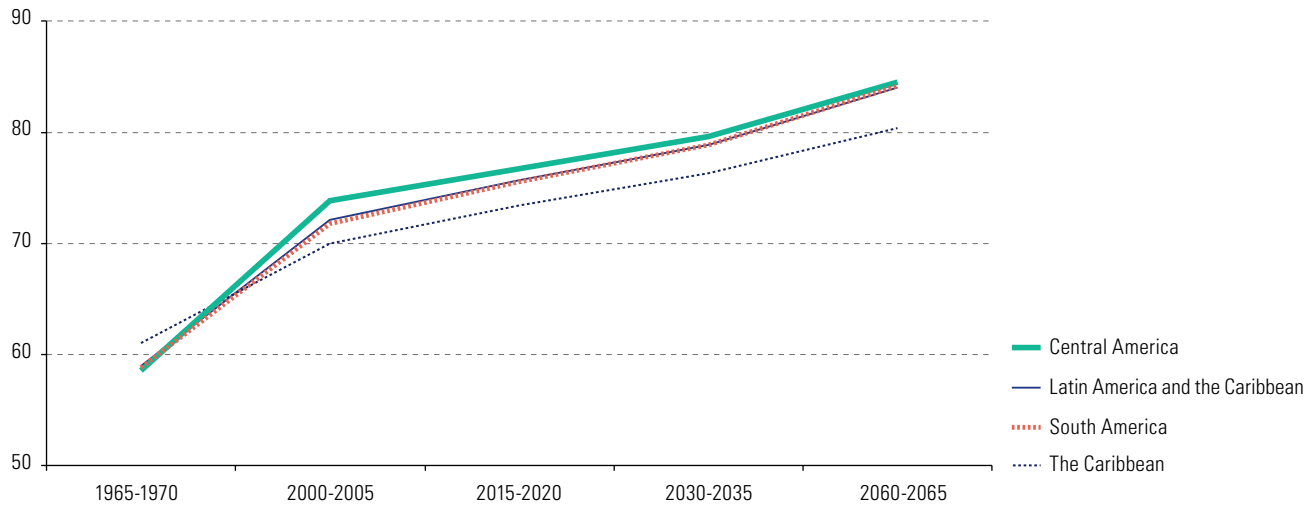
2. Longer life expectancy

As in developed countries, the start of the demographic transition in the region was linked to the decline in the mortality rate. However, unlike in Europe, the fall in the mortality rate in Latin America and the Caribbean was triggered by the declining infant mortality rate. This change was mainly the result of socioeconomic and cultural shifts, improved living conditions, an increasingly urbanized population, higher education levels, the availability of health-care technology and successful policies. The result was an unprecedented breakthrough in the control of infectious and parasitic diseases, and treatment of maternal, perinatal and nutritional problems (DiCesare, 2011; ECLAC, 2008 and 2015). The epidemiological shift benefited mainly the younger population, women and children, which led to significant demographic changes, in particular a large increase in life expectancy at birth, due initially to the decrease in infant mortality and later to the drop in mortality at other ages.

Life expectancy has increased steadily over the past century and continues to rise today. From an average of some 59 years in 1965-1970, life expectancy rose to almost 76 years between 2010 and 2015. On average, people have gained 17 years of life in the last 55 years, which is almost 1.5 more years every five years. However, the regional average is equal to that of developed countries some 25 years ago (ECLAC, 2008). Life expectancy improved in all countries, but considerable differences remain among countries and among the subregions, which are unacceptable in the light of the epidemiological and socioeconomic gains (see figure I.3 and table I.2).

Major differences remain between the more and less developed countries within the subregions —Central America (10 years) and the Caribbean and South America (16 years)— revealing substantial disparities in health conditions. Chile and Haiti have the region's highest and lowest life expectancies (83 and 64 years, respectively). In the Caribbean, lifespan dispersion has not changed significantly since the end of the 1960s, but, if the Dominican Republic and Haiti are excluded, the lifespan dispersion of the other countries has increased: the gap widens from 7 years to 9 years. Something similar occurs in South America: if the Plurinational State of Bolivia is excluded, dispersion shrinks by just one year, from 17 to 16 years. In Central America, dispersion narrowed, with the gap between the two extremes dropping from more than 15 years to 10.

Figure I.3
Latin America and the Caribbean: life expectancy at birth by subregion, 1960-2065
(Years)



Source: United Nations, "World Population Prospects: The 2015 Revision, Key Findings and Advance Tables", *Working Paper*, No. 241 (ESA/P/WP.241), New York, Population Division, 2015 [online] http://esa.un.org/unpd/wpp/.

Table I.2
Latin America and the Caribbean (31 countries): life expectancy at birth by subregion and country, 1965-2065
(Years)

	1965-1970	2000-2005	2015-2020	2030-2035	2060-2065
Latin America and the Caribbean	**58.95**	**72.15**	**75.71**	**78.88**	**84.03**
The Caribbean	**61.01**	**69.97**	**73.45**	**76.32**	**80.41**
Antigua and Barbuda	65.04	74.02	76.67	79.16	84.01
Bahamas	65.22	73.18	75.96	78.37	83.23
Barbados	64.59	73.75	76.17	78.60	83.32
Cuba	68.48	77.16	80.04	82.66	86.71
Dominican Republic	56.91	71.09	74.08	76.55	81.10
Grenada	63.00	70.89	73.89	76.04	80.57
Haiti	46.21	58.34	63.85	67.80	73.42
Jamaica	67.61	72.78	76.11	78.19	82.53
Saint Lucia	61.57	72.07	75.57	77.80	82.27
Saint Vincent and the Grenadines	63.94	70.71	73.29	74.98	78.61
Trinidad and Tobago	64.77	68.67	70.74	72.33	75.90
Central America	**58.57**	**73.87**	**76.76**	**79.61**	**84.52**
Belize	64.26	68.52	70.46	72.35	76.28
Costa Rica	65.17	77.81	80.10	82.75	86.62
El Salvador	53.91	69.60	73.87	77.03	82.37
Guatemala	50.11	69.02	72.64	75.65	80.66
Honduras	51.03	70.96	73.84	76.51	81.43
Mexico	60.29	74.89	77.50	80.35	85.36
Nicaragua	51.96	70.92	75.90	79.43	84.79
Panama	64.35	75.54	78.18	80.70	84.88
South America	**58.82**	**71.76**	**75.59**	**78.88**	**84.15**
Argentina	65.80	74.34	76.92	79.55	84.33
Bolivia (Plurinational State of)	44.70	62.11	69.58	73.83	79.33
Brazil	57.97	71.10	75.42	79.04	84.56
Chile	61.46	77.87	82.67	85.60	89.74
Colombia	60.07	71.67	74.73	77.57	82.83
Ecuador	56.78	73.62	76.72	79.87	85.05
Guyana	61.55	65.28	66.75	68.30	71.45
Paraguay	65.04	70.75	73.19	74.75	78.42
Peru	51.49	71.61	75.50	79.06	84.76
Suriname	62.42	68.08	71.56	73.58	77.74
Uruguay	68.55	75.33	77.75	80.03	84.38
Venezuela (Bolivarian Republic of)	63.27	72.82	74.88	77.60	82.74

Source: United Nations, "World Population Prospects: The 2015 Revision, Key Findings and Advance Tables", *Working Paper*, No. 241 (ESA/P/WP.241), New York, Population Division, 2015 [online] http://esa.un.org/unpd/wpp/.

On average in the region, women are expected to live nearly seven years more than men, a figure that is close to that of the most developed countries (United Nations, 2015b). In the Bolivarian Republic of Venezuela, Colombia, El Salvador and Guatemala, that difference is greater, fluctuating between seven and more than nine years, which could be linked to excess male mortality due to violence. This difference is expected to decrease as the incidence of some epidemiological risks evens out between men and women.

3. Life expectancy after age 60

Another important feature of longer life expectancy is that older persons are living longer, with a systematic increase in the life expectancy of those aged 60. Between 2015 and 2020, a 60-year-old in the region has, on average, another 22.4 years left to live (see table I.3). There are of course gender differences; women live 3.2 years longer than men in this age group. People aged 60 in Chile, Costa Rica, Cuba and Panama have the longest life expectancy, ranging from 23 to 26 years. The life expectancy of

older persons will continue to increase; by 2030-2035, 60-year-olds can expect to live another 24 years and by 2060-2065, another 27 years.

On average, women will continue to live longer than men, although there will be differences between countries. By 2030-2035, the largest gender gap (five years) will be in Argentina, Trinidad and Tobago and Uruguay, and the smallest (two years) in Haiti and Guyana. By 2060-2065, the difference between women and men will be four years in Argentina, Belize, Chile, Suriname, Trinidad and Tobago, and Uruguay.

Table I.3
Latin America and the Caribbean: life expectancy at age 60 by sex and subregion, 2015-2065
(Years)

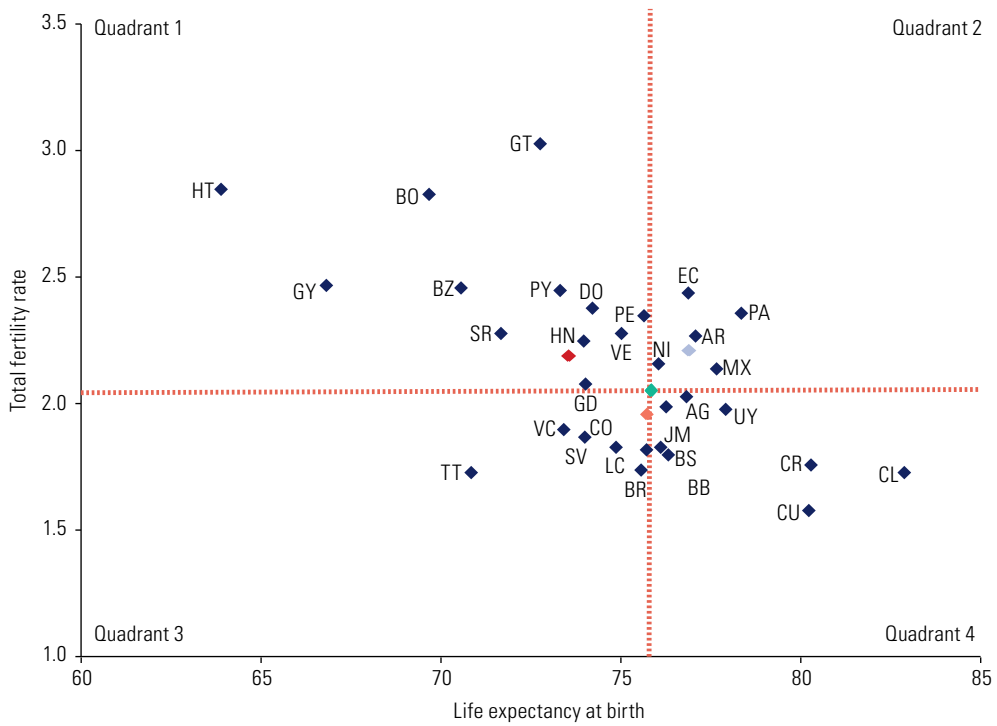
	2015-2020			2030-2035			2060-2065		
	Men	Women	Both sexes	Men	Women	Both sexes	Men	Women	Both sexes
Latin America and the Caribbean	20.7	23.9	22.4	22.2	25.6	24.0	25.7	28.3	27.0
The Caribbean	20.8	23.7	22.3	22.2	25.0	23.6	23.9	26.6	25.3
Central America	22.0	24.1	23.1	23.4	25.6	24.5	26.7	28.3	27.5
South America	20.2	23.9	22.2	21.9	25.6	23.8	25.4	28.5	27.0

Source: United Nations, "World Population Prospects: The 2015 Revision, Key Findings and Advance Tables", *Working Paper*, No. 241 (ESA/P/WP.241), New York, Population Division, 2015 [online] http://esa.un.org/unpd/wpp/.

4. Countries' position in the demographic transition

Fertility and mortality trends place countries at different stages of the demographic transition. Because the changes have varied in pace and intensity, the countries are at different stages of the transition in the current five-year period (2015-2020). Figure I.4 shows the levels of the total fertility rate in the countries and their life expectancy at birth, revealing which countries are the most advanced and which are furthest behind in the demographic transition.

Figure I.4
Latin America and the Caribbean: total fertility rate and life expectancy at birth, 2015-2020
(Children per woman and years)



Source: United Nations, "World Population Prospects: The 2015 Revision, Key Findings and Advance Tables", *Working Paper*, No. 241 (ESA/P/WP.241), New York, Population Division, 2015 [online] http://esa.un.org/unpd/wpp/.

While gross birth and mortality rates are traditionally used to study the demographic transition, these rates are known to be affected mainly by the age structure of the population and other spurious factors, so they do not reveal the true extent of the transition. To overcome these problems two rates are used: the total fertility rate, which indicates the average number of children per woman, and life expectancy at birth, which is the average number of years that the population born in a specific year will live.

The countries located in quadrant 1 of figure I.4 are those that are furthest behind the regional average (75.7 years of life expectancy at birth and 2.05 children per woman), as they have high total fertility rates and low life expectancies at birth. In this group, Guatemala, Haiti and the Plurinational State of Bolivia are the furthest behind in the transition. The rest of the countries in this quadrant show a smaller lag, with a fertility rate above replacement level, but fewer than 2.5 children per woman and a life expectancy at birth of more than 70 years and in some cases very close to the regional average.

Quadrant 2 contains those countries that have fertility rates at or near replacement level, but life expectancies higher than the regional average (Argentina, Ecuador, Mexico, Nicaragua and Panama). Six countries (Brazil, Colombia, El Salvador, Saint Lucia, Saint Vincent and the Grenadines, and Trinidad and Tobago) are in quadrant 3, as they have total fertility rates lower than replacement level and life expectancy lower than the regional average. Quadrant 4 contains the countries furthest ahead in the demographic transition, notably Chile, Costa Rica and Cuba, which have the lowest fertility rates, fewer than 1.8 children per woman, and life expectancy at birth of more than 80 years.

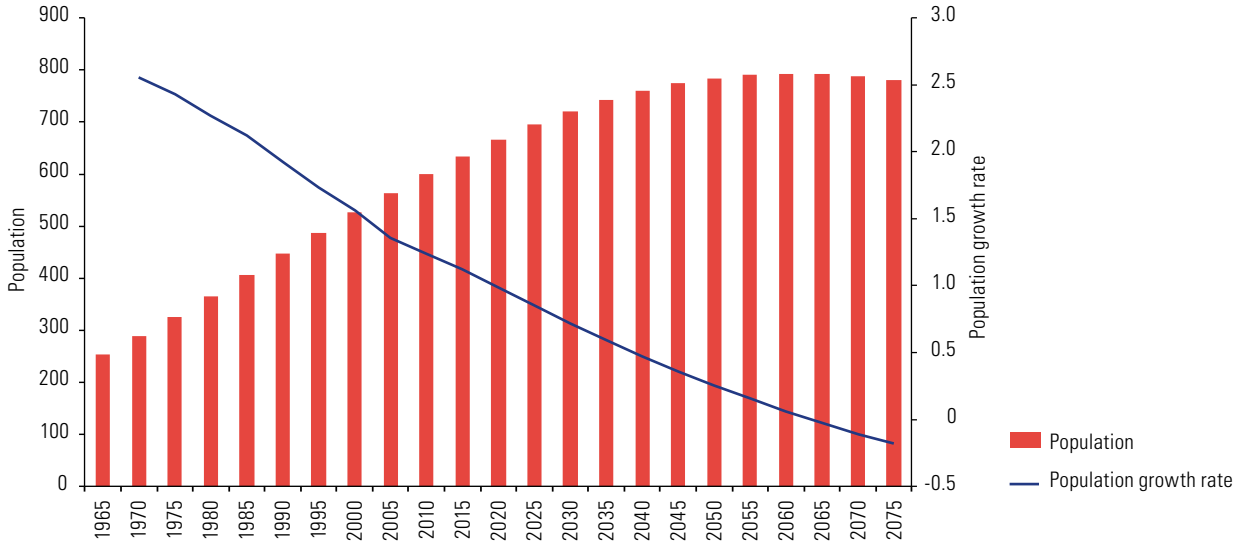
This snapshot of the demographic transition in countries for the period 2015-2020 shows the consolidation of the process in the region. The upper limits of the fertility and mortality rates are clearly much lower than in previous decades and, except for those countries that are relatively further behind in the transition, the old picture of dispersion has been replaced by apparent convergence. However, it should be borne in mind that these national figures mask heterogeneities within countries, mainly between urban and rural areas, and among socioeconomic strata and ethnic groups.

5. The population will continue to grow until the middle of the century

Figure I.5 shows the increase in the population in absolute terms since 1965 and projections up to 2075. At the beginning of the period, Latin America and the Caribbean had a population of 254 million; in 2017, the total was 648 million, and it is expected to continue to grow in absolute terms, peaking at 793 million in 2060, after which it will start to decline in absolute terms (United Nations, 2015b).

Figure I.5 also shows the population growth rate, which indicates how quickly the population has increased. The average annual growth rate has been declining over the decades. While the population grew at an average annual rate of 2.6% between 1965 and 1970, by 2015-2020 the growth rate is down to 1% and will continue to slow over the next 15 years, reaching 0.6%. This does not mean that the population decreased in absolute terms, but rather, as the figure shows, that its growth has slowed more and more and will continue to do so. The growth rate of the region's population is expected to turn negative (-0.03%) in 2060-2065, coinciding with the start of the decline in absolute population figures, since the population will peak in 2060 and begin to shrink thereafter.

Figure I.5
Latin America and the Caribbean: population and population growth rates, 1965-1975
(Millions and per 100)



Source: United Nations, "World Population Prospects: The 2015 Revision, Key Findings and Advance Tables", *Working Paper,* No. 241 (ESA/P/WP.241), New York, Population Division, 2015 [online] http://esa.un.org/unpd/wpp/.

Population growth rates continue to vary significantly owing to the different stages that countries have reached in the demographic transition. For the period 2015-2020, population growth rates are less than 0.5% in the countries at advanced stages of the demographic transition, although in Cuba the rate will be negative (-0.04%), while the countries in the early stages of the transition have population growth rates above 1.5%. This growth will not be directly related to the fertility rate, but to demographic inertia, i.e. the tendency for population growth to continue beyond the time that replacement-level fertility has been achieved because of the change in age structure, as a large cohort will be of childbearing age (ECLAC, 2008).

B. The impact of demographic change

The impact of demographic change can be seen from the two perspectives: its effects on individuals and populations. If the analysis focuses on individuals, the effects include higher survival rates, resulting from the fall in the mortality rate, which means higher costs to ensure good health and well-being over the course of a longer life cycle, and declining fertility rates, which have allowed women to devote less time to raising children and participate more in economic life, increasing their autonomy and well-being at home. The main consequences for populations are declining population growth and, perhaps the most significant now and in the medium and long terms, the changing age structure, which leads to population ageing as young societies gradually become mature, then aged.

1. The young population declines and the older population increases

As the demographic transition progresses in the region, mortality and fertility rates are reaching low or very low levels, lessening their direct impact on natural population growth, as mentioned in section A. These developments are, however, having a

profound and far-reaching effect on the population age structure as generations from the different phases of demographic change progress through their life cycle. Since the 1960s, the population age structure of Latin American and Caribbean countries has undergone major changes, shifting from a relatively young population at that time to one that is now starting to age rapidly (see figure I.6). The weight of the population aged under 20 (estimate for the school-age population) started to decrease at the end of the 1960s. As large cohorts of those born before that decade were reaching working age, the weight of the potentially active population (20 to 64 years) began to increase, giving rise to the demographic dividend.

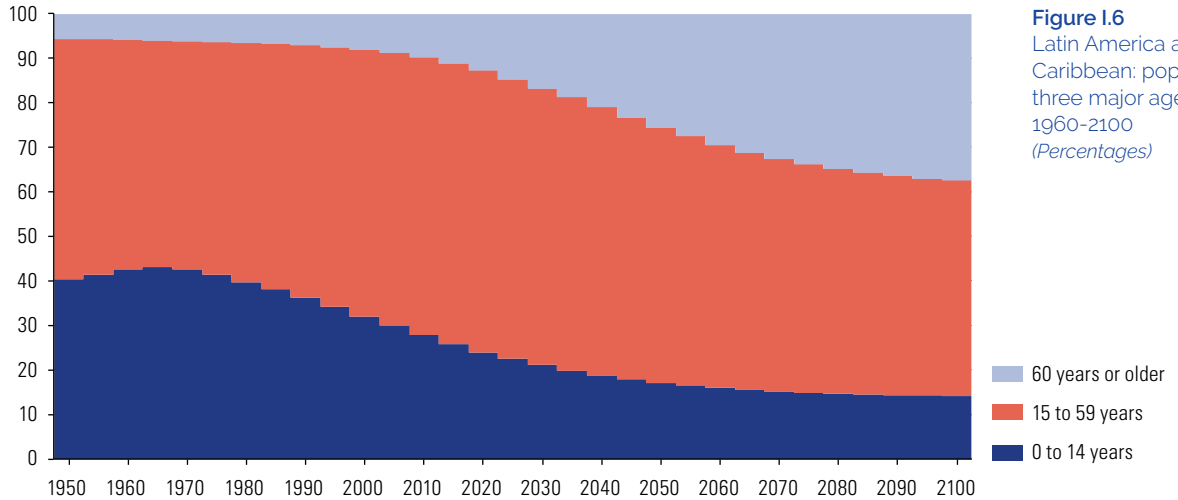


Figure I.6
Latin America and the Caribbean: population by three major age groups, 1960-2100
(Percentages)

Source: United Nations, "World Population Prospects: The 2015 Revision, Key Findings and Advance Tables", *Working Paper,* No. 241 (ESA/P/WP.241), New York, Population Division, 2015 [online] http://esa.un.org/unpd/wpp/.

Moreover, longer life expectancy, owing to decreasing mortality rates, increased the proportion of older persons (60 or older) in the region, which rose from 6% in 1965 to 11.8% in 2017.

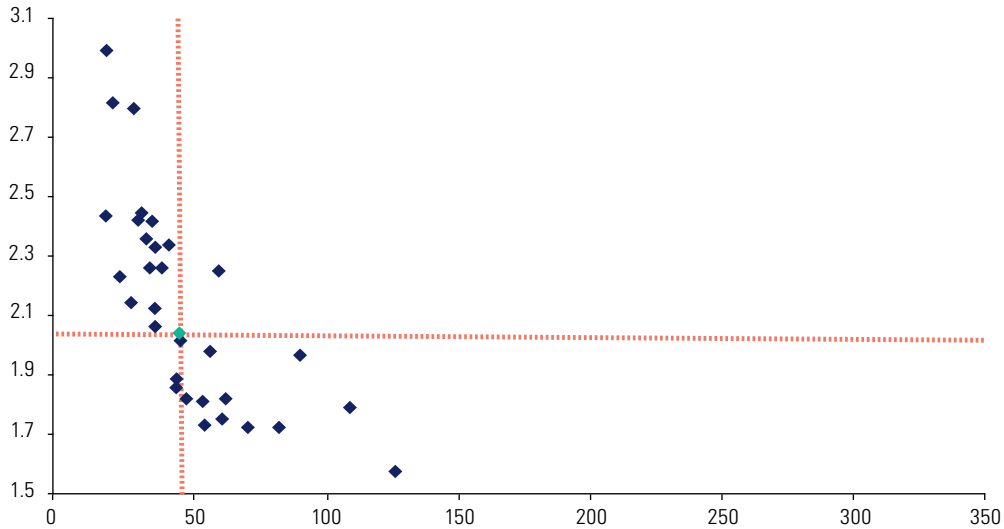
Although this proportion may seem small, it shows that the population has already entered the phase of accelerated growth (accelerated ageing). At this rate, the region will hit an important milestone in 2037, when the proportion of older persons will be equal to that of young people aged under 25 (20%). In absolute terms, the population aged under 15 is the only group that is decreasing. The downtrend began in 2005, when the youth population reached 168.5 million. The working-age population (those aged 15-59) became the largest population group in 1985, when it reached 224 million, marking the start of the relative predominance of that age group. This group will continue to grow until more than doubling by 2040, when it will peak at 458 million. The population aged 60 or older, some 76 million people, will experience a period of strong growth to reach 147 million —overtaking the young population— by 2037, and 264 million by 2075. Although Latin America and the Caribbean is entering an accelerated ageing phase, this process is still incipient in half of the countries.

2. Different stages of the ageing process

Countries are currently at different stages of the ageing process owing to the heterogeneous progress in the demographic transition in the region. However, in recent decades, population ageing has become consolidated in several countries, while in others the first signs are just beginning to be seen.

The countries' positions in figure I.7 are based on two indicators that reveal the extent of population ageing. One is the total fertility rate and the other is the ageing index.[1] The average fertility rate for the region is slightly below replacement level (2.05 children per woman) and the region's ageing index is 47.2 people aged 60 or older per 100 young people aged under 15.

Figure I.7
Latin America and the Caribbean: total fertility rate and ageing index, 2015-2020
(Number of children per woman and percentages)



Source: United Nations, "World Population Prospects: The 2015 Revision, Key Findings and Advance Tables", *Working Paper*, No. 241 (ESA/P/WP.241), New York, Population Division, 2015 [online] http://esa.un.org/unpd/wpp/.

Eighteen countries are currently below the regional average: Belize, Guatemala and Haiti are at an early stage of the ageing process with total fertility rates higher than 2.7 children per woman and ageing indexes that do not exceed 20 older persons per 100 young people aged under 15. Further along in the process are 13 countries (Bolivarian Republic of Venezuela, Dominican Republic, Ecuador, Grenada, Guyana, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Plurinational State of Bolivia and Suriname), which have total fertility rates between replacement level and 2.8 children per woman, and ageing indexes between 25 and 43 older persons per 100 young people aged under 15. Eight countries are at a moderately advanced stage (Antigua and Barbuda, Argentina, Brazil, Colombia, El Salvador, Jamaica, Saint Lucia and Saint Vincent and the Grenadines), with total fertility rates between replacement level and 1.8 children per woman, and ageing indices between 46 and 62 older persons per 100 young people aged under 15. Five countries are at an advanced stage of the ageing process (Bahamas, Chile, Costa Rica, Trinidad and Tobago, and Uruguay), with fertility rates below replacement level and ageing indices between 63 and 93 older persons per 100 young people aged under 15. Lastly, Barbados and Cuba have reached a very advanced stage of the process, since they have fertility rates —like the previous group— below replacement level, but an older population that outnumbers the under-15s, with ageing indices of 128 and 111 persons aged over 60 per 100 young people, respectively.

In less than 15 years, population ageing will be an increasingly widespread phenomenon in the region. By 2030, Belize, Guatemala and Haiti will continue to lag behind, although their total fertility rates will be approaching replacement level and their ageing indices are projected to be slightly higher, but will not exceed 34 older persons per 100 young people aged under 15. Seven countries (Dominican Republic, Ecuador, Guyana, Honduras,

[1] The ageing index expresses the ratio between the number of older persons and the number of children and young people, and is calculated by dividing the number of people aged 60 or older by the number of people under 15, multiplied by 100.

Nicaragua, Paraguay and Plurinational State of Bolivia) will still be at an intermediate stage of the process, with total fertility rates at or slightly below replacement level and ageing indices ranging from 40 to 59 people aged 60 or older per 100 under-15s. Twelve countries (Antigua and Barbuda, Argentina, Bolivarian Republic of Venezuela, Colombia, El Salvador, Grenada, Jamaica, Mexico, Panama, Peru, Saint Vincent and the Grenadines and Suriname) will be around the regional average, with fertility rates lower than replacement level, but with ageing indices falling short of 100, placing them at a moderately advanced stage of population ageing. Six countries will have reached an advanced stage of population ageing (Bahamas, Brazil, Costa Rica, Saint Lucia, Trinidad and Tobago, and Uruguay). Here, older persons will outnumber children, as the ageing index will be higher than 100. Barbados, Chile and Cuba will be at a very advanced stage of the process, with Cuba maintaining a sizeable lead, with a projected ageing index of 232 over-60s per 100 under-15s.

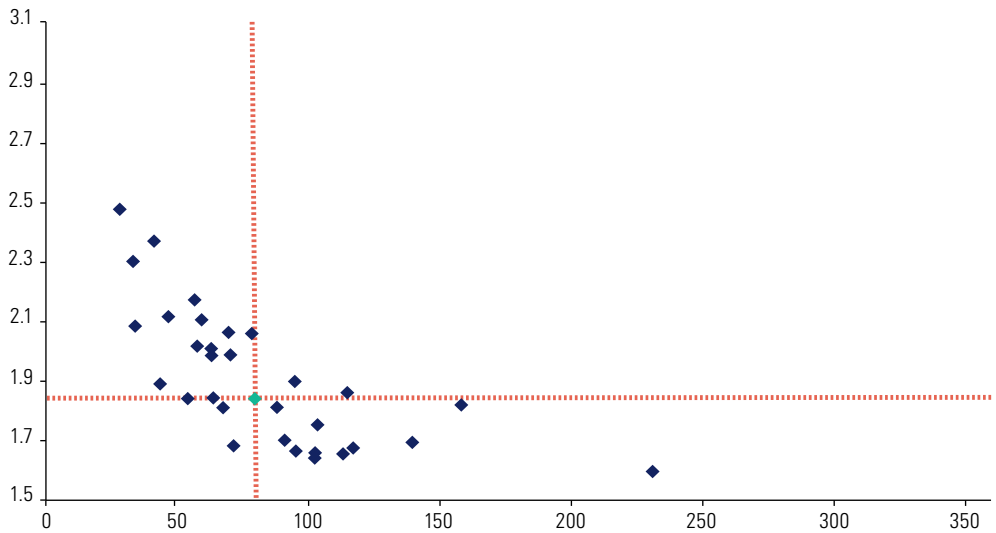


Figure I.8
Latin America and the Caribbean: total fertility rate and ageing index, 2030-2035
(Number of children per woman and per 100)

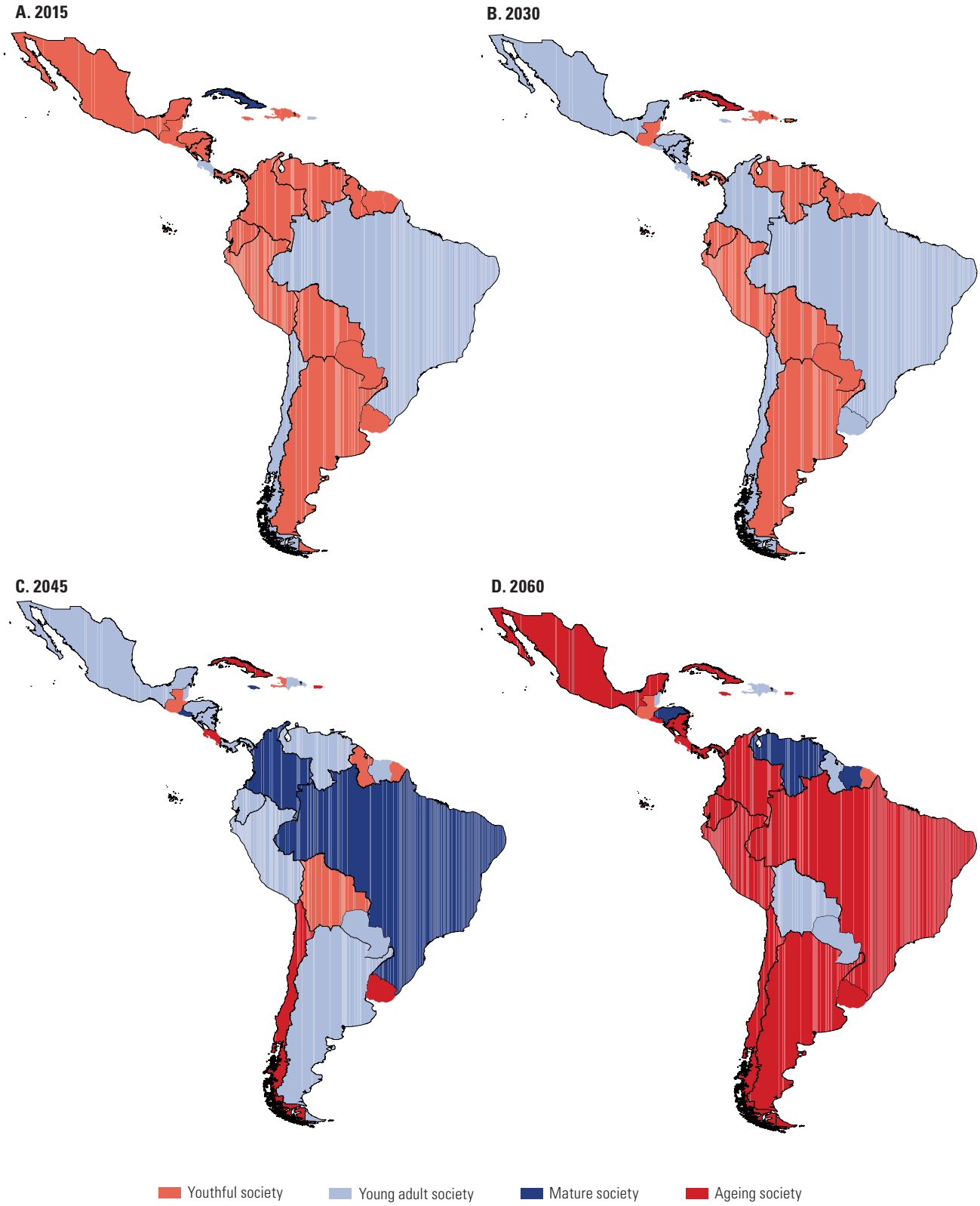
Source: United Nations, "World Population Prospects: The 2015 Revision, Key Findings and Advance Tables", *Working Paper*, No. 241 (ESA/P/WP.241), New York, Population Division, 2015 [online] http://esa.un.org/unpd/wpp/.

Projections indicate that the populations of all the region's countries will be ageing by 2060. Some will continue to lag behind, but 27 countries will have more older persons than children aged under 15. Cuba will continue to lead the field, although Brazil, Chile and Costa Rica will be close behind.

2. Towards aged societies and economies

The rapid ageing of the population will become the most significant demographic trend in the region. When that happens, age structure changes will be dominated by the needs of older generations, making ageing and its impact on social demands the most influential demographic phenomena. Age structure changes follow a particular sequence. This is illustrated by analysing the evolution of the population in four main age groups: 0-19 (children and adolescents), 20-39 (young adults), 40-59 (adults) and persons aged 60 or over (older people). Historically, the predominant population group in the region has been children and adolescents, aged 0-19. However, the year 2023 is projected to mark the end of the youthful society in the region, with the group aged 20-39 becoming the largest population segment. In 2045, the population aged 40-59 is expected to exceed those aged 20-39, giving rise to a more mature society. Seven years later, in 2052, those aged 60 or over will become the predominant group, ushering in the era of an aged society (see map I.1).

Map I.1
Latin America and the Caribbean: changing age structures of the population, 2015-2060



Source: United Nations, "World Population Prospects: The 2015 Revision, Key Findings and Advance Tables", *Working Paper*, No. 241 (ESA/P/WP.241), New York, Population Division, 2015 [online] http://esa.un.org/unpd/wpp/.

As the different age groups successively become the predominant one, the structure of the population's economic and social demands and contributions changes. This requires the redistribution of financial resources, with a shift in priorities from the needs of children and adolescents (education) to those of older people (health, care and pensions). The point at which the financial resources consumed by older persons exceed those consumed by children and adolescents marks the beginning of an ageing economy.

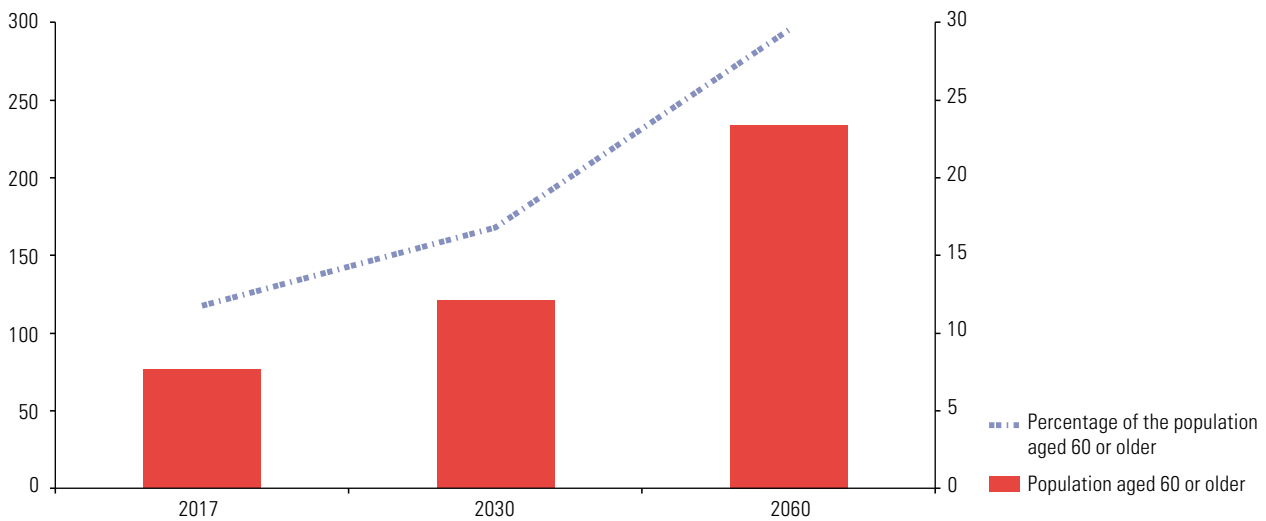
In 1985, children and adolescents consumed between five and eight times more resources than older persons in most countries in the region. By 2015, there was a significant shift towards consumption by older persons in most countries. Cuba became the region's first ageing economy in 2010. Between 2015 and 2030, five other countries will join that category: Uruguay (2017), Chile (2020), Costa Rica (2025), Brazil (2028) and Colombia (2030). After 2030, nearly all the economies of the region will become ageing economies: Mexico (2037), Argentina (2037), El Salvador (2038), Panama (2038), Peru (2040), Nicaragua (2042), the Bolivarian Republic of Venezuela (2042), Ecuador (2044), the Dominican Republic (2045), Honduras (2047), Paraguay (2051), the Plurinational State of Bolivia (2057) and Haiti (2060).

C. Sociodemographic status of older persons

1. Size and structure of the population by sex and age

According to United Nations estimates and projections, Latin America and the Caribbean will have 76.3 million older persons in 2017, representing 11.8% of the regional population. By 2030, this population will reach 121 million, or 17% of the total population of the region. By 2060, when practically all the countries of the region will have an ageing population, older persons will make up 30% of the regional population, numbering some 234 million (see figure I.9 and annex tables I.A1.1 and I.A1.2).

Figure I.9
Latin America and the Caribbean: number and proportion of persons aged 60 or older, 2017-2060
(Millions and percentages)



Source: United Nations, "World Population Prospects: The 2015 Revision, Key Findings and Advance Tables", *Working Paper,* No. 241 (ESA/P/WP.241), New York, Population Division, 2015 [online] http://esa.un.org/unpd/wpp/.

As shown in figure I.9, the absolute and relative growth in the number of people aged 60 or older will be very rapid. Between 2017 and 2030 this group will expand an annual average rate of 3.5%, well above the total population growth rate discussed above. Growth in this age group will be even faster in the period 2030-2060, with an average annual rate of 5.1%.

Since the population ageing process began in the region, women have outnumbered men among older persons and projections indicate that this will continue to be the case. Today, the femininity index (number of women per 100 men) of older people is 122.7, a ratio that will remain unchanged for the next 13 years (see table I.4 and annex table I.A1.3). This indicator is expected to decrease slightly by 2060 (115 women per 100 men) although it will continue to be weighted towards women.

Table I.4
Latin America and the Caribbean: number and proportion of persons aged 60 or older by sex, 2017-2060
(Thousands and percentages)

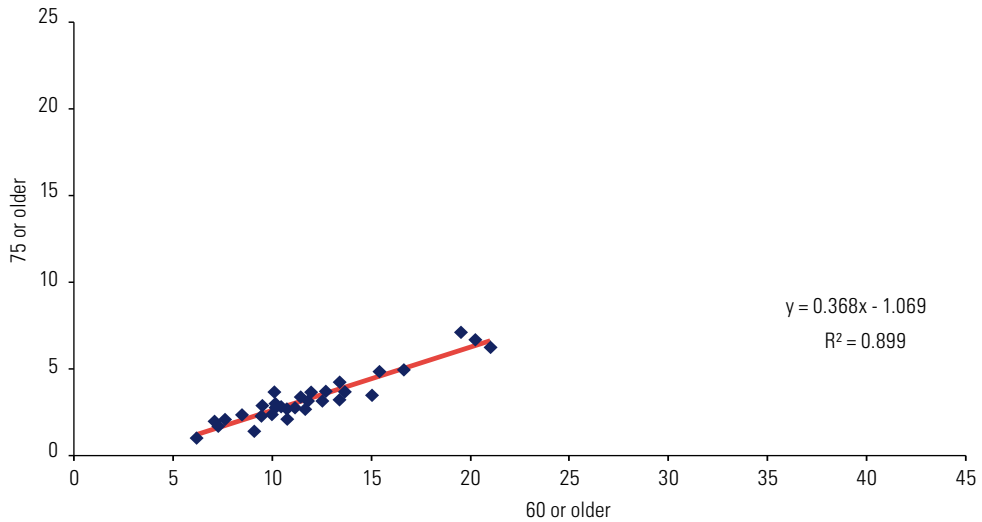
Year	Women		Men		Femininity index
	Population	Percentage	Population	Percentage	
2017	42 038	12.8	34 253	10.7	122.7
2030	66 611	18.2	54 348	15.3	122.6
2060	125 098	31.2	108 746	27.7	115.0

Source: United Nations, "World Population Prospects: The 2015 Revision, Key Findings and Advance Tables", *Working Paper*, No. 241 (ESA/P/WP.241), New York, Population Division, 2015 [online] http://esa.un.org/unpd/wpp/.

However, as will be seen below, this preponderance of women, owing to their longer life expectancy at a later age, is not synonymous with well-being and masks significant inequalities and disadvantages.

Another important characteristic of the over-60 age group is how it breaks down by age (see figure I.10). Disaggregating the group data by age reveals that the countries in the early stages of population ageing have lower numbers of people aged 75 or older. That is to say, the cohorts that have joined the over-60 age group did so more recently and therefore fall mainly in the 60-74 group. Moreover, in those countries, life expectancy after 75 years is not as long.

Figure I.10
Latin America and the Caribbean: population aged 60 or older and 75 or older, 2017
(Percentages)



Source: United Nations, "World Population Prospects: The 2015 Revision, Key Findings and Advance Tables", *Working Paper*, No. 241 (ESA/P/WP.241), New York, Population Division, 2015 [online] http://esa.un.org/unpd/wpp/.

Figure I.10 compares two indicators —the percentage of the population aged 60 or older and the percentage of the population aged 75 or older— with each point representing a country of the region for which those data are available. In Barbados, Cuba and Uruguay, the percentage of the population aged 60 or older in 2017 will be higher than 20% and the proportion aged 75 or older will be between 6% and 7%. At the other extreme are Belize, Guatemala, Guyana and Haiti, with less than 2% of the population aged 75 or older. The population aged 75 or older in the other countries of the region does not exceed 4%, while the percentage of the population aged 60 or older is less than 16%.

Figure I.11 indicates the panorama in 2030, when the proportion aged 60 or older will have increased to between 9% and 32%. There is also a fairly direct correlation between the greater proportion of older people and the higher percentage of the population aged 75 or older. Cuba still has the highest percentages, followed by Barbados (28% and 9.3%), Uruguay (22% and 8%) and Chile (23.7% and 8%). The countries that are still at the earlier stages of the demographic transition have the lowest percentages: Guatemala (8.6% and 2.5%), Belize (9.1% and 1.5%), Haiti (9.3% and 2.1%) and Guyana (14.9% and 2.3%)

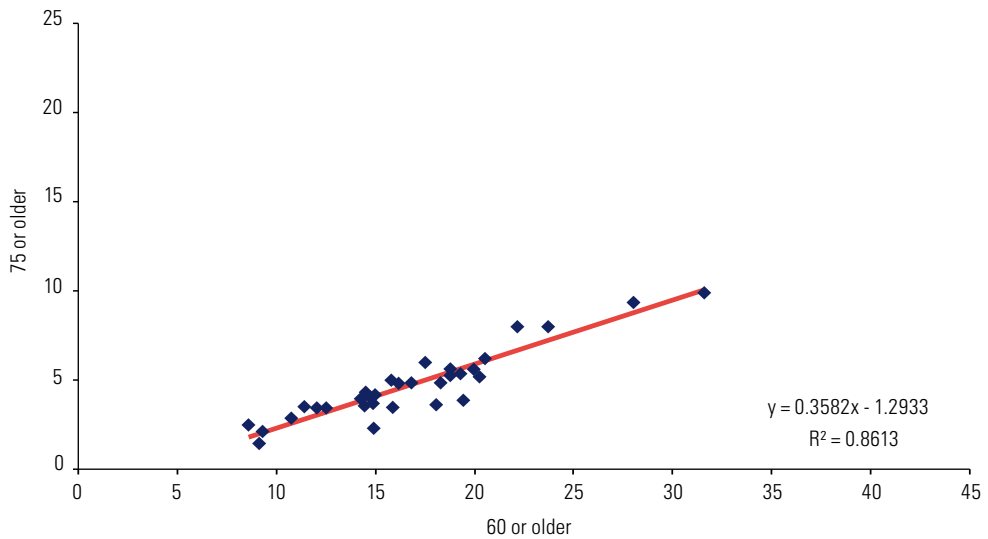


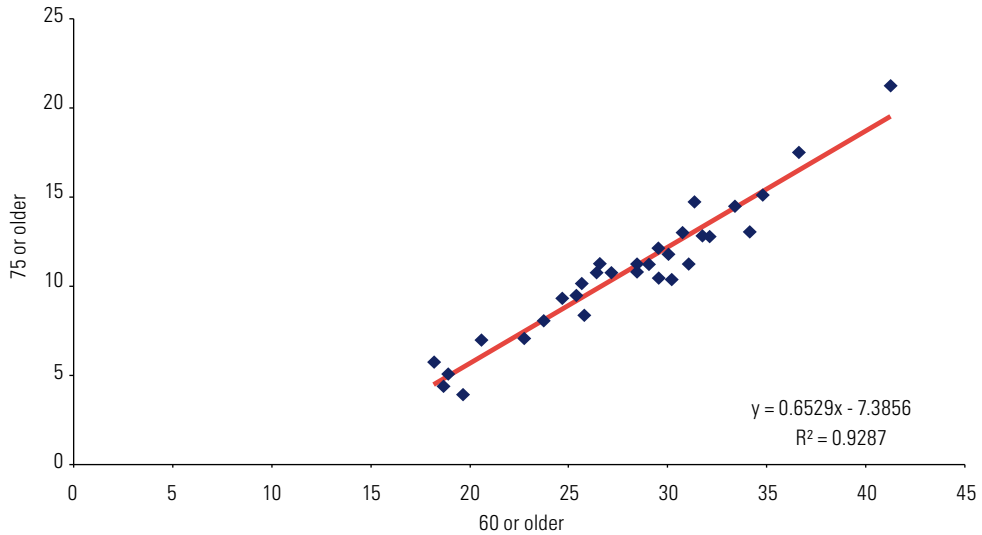
Figure I.11
Latin America and the Caribbean: population aged 60 or older and 75 or older, 2030
(Percentages)

Source: United Nations, "World Population Prospects: The 2015 Revision, Key Findings and Advance Tables", *Working Paper*, No. 241 (ESA/P/WP.241), New York, Population Division, 2015 [online] http://esa.un.org/unpd/wpp/.

Projections for 2060 (see figure I.12) show that older persons will account for between 18% and 41% of the population, with a regional average of 29%. The proportion of people aged 75 or older will increase in all countries of the region, accounting for between 40% and 50% of the total older population in some countries. Cuba will remain in the vanguard with the highest percentages (41.3% and 21.2%), closely followed by Chile (36.6% and 17.5%), Costa Rica (34.8% and 15.2%), Barbados (31.3% and 14.7%) and Brazil (33.4% and 12.8%). The percentage of older persons will also increase in the countries that are furthest behind in the demographic transition, exceeding 18% of the total population in all countries, although the proportion aged 75 or older will still not exceed 6%.

It is important that countries are aware of the size of their population aged 75 or older, the characteristics of this population subgroup and how it will evolve over the coming decades, given that these persons tend to have less autonomy and greater disabilities, and therefore need more care, owing to a higher incidence of chronic and degenerative diseases.

Figure I.12
Latin America and the Caribbean: population aged 60 or older and 75 or older, 2060
(Percentages)



Source: United Nations, "World Population Prospects: The 2015 Revision, Key Findings and Advance Tables", *Working Paper*, No. 241 (ESA/P/WP.241), New York, Population Division, 2015 [online] http://esa.un.org/unpd/wpp/.

2. Territorial differences

The relative numbers of older persons at the national level mask territorial differences within countries, for example between urban and rural areas. This is due, in large part, to the striking unevenness in the demographic transition between urban and rural areas, which has resulted in a more intense ageing process in the former. However, this phenomenon is blurred by the effect of internal migration, in particular rural-to-urban flows. Even though rural-to-urban migration is not the main form of migration in most countries of the region (flows between cities are now the largest), there is nonetheless more migration into than out of cities, which results in a net transfer of population from the countryside.

As the population that migrates from the countryside to cities tends to be of working age, the result is premature ageing in rural areas (strictly speaking, there is a much higher dependency ratio than there would be in the absence of rural-to-urban migration) and a dramatic expansion of intermediate age groups and an overrepresentation of women in cities (CELADE, 2003). This does not mean that urban areas have a lower level of ageing than rural areas. Indeed, the data show that urban ageing is similar to the nationwide total. The much more advanced stage of demographic transition in urban areas should result in a higher proportion of older adults. However, this is not the case because of the inflows of young people into the city from the countryside. The selectivity of internal migration in Latin America and the Caribbean by sex —with women making up the majority of migrants (Rodríguez, 2004)— is revealed in the differences between urban and rural ageing in terms of men and women.

Two territory-related features of ageing coexist in the region: (i) a predominance of urban location among older adults (which influences their living conditions and requirements); and (ii) premature ageing in the countryside (which will impact on the development and needs of rural areas). The regional situation obviously differs from country to country, as some have an older rural than urban population (the Dominican Republic, Ecuador, Honduras, Mexico, Panama and the Plurinational State of Bolivia), while others have a similar level of ageing in rural and urban areas or have been somewhat erratic (the Bolivarian Republic of Venezuela, Brazil and Uruguay) and yet others have an older urban than rural population (Argentina, Cuba and Costa Rica) (see table I.5).

Table I.5
Latin America (selected countries): population aged 60 or older by urban and rural area, 1990, 2000 and 2010 census rounds
(Percentages)

Country	Urban			Rural		
	1990	2000	2010	1990	2000	2010
Argentina	13.2	13.6	14.4	10.8	11.8	12.6
Bolivia (Plurinational State of)	5.5	5.7	7.7	8.6	9.2	11.7
Brazil	7.4	8.6	10.8	6.9	8.4	11.0
Cuba			19.0			16.0
Costa Rica	-	8.5	10.8	-	7.0	9.5
Dominican Republic	-	7.7	8.7	-	8.7	10.2
Ecuador	6.0	8.7	8.7	7.1	9.8	10.2
Honduras	-	5.7	11.9	-	5.9	13.6
Mexico	6.8	7.0	9.1	6.7	8.2	10.4
Panama	7.8	8.3	10.5	7.4	9.1	10.8
Uruguay	17.5	17.9	18.7	15.5	16.2	18.9
Venezuela (Bolivarian Republic of)	5.9	7.0	9.1	6.8	7.6	8.6

Source: Latin American and Caribbean Demographic Centre (CELADE)-Population Division of ECLAC, database of the Spatial distribution and urbanization in Latin America and the Caribbean (DEPUALC) Project, 2017.

Cities and their components offer a smaller territorial scale for studying population ageing. There is a great variety of cities in Latin America and the Caribbean in terms of size, configuration and function. Table I.6 sets out information on the population ageing process in 12 cities of the region with 1 million or more inhabitants. The percentage of people aged 60 or older shows that, regardless of the geographical scale of the analysis, the ageing process marches on, albeit at different speeds depending on that stage the countries have reached in the demographic transition.

Table I.6
Latin America (selected cities): total population, population aged 60 and older, and ageing indicators, 2000 and 2010 census rounds

City	Census year	Population		Percentage of older persons	Old-age dependency ratio	Ageing index
		Total	60 years and older			
Greater Buenos Aires	2001	12 046 602	1 827 204	15.2	25.3	60.9
	2010	13 578 548	2 091 150	15.4	25.2	65.5
La Paz	2001	1 436 935	85 280	5.9	9.9	17.3
	2012	1 687 426	137 999	8.2	13.0	28.5
São Paulo	2000	17 076 766	1 345 346	7.9	12.6	31.9
	2010	19 459 583	2 079 309	10.7	15.8	48.8
Rio de Janeiro	2000	11 056 863	1 158 738	10.5	17.2	44.9
	2010	11 777 368	1 569 295	13.3	20.2	64.0
San José	2000	1 031 817	93 157	9.0	14.3	32.4
	2011	1 202 680	142 381	11.8	17.9	53.9
Quito	2001	1 399 378	117 474	8.4	13.3	29.4
	2010	1 607 734	149 984	9.3	14.6	34.8
Guayaquil	2001	2 159 910	185 799	8.6	13.9	29.2
	2010	2 509 530	210 652	8.4	13.4	29.1
Tegucigalpa	2001	773 978	41 326	5.3	8.9	15.4
	2013	1 055 729	77 694	7.4	12.3	25.1
Mexico City	2000	17 506 282	1 220 766	7.0	11.0	23.9
	2010	19 519 434	1 935 139	9.9	15.2	39.8
Panama City	2000	1 212 435	97 460	8.0	12.6	28.8
	2010	1 577 959	158 024	10.0	15.6	38.9
Santo Domingo	2002	2 148 261	157 724	7.3	11.9	23.7
	2010	3 119 494	253 277	8.1	12.9	28.3
Caracas	2001	2 876 858	276 313	9.6	14.9	37.2
	2011	2 901 918	369 677	12.7	19.3	59.8

Source: Latin American and Caribbean Demographic Centre (CELADE)-Population Division of ECLAC, database of the Spatial distribution and urbanization in Latin America and the Caribbean (DEPUALC) Project, 2017.

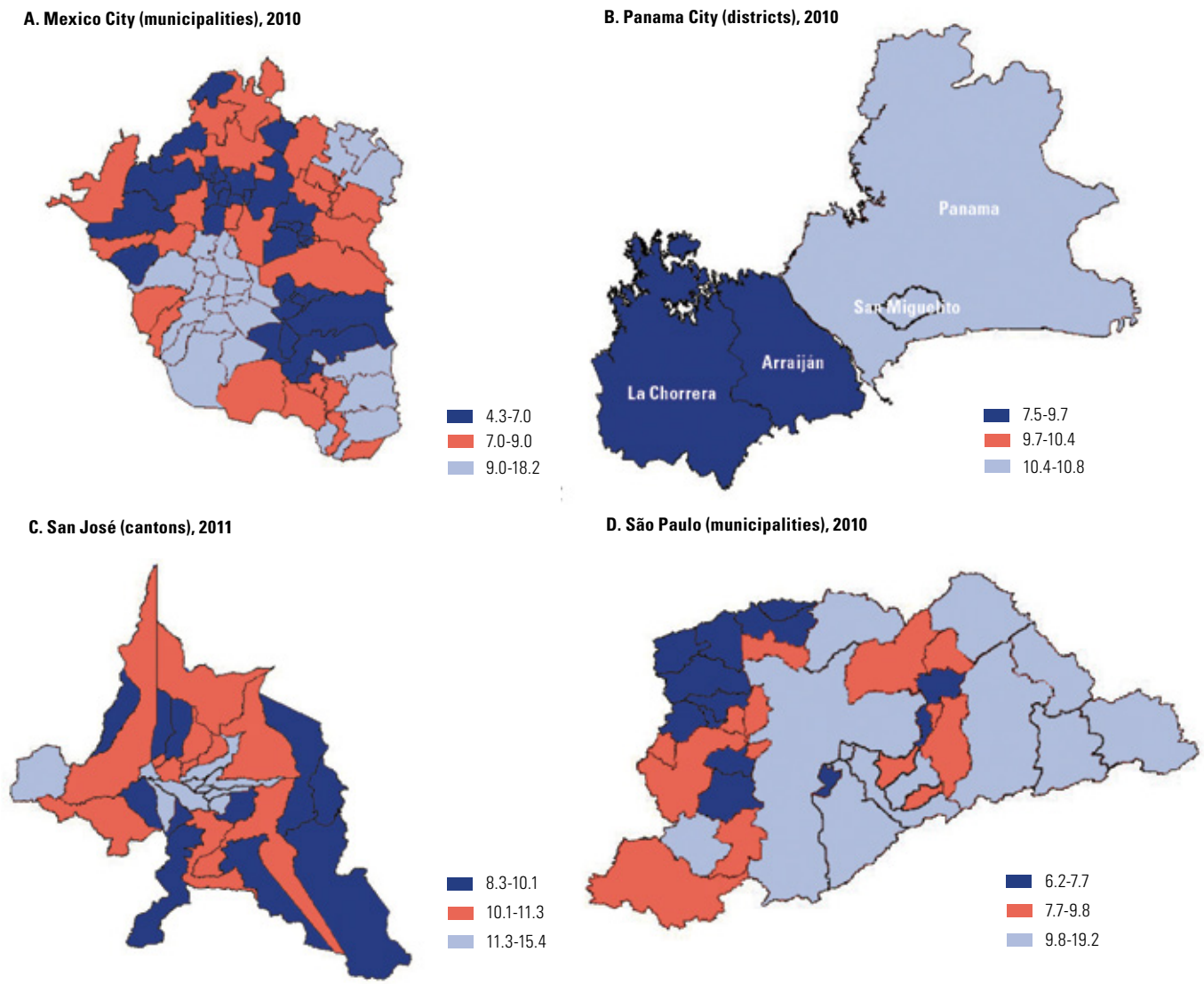
The picture is more heterogeneous in the big cities (see table I.6). Greater Buenos Aires has the oldest population of the cities under consideration. Its percentage of older persons did not vary much from one census to the next and was systematically higher than the national and urban averages. Rio de Janeiro was the second most aged city in 2010 and had a higher proportion of older persons than the national and urban averages in both years. In third place is Caracas. Older persons accounted for 12.7% of the total population in 2011, a considerable increase from the previous census, and remained higher than the national and urban averages. In São Paulo, the percentage of older persons, which was below the national and urban average in 2000, increased by 3%, bringing it into line with the national urban average by 2010. In 2001, the percentage of older persons in Quito was below the national and urban average; however, in the last census (2010) the proportion of the population aged 60 or older was higher than in other urban areas and equal to the national average. Guayaquil is the city where population ageing is least advanced, with the percentage of older persons at 8.6% in 2000 and 8.4% in 2010. Older persons living in Mexico City currently account for 9.9% of the city's total population, higher than the national and urban averages. Meanwhile, the percentage of older persons in Panama City was similar to the national and urban averages over the period under consideration.

Buenos Aires, Rio de Janeiro and Caracas had the highest old-age dependency ratios and ageing indices. In 2010, there were 25, 20 and 19 persons aged 60 or older per 100 potentially active people, respectively, while for every 100 people aged 15 or younger, there were between 60 and 65 older persons. The old-age dependency ratios were under 18% in the 2010s in the other cities examined, with the lowest ratio in Tegucigalpa (12 persons aged 60 or older per 100 potentially active people). Analysis of the ageing index reveals a similar situation: there were 25 persons aged 60 or older per 100 people aged 15 or younger in Tegucigalpa (see table I.6).

The most direct policy actions are those carried out on a smaller territorial scale. Here, the local level is especially important, making it essential to have information about population ageing and the characteristics of older persons at smaller territorial levels. Thus, when designing a care programme for older persons, or a disaster prevention or mitigation plan that address this more vulnerable population group in such situations, the authorities must know, for example, the areas of the city with the oldest population, where older people live in large cities and their sociodemographic characteristics. Census microdata provide information about the ageing process and the characteristics of older persons at these levels, allowing for analysis of trends within metropolitan areas.

An example of this level of analysis is the information presented in map I.2, which shows the proportion of older persons disaggregated by the minor administrative divisions that comprise these big cities. In the four metropolitan areas under consideration, a greater proportion of older persons live in the more central and oldest parts of the city. For example, more than 15% of the population of the six central municipalities of Mexico City is aged 60 or older. In Panama City, the districts that have the highest proportion of older people —over 10%— are the two oldest (Panama and San Miguelito). Older people account for more than 11% of the population of the central cantons of San José. While São Paulo presents a somewhat different picture, as the percentage of older people exceeds 9.8% in several central municipalities, as well as other areas located more on the outskirts.

Map I.2
Population aged 60 or older in four Latin American cities by minor administrative division, 2010 census round
(Percentages)



Source: Latin American and Caribbean Demographic Centre (CELADE)-Population Division of ECLAC, database of the Spatial distribution and urbanization in Latin America and the Caribbean (DEPUALC) Project, 2017.

3. Greater access to formal education

In the past, a defining feature of older persons was their lower level of education, the result of inequalities of access to education that this population group experienced growing up. Over the decades, this situation has started to change, clearly illustrated by the decline in the illiteracy rate among older persons (see table I.7), either because more educated cohorts, who had greater access to formal education when they were young, are now moving into that population group or because they were the beneficiaries of government adult literacy programmes. However, gaps continue to exist between

countries: Uruguay had an older adult illiteracy rate of 3% in 2010, compared with 30% in the Dominican Republic and the Plurinational State of Bolivia. Meanwhile, gaps persist within countries between urban and rural areas, and between men and women.

It is encouraging that older population this decade is more educated than in the past, and probably will continue to be in the future. However, territorial and gender inequalities among older persons are still evident and it will take several more decades for these gaps to be significantly reduced.

Table I.7
Latin America (10 countries): illiterate population aged over 70 years by sex, 1990, 2000 and 2010 census rounds
(Percentages)

Country	1990			2000			2010		
	Men	Women	Both sexes	Men	Women	Both sexes	Men	Women	Both sexes
Argentina	10.7	12.4	11.6	5.4	6.1	5.8	4.0	4.4	4.2
Bolivia (Plurinational State of)	38.1	67.2	53.5	30.3	62.3	47.5	17.9	40.8	30.2
Brazil	39.3	47.0	43.4	31.2	36.6	34.2	24.9	27.4	26.3
Costa Rica	-	-	-	16.5	16.1	16.3	8.0	8.0	8.0
Dominican Republic	-	-	-	29.8	35.5	32.7	28.8	31.7	30.3
Ecuador	27.7	38.9	33.5	21.6	29.3	25.6	19.6	28.2	24.1
Mexico	-	-	-	24.1	36.0	30.4	18.7	27.5	23.4
Panama	28.1	28.7	28.4	22.6	23.0	22.8	16.7	17.2	16.9
Uruguay	8.5	6.5	7.4	-	-	-	3.8	2.5	3.0
Venezuela (Bolivarian Republic of)	25.0	32.6	29.1	21.4	29.5	25.8	14.6	18.0	16.4

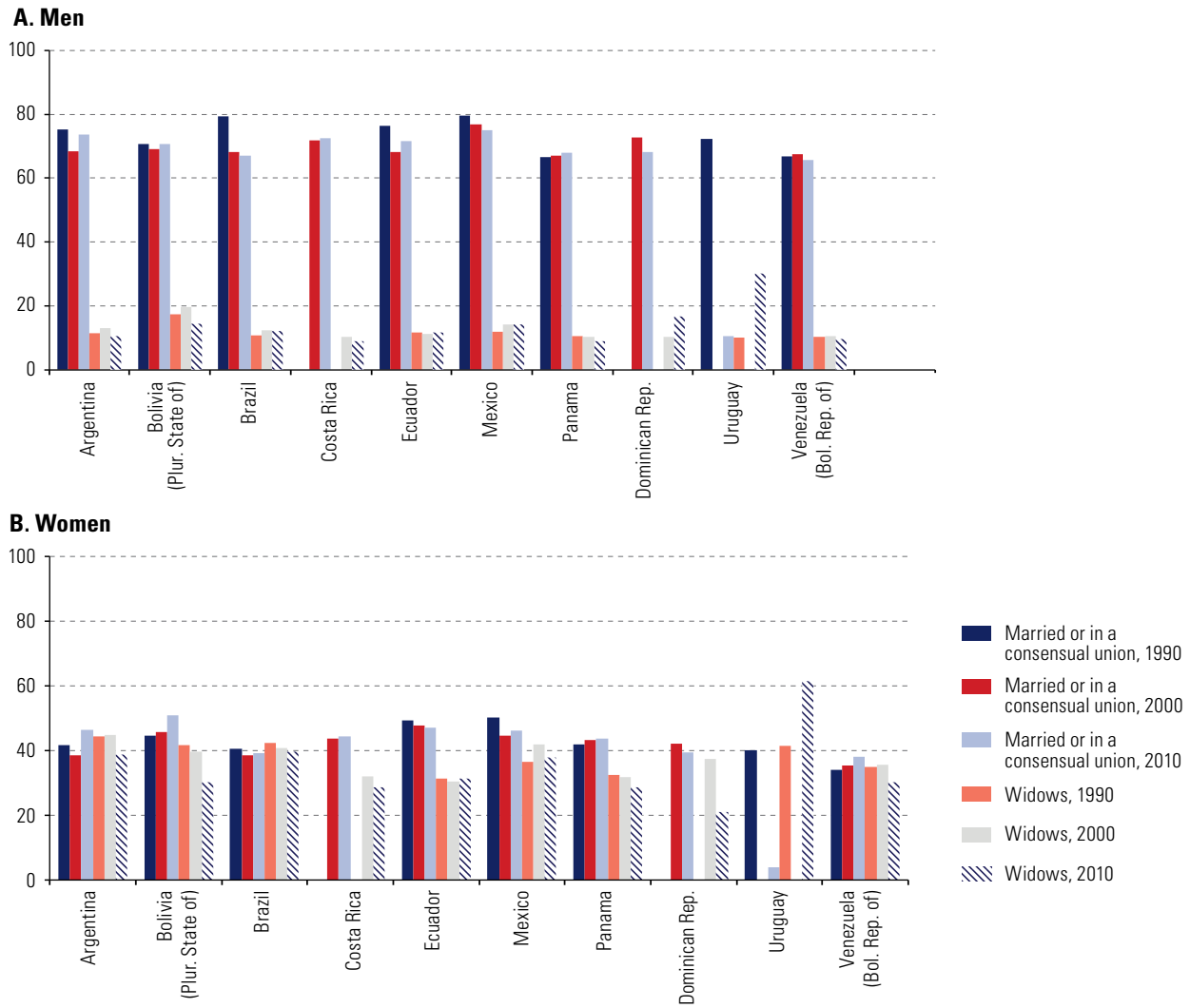
Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of census microdata provided by the Latin American and Caribbean Demographic Centre (CELADE)-Population Division of ECLAC, processed using Retrieval of data for small areas by microcomputer (REDATAM) software.

4. Companionship in old age

In general, censuses from previous decades indicate that widowhood is more prevalent among women, while a high proportion of men remain married or in a relationship. One of the reasons suggested for this is that women tended to marry older men who, having a shorter life expectancy, died before their spouses, leaving them widowed at a younger age. Those women then have not remarried or entered another relationship for cultural reasons. Meanwhile, men usually marry younger women, so when they reach old age they are still with their partners or, if they are widowed, they often remarry or enter a new relationship.

Figure I.13 partly illustrates this. In the case of older men (see figure I.13.A), a high proportion are married, over 65% in all the countries, while the percentage of widowers does not exceed 17%. Figure I.13B, which illustrates the situation of women, indicates a trend that appears to be going into reverse. While the percentage of widows remains relatively high (greater than 30%) compared to the number of widowers, it is starting to decrease in some countries and the percentage of women married or in relationships is beginning to edge up, in some cases surpassing 40%. It seems that the cohorts of younger women who have joined the older adult population are tending to change the sociocultural pattern by which older women did not enter another relationship. They are either seeking out new partners at an older age or entering relationships with somewhat younger men who tend to live longer.

Figure I.13
Latin America and the Caribbean (selected countries): persons married or in a consensual union, widowers and widows, 1990, 2000 and 2010 census rounds
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of census microdata provided by the Latin American and Caribbean Demographic Centre (CELADE)-Population Division of ECLAC, processed using Retrieval of data for small areas by microcomputer (REDATAM) software.

5. Older women who are heads of household

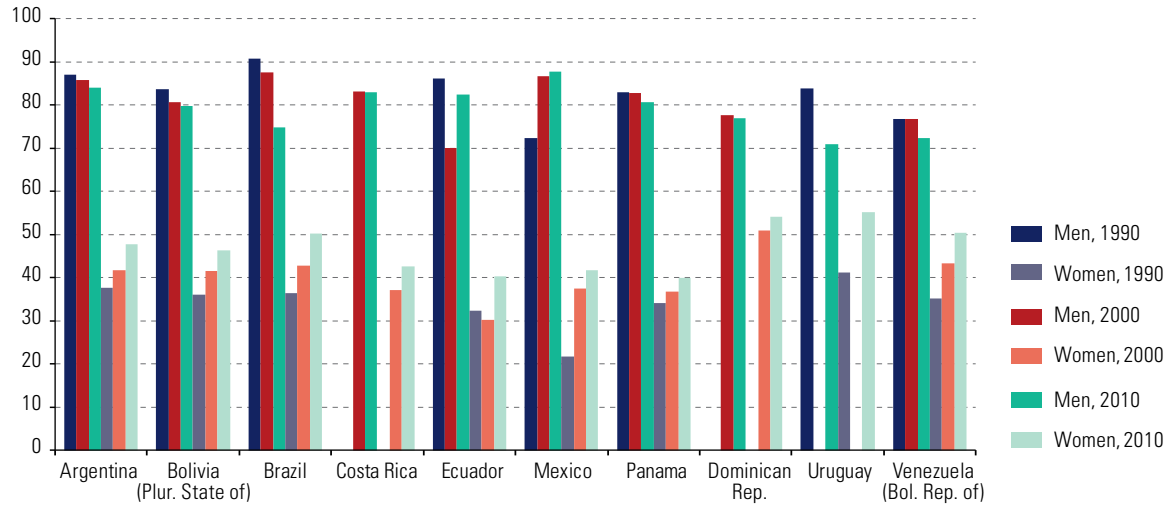
Although household headship rates have always been higher among men, in recent decades there has been an increase in the number of female-headed households. In Latin America and the Caribbean, a high proportion of older persons are still head of the households. In most countries, more than 50% of older persons head the households in which they live. However, the totals mask gender differences in the role of head of household; although there are more male heads of household, female headship is growing steadily and the number of older male heads of households has decreased slightly.

In 1990, less than 40% of older women were the head of their households in the region (the figure was higher only in Uruguay). Census data for the 2000s reveal that this percentage continues to grow, with more than 40% of older women heading households in several countries (Argentina, the Bolivarian Republic of Venezuela, Brazil,

the Dominican Republic and the Plurinational State of Bolivia). Today, nearly 50% of older women are heads of households, and the percentage is even higher in the Bolivarian Republic of Venezuela, Brazil, the Dominican Republic and Uruguay (see figure I.14).

The role of head of household may be assigned on the basis of three criteria: (i) recognition, when they are self-appointed or chosen by other household members; (ii) authority, when it is assigned according to the person's authority and ability to lead decision-making processes and oversee the upkeep of the household; or (iii) economic, when it is decided on the basis of a member's economic contribution to the upkeep of the household. One reason for the greater number of older female heads of household is that they are in the later stages of the life cycle and a percentage of them are widows. However, more women are now recognized as heads of household, including older women, even when they live with their partner in two-parent households. It is also important to note that in some households in the region, an older person residing there is designated head of household because they are the main breadwinner.

Figure I.14
Latin America and the Caribbean (selected countries): older heads of households by sex, 1990, 2000 and 2010 census rounds
(Percentages)



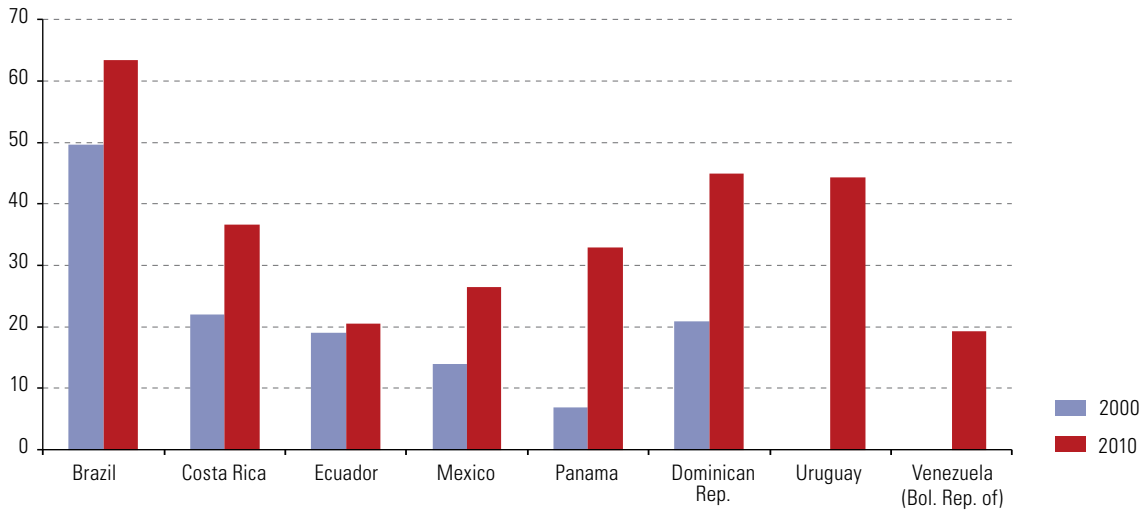
Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of census microdata provided by the Latin American and Caribbean Demographic Centre (CELADE)-Population Division of ECLAC, processed using Retrieval of data for small areas by microcomputer (REDATAM) software.

6. Increase in disability

According to the data from the 2010 census round for eight Latin American countries, for every 100 older persons, some 41 have some form of disability (see figure I.15). The incidence is higher in women than in men, 43% compared to 38.8%. These aggregate figures indicate that a significant section of the older population live with some form of disability. Accordingly, it is important to be aware of their sociodemographic characteristics, as disability poses enormous health and care challenges to households.

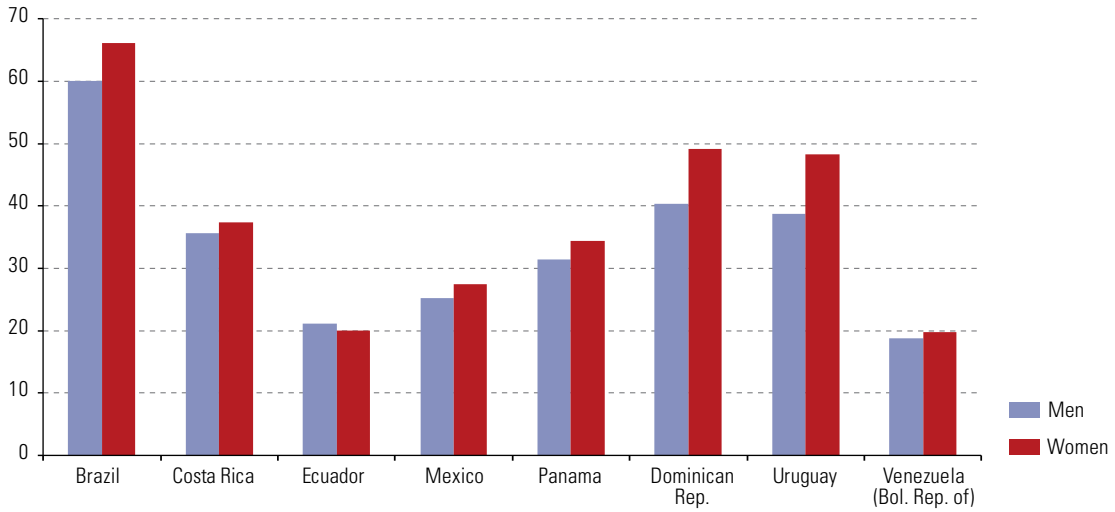
A striking characteristic is that the masculinity ratio of persons with at least one disability is systematically less than 100, in other words, there are more women with disabilities. A study by ECLAC (2013) on the matter indicates that the prevalence rate of disabilities is higher among women than among men in more than half the countries of the region. Figure I.16 illustrates this, as it shows that in the population aged 60 or older, disabilities are more prevalent among older women in all the countries analysed, except Ecuador. This may be because women's higher life expectancy increases their chances of acquiring a disability as a result of an accident or chronic illness later in life.

Figure I.15
Latin America and the Caribbean (selected countries): older persons with a disability, 2000 and 2010 census rounds
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of census microdata provided by the Latin American and Caribbean Demographic Centre (CELADE)-Population Division of ECLAC, processed using Retrieval of data for small areas by microcomputer (REDATAM) software.

Figure I.16
Latin America and the Caribbean (selected countries): older persons with a disability by sex, 2010 census round
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of census microdata provided by the Latin American and Caribbean Demographic Centre (CELADE)-Population Division of ECLAC, processed using Retrieval of data for small areas by microcomputer (REDATAM) software.

This pattern can be seen clearly in the case of Uruguay: almost half (48%) of older women have some form of disability, compared with 38% of older men, according to the 2011 census. Uruguay is one of the countries in the region with the oldest populations and, therefore, has a high percentage of women aged 60 or older, who, as indicated above, are more likely to have some form of disability. The situation is similar in Brazil and Costa Rica, which, though at a less advanced stage of the ageing process, have over 13% of their population in this age group and, therefore, at greater risk of acquiring a disability.

As the population ageing process unfolds in countries of the region, women are likely to make up a greater proportion of persons with disabilities. Public policy should address

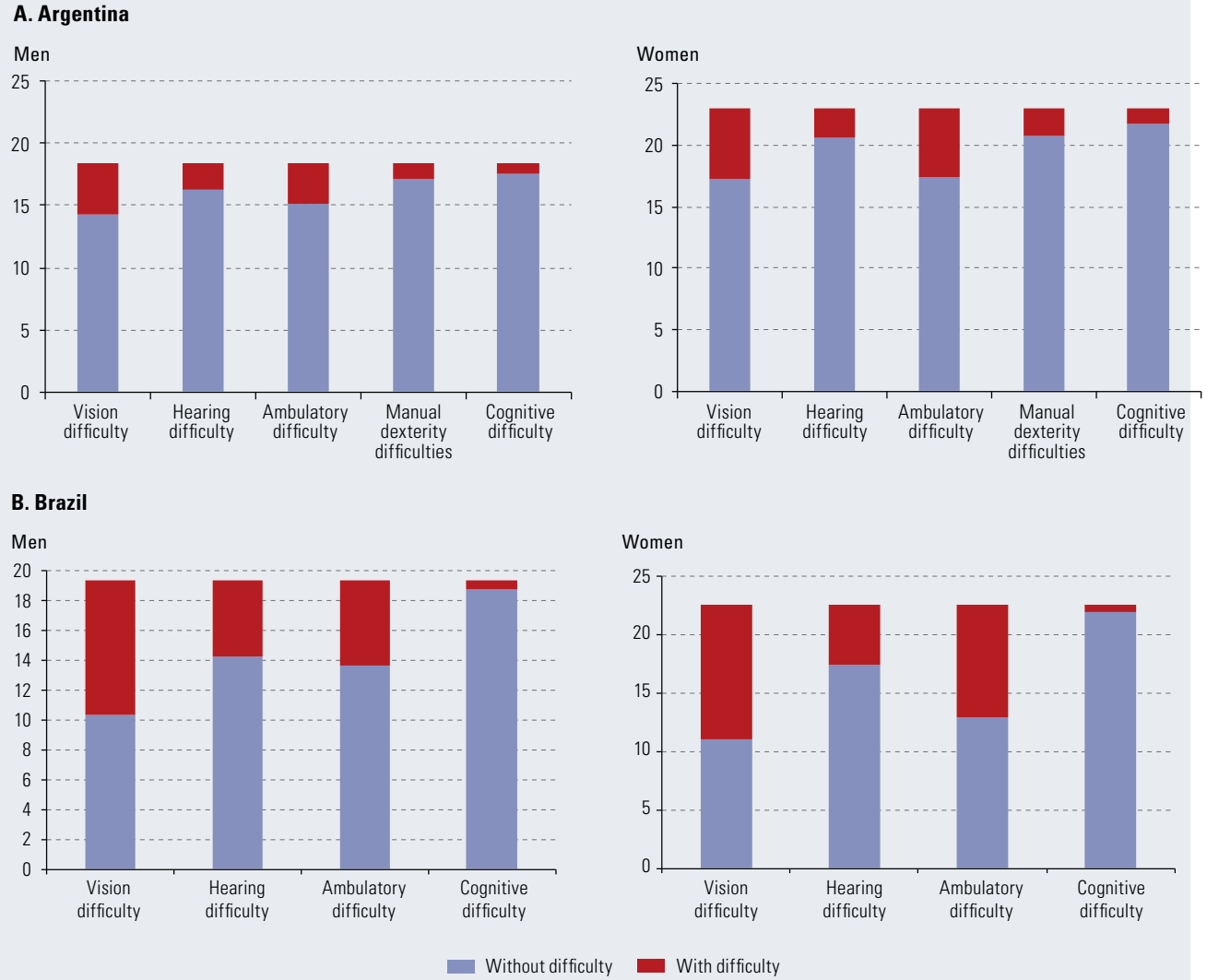
this issue because gender is known to intersect with other variables, such as disability, age and social class, to create greater inequality. Thus, as a result of the inequalities suffered over the course of their lives, women tend to spend more years with functional limitations than men. For women —as for men, albeit to a lesser extent— disease has ceased to be an acute and generally fatal episode and become a chronic condition that, without the necessary care, results in a marked deterioration in quality of life in old age (see box I.1).

Box I.1
Disability-free life expectancy in old age

On the basis of 2010 census data and mortality tables prepared by the national statistical offices, figure 1 shows the results of applying Sullivan's index for calculating disability-free life expectancy to several countries of the region.

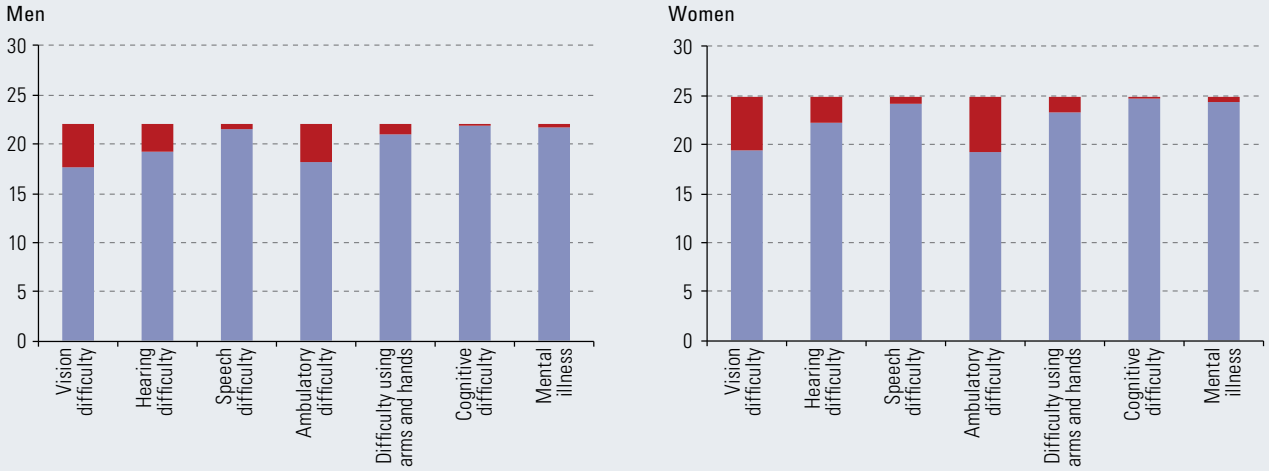
The population aged 60 or older is most likely to be affected by vision, ambulatory and hearing difficulties or limitations. When the data are disaggregated by sex, it becomes clear that women live longer with some sort of difficulty or limitation, which directly affects their quality of life. That said, in Brazil and the Dominican Republic, disability-free life expectancy is virtually the same for women and men in the case of vision difficulty or limitation.

Figure 1
Latin America (5 countries): disability-free life expectancy and life expectancy with some degree of disability at age 60, by sex, 2010 census round
(Years)

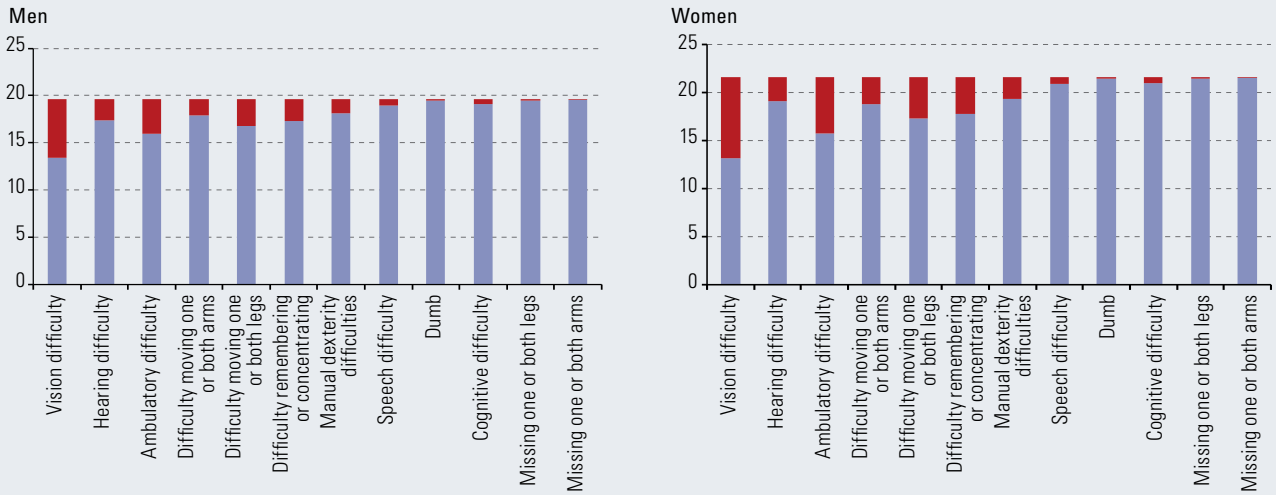


Box I.1 (continued)

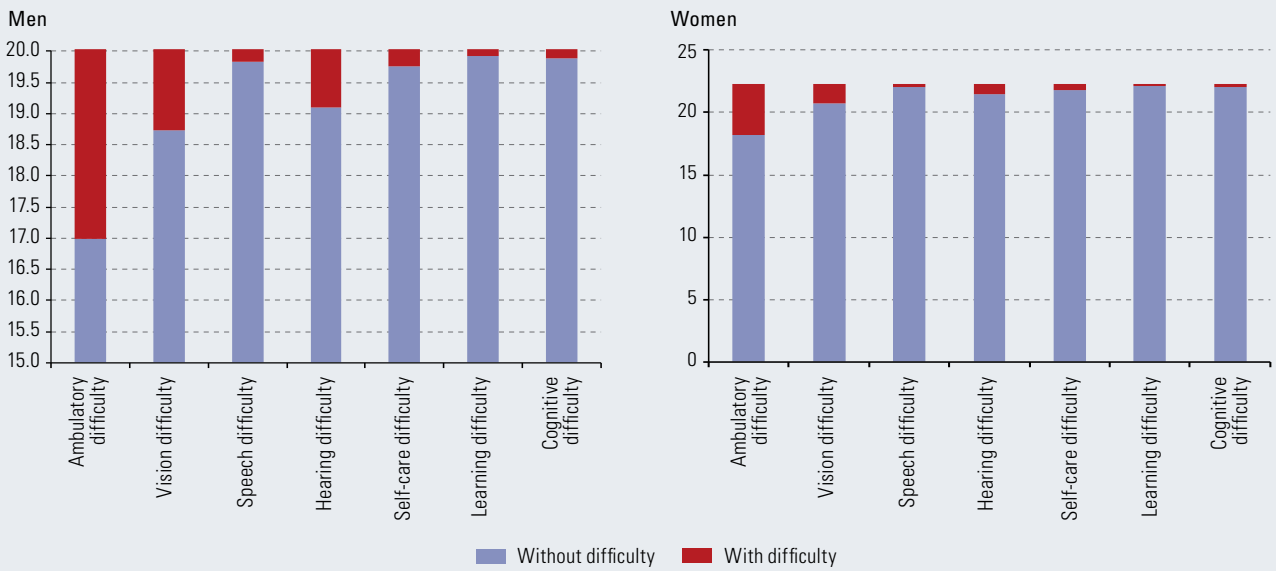
C. Costa Rica



D. Dominican Republic



E. Mexico



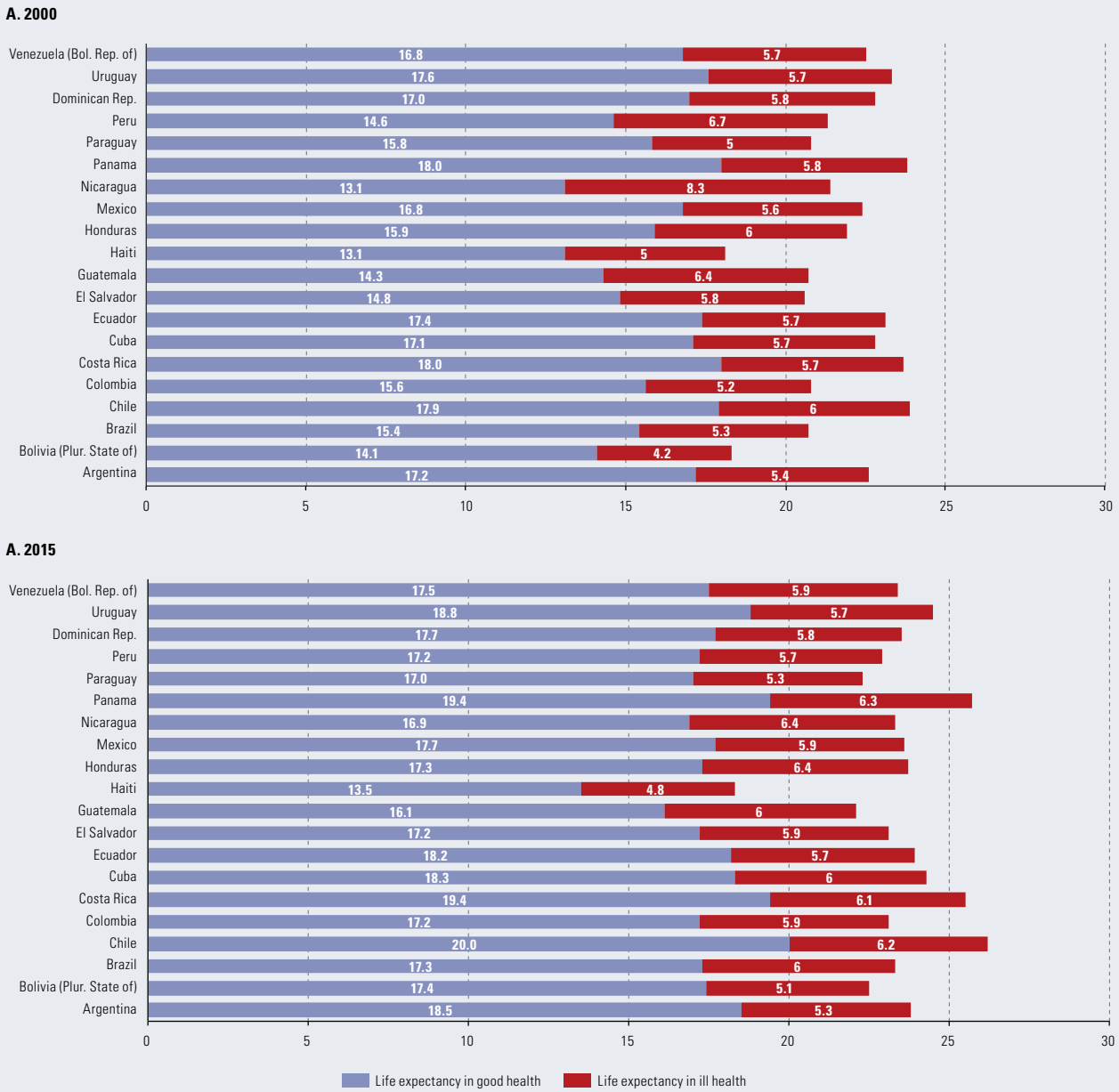
Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of data from the 2010 census round and mortality tables published by the national statistical offices of the respective countries.

Box I.1 (concluded)

Similarly, the average number of years that women aged 60 or older can expect to live with a disease increased between 2000 and 2015. Figure 2 breaks down life expectancy at age 60 into life expectancy in good health and in ill health for the same period. In more than half the countries studied, there was an increase in the number of years that an older person could expect to live with some sort of disability or limitation. In the Dominican Republic, Ecuador and Uruguay, life expectancy in ill health remained the same between 2000 and 2015, while in Argentina, Guatemala, Haiti, Nicaragua and Peru it decreased by between 0.1 and 1.9 years.

Figure 2

Latin America and the Caribbean (20 countries): life expectancy in good and ill health at age 60, 2000 and 2015
(Years)



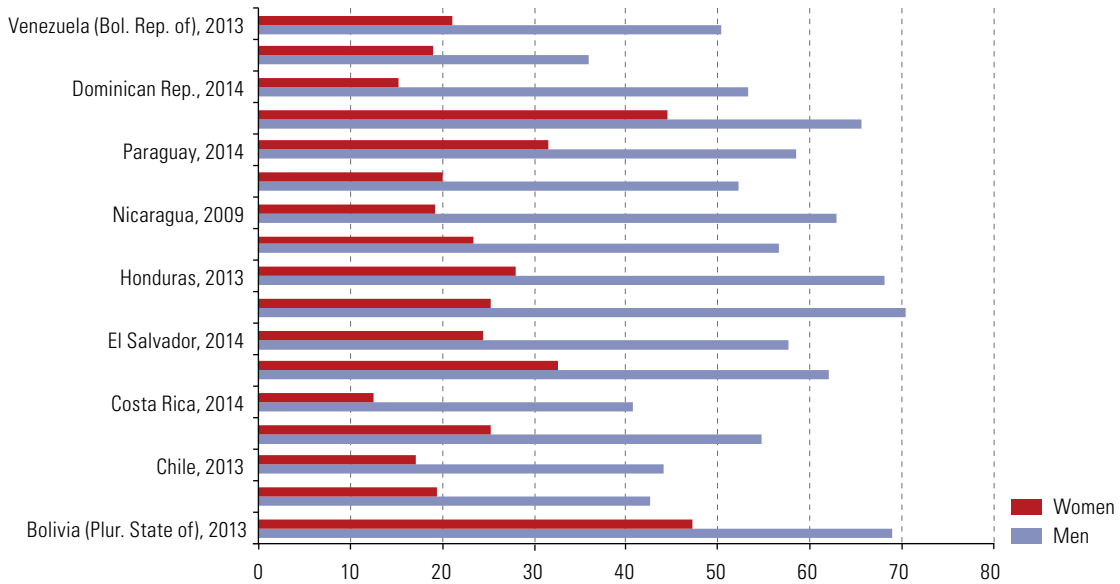
Source:Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of data and statistics from data repository of World Health Organization (WHO).

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of census data from the 2010 census round and data provided by the World Health Organization (WHO).

7. Older people remain economically active

The economic participation of the population aged 60 or older is heterogeneous. Among older men it ranges from 35.8% in Uruguay to 70.2% in Guatemala, while among older women it varies between 12.4% in Costa Rica and 47.0% in the Plurinational State of Bolivia (see figure I.17).

Figure I.17
Latin America (17 countries): participation rate of persons aged 60 or over by sex, around 2014
(Percentages of the economically active population aged 15 and older)

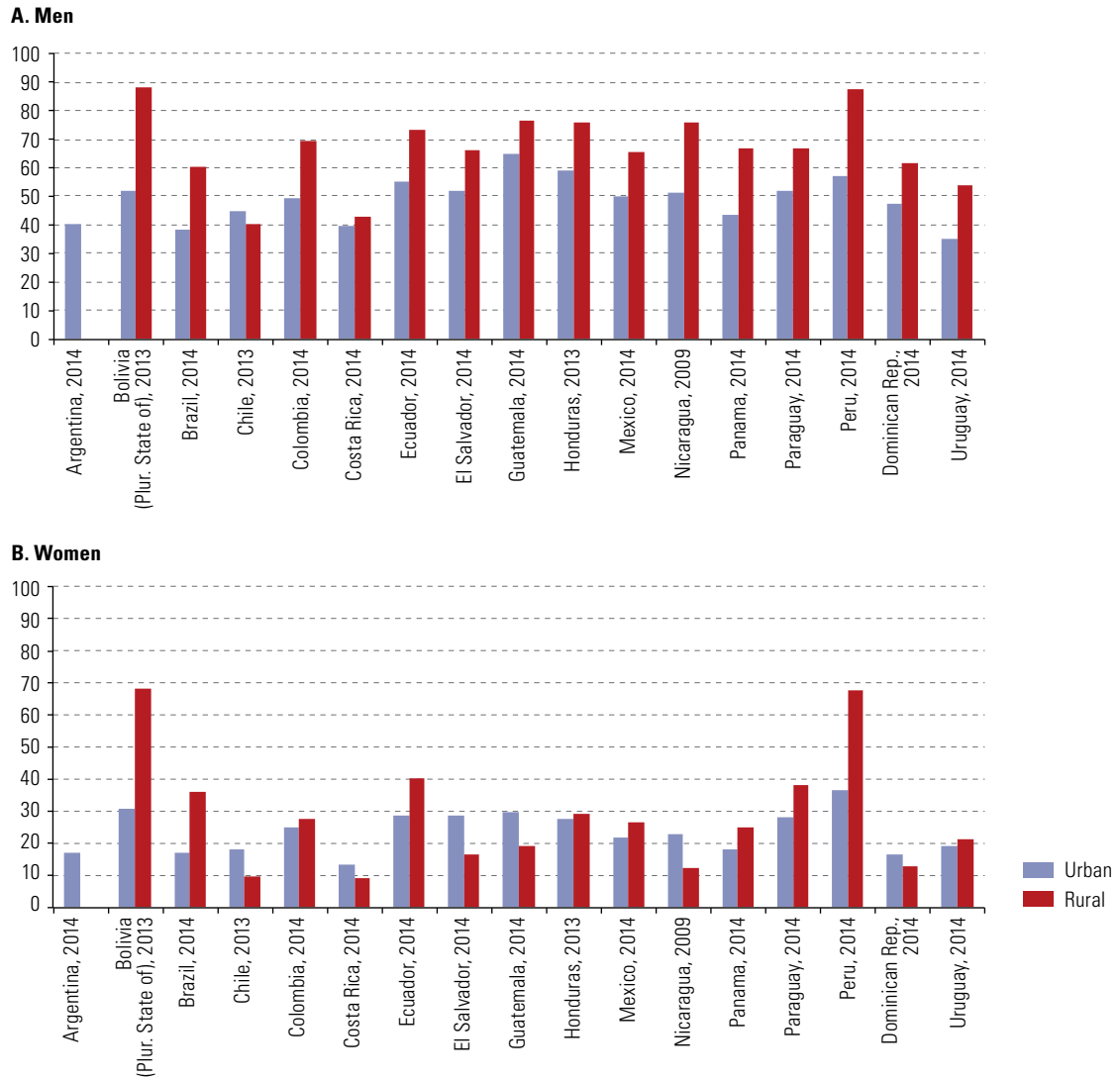


Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of CEPALSTAT.

The economic participation of this population group also varies by geographical area, with the highest rates for older men occurring in rural areas, with the exception of Chile (see figure I.18.A).[2] Among older women the picture is mixed: while in Brazil, Colombia, Ecuador, Honduras, Mexico, Panama, Paraguay, Peru, the Plurinational State of Bolivia and Uruguay, older women's economic participation is higher in rural areas, in Chile, Costa Rica, the Dominican Republic, El Salvador, Guatemala and Nicaragua the reverse is true (see figure I.18.B).

[2] Data for Argentina refer to urban areas only.

Figure I.18
Latin America (17 countries): participation rate of the population aged 60 and older by urban or rural area, around 2014
(Percentages of the economically active population aged 15 and over)

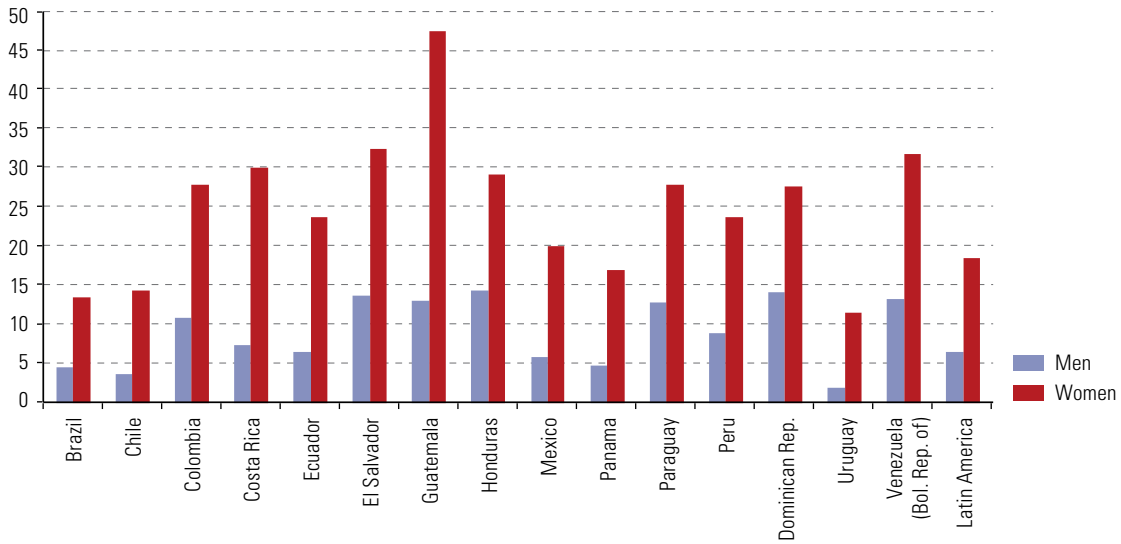


Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of CEPALSTAT.

8. Persistence of the gender wage gap in old age

The socioeconomic gaps between older men and women are replicated in the wage gap, where women are a severe disadvantage. Figure I.19 sets out the percentages of the population aged 60 or older with no income of their own by sex for 15 countries of the region. In the Dominican Republic, twice as many women as men lack income of their own, while in Uruguay six times as many women as men have no independent income. With regard to geographical area, the gap between rural and urban older women is not significant, as in both cases it is narrowing.

Figure I.19
Latin America (15 countries): persons aged 60 or older with no income of their own by sex, around 2014[a]
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of CEPALSTAT.
[a] Weighted average.

D. Conclusions

The timing and intensity of the demographic transformations experienced by Latin American and Caribbean countries over the past five decades have varied, so that the situation is very diverse across the region. However, the main consequences of declining fertility and morality rates have been the slowdown in population growth and the changing age structure, leading to population ageing.

The countries in the region that began the demographic transition later still have a good portion of the demographic window before them to improve the outcomes of their education, health and pension policies. Meanwhile, the countries that are further along in the demographic transition are already undergoing rapid population ageing and face mounting demands to finance pension plans, to adapt their health systems to an increasingly onerous epidemiological profile and to manage appropriate care services.

A wide range of policies is needed to respond to the effects of demographic change, which include those aimed at broadening opportunities in relation to the education and employment of young persons, health, social security and pensions. A public care system must also be established and fiscal policies adapted to achieve balanced intergenerational transfers. These policies call for a comprehensive and long-term approach that considers demographic trends, incorporates a life-cycle, gender and rights perspective, and gives due consideration to interculturalism and intergenerational processes in line with national contexts.

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Annex I.A1

Table I.A1.1
Latin America and the Caribbean: population aged 60 years and over by sex, by subregion and country, 1965-2060

Region, subregion, country	1965			1980			1995		
	Both sexes	Men	Women	Both sexes	Men	Women	Both sexes	Men	Women
Latin America and the Caribbean	**15 224**	**7 116**	**8 109**	**23 753**	**10 872**	**12 881**	**36 701**	**16 359**	**20 342**
The Caribbean	**1 587**	**790**	**797**	**2 551**	**1 232**	**1 320**	**3 549**	**1 659**	**1 890**
Antigua and Barbuda	4	1	2	6	2	3	7	3	4
Bahamas	7	3	4	13	6	7	20	8	11
Barbados	26	9	17	36	15	21	37	15	22
Cuba	647	350	297	1 065	526	539	1 383	652	732
Dominican Republic	162	85	77	285	148	136	538	272	266
Grenada	7	3	4	9	4	5	10	4	6
Haiti	245	115	130	361	170	192	478	220	258
Jamaica	142	63	79	200	93	107	247	116	131
Saint Lucia	7	3	4	9	4	5	15	7	8
Saint Vincent and the Grenadines	6	2	4	8	4	5	10	4	5
Trinidad and Tobago	52	25	27	87	41	46	109	48	61
Central America	**3 225**	**1 531**	**1 694**	**5 007**	**2 299**	**2 708**	**8 367**	**3 765**	**4 602**
Belize	7	3	4	9	4	5	13	6	7
Costa Rica	80	40	40	146	72	74	267	125	142
El Salvador	164	75	89	248	113	135	410	188	222
Guatemala	214	105	110	329	161	168	579	275	304
Honduras	114	54	61	174	82	93	299	143	157
Mexico	2 489	1 180	1 309	3 835	1 743	2 093	6 354	2 821	3 533
Nicaragua	83	38	46	142	63	79	242	108	134
Panama	74	38	36	123	61	61	203	98	104
South America	**10 412**	**4 794**	**5 618**	**16 194**	**7 341**	**8 853**	**24 785**	**10 936**	**13 850**
Argentina	2 194	1 073	1 121	3 376	1 510	1 866	4 653	1 985	2 668
Bolivia (Plurinational State of)	258	116	142	327	148	179	528	248	280
Brazil	4 400	1 968	2 432	7 049	3 194	3 856	11 136	4 865	6 270
Chile	682	304	378	969	424	544	1 433	623	810
Colombia	991	445	546	1 560	706	854	2 413	1 077	1 335
Ecuador	351	162	189	482	227	255	761	360	401
Guyana	35	16	19	43	21	22	48	22	26
Paraguay	114	51	63	186	86	101	296	139	157
Peru	643	301	342	969	451	518	1 587	743	844
Suriname	20	10	10	23	11	12	35	16	19
Uruguay	332	153	179	430	191	239	553	233	320
Venezuela (Bolivarian Republic of)	390	194	196	776	370	406	1 336	621	715

Table I.A1.1 (concluded)

Region, subregion, country	2015			2030			2045			2060		
	Both sexes	Men	Women	Both sexes	Men	Women	Both sexes	Men	Women	Both sexes	Men	Women
Latin America and the Caribbean	**70 922**	**31 827**	**39 095**	**120 959**	**54 348**	**66 611**	**180 447**	**81 918**	**98 530**	**233 842**	**108 746**	**125 097**
The Caribbean	**5 745**	**2 659**	**3 086**	**8 946**	**4 133**	**4 813**	**11 400**	**5 233**	**6 166**	**13 346**	**6 196**	**7 150**
Antigua and Barbuda	10	4	5	21	9	12	27	12	15	32	14	18
Bahamas	49	21	28	90	40	50	122	55	67	152	70	82
Barbados	56	25	32	81	35	45	88	38	50	87	38	48
Cuba	2 215	1 047	1 168	3 552	1 696	1 856	4 030	1 943	2 088	3 951	1 937	2 014
Dominican Republic	1 023	489	533	1 722	801	921	2 511	1 149	1 362	3 303	1 527	1 776
Grenada	11	5	6	16	7	9	23	11	12	32	15	17
Haiti	755	342	413	1 168	532	635	1 853	842	1 011	2 742	1 244	1 498
Jamaica	357	172	185	537	256	281	695	313	382	872	403	469
Saint Lucia	23	11	13	39	17	21	53	24	29	65	30	35
Saint Vincent and the Grenadines	12	6	6	21	10	10	26	13	14	31	14	16
Trinidad and Tobago	193	87	106	277	120	157	344	144	200	349	144	205
Central America	**16 144**	**7 508**	**8 636**	**28 786**	**13 275**	**15 510**	**46 832**	**21 658**	**25 174**	**65 548**	**31 100**	**34 449**
Belize	21	11	11	42	19	23	73	31	41	118	51	67
Costa Rica	613	290	323	1 111	525	587	1 580	753	827	2 001	969	1 032
El Salvador	703	302	400	1 010	406	604	1 387	541	846	1 921	788	1 133
Guatemala	1 145	519	627	1 834	776	1 058	3 307	1 414	1 893	5 516	2 471	3 045
Honduras	581	278	304	1 044	492	552	1 827	847	980	2 985	1 404	1 581
Mexico	12 177	5 696	6 481	22 094	10 311	11 784	35 909	16 814	19 095	49 128	23 585	25 543
Nicaragua	473	209	264	878	383	495	1 560	693	867	2 324	1 088	1 236
Panama	430	204	227	773	364	408	1 189	564	625	1 556	744	812
South America	**49 033**	**21 661**	**27 372**	**83 227**	**36 940**	**46 287**	**122 216**	**55 027**	**67 189**	**154 948**	**71 450**	**83 498**
Argentina	6 559	2 753	3 807	8 634	3 687	4 947	11 947	5 294	6 653	15 177	6 955	8 222
Bolivia (Plurinational State of)	988	468	520	1 499	699	800	2 359	1 092	1 268	3 486	1 615	1 870
Brazil	24 392	10 726	13 665	42 879	18 860	24 019	63 803	28 501	35 302	78 815	36 123	42 692
Chile	2 818	1 219	1 598	4 800	2 129	2 671	6 515	2 961	3 554	7 924	3 691	4 233
Colombia	5 226	2 347	2 879	9 721	4 386	5 335	13 872	6 247	7 624	17 146	7 839	9 307
Ecuador	1 602	751	851	2 840	1 333	1 507	4 427	2 083	2 344	6 185	2 960	3 225
Guyana	64	29	34	122	58	64	120	56	64	154	74	80
Paraguay	598	292	306	942	455	487	1 398	666	732	2 082	982	1 100
Peru	3 127	1 440	1 687	5 409	2 464	2 944	8 537	3 976	4 560	11 726	5 629	6 097
Suriname	56	25	31	94	42	52	123	54	69	147	64	83
Uruguay	657	268	389	796	335	461	957	421	536	1 119	513	606
Venezuela (Bolivarian Republic of)	2 925	1 332	1 592	5 442	2 468	2 974	8 073	3 637	4 436	10 865	4 948	5 917

Source: United Nations, "World Population Prospects: The 2015 Revision [DVD Edition]", New York, Department of Economic and Social Affairs, 2015.

Table I.A1.2
Latin America and the Caribbean: percentage of the population aged 60 and over and 75 and over, by subregion and country, 1965-2060

Region, subregion, country	Percentage of the population aged 60 and over							Percentage of the population aged 75 and over						
	1965	1980	1995	2015	2030	2045	2060	1965	1980	1995	2015	2030	2045	2060
Latin America and the Caribbean	**6.0**	**6.5**	**7.5**	**11.2**	**16.8**	**23.3**	**29.5**	**1.1**	**1.4**	**1.8**	**3.0**	**4.8**	**8.2**	**12.2**
The Caribbean	**6.9**	**8.6**	**9.8**	**13.3**	**19.2**	**23.7**	**28.2**	**1.4**	**2.0**	**2.8**	**4.0**	**5.8**	**9.4**	**11.6**
Antigua and Barbuda	6.4	7.9	10.8	10.8	19.7	23.8	27.9	1.4	1.6	3.6	3.1	4.2	9.9	10.9
Bahamas	5.3	6.1	7.1	12.5	20.1	25.4	30.3	1.0	1.2	1.6	3.1	5.7	9.8	12.4
Barbados	11.1	14.1	13.9	19.8	27.7	30.9	31.5	2.3	3.9	4.9	6.1	9.2	13.4	14.9
Cuba	8.1	10.8	12.7	19.4	31.6	37.8	41.3	1.6	2.7	4.0	6.3	10.0	18.8	21.3
Dominican Republic	4.2	4.9	6.8	9.7	14.2	19.2	24.7	0.7	0.9	1.5	2.8	4.0	6.6	9.4
Grenada	7.5	9.7	10.2	10.2	14.3	20.8	30.1	1.7	2.4	3.0	3.3	3.7	6.2	10.3
Haiti	5.7	6.3	6.1	7.1	9.3	13.3	18.9	0.9	1.1	1.3	1.6	2.1	3.1	5.1
Jamaica	8.1	9.3	9.9	12.8	18.7	25.1	34.1	1.8	2.5	3.4	4.2	5.5	9.5	13.1
Saint Lucia	6.9	7.7	10.3	12.5	19.1	25.5	32.0	1.4	1.6	3.4	4.0	5.2	9.3	12.8
Saint Vincent and the Grenadines	6.7	8.2	9.0	10.9	18.3	23.8	29.5	1.3	1.9	2.7	3.2	4.3	8.1	10.7
Trinidad and Tobago	5.7	8.0	8.7	14.2	20.2	26.1	28.5	0.9	1.7	2.2	3.2	5.2	7.7	10.9
Central America	**5.4**	**5.4**	**6.6**	**9.3**	**14.2**	**20.9**	**28.0**	**1.0**	**1.3**	**1.6**	**2.6**	**4.0**	**7.0**	**11.1**
Belize	6.4	6.4	6.2	5.9	8.9	12.9	18.8	1.3	1.7	1.7	1.3	1.5	2.8	4.6
Costa Rica	5.0	6.1	7.6	12.8	20.5	27.6	34.8	0.9	1.3	1.8	3.4	6.2	11.1	15.2
El Salvador	5.1	5.4	7.3	11.5	15.8	21.5	31.1	0.9	1.1	1.6	3.4	5.0	7.6	11.3
Guatemala	4.5	4.6	5.6	7.0	8.6	12.6	18.2	0.8	0.9	1.1	1.9	2.5	3.4	5.7
Honduras	4.9	4.8	5.4	7.2	10.7	16.7	25.8	0.9	1.0	1.2	2.0	2.9	4.9	8.4
Mexico	5.6	5.5	6.7	9.6	14.9	22.3	29.6	1.1	1.4	1.7	2.6	4.2	7.6	12.1
Nicaragua	4.0	4.4	5.2	7.8	12.5	20.2	29.0	0.7	0.8	1.1	2.2	3.5	6.3	11.3
Panama	5.7	6.2	7.4	10.9	16.2	21.9	26.6	1.2	1.4	1.9	3.1	4.9	8.0	11.3
South America	**6.1**	**6.7**	**7.7**	**11.7**	**17.7**	**24.4**	**30.3**	**1.1**	**1.3**	**1.7**	**3.1**	**5.1**	**8.7**	**12.7**
Argentina	9.8	12.0	13.3	15.1	17.5	22.1	26.4	1.8	2.7	3.6	4.7	6.0	7.7	10.8
Bolivia (Plurinational State of)	6.3	5.8	7.0	9.2	11.4	15.4	20.5	1.2	1.0	1.5	2.7	3.5	4.7	7.0
Brazil	5.2	5.8	6.8	11.7	18.8	26.8	33.4	0.9	1.1	1.3	3.0	5.3	9.6	14.5
Chile	7.9	8.6	10.1	15.7	23.7	30.4	36.6	1.6	2.1	2.7	4.7	8.0	13.6	17.5
Colombia	5.2	5.6	6.4	10.8	18.3	25.2	31.7	0.9	1.2	1.5	2.5	4.8	9.0	12.9
Ecuador	6.7	6.0	6.6	9.9	14.5	19.9	25.7	1.5	1.4	1.7	2.7	4.3	7.0	10.2
Guyana	5.4	5.4	6.6	8.3	14.9	14.7	19.7	1.0	1.2	1.7	1.4	2.3	4.7	4.0
Paraguay	5.2	5.9	6.2	9.0	12.0	16.1	22.7	1.0	1.2	1.5	2.3	3.5	4.8	7.1
Peru	5.5	5.6	6.6	10.0	14.7	20.9	27.1	0.8	1.0	1.5	2.7	4.1	7.0	10.8
Suriname	6.0	6.2	7.8	10.2	15.7	19.8	23.8	1.3	1.7	1.6	2.6	3.4	6.2	8.0
Uruguay	12.3	14.7	17.1	19.1	22.1	26.1	30.7	3.0	3.8	4.9	7.0	8.0	10.3	13.0
Venezuela (Bolivarian Republic of)	4.0	5.1	6.0	9.4	14.8	19.9	25.4	0.7	0.9	1.3	2.3	3.7	6.7	9.5

Source: United Nations, "World Population Prospects: The 2015 Revision [DVD Edition]", New York, Department of Economic and Social Affairs, 2015.

Table I.A1.3
Latin America and the Caribbean: femininity ratio of the population aged 60 and over and 75 and over, by subregion and country, 1965-2060

Region, subregion, country	Femininity ratio of the population aged 60 and over							Femininity ratio of the population aged 75 and over						
	1965	1980	1995	2015	2030	2045	2060	1965	1980	1995	2015	2030	2045	2060
Latin America and the Caribbean	**114.0**	**118.5**	**124.3**	**122.8**	**122.6**	**120.3**	**115.0**	**131.3**	**135.2**	**148.5**	**147.9**	**143.2**	**139.9**	**131.3**
The Caribbean	**100.8**	**107.1**	**113.9**	**116.1**	**116.5**	**117.8**	**115.4**	**112.0**	**114.4**	**126.1**	**133.2**	**132.7**	**129.8**	**131.3**
Antigua and Barbuda	191.6	153.0	146.5	124.2	127.2	133.9	126.4	329.0	257.0	157.2	158.4	149.3	151.5	154.4
Bahamas	142.3	126.3	133.8	130.5	125.1	122.3	117.2	170.7	162.4	168.9	171.4	148.5	142.6	133.5
Barbados	182.4	144.9	147.6	129.0	128.4	129.6	126.2	262.1	194.2	168.5	158.3	148.3	148.1	139.8
Cuba	85.1	102.6	112.3	111.5	109.4	107.5	104.0	87.7	99.4	123.0	128.2	123.5	115.8	113.6
Dominican Republic	91.1	92.2	97.7	109.0	114.9	118.6	116.3	101.2	106.5	103.8	117.0	126.3	132.6	133.3
Grenada	168.2	142.2	149.3	129.0	120.9	113.0	112.7	223.1	188.4	172.0	169.9	145.2	142.7	128.2
Haiti	113.0	112.9	117.6	120.9	119.3	120.2	120.4	125.6	117.1	124.9	137.5	137.4	138.9	141.8
Jamaica	125.6	115.1	113.4	107.4	110.1	121.9	116.4	169.4	141.0	135.2	128.0	119.4	125.7	139.7
Saint Lucia	154.2	125.3	114.8	117.1	120.3	124.1	119.6	186.9	155.8	134.2	136.1	139.9	141.2	141.0
Saint Vincent and the Grenadines	164.3	134.3	124.9	112.0	104.2	111.1	115.4	244.8	182.3	139.4	137.5	125.5	121.2	131.1
Trinidad and Tobago	106.8	112.3	127.3	122.2	131.3	138.3	142.5	116.5	132.2	155.9	164.2	170.9	193.0	189.0
Central America	**110.6**	**117.8**	**122.3**	**115.0**	**116.8**	**116.2**	**110.8**	**118.1**	**123.9**	**136.7**	**132.4**	**126.2**	**127.8**	**122.4**
Belize	106.5	106.7	105.3	98.6	116.1	131.8	131.5	114.3	114.0	123.3	107.5	129.5	160.3	175.9
Costa Rica	100.2	103.2	113.4	111.5	111.8	109.8	106.4	110.0	111.6	131.6	127.1	123.0	119.9	115.4
El Salvador	119.4	119.5	117.7	132.5	148.8	156.2	143.8	146.6	140.4	139.9	131.5	158.7	174.8	177.1
Guatemala	104.9	104.7	110.4	120.8	136.4	133.9	123.2	110.9	112.9	118.5	126.2	142.6	161.8	149.8
Honduras	113.4	113.1	109.6	109.4	112.3	115.7	112.6	123.4	129.7	128.4	125.0	125.6	129.6	129.4
Mexico	111.0	120.1	125.3	113.8	114.3	113.6	108.3	117.1	124.0	139.0	134.1	123.1	124.0	118.5
Nicaragua	121.3	125.5	124.4	126.2	129.4	125.1	113.6	143.4	147.2	144.0	135.4	142.4	143.9	131.0
Panama	95.1	100.6	106.1	111.4	112.0	110.9	109.2	100.9	110.1	118.3	120.6	124.7	122.3	117.7
South America	**117.2**	**120.6**	**126.6**	**126.4**	**125.3**	**122.1**	**116.9**	**139.9**	**144.0**	**157.9**	**156.0**	**150.9**	**145.8**	**135.1**
Argentina	104.4	123.6	134.4	138.3	134.2	125.7	118.2	126.0	145.3	174.1	188.7	176.3	161.6	141.2
Bolivia (Plurinational State of)	121.6	120.7	113.0	111.2	114.5	116.1	115.8	120.0	123.9	125.7	125.6	127.9	133.6	133.5
Brazil	123.6	120.7	128.9	127.4	127.4	123.9	118.2	150.1	150.4	167.4	155.0	152.2	148.5	136.4
Chile	124.1	128.3	130.0	131.1	125.5	120.0	114.7	146.7	147.0	156.3	165.1	156.3	141.3	134.8
Colombia	122.7	120.9	124.0	122.7	121.7	122.0	118.7	146.9	138.3	142.3	142.4	139.7	139.9	135.9
Ecuador	116.4	112.0	111.4	113.2	113.1	112.5	109.0	135.1	126.7	122.3	126.2	125.2	124.1	118.7
Guyana	119.5	104.8	117.9	116.4	110.7	115.6	109.4	173.4	122.5	148.7	115.7	133.5	128.1	136.2
Paraguay	124.3	117.9	113.3	105.0	107.1	110.0	111.9	148.4	139.3	132.0	123.1	118.9	126.4	128.5
Peru	113.8	114.8	113.7	117.2	119.5	114.7	108.3	126.9	132.2	132.2	136.0	136.0	134.9	120.9
Suriname	107.3	107.5	117.7	126.9	122.1	127.7	129.3	121.2	128.7	139.9	158.5	166.5	158.8	162.7
Uruguay	117.2	125.5	137.6	145.4	137.4	127.4	118.0	148.2	156.5	178.4	203.3	184.0	164.1	143.1
Venezuela (Bolivarian Republic of)	101.1	109.9	115.1	119.5	120.5	121.9	119.6	117.0	123.4	134.8	149.9	149.6	147.1	143.0

Source: United Nations, "World Population Prospects: The 2015 Revision [DVD Edition]", New York, Department of Economic and Social Affairs, 2015.
Note: Femininity index = (female population aged 60 years and over/male population aged 60 years and over) * 100 or (female population aged 75 years and over/male population aged 75 years and over) * 100.

Table I.A1.4
Latin America and the Caribbean: ageing index and old-age dependency ratio, by subregion and country, 1965-2060

Region, subregion, country	Ageing index							Old-age dependency ratio						
	1965	1980	1995	2015	2030	2045	2060	1965	1980	1995	2015	2030	2045	2060
Latin America and the Caribbean	**13.9**	**16.4**	**22.1**	**43.5**	**79.4**	**130.6**	**185.0**	**11.8**	**12.1**	**12.9**	**17.7**	**27.0**	**39.6**	**54.0**
The Caribbean	**16.6**	**23.5**	**30.8**	**53.0**	**89.0**	**126.7**	**166.7**	**13.3**	**15.6**	**16.7**	**21.6**	**32.3**	**41.1**	**51.4**
Antigua and Barbuda	15.2	23.5	36.6	44.5	93.4	131.3	164.9	12.3	13.4	18.0	16.5	33.2	41.1	50.5
Bahamas	12.2	16.5	22.5	59.9	104.2	153.3	188.2	10.3	10.7	11.5	18.8	33.2	43.8	56.6
Barbados	28.5	47.5	61.0	102.4	155.9	179.7	185.4	22.3	25.2	22.1	32.6	51.0	59.5	61.1
Cuba	21.9	34.2	56.2	119.3	232.1	302.4	331.5	14.9	18.8	19.6	30.3	57.7	76.2	89.2
Dominican Republic	8.5	11.5	18.4	32.4	57.5	93.0	139.5	8.9	9.3	12.2	16.1	23.4	32.0	42.9
Grenada	15.2	24.3	26.8	38.4	63.2	115.0	189.8	17.6	19.3	19.7	16.0	22.7	34.0	55.7
Haiti	13.7	15.5	14.4	20.9	32.7	55.9	91.6	10.9	12.1	11.9	11.9	14.9	21.2	31.2
Jamaica	18.6	23.2	29.4	54.2	87.8	151.7	225.2	16.7	18.5	17.7	20.1	31.3	43.1	67.2
Saint Lucia	14.6	17.5	29.6	54.2	100.8	161.3	221.3	15.0	15.9	18.9	19.5	30.8	43.5	59.7
Saint Vincent and the Grenadines	13.2	18.7	26.2	44.6	92.4	141.0	192.7	15.6	17.0	16.0	17.0	29.6	40.2	53.4
Trinidad and Tobago	13.0	23.6	28.2	68.4	117.2	160.2	181.6	11.1	13.8	14.3	21.9	32.3	45.2	51.1
Central America	**11.5**	**12.0**	**17.6**	**32.7**	**61.3**	**110.8**	**170.9**	**11.2**	**10.9**	**11.8**	**15.1**	**22.6**	**34.6**	**50.2**
Belize	13.7	13.7	14.6	18.3	32.7	57.9	95.9	13.8	13.6	12.2	9.6	14.0	20.0	30.5
Costa Rica	11.2	16.6	22.7	57.2	113.5	180.2	246.5	9.9	10.7	13.0	19.6	33.4	48.4	68.2
El Salvador	11.2	12.4	19.5	42.4	71.4	123.2	205.4	10.4	10.7	13.3	18.7	25.4	35.2	57.7
Guatemala	10.0	10.2	12.6	19.1	27.8	49.1	83.8	9.0	9.3	11.2	12.4	14.1	20.3	30.2
Honduras	10.3	10.2	12.1	22.7	43.3	85.2	155.6	10.1	9.9	10.6	11.8	16.6	26.2	44.7
Mexico	11.9	12.2	18.6	34.7	67.5	124.8	191.0	11.7	11.2	11.8	15.3	23.7	37.2	53.8
Nicaragua	8.2	9.3	12.1	25.9	53.9	110.0	186.6	8.6	9.0	10.1	12.5	19.4	32.9	52.4
Panama	12.7	15.1	22.0	40.3	69.9	110.4	151.9	11.3	11.7	12.6	17.7	26.6	37.5	47.5
South America	**14.5**	**17.5**	**23.1**	**47.6**	**87.3**	**140.6**	**193.6**	**11.8**	**12.1**	**12.9**	**18.4**	**28.5**	**41.8**	**56.1**
Argentina	32.7	39.6	45.6	60.0	78.5	112.0	148.7	16.4	20.8	23.1	25.3	29.0	37.9	47.3
Bolivia (Plurinational State of)	14.8	13.8	17.5	28.4	41.1	65.1	100.6	12.5	11.3	13.1	15.8	18.7	25.2	34.8
Brazil	11.9	15.0	21.0	51.0	102.4	172.4	234.6	10.3	10.3	11.3	18.0	29.8	46.6	63.8
Chile	20.2	25.9	35.8	77.9	140.0	206.5	264.0	14.9	14.8	16.4	24.5	39.9	55.4	73.8
Colombia	11.0	13.9	18.8	44.6	95.5	155.1	214.6	10.8	10.5	10.9	16.7	29.2	43.1	59.3
Ecuador	15.0	14.4	18.2	34.2	59.3	96.6	144.6	13.7	11.6	11.7	16.3	23.8	33.3	45.3
Guyana	11.2	12.6	19.0	28.8	56.5	66.4	99.1	11.4	10.6	11.4	13.2	25.4	23.2	32.5
Paraguay	11.0	13.8	15.4	29.9	46.5	74.8	120.6	11.1	11.3	11.6	14.8	19.3	25.8	38.9
Peru	12.4	13.2	18.2	35.7	63.0	107.5	160.9	11.1	10.7	11.6	16.0	23.7	34.9	48.5
Suriname	12.4	15.7	22.7	38.2	69.1	100.1	134.1	13.1	11.5	13.5	16.3	25.6	32.7	40.7
Uruguay	43.9	54.7	68.5	89.4	115.1	151.7	193.1	20.6	25.3	29.6	32.2	37.8	46.1	57.6
Venezuela (Bolivarian Republic of)	8.5	12.3	16.6	33.5	63.1	99.9	145.2	8.0	9.4	10.4	15.0	24.1	33.0	44.3

Source: United Nations, "World Population Prospects: The 2015 Revision [DVD Edition]", New York, Department of Economic and Social Affairs, 2015.
Note: Ageing index = (population aged 60 and over/population aged 0-14 years) * 100; old-age dependency ratio = (population aged 60 and over/population aged 15-59 years) * 100.

Table I.A1.5
Latin America and the Caribbean: parent support ratio and potential support ratio, by subregion and country, 1965-2060

Region, subregion, country	Parent support ratio (per 100)							Potential support ratio						
	1965	1980	1995	2015	2030	2045	2060	1965	1980	1995	2015	2030	2045	2060
Latin America and the Caribbean	**5.5**	**7.4**	**10.2**	**12.2**	**16.0**	**26.1**	**40.2**	**8.5**	**8.3**	**7.7**	**5.6**	**3.7**	**2.5**	**1.9**
The Caribbean	**6.0**	**9.7**	**12.8**	**15.1**	**19.9**	**31.7**	**41.5**	**7.5**	**6.4**	**6.0**	**4.6**	**3.1**	**2.4**	**1.9**
Antigua and Barbuda	7.7	8.7	…	10.7	11.0	28.0	37.1	8.1	7.5	5.6	6.1	3.0	2.4	2.0
Bahamas	5.9	7.4	8.6	9.1	17.3	30.5	43.9	9.7	9.3	8.7	5.3	3.0	2.3	1.8
Barbados	8.3	16.1	20.6	17.1	26.4	48.1	56.7	4.5	4.0	4.5	3.1	2.0	1.7	1.6
Cuba	5.4	11.1	14.4	17.4	25.5	59.6	86.4	6.7	5.3	5.1	3.3	1.7	1.3	1.1
Dominican Republic	4.4	4.8	9.6	13.3	15.7	23.3	31.6	11.2	10.7	8.2	6.2	4.3	3.1	2.3
Granada	8.4	11.7	…	14.4	14.0	17.3	29.3	5.7	5.2	5.1	6.2	4.4	2.9	1.8
Haiti	3.8	5.0	9.2	7.9	8.6	9.3	13.3	9.1	8.3	8.4	8.4	6.7	4.7	3.2
Jamaica	8.2	17.3	17.2	18.2	18.9	27.2	42.1	6.0	5.4	5.7	5.0	3.2	2.3	1.5
Saint Lucia	7.1	7.3	…	15.7	16.5	26.7	39.7	6.6	6.3	5.3	5.1	3.3	2.3	1.7
Saint Vincent and the Grenadines	7.1	10.1	…	10.5	12.5	23.9	29.9	6.4	5.9	6.3	5.9	3.4	2.5	1.9
Trinidad and Tobago	5.5	8.1	…	9.0	13.8	19.8	29.2	9.0	7.2	7.0	4.6	3.1	2.2	2.0
Central America	**6.4**	**8.7**	**10.1**	**12.9**	**14.2**	**22.7**	**36.9**	**8.9**	**9.1**	**8.5**	**6.6**	**4.4**	**2.9**	**2.0**
Belize	6.3	12.7	11.9	6.7	4.9	7.6	11.7	7.2	7.4	8.2	10.4	7.2	5.0	3.3
Costa Rica	5.0	6.9	9.7	12.3	20.5	33.3	50.9	10.1	9.3	7.7	5.1	3.0	2.1	1.5
El Salvador	5.3	5.9	9.6	15.0	19.0	23.7	33.9	9.6	9.4	7.5	5.4	3.9	2.8	1.7
Guatemala	4.9	6.2	8.5	12.8	12.9	13.3	19.2	11.1	10.8	9.0	8.0	7.1	4.9	3.3
Honduras	4.6	7.0	10.2	12.3	12.3	15.0	23.6	9.9	10.1	9.4	8.5	6.0	3.8	2.2
Mexico	6.8	9.4	10.3	12.9	13.9	23.9	40.3	8.5	8.9	8.5	6.6	4.2	2.7	1.9
Nicaragua	4.2	5.3	9.8	11.7	12.7	19.7	34.9	11.6	11.1	9.9	8.0	5.2	3.0	1.9
Panama	6.8	9.0	11.0	13.9	17.5	28.6	41.7	8.8	8.5	8.0	5.7	3.8	2.7	2.1
South America	**5.1**	**6.7**	**10.0**	**11.7**	**16.3**	**27.0**	**41.6**	**8.5**	**8.3**	**7.7**	**5.4**	**3.5**	**2.4**	**1.8**
Argentina	5.4	8.4	14.6	19.6	21.5	27.0	38.7	6.1	4.8	4.3	4.0	3.4	2.6	2.1
Bolivia (Plurinational State of)	4.9	4.2	11.2	15.3	16.3	17.7	23.8	8.0	8.9	7.6	6.3	5.4	4.0	2.9
Brazil	4.5	5.5	8.3	10.1	15.6	28.2	45.3	9.7	9.7	8.9	5.6	3.4	2.1	1.6
Chile	7.4	10.5	11.7	16.2	25.5	44.2	66.7	6.7	6.7	6.1	4.1	2.5	1.8	1.4
Colombia	5.1	7.2	10.3	9.3	14.0	25.5	39.8	9.3	9.6	9.2	6.0	3.4	2.3	1.7
Ecuador	7.5	8.7	10.2	12.3	15.8	24.6	36.2	7.3	8.6	8.6	6.2	4.2	3.0	2.2
Guyana	6.2	7.2	…	3.7	6.0	15.4	10.5	8.8	9.5	8.8	7.6	3.9	4.3	3.1
Paraguay	5.8	6.5	10.8	10.8	14.7	15.7	20.9	9.0	8.8	8.6	6.8	5.2	3.9	2.6
Peru	3.5	5.2	9.4	12.1	14.1	22.3	37.2	9.0	9.3	8.6	6.2	4.2	2.9	2.1
Suriname	8.0	10.2	8.3	9.2	10.5	18.8	23.2	7.6	8.7	7.4	6.1	3.9	3.1	2.5
Uruguay	10.7	11.8	15.7	26.7	28.0	35.8	46.4	4.8	4.0	3.4	3.1	2.6	2.2	1.7
Venezuela (Bolivarian Republic of)	4.5	5.6	8.2	9.2	13.2	22.0	31.9	12.4	10.7	9.6	6.6	4.2	3.0	2.3

Source: United Nations, "World Population Prospects: The 2015 Revision [DVD Edition]", New York, Department of Economic and Social Affairs, 2015.
Note: Three dots (…) indicate that data are not available on the population aged 80 and over.Parent support ratio = (population aged 80 and over/population aged 50-64) * 100; potentials support ratio = population aged 15-59/population aged 60 and over.

Chapter

II

Human rights in the context of ageing and the need for enhanced protection of older persons in the framework of the United Nations

Introduction

Progress by older persons towards an equal status in society has been very similar to that made by other discriminated groups, such as women or persons with disabilities. The underlying reason for the similarity is the standard of normality upon which society has been built and its consequent inability to create decent and equal conditions for those who are different. The standard of normality is not neutral, but rather biased in favour of a culturally dominant stereotype (Courtis, 2004).

The standard of normality is based on an archetype of power —related to a white, male and preferably young person, free from any deficiencies— through which human existence is interpreted. The dominant archetype is then extended to all members of society as a valid reference. Anyone not matching these attributes diverges from the "normal" and therefore suffers the effects of sexism, racism or ageism on a daily basis (Huenchuan, 2005). Whether it relates to sex, age, ethnicity or capacities, the point of difference immediately becomes a source of adversity, restricting or preventing that person from leading a free and autonomous life.

Individuals and groups who are "different" have therefore shared a very similar social trajectory. From the initial construction of an image as undesirable beings —sometimes attributed to a magical religious origin— they became objects of protection and of the compulsion to disguise what made them different, before being acknowledged as subjects of law. In policy terms, they suffer the effects of well-being interventions that, although well-intentioned, are based on a perception of difference as a deficiency, a defect or a mutilation in need of remedy. They are also conceived as incapable of leading their own lives. That task is therefore entrusted to a superior or specialist third party, be it the husband or father for women, doctors for persons with disabilities or care providers for older persons. Medicalization and long-term care institutionalization are practices to which older individuals and persons with disabilities are all too frequently subjected.

The recognition of older persons as subjects of law must be interpreted in the context of a wider struggle for the development of an inclusive and democratic society, which considers difference to be part of the rich variety of humankind, rather than a reason for segregation. This, however, is a long-term goal that is beset by various difficulties. Yet a legally-binding instrument is attainable and would be a fundamental step towards its future achievement in reality.

This context frames the efforts to discuss and resolve the issues concerning older persons and their rights today. It is not just about older persons, however; it is about the society in which they live. It is about questioning assumptions of homogeneity and rejection of difference, a reminder of the ever-present and threatening "otherness". Perhaps owing to the depth of personal and collective questioning inspired by old age, issues concerning the rights of older persons tend to be difficult to address, whether on a political, academic or daily basis.

Over the years, the Economic Commission for Latin America and the Caribbean (ECLAC) has pursued discussions on the human rights of older persons in the region. From timid beginnings, the movement has progressively gained strength and supporters from diverse areas of social policy, civil society, medicine and legislative work. It has not always been a smooth process, and gaining acceptance has not been straightforward. Numerous meetings, seminars and workshops have been held to lay the groundwork for a consensus. In different countries, leaders have emerged and pledged their firm support concerning the need for a human rights perspective in relation to older persons.

Today, the human rights of older persons are protected in both the Inter-American and African systems. Furthermore, discussions on the subject are taking into account

This chapter is not meant to address all contemporary issues concerning the human rights of older persons. Rather, it is intended as a means to galvanize the debate and to put forward certain ideas for future analysis.

the fact that the current legal context of the rights of older persons is one of normative fragmentation across different international instruments, which makes these rights difficult to apply. Yet, even now, old issues continue to crop up, requiring fresh thinking and new ideas in order for progress to continue within the framework of the United Nations.

The adoption of a human-rights-based approach requires deeper understanding of human rights in context of ageing. The academic and literary work surrounding the formulation of the Convention on the Rights of Persons with Disabilities barely begins to touch upon the issues involved here.

Progress has been made with regard to human rights, with the creation of the special procedures for the Human Rights Council, for example. However, these accomplishments have not fully encompassed the essence and rationale of recognizing older persons as rights-holders within the United Nations, particularly as those in the southern hemisphere are yet to be involved in discussions on this matter.

This chapter is not meant to address all contemporary issues concerning the human rights of older persons. That would be a much greater undertaking. Rather, it is intended as a means to galvanize the debate and to put forward certain ideas for future analysis.

A. The social construct of ageing underlying difference and lack of autonomy

The first question to be addressed in analysing the protection of human rights for older persons is what exactly makes them different. John Williams (2011) suggests that older persons, as adults, have the right to autonomy and that, therefore, the real challenge lies in ensuring full respect for that right.

Williams draws a comparison between two age groups: children and older persons. The two groups share a common condition —their age— that marks them out as different and that seems to determine their state of dependence. In the first case, it is reflected in an inability to make independent decisions during childhood; in the second, in a loss of autonomy or a weakened capacity to exercise it.

However, there is a fundamental difference between the two groups —the durability of the dependence. On the one hand, children are protected so that they can develop the capacity to become autonomous. On the other hand, older persons are progressively denied the opportunity to decide for themselves.

Age is a major dimension of social organization. However, the social construct of age is not clearly related to the various rights and responsibilities for different life course phases (Neugarten and Neugarten, 1987). As has been documented for several decades, to a certain degree, old age itself is the determining factor behind the diminished status of older persons in Western societies, often restricting their autonomy.

This statement is already beyond debate for activists, academics and even policymakers on matters relating to older persons. However, the evidence still does not seem to be enough for the international community. Just as deficiency had to be distinguished from disability in reference to persons with disabilities, and sex had to be distinguished from gender in relation to women, ageism must be distinguished from old age in this case.

Chronological age determines when each new phase of life begins; old age is generally associated with retirement, as a "natural" phenomenon for everyone, whereas the dividing line between adults and elders is in fact more closely related to

physiological age. Both changes —chronological and physiological— entail changes in the lives of older persons and those surrounding them, owing to a stereotyped and negative vision of old age.

The relationship between older persons and society thereby takes on an oppressive nature. The same scheme applies for both women and persons with disabilities, based on different causes. Women are determined by their anatomy, persons with disabilities by their deficiency (Palacios and Bariffi, 2007) and older persons by age.

Nevertheless, the complexities involved in distinguishing older persons and recognizing their specific rights lie in the cause of the discrimination itself. Continual change is an inherent characteristic of classification by age. Williams (2011) argues that, as adults, older persons are entitled to equality in a real and formal sense. Other than in cases of premature death, everyone reaches old age and runs the risk of suffering age-based discrimination, regardless of the status they may have held earlier in their lives. So, why and how is negative prejudice towards older persons perpetuated? Why is the autonomy acquired during adulthood lost during the final phase of the life cycle before death?

Traxler (1980) defines older persons as a group discriminated against on the basis of age, whose rights are limited by negative perceptions of that group. He proposed four reasons for the development of ageism in Western society: fear of death, emphasis on the youth culture, a narrow conceptualization of productivity in terms of earning potential, and the concentration on older persons in long-term care facilities.

Fear of ageing is caused in part by the fear of dying. Western civilization conceptualizes death as outside the human life cycle and even as an affront to existence itself (Butler and Lewis, 1977). For the collective imagination, old age represents uselessness, impotence and the brevity of life, and ageism —expressed as personal rejection and collective aversion towards older persons— appears to reflect the profound unease of the young and adults in the middle years of the life cycle vis-à-vis older persons. Fear of dying is cultural; until they have learned that fear, children tend to treat older persons with more compassion.

The emphasis on the youth ideal goes hand in hand with society's collective preoccupation with productivity. Attributes of eternal youth —such as beauty, vigour and sexuality— are overvalued by society (Northcott, 1975). The same can be said of the accumulation of material goods and the predominance of personal life plans, both of which are associated with success and power. During old age, people lose both youth and professional productivity. They are therefore perceived as a burden on society, in contrast to children, who still have the potential to develop these assets (Butler, 1969).

Lastly, old age is often associated with long-term care residences, albeit less now than it once was. In the past, one of the most traditional forms of care for older persons was provided in retirement homes or senior residences, whose moralistic and segregating practices still affect the image of old age today (Guillemard, 1992).

In order to enjoy rights, people must be perceived as unique individuals who are capable of forming independent moral judgments. They must also be a part of the political community and able to empathize with others (Hunt, 2009), attributes that are difficult to sustain when physiological decline is associated with disability.

Certainly, not all older persons feel that they suffer from age-based discrimination. The absence of a shared experience of discrimination is often used as an argument against treating them as a differentiated social cohort. Yet this was no impediment to the consensuses reached on eliminating discrimination for reasons of gender, disability or ethnicity. It is rather paradoxical that a greater number of shared attributes are demanded of older persons for their rights to be recognized.

B. The foundations and standardization of the human rights of older persons

Human rights must have three interconnected characteristics: they must be natural, i.e. inherent in all human beings; they must be equal, i.e. the same for everyone; and they must be universal, i.e. applicable everywhere (Hunt, 2009).

The available literature on the subject shows that the natural —as opposed to the divine or animal—quality of human rights has been accepted more easily than their universality or equality (Hunt, 2009). This shows in the constant efforts of discriminated-against groups to receive specific recognition. In each case, the main argument from the members of these groups is that they find themselves marginalized or at a disadvantage compared with society as a whole, owing to their specific characteristics or needs (Rodríguez-Piñero, 2010).

This imbalance may be the result of modern society's inability to accept social diversity and to treat all citizens equally. Various authors have stated that a concept of equality blind to social differences, combined with the State's neutrality on questions of what is right and what a good life is, as well as the lack of the tolerance required to guarantee pluralism have, together, resulted in a trenchant social homogeneity that discriminates against those who are different and oppresses disadvantaged groups. However, the recognition of a full set of rights for these social groups could remedy this oversight (Rodríguez Abascal, 2002).

The Office of the United Nations High Commissioner for Human Rights states that "the principle of universality of human rights is the cornerstone of international human rights law. This principle, as first emphasized in the Universal Declaration on Human Rights in 1948, has been reiterated in numerous international human rights conventions, declarations, and resolutions".[1]

The World Conference on Human Rights held in Vienna in 1993, for example, noted that it is the duty of States to promote and protect all human rights and fundamental freedoms, regardless of their political, economic and cultural systems. In spite of this broad recognition, it has not always been easy to reach an agreement on the meaning and scope of their universality. Certain authors go as far as to say that this notion has become a platitude often spoken but, in reality, rarely addressed properly (Gutiérrez, 2011).

Discussions relating to the human rights of older persons are no exception. Frequent references to the universality of older persons' human rights are heard both from those who believe that the international community should be more rigorous in providing legal protection and from those who argue that more needs to be done to enforce existing instruments. Meanwhile, the principle of universality dictates that human rights must constitute an ethical threshold, achievable by everyone in the present time. Accordingly, having established the rationale for human rights, they must be catalogued (Lema Añon, 2011).

In theory, older persons should enjoy the same rights as all human beings. In order to achieve this, their status as rights-holders must be reinforced. All those involved in ongoing discussions on the human rights of older persons agree that, from an ethical perspective, the universality of human rights encompasses older persons. However, the close connection between ageing and welfare resulted in the facile conclusion that older persons needed only social and health-care services in order to lead a dignified life.[2]

1 See [online] http://www.ohchr.org/SP/Issues/Pages/WhatareHumanRights.aspx.

2 The Council of Europe Steering Committee for Human Rights (CDDH) drew attention to this issue when acknowledging that, although a concern for older persons is nothing new for the Council of Europe —as demonstrated by the range of issues addressed in the decisions and resolutions of the Council of Ministers and the European Parliament—, they have generally been treated as a group that required protection, rather than a group of rights-holders.

If these human rights referred exclusively to an ideal vision of conduct towards older persons —as is the case with the current United Nations Principles for Older Persons, adopted by the General Assembly in resolution 46/91— it would not be so difficult to gain the recognition of the international community. Discord arises because the human rights need to be recognized by means of a legally binding instrument, as a sine qua non for making such conduct enforceable (Gutiérrez, 2011).

This is the stage that international discussions have reached. The challenge is to establish whether the existing catalogue of human rights recognized by the United Nations genuinely serves to protect the rights of older persons. Various Latin American, African and even European countries have indicated that this is not the case and, without refuting the universality of human rights, have suggested that a specific instrument should be adopted to interpret these rights in relation to older persons.[3]

In other words, the standards set by human rights must not be interpreted in a dogmatic way, as if the underlying moral rationale were static. The insistence on specifying human rights in the context of ageing is proof that the existing instruments, created in decades gone by, are neither infallible nor invulnerable to change (Hunt, 2009).

The United Nations Committee on Economic, Social and Cultural Rights had already reached this understanding in 1995, when it stated in its General Comment No. 6 that, "neither the Covenant nor the Universal Declaration of Human Rights refers explicitly to age as one of the prohibited grounds. Rather than being seen as an intentional exclusion, this omission is probably best explained by the fact that, when these instruments were adopted, the problem of demographic ageing was not as evident or as pressing as it is now" (United Nations, 1995).

C. The main issues in relation to the human rights of older persons

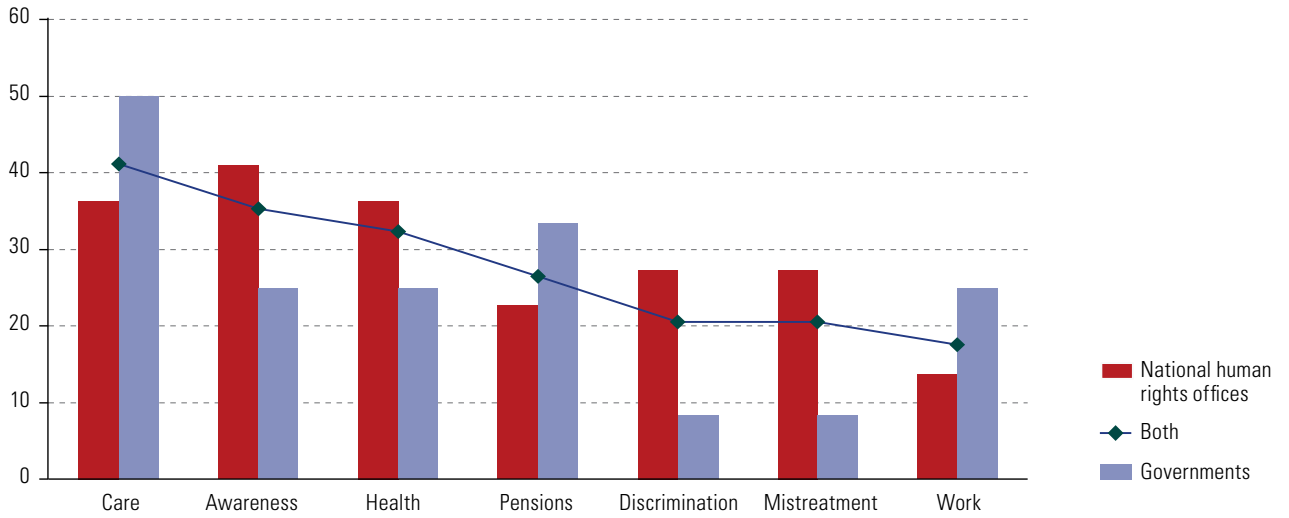
In recent years, reports both from the United Nations Secretary-General and from the High Commissioner for Human Rights have shed further light on the difficulties and limitations that older persons have in exercising their rights. In 2013, the Office of the United Nations High Commissioner for Human Rights convened a broad consultation on the promotion and protection of the rights of older persons. Information was gathered from United Nations Member States from all around the world, with responses provided by governments, national human rights offices, academic institutions and civil society organizations.

The information gathered from 34 of the countries taking part[4] highlights the main concerns of governments and national human rights offices regarding the rights of older persons. An analysis of the responses reveals that the issue of care, mentioned by 41.2% of respondents, is the most frequently identified area of concern, followed by the lack of awareness of the reality and rights of older persons (35.3%), health (32.4%), pensions (26.5%), discrimination and mistreatment (21%) and work (17.6%) (see figure II.1).

[3] One example of human rights principles being interpreted in a specific context took place in the lead-up to the adoption of a convention on the rights of persons with disabilities. On this occasion, experts and members of civil society warned that, although the basic values supported by human rights may well form the foundations of a system of basic freedoms protecting against the abuse of power and facilitating the development of the human spirit, for them to be useful they had to be framed in the specific context of disability (Quinn and Deneger, 2002).

[4] Although a total of 37 States provided responses, this analysis does not take into account the results of the three States whose responses were not provided in one of the official languages of the United Nations.

Figure II.1
Principal areas of concern related to the rights of older persons, according to the governments and national human rights offices of 34 countries, 2013
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of Office of the United Nations High Commissioner for Human Rights (OHCHR), "Public consultation on the right to health of older persons", 2013 [online] http://www.ohchr.org/EN/Issues/Health/Pages/HealthOfOlderPersons.aspx.

The governments of Member States consider that care-related issues are the main problem facing older persons, followed in order of priority by the separate issues of pensions, work, public awareness, health, and discrimination and mistreatment. As far as the national human rights offices are concerned, the main problem is a lack of public awareness, followed by issues related to care, health, discrimination and mistreatment, pensions and work. Regardless of geographical location, these are identified as the seven areas most urgently requiring affirmative action in order to allow older persons to better exercise their rights.

1. Care

The issue of care was frequently cited —in the responses of both developed and developing countries. The Equality and Human Rights Commission in the United Kingdom, for example, emphasized the difficulties that older persons experience in exercising their rights whilst receiving long-term care. A recent survey concluded that older persons felt they had little or no say over how they lived their lives, and were often confused about the options available to them. Most older persons thought that ageism and the stigma associated with old age were prevalent in the treatment they received from care providers, and felt that they were viewed as merchandise rather than as consumers with rights. Challenges were also evident in relation to home care: a survey carried out by the Equality and Human Rights Commission showed that about half of the older persons interviewed were dissatisfied with the services, felt mistreated and received inadequate support with food and drink. They also complained of insufficient time being taken to attend to their needs, of their requests often being ignored and of a lack of respect for their personal privacy and autonomy. Furthermore, in contrast to care for younger adults, it was pointed out that care for older persons rarely included support for social activities. The research revealed that care shortcomings caused a sense of isolation and loneliness among older persons, with impacts on their physical well-being and personal confidence.

The report from Serbia made reference to the State's weaknesses in terms of providing access to long-term care services, above all in rural areas. It indicated a rise in the social exclusion of older persons as a result of the economic crisis, despite the positive outcomes of programmes over the previous period. The Afghanistan Independent Human Rights Commission reported the difficulties that families face in caring for older persons. In Islamic culture, older persons are traditionally cared for by their children, but high unemployment rates in the country were making it increasingly difficult for children to assume this responsibility, the report found.

2. Awareness

The need to increase public awareness is a recurring theme in the countries' responses. The majority of the respondents emphasize the need to encourage a positive attitude towards older persons and greater awareness of their human rights. The report from Costa Rica mentioned an evident lack of suitable tools for making older persons aware of the rights that protect them, encouraging them to demand these rights and ensuring that relevant institutions fulfil their duties in this regard. The response from Ireland reached a similar conclusion, while the report from Cyprus alluded to the need to combat stereotypes, preconceptions and harmful practices. The Government of the Dominican Republic focused on the need to raise awareness of the capabilities and societal contributions of older persons, as did the Governments of Haiti and Romania, among others.

3. Health

Health is another issue that arises time and again. Some countries focus on mental health issues, while others concentrate on the prevention of disease, whether contagious or chronic. The report from the Bolivarian Republic of Venezuela referred to the need to provide improved access to comprehensive health care for older persons. The Australian Human Rights Commission made a similar allusion, reporting that an increasing amount of resources was required in order to attend to the health-care needs of older persons. The Human Rights Commission of Malaysia indicated that a shortage of health-care professionals in the country, particularly in the field of geriatrics, could be having an impact on the quality of the services provided for older persons. The National Human Rights Council of Morocco pointed out that a high proportion of older persons lacked health insurance, while the report from the Uganda Human Rights Commission referred to crucial determinants of health, particularly access to water and basic sanitation. It claimed that older persons were incapable of travelling long distances to collect water, citing a government survey from 2002 that had revealed that 41.8% of older persons used wells while 59.2% used water from other sources. The report from Haiti underlined the far from satisfactory health conditions of the country's older persons. It referred to the serious difficulties experienced in accessing health-care services, above all in rural areas, where lack of mobility prevented older persons from travelling long distances for medical treatment. The report also warned that the country did not have enough skilled health personnel to attend to this section of society.

4. Social security

Social security is another issue mentioned by various countries. The reports from both France and Romania framed this issue in the context of the sustainability of their respective pension systems, while the response from Peru alluded to the need

for a social security policy aimed at facilitating access to non-contributory pensions. The Afghanistan Human Rights Commission pointed out that, under the country's constitution, the State was obliged to provide pensions to its citizens but that, as a result of economic difficulties, these were only being paid to former government employees. The Australian Human Rights Commission cautioned that older persons in Australia were very vulnerable to poverty, explaining that pensions were their main form of income, but that many experienced a long period of unemployment before reaching retirement age. The report went on to cite the 140,750 Australians over the age of 50 who were unemployed in June 2010, seriously undermining any prospects they may have had of receiving retirement benefits. The Human Rights Commission of Malaysia also expressed concern in this regard. Its report stated that the country did not have a universal, comprehensive and coherent social security system; the system such as it was covered only those workers in the formal economy, thereby excluding informal sector workers.

5. Discrimination

The issue of discrimination was brought up in various reports, and was often directly related to ageism in the workplace. The response from Cyprus pointed out that much effort had been put into awareness-raising on the right to non-discrimination in the workplace. However, it conceded that few complaints on these issues were being submitted to the competent authorities. Stereotypes and prejudices in relation to the characteristics and competences of older persons also continued to hinder progress towards true workplace equality. The findings of a national survey carried out on the subject of discrimination in Mexico in 2010 —offered as part of this country's response— indicated that older persons suffered from high levels of exclusion owing to a lack of recognition and to certain obstacles that prevented them from exercising their rights and accessing basic opportunities. Fully 27.9% of those older persons interviewed in 2010 believed that their rights had not been respected because of their age. Older persons struggle to access the labour market in the Republic of Moldova, and are at risk of losing their employment because of their age. Switzerland and the Bolivarian Republic of Venezuela also conceded in their reports that discrimination of this nature was a problem on their territory.

The Australian Human Rights Commission added that age-based discrimination constituted a significant obstacle preventing older persons from reaching their full potential. In the workplace, this issue was reflected both in negative employer attitudes and in discriminatory laws and policies. The Commission's report pointed out that, between 1 July and 31 December 2012, the largest proportion of age discrimination complaints related to employment (63%), followed by the provision of goods, services and facilities (21%). The Human Rights Commission of Malaysia acknowledged that an adverse cultural image and discriminatory social representations of ageing represented a serious issue in the country.

6. Mistreatment

Mistreatment is also singled out as a cause for concern in several reports. The United Kingdom Equality and Human Rights Commission, for example, expressed concern over incidences of mistreatment towards older persons receiving long-term care services. Such incidences were detailed in two independent investigations,

conducted in February 2010 and February 2013. The report from the first independent inquiry had found evidence of poor care, denials of privacy, dignity and respect, and unnecessary suffering experienced by in-patients. At the hospitals inspected, older persons had also experienced difficulties getting help with eating and drinking and were not receiving the medicines that they had been prescribed. The second inquiry was set up to investigate why the problems identified had not been reported earlier. It identified shortcomings in the social security system, including a failure to listen to patients' complaints and to take the necessary action to protect them. The inquiry blamed these failings on an institutional culture which put business imperatives ahead of the protection of older patients.

The Uganda Human Rights Commission indicated that the cultural and traditional customs of certain communities —such as the lack of support or approval from family members for widowed older persons to re-marry— violated their rights and could result in secret sexual engagements and potential exposure to HIV infection. The breakdown of traditional community support systems, as a consequence of economic difficulties, had led to older persons suffering isolation, abuse, stress, chronic poverty and neglect. The report from France explained that mistreatment remained a reality for a large number of older persons. Despite the difficulties involved in gauging the extent of mistreatment, the response estimated that it affected around 600,000 older persons in the country at the time of the survey.

The report from Haiti raised concern over instances of physical abuse of older persons by care providers. It also indicated that older persons were often treated like children and not allowed to take decisions regarding their own needs. Certain studies have alluded to older persons being subjected to degrading treatment and to age more generally being associated with madness, a misconception that can even lead to the death of those affected.

7. Work

Although ageism is one of the most significant factors affecting older persons at work, they also have to confront other negative workplace scenarios. The Uganda Human Rights Commission indicated that 85% of active older persons in the country were engaged in crop farming, an activity characterized by fluctuations in prices, irregular incomes and low returns to labour. The economic strain on them was worsened by the burden of looking after orphans and other vulnerable children left by younger persons who had died from HIV/AIDS, making it difficult for those older persons to work and earn a secure income. The Netherlands National Human Rights Institute indicated that the employment rates of older workers were relatively low, and that they were disadvantaged in the labour market compared with younger workers. When older individuals lose their jobs, they have no chance of returning to work.

The Australian Human Rights Commission reported that 34% of older persons in the country find it hard to obtain work because of their age. Lack of workplace flexibility was identified as a problem by many older workers. In the Republic of Moldova, older persons find it hard to access the labour market. At the same time, their financial burdens grow ever greater as a result of their deteriorating state of health. Several studies found that most retired persons need other income in addition to their State pensions, regardless of where they live or their economic activity status. The inadequacy of their pensions was forcing older persons into work, but they struggled to find the opportunities to do so.

8. Other areas of concern

The respondents made reference to other, equally important, difficulties experienced by older persons. These include food insecurity (the Government of Haiti and the Afghanistan Independent Human Rights Commission), access to justice (the Governments of Costa Rica and Trinidad and Tobago, and the national human rights office of Panama), housing (the Afghanistan Independent Human Rights Commission and the Australian Human Rights Commission), access to public spaces (the Afghanistan Independent Human Rights Commission), access to information and decision-making (the Australian Human Rights Commission), participation (the Holy See, the Government of the Dominican Republic and the Australian Human Rights Commission) and identity (the national human rights office of the Plurinational State of Bolivia).

Certain difficulties were also recognized that are specific to particular groups of older persons, who therefore need special measures in order to exercise their rights. These included older migrants (the Government of Mexico), older persons in rural areas (the Governments of Mexico and Serbia) and remote areas (the Government of Serbia, the national human rights office of Colombia and the Australian Human Rights Commission), older women (the Governments of Peru and Romania, the Uganda Human Rights Commission and the Australian Human Rights Commission), indigenous older persons (the Australian Human Rights Commission), older members of the lesbian, gay, bisexual and transgender (LGBT) community (the Australian Human Rights Commission), incarcerated older persons (the national human rights office of Colombia) and older persons in emergency situations (the Government of Haiti).

D. Provisions of particular interest in relation to the human rights of older persons

There are certain general provisions on human rights that are directly relevant to older persons. There are also certain specific measures that must be taken in order to remove the obstacles preventing this group from fully enjoying their rights (CDDH, 2013b). By analysing ongoing discussions from around the world, as well as the answers provided to the above-mentioned OHCHR consultation on the promotion and protection of the rights of older persons, it is possible to identify those areas in which protection needs to be reinforced and those in which measures must be taken to ensure that autonomy is respected.

1. Identifying and defining rights-holders

A clear definition of older persons may be required in order to establish their specific status as rights-holders. It should nevertheless be noted that this is not an absolute necessity.

If older persons are to be defined as subjects enjoying protection under an international instrument, then it is necessary to define the parameters of old age, whether in chronological, physiological or social terms. This is an extremely complex task, since one of the defining characteristics of this social group —and of humanity as a whole— is its heterogeneity.

These distinctions arise at a regional level, as well. Even if old age is defined in solely chronological terms, there are differences in the thresholds when it is considered to begin. In Latin America alone, the age that the law treats as the onset of this part of the life cycle varies from one country to the next.

However, the calendar is not the only instrument that can be used to delimit old age from earlier phases in the life cycle; a distinction could also be drawn on the basis of functionality. However, there is no certain point at which people lose functionalities. Certainly, it cannot be said that the process is the same for men and women, for individuals of different ethnicities or for other socially-specific groups. Furthermore, establishing a functional boundary as the basis for defining old age would be akin to saying that women's discriminated position is defined by their sex, or that persons with disabilities are defined by their disability.

The best solution would appear to be to define old age on the basis of the discrimination to which older persons are subjected. The Drafting Group on the Human Rights of Older Persons (2013), working under the purview of the Council of Europe Steering Committee for Human Rights (CDDH), indicates that any definition of older persons should make reference to the condition of vulnerability that characterizes the ageing process for all human beings. This condition is a product of prevailing attitudes, negative social perceptions and other factors that act as barriers to the enjoyment of their human rights, discriminating, restricting and challenging their freedom to exercise those rights.

Beyond concerns over whether the concept of vulnerability is appropriate for the definition of old age,[5] accepting a definition of this nature would focus discussions on the discrimination that affects this segment of society by reason of their stage of the life cycle. It would help to shift the issue from the older person as an individual and transfer it onto society as a whole, shifting the focus from individual functionality to the social obstacles older persons encounter. Such criteria have already been used in relation to persons with disabilities (Etxeberría, 2008).

This would serve as an acknowledgement that society, because of its structure and dynamics, marginalizes those who display certain characteristics, preventing them from fully realizing their capabilities. In other words, it is not old age that stands in the way of older persons enjoying their human rights; it is society's notion of old age (Mégret, 2011).

However suitable this definition would appear, thus far it has been applied only once, in recommendation CM/Rec(2014)2 of the Committee of Ministers of the Council of Europe. The Organization of American States (OAS), when outlining the scope of the Inter-American Convention on Protecting the Human Rights of Older Persons, defined older persons as those aged 60 or older, except where domestic legislation has determined a lower or higher threshold, provided that it is not over 65 years.[6] The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Older Persons in Africa also defined older persons as those aged 60 or older.

2. The multifaceted nature of human rights in old age

ECLAC (2010) states that the definition of the minimum rights of older persons varies greatly in international human rights, owing to the plurality of existing normative sources, their different legal status, and their varied regional or material scope. This divergence entails significant practical difficulties for duty-bearers, and particularly for States, which are ultimately responsible for the adoption of legislative measures and policies to promote older persons' rights. This situation also affects rights-holders and other stakeholders, inasmuch as they play a substantive role in promoting the protection of and respect for those rights.

5 Robin Allen (2012) analysed this issue in depth. He suggested the following definition: "older persons include those who by reason of their having an older age or perception of their having such an older age suffer barriers to the full and effective participation in society on an equal basis with others".

6 OAS, Inter-American Convention on Protecting the Human Rights of Older Persons [online] http://www.oas.org/en/sla/dil/docs/inter_american_treaties_A-70_human_rights_older_persons.pdf.

Up until now, despite the existence of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Older Persons in Africa and the Inter-American Convention on Protecting the Human Rights of Older Persons, no agreement has yet been reached regarding the minimum content of any potential United Nations international standard for the human rights of older persons.

Different points of view remain, and this undoubtedly affects the obligations that would result from the adoption of any instrument enshrining these rights. Some opinions demand that the catalogue of human rights from existing international covenants be rewritten, in order to insert an explicit reference in each of them to the particular situation of older persons. This exercise sometimes seems akin to the drafting of a detailed action plan and, in practice, the key objective —that of identifying the essence and basis of human rights in the context of ageing— is lost.

Elsewhere, it is stated that progress must be made in identifying measures aimed at eliminating discrimination against this group. It is argued that the principle of equality and non-discrimination justifies the need to develop specific international instruments on the rights of older persons. In this regard, rather than an instrument on the rights of older persons, it would appear that what is required is an international instrument to eliminate all forms of discrimination against older persons (Rodríguez-Piñero, 2012).

Lastly, a third stance is based on the grounds that the human rights violations encountered by older persons are, in some way, different in nature from those suffered by other people, and that failure to consider this difference is what prevents human rights instruments from fully protecting those rights in the case of older persons. As was the case for persons with disabilities, it would appear that action needs to be taken on two fronts: first, to deepen appreciation of what existing human rights mean for older persons and, second, to clarify State obligations regarding the promotion and protection of these rights in the context of ageing. A human rights standard would serve to de-naturalize certain issues and re-politicize others (Mégret, 2011).

In addition to taking measures to protect older persons against discrimination, another priority must be to create the conditions in which they can live autonomous and independent lives. This is apparent in the responses to the OHCHR consultation. Some of the problems identified are related to discriminatory practices, but many others simply concern their access to an adequate quality of life.[7]

The principle of equality and non-discrimination is undoubtedly one justification for the adoption of an international instrument, but it is not the only one. Other values that are inherent to human rights, such as dignity and solidarity, are of equal importance. Therefore, any initiative intended to protect the rights of older persons must guarantee their economic, social and cultural rights, as well as their autonomy and inclusion.[8]

[7] It seems likely that the discussions on the rights of older persons will cover the same ground as previous discussions on persons with disabilities, when some States expressed a preference for a much narrower instrument than the one ultimately adopted, which focused on the anti-discriminatory aspect but was weaker regarding State obligations.

[8] Furthermore, it is imperative to move on from the present focus on vulnerability in issues relating to older persons. In law, the adjective "vulnerable" is employed to refer to those individuals who need to be protected because they possess characteristics that prevent them from being autonomous. Children are the most obvious example. Due to their age —i.e. a personal characteristic— they do not enjoy the same autonomy as adults and they have no recognized legal capacity, even though they are protected by the principle of best interests of the child. To treat older persons as a vulnerable group implies that they will always be in that state of vulnerability and in need of protection, regardless of their circumstances. An instrument on the rights of older persons must be drawn up from a different perspective. It is necessary, first, to identify the exogenous conditions that lead older persons to need special measures, then to take specific action to address those conditions in order to enable older persons to exercise their autonomy. The vulnerability approach is still very present in the ongoing discussions on the rights of older persons. But these rights must be protected, promoted and respected for the inherent dignity of older persons. They are not an instrument for incorporating older persons into the wider society, which would be to assume that the non-inclusion of older persons is their responsibility through failure to exercise their rights. On the contrary: the rights are an end in themselves and must be valued as such.

3. Specific issues related to the human rights of older persons

(a) Dignity in old age

Dignity is one of the values that underpin human rights. Each and every human being is of inestimable value with inherent self-worth, nobody is insignificant and all individuals are ends in themselves. This means that people are to be valued regardless of their economic capacity, or any other characteristic that is exogenous to their status as a human being (Quinn and Deneger, 2002).

Resolution 67/139, adopted by the General Assembly in December 2012, embraced dignity as a key element in the proposed formulation of "a comprehensive and integral international legal instrument to promote and protect the rights and dignity of older persons". Dignity was also recognized as a key value in the discussions surrounding the formulation of a convention on the rights of persons with disabilities. This is no mere coincidence; regrettably, the dignity of both groups is impaired by practices or attitudes that undermine the respect for them as human beings, such as pity or disregard.

Society is organized in such a way that not everybody can develop to their fullest capacity until the end of their lives. There are certain obstacles that permit the offence and humiliation of older persons, and prevent them from living freely and autonomously. This is why any international instrument on human rights, whatever its nature, must underline that the State has a responsibility for the dignity of older persons and must take into account and build upon the individual conditions in which they live, and identify and eliminate obstacles posed by the social and physical environment (Etxeberría, 2008).

(b) Recognizing the autonomy of older persons

Over the past 20 years, many countries have reformed legal capacity and guardianship laws in order to shift from a medical model focusing only on a diagnosis of incapacity to a model whose aim is to assess the individual's functional abilities (OHCHR, 2012). However, protective measures often arbitrarily strip older persons of their legal capacity to deal with their own needs, express their desires, make choices and achieve their goals. This limits any possibility that they may have of managing their lives (CDDH, 2013b).

Often no distinction is made between moral autonomy and factual autonomy.[9] Without the latter, the capacity of older persons to make decisions is immediately restricted. This flies in the face of international law, which dictates that no limitation, whatever its nature, should be considered as absolute and permanent.[10]

In the case of older persons, capacity must be continually assessed in relation to a specific task or the circumstances in which it is carried out (CDDH, 2013a). The focus should therefore be on strengthening mechanisms to provide the conditions in which individuals can continue exercising their autonomy for as long as possible, rather than turning to formulas that remove their decision-making capacities.

9 The former relates to the individual's rational capacity to make the decisions for which he or she may be responsible, while the latter concerns the capacity to carry out these decisions (Etxeberría, 2008).

10 In the international human rights doctrine, the fundamental provisions of law related to the legal capacity and decision-making rights of persons with disabilities on an equal basis with others are set forth in the Convention on the Rights of Persons with Disabilities. Article 12 establishes the State's obligation to "recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life" and to "take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity". Article 17 stipulates that "every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others". These protections have prompted a shift towards the adoption of decisions offering support as an alternative to protection, emphasizing the autonomy and independence of individuals rather than their dependence and incapacity.

This means that any instrument on the rights of older persons must, in the first place, guarantee them the chance to manage their life autonomously, on both a personal level and as members of society, such that they can lead an independent life in a familiar setting as long as they wish and are able to, as well as actively participate in the civic and political dimensions of society (Etxeberría, 2008; CDDH, 2013b).

(c) Special protection measures for specific groups

The "Guidelines for a Convention on the Rights of Older Persons",[11] drawn up by the countries of Latin America and the Caribbean that participated in the Third Follow-up meeting of the Brasilia Declaration on the Rights of the Older Persons, held in Santiago in October 2009, identified the following groups of older persons as requiring special protection measures: women, persons pertaining to indigenous peoples, persons who belong to ethnic, national, linguistic or religious minority groups, and older persons in situations of risk and humanitarian emergencies. Uruguay also wished to incorporate incarcerated older persons, but this proposal did not receive sufficient support.

One of the grounds for identifying these specific groups —the result of a consensus between the 26 countries that participated in the meeting— was the need to provide particular protection for those individuals for whom age is not the only source of the discrimination, or who more frequently run the risk of having their rights disregarded or violated. These groups were not identified in a cursory manner, but rather as the outcome of respectful talks that commenced at the Second Follow-up meeting of the Brasilia Declaration, held in Buenos Aires in May 2009. These guidelines served as the basis for the Inter-American Convention on Protecting the Human Rights of Older Persons.

This decision was consistent with the processes already under way in Africa and Europe. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Older Persons in Africa includes a reference to the special protection required by specific groups of older persons and establishes State obligations in this regard. Those groups include older women, older persons caring for orphans and vulnerable children, those with disabilities and those in situations of conflict or in natural disasters (Permanent Mission of South Africa to the United Nations, 2013). Incarcerated older persons are explicitly mentioned in recommendation CM/Rec(2014)2 on the promotion of human rights of older persons, adopted by the Committee of Ministers of the Council of Europe, whose explanatory report also draws attention to the specific cases of older women, older immigrants and older persons with disabilities (Council of Europe, 2014).

The criteria of both the African Commission on Human and Peoples' Rights and CDDH are in line with those applied by the United Nations, both in the Convention on the Rights of Persons with Disabilities, which calls for specific measures for women with disabilities (article 6) and children with disabilities (article 7), and in the Convention on the Rights of the Child, which provides special measures for children deprived of their family environment (article 20), child refugees (article 22), children with disabilities (article 23) and children belonging to a minority group or of indigenous origin (article 30). Similarly, the United Nations Declaration on the Rights of Indigenous Peoples

[11] See [online] scm.oas.org/pdfs/2012/CP27862S.doc.

establishes that "particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children and persons with disabilities" (article 22).[12]

The international talks on the protection of the rights of older persons will have to consider all points of view and arguments both for and against the adoption of special protection measures. Ultimately, what must be ensured is that the protection provided is sufficiently far-reaching and addresses the specific requirements of certain groups of older persons who, through a combination of age and other causes of discrimination, face extreme violations of their civil, political, economic, social and cultural rights.

E. Lessons learned from the Convention on the Rights of Persons with Disabilities

A declaration is not always an end in itself, but can rather serve as a mechanism to aid the development of an international consensus. This was the case with the Declaration on the Rights of Disabled Persons, drawn up 30 years before the adoption of the Convention on the Rights of Persons with Disabilities. The Declaration not only reaffirmed that persons with disabilities had the same rights as all human beings, but also established that they have the inherent right to respect for their human dignity, are entitled to the measures designed to enable them to become as self-reliant as possible, have the right to economic and social security and to a decent level of living, to participate in progress, to live with their families, to not be subjected, as far as their residence is concerned, to differential treatment other than that required by their condition or by the improvement which may derive therefrom, and to be protected against all exploitation, all regulations and all treatment of a discriminatory, abusive or degrading nature (United Nations, 1975).

Despite the existence of this instrument, by the 1980s it seemed that the world had made very little progress with respect to the protection of the rights of persons with disabilities and the need for a specific convention was raised. Italy prepared a draft convention and presented it to the General Assembly at its forty-second session. Sweden later outlined a series of other proposals for a draft convention for consideration at the forty-fourth session. However, no consensus was reached on either occasion. Many representatives took the view that the existing documents on human rights already guaranteed persons with disabilities the same rights as all other individuals (United Nations, 1993).

The next step forward was achieved with the adoption of the Standard Rules on the Equalization of Opportunities for Persons with Disabilities, by virtue of resolution 48/96 of 1993. Experts in the subject consider this a milestone document, insofar as it provided an oversight mechanism with the appointment of a United Nations Special

[12] This did not occur in the case of the draft inter-American Convention on the rights of older persons. In February 2013, within the framework of the OAS Working Group on Protection of the Human Rights of Older Persons, the chapter on specific groups was removed at the suggestion of the Chair. The following explanation was given: "The suggestion is to delete this chapter on the rights of specific groups because, by identifying certain groups as victims of structural inequality or as highly vulnerable as they are called in the draft, there is a risk of leaving out other population groups that also need special protection from the State. It should also be noted that within each state there are differences that call for positive action for groups, hence effort at identification should be made at the domestic level. And finally, it should be pointed out that in reviewing the various human rights protection instruments, groups that require special measures by States Party do not seem to have been explicitly identified. In view of the foregoing, we suggest including only Article 26 on affirmative measures, an article that recognizes in generic terms groups that are at a disadvantage and require specific protection within each State Party, without identifying them" (OAS, 2013). Brazil, seconded by other delegations, initially opposed the proposal to eliminate the special measures for specific groups. However, the Chair's proposal was carried and the chapter on specific groups was not included in the draft convention. Following the statement of the Dominican Republic, seconded by other delegations, one specific mention was included, referring to older persons in emergency situations.

Rapporteur on the rights of persons with disabilities for a three-year period. It also invited organizations of persons with disabilities to create among themselves a panel of experts to be consulted by the Special Rapporteur and, when appropriate, the Secretariat.

The role of the Rapporteur was to review, advise and provide feedback and suggestions on the promotion, implementation and monitoring of the Standard Rules to States, and to report to the Commission for Social Development. Although the fact that the Special Rapporteur reported to this Commission in New York —and not to the Human Rights Commission[13] in Geneva— kept matters relating to persons with disabilities in the domain of social policy rather than the human rights arena, the Standard Rules did afford greater visibility to the rights of this group.

As is clear, it took a long time to arrive at a binding instrument to protect the rights of persons with disabilities. However, a landmark was achieved in 2001, when the then President of Mexico made this issue an international priority for his administration. That same year, Mexico tabled a resolution aimed at preparing a draft binding treaty. In deference to the recently elected head of State, the European Union held back from vetoing the resolution, despite opposition by some of its members, and an ad hoc mechanism to consider proposals for a convention was settled upon. It was thought that, following the analysis of the proposals, no more headway would be made on the issue, at least in the General Assembly. However, things turned out differently: firm progress was made, even if not all States were in agreement with it (Quinn, 2004).

An international declaration on the rights of older persons, comparable to the one drawn up on the rights of persons with disabilities, is yet to materialize. Yet, in the process under way within the United Nations, much can be learned from the development of instruments concerning persons with disabilities, albeit there are significant differences between the two issues.

As noted earlier, before the Convention was finally adopted there had been other General Assembly resolutions that had addressed the rights of persons with disabilities in one way or another. Another difference relates to the role played by the civil society and academic institutions. In the case of disability rights, both made significant contributions throughout the process, including by publishing compelling reports on the issue. These sectors have been less forceful on the subject of the rights of older persons, particularly in developing countries.

Furthermore, the context in which the negotiations on the Convention on the Rights of Persons with Disabilities were initiated was different. There are currently two regions in the world that have their own binding instruments on the rights of older persons: Africa and the Americas. In 2013, The Human Rights Council adopted resolution 24/20, in which it decided to appoint an Independent Expert on the enjoyment of all human rights by older persons. In her 2016 report, the Independent Expert flagged up the need to expand the protection of these rights (United Nations, 2016). Finally, at its seventh session, held in December 2016, the United Nations Open-ended Working Group on Ageing resolved to begin drafting contents for a future international instrument. These are complementary mandates and so far similar conclusions have been reached, particularly the need to broaden the protection of the rights and dignity of older persons.

All indications suggest that the journey is already well under way. Over its course, lessons can be drawn from the process undergone on the rights of persons with disabilities, particularly with regard to strengthening the participation of rights-holders, above all those who are living and growing older in the southern hemisphere.

[13] Replaced in 2006 by the Human Rights Council.

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Chapter

III

The value and importance of the Inter-American Convention on Protecting the Human Rights of Older Persons

Introduction

On 15 June 2015, the Organization of American States (OAS) adopted the Inter-American Convention on Protecting the Human Rights of Older Persons. In doing so, it became the first intergovernmental organization to establish a legally binding instrument on the rights of older persons.

The purpose of the Convention is to promote, protect and ensure the recognition and full enjoyment and exercise, on an equal basis, of all human rights and fundamental freedoms of older persons, in order to contribute to their full inclusion, integration, and participation in society.[1]

The preamble to the Convention recalls that all the human rights and fundamental freedoms that have been recognized in international human rights instruments are applicable to older persons. However, as it also recognizes the discrimination that older persons encounter for reasons of age often obstructs their full enjoyment of those rights and freedoms. The Convention defines age-based discrimination against older persons as any distinction, exclusion, or restriction with the purpose or effect of hindering, annulling, or restricting the recognition, enjoyment, or exercise, on an equal basis, of human rights and fundamental freedoms in the political, cultural, economic, social, or any other sphere of public and private life.

This new treaty rectifies an omission in international human rights law concerning this social group. It sets important standards that no other international binding instrument has explicitly established in relation to older persons, on the crossover between the right to life and dignity in old age and on the right to independence and autonomy.

This chapter offers a general overview of the Convention's drafting process and its content, in order to both reaffirm its importance and promote action by stakeholders, especially by rights-holders. It also provides examples of how particular States have implemented the Convention.

A. The drafting process of the Inter-American Convention on Protecting the Human Rights of Older Persons

The governments formally signalled the desire for an international treaty to protect the human rights of older persons in the Brasilia Declaration (ECLAC, 2011). This was adopted at the Second Regional Intergovernmental Conference on Ageing in Latin America and the Caribbean, jointly organized by the Economic Commission for Latin America and the Caribbean (ECLAC) and the Government of Brazil, in 2007.

At the Conference, government representatives discussed in depth the need for an international treaty to protect the human rights of older persons. Brazil initially proposed aiming for a commitment to creating an international convention on the rights of older persons. Following hours of dialogue, and having conferred with their respective capitals, the participants eventually agreed on a text on which to consult with the respective governments.[2]

1 See OAS, Inter-American Convention on Protecting the Human Rights of Older Persons [online] http://www.oas.org/en/sla/dil/inter_american_treaties_a-70_human_rights_older_persons.asp.

2 See paragraph 26 of the Brasilia Declaration: "We pledge to make the necessary consultations with our Governments to promote the drafting of a convention on the rights of older persons within the framework of the United Nations."

By 2009, protection of the rights of older persons was well established in the discourse of the national institutions that represent this social cohort. Some of them were working with the respective ministries of foreign affairs to develop stances favourable to a convention.

In accordance with paragraph 26 of the Brasilia Declaration, older persons' institutions in the countries entered into official consultations with their governments. Their actions went further, however, and the agreement came to serve as a map for raising awareness of the need for a legally binding instrument to enlarge the scope of protection for older persons in international law.[3] To this end, ECLAC held three meetings in follow-up to the Brasilia Declaration.[4] At two of these, the participants worked on a set of proposed guidelines for a convention on the rights of older persons, which ultimately served as the foundations of the draft inter-American convention (ECLAC, 2009c).

By 2009, protection of the rights of older persons was well established in the discourse of the national institutions that represent this social cohort. Some of them —including institutions in Argentina, Brazil, Chile, Costa Rica, El Salvador, Mexico and Uruguay— were working with therespective ministries of foreign affairs to develop stances favourable to a convention within OAS and the United Nations. This work paved the way for the Declaration of Commitment of Port of Spain in April 2009, in which the heads of State and government of the Americas pledged to review the viability of an inter-American convention on the rights of older persons, with the support of the Pan American Health Organization (PAHO) and ECLAC. The OAS member States began discussions in this regard, which were then reflected in the decisions made by the organization's General Assembly.[5]

Firstly, the OAS Permanent Council convened a meeting of experts, in October 2010, so that the organization's member States could explore the possibility of drafting an inter-American treaty with specialists from international organizations and civil society.[6] Almost a year later, in September 2011, a Working Group on Protection of the Human Rights of Older Persons[7] was set up with a mandate to report on the situation of older persons on the American continent, as well as on the effectiveness of universal and regional binding human rights instruments for protecting their rights.[8] Once this initial task had been completed, the Working Group would then be tasked with preparing the draft inter-American convention.

Chaired by Argentina, the Group held six formal working sessions to prepare the first draft of the inter-American convention on the human rights of older persons. The draft convention was then presented to the OAS Permanent Council. PAHO and ECLAC provided technical support throughout this period and up until the completion of the draft in 2015.

The negotiations on the draft convention can be divided into three stages for the purposes of analysis. The first round of negotiations lasted 7 months, from September 2012 to May 2013. During this period, the Working Group held 19 formal meetings and 8 informal meetings. The Group analysed the draft convention article by article, revising content and wording. Most of the paragraphs were discussed during this period; consensus was reached for some, while others gained majority support among the delegations. However, by May 2013, the participants had still not come to

3 In order to help to fulfil the pledge made in the Brasilia Declaration, institutions and organizations of older persons started providing training on the general subject of human rights, as well as on how to further the preparation of an international convention in an efficient manner.

4 The meetings were organized by ECLAC jointly with the Government of Brazil (in 2008), the Government of Argentina (2009) and the Government of Chile (2009). For more information, see ECLAC (2008), (2009) and (2011).

5 As the Inter-American Commission on Human Rights pointed out during the talks over the text of the Convention, certain provisions and obligations applying exclusively to older persons already existed within the inter-American system. Examples include article 4, paragraph 5 of the American Convention on Human Rights, in addition to article 9, paragraph 1 and article 17 of the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights.

6 See OAS General Assembly resolutions: AG/RES. 2455 (XXXIX-O/09), adopted on 4 June 2009, and AG/RES 2562 (XL-O/10), adopted on 8 June 2010 (OAS, 2009 and 2010).

7 The Working Group on Protection of the Human Rights of Older Persons met over a period of four years. However, a new mandate from the OAS General Assembly was needed for each session. The mandate was therefore repeatedly extended until consensus was reached on a text to be submitted to the General Assembly.

8 See OAS General Assembly resolution AG/RES 2654 (XLI-O/11), adopted on 7 June 2011.

a satisfactory agreement on several articles. For this reason, during the forty-second session of the OAS General Assembly, the Working Group's mandate was extended so that negotiations on the draft convention could resume.[9]

During the second stage of negotiations, from 5 September 2013 to 9 May 2014, the contents of the draft convention were closely examined and the discussion on the text was organized. Twelve formal and two informal meetings were held, chaired by the Alternate Representative of Panama. It was also arranged that the OAS Department of International Law and the Inter-American Commission on Human Rights (IACHR) would convey comments on the draft convention.[10]

A total of 23 titles, 11 articles and 161 paragraphs had been adopted by May 2014, while a further 3 titles, 3 articles and 78 paragraphs[11] had been agreed upon. However, despite the progress made, certain countries (Chile, Colombia and Peru) still harboured concerns over possible duplications contained either within the draft convention or in relation to the American Convention on Human Rights and other international treaties.[12]

The third stage began on 17 October 2014 under the chairship of the Alternate Representative of Chile, and concluded on 15 May 2015 under the chairship of the Alternate Representative of Panama. During this period, the Group worked to eliminate the duplications identified in the previous stage, to facilitate the prompt adoption of the draft at the OAS General Assembly in Asuncion. The new proposal was debated at 19 formal meetings, 2 informal meetings and during a meeting of experts that took place on 20 and 21 April 2015 at the OAS headquarters in Washington D.C. By the end of this period, all the draft convention's articles had been finalized and adopted, although some of them remained *ad referendum* of certain States.[13]

On 19 May 2015, the Permanent Council formed a drafting group (composed of Brazil, Haiti, Jamaica and Panama) to ensure equivalence between the versions of the text in the four official OAS languages. One month later, the General Assembly adopted the Inter-American Convention on Protecting the Human Rights of Older Persons.

B. Non-regressive consensus-building at the inter-American level

The Working Group had to make various decisions during the drafting process. One of the most important was to define the overall approach of the text. Huenchuan (2012) identifies three possible options: the first was to reaffirm the catalogue of human rights from existing international treaties, including specific references to older persons in each

9 See OAS General Assembly resolution AG/RES. 2726 (XLII-O/12), adopted on 4 June 2012.

10 On 16 August 2013, the Department delivered its opinion on the text, largely focusing on the follow-up mechanism and protection measures. The IACHR report, submitted on 8 November 2013, made reference to the following contents: the principle of equality and non-discrimination, legal capacity, the informed consent and autonomy of older persons, and the right to live independently and to be included in the community.

11 A certain issue, or part of the draft, was considered to be "agreed" when consensus was reached in a meeting where quorum had been established to meet but not to approve decisions; it was considered to be "adopted" when consensus was reached in a meeting where quorum had been established to approve decisions.

12 For example, article 9, paragraph 2 declared: "States will adopt all legislative, administrative or other measures as may be necessary to avoid older persons being submitted to torture or other cruel, inhuman or degrading treatments or punishments." This language was judged to be too similar to article 2 of the American Convention on Human Rights.

13 *Ad referendum* means that a State can agree with the proposal pending approval from its relevant domestic political bodies (LeBlanc, 1977). At the end of the third stage, the following content was still *ad referendum*: article 6, "Right to life and dignity in old age" (entire article *ad referendum* of Nicaragua, paragraph 1 *ad referendum* of Guatemala); article 7, "Right to independence and autonomy" (article 7(a) *ad referendum* of Guatemala); article 19, "Right to health" (article 19(c) *ad referendum* of Nicaragua and Paraguay); and article 36, "System of individual petitions" (paragraphs 1, 2 and 4 *ad referendum* of the Bolivarian Republic of Venezuela, and paragraph 3 *ad referendum* of Nicaragua and the Bolivarian Republic of Venezuela).

of the rights; the second was to identify measures to eliminate the discrimination that older persons encounter;[14] and the third was to increase the significance that existing human rights held for older persons, while clarifying State obligations with respect to the promotion and protection of these rights in the context of ageing (Huenchuan, 2012).

OAS had already implemented the second approach by drawing up the Inter-American Convention on the Elimination of All Forms of Discrimination against Persons with Disabilities, adopted in 1999. However, in the case of older persons, the Working Group adopted the third approach.

Another important decision had to be made over whether or not to include new rights. The Working Group initially stressed that this did not form part of the convention's aims. However, as the text started to take shape, it became evident that it would not be enough to explicitly mention older persons into the existing human rights texts. As a result, the text offers new interpretations and broadens the content of certain rights that had already been established in treaties, adapting them to the needs and demands arising as a result of population ageing.[15]

Lastly, the Working Group had to ensure that the draft remained consistent with the principles and rights recognized in other international human rights instruments. While article 1 establishes that nothing in the Convention should be interpreted as placing limits on broader or additional rights recognized to older persons in international law or the domestic laws of States parties, in practice any error in this regard could generate confusion by delaying or restricting the implementation of other international instruments, especially the Convention on the Rights of Persons with Disabilities.

Until June 2012, there was some ambiguiety between various articles of the new draft convention and the Convention on the Rights of Persons with Disabilities. The article on legal capacity was particularly controversial: the convention permitted restrictions in the exercising of this right,[16] thereby contradicting the provisions of the Convention on the Rights of Persons with Disabilities,[17] which favours decision-making on an equal footing.[18] Some of these difficulties were resolved in the text adopted in June 2015, thanks to the input of organizations including IACHR, ECLAC, PAHO and Sociedad y Discapacidad (SODIS), a Peruvian non-governmental organization that submitted an authoritative report on this issue.[19]

[14] The principle of equality and non-discrimination is the main justification for the need for specific international instruments. The Inter-American Court of Human Rights and the Inter-American Commission on Human Rights have frequently reiterated that the right to equality and non-discrimination is the central and fundamental pillar of the inter-American human rights system.

[15] For example, the Inter-American Convention on Protecting the Human Rights of Older Persons incorporates new elements in the sphere of palliative care, by treating it as a right. This was the approach favoured by the Latin American Association of Palliative Care (ALCP), jointly with other organizations, which provides support for the drafting of certain articles of the Convention that specifically concern this issue.

[16] In the April 2012 version of the draft convention, article 33, "Judicial guarantees in processes to determine the legal capacity of older persons", envisaged situations in which the exercise of this capacity might be restricted. For example, it contained the following passage: "Any and all restrictions on legal capacity must be properly substantiated, limited in time, subject to periodic review and applied solely to specific decisions in which a lack of capacity and the need for proxy consent has been determined." In the opinion of some organizations, ECLAC and IACHR included, this language legitimized the belief that older persons were not capable of taking care of their own well-being, which led to them being denied their legal capacity by protective measures that curtailed their ability to make decisions about their lives. This text was subsequently amended and ended up under article 30 of the Convention.

[17] Article 12 of the Convention on the Rights of Persons with Disabilities establishes the State's obligation to "recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life" and to "take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity"; article 17 of the Convention on the Rights of Persons with Disabilities states that "every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others".

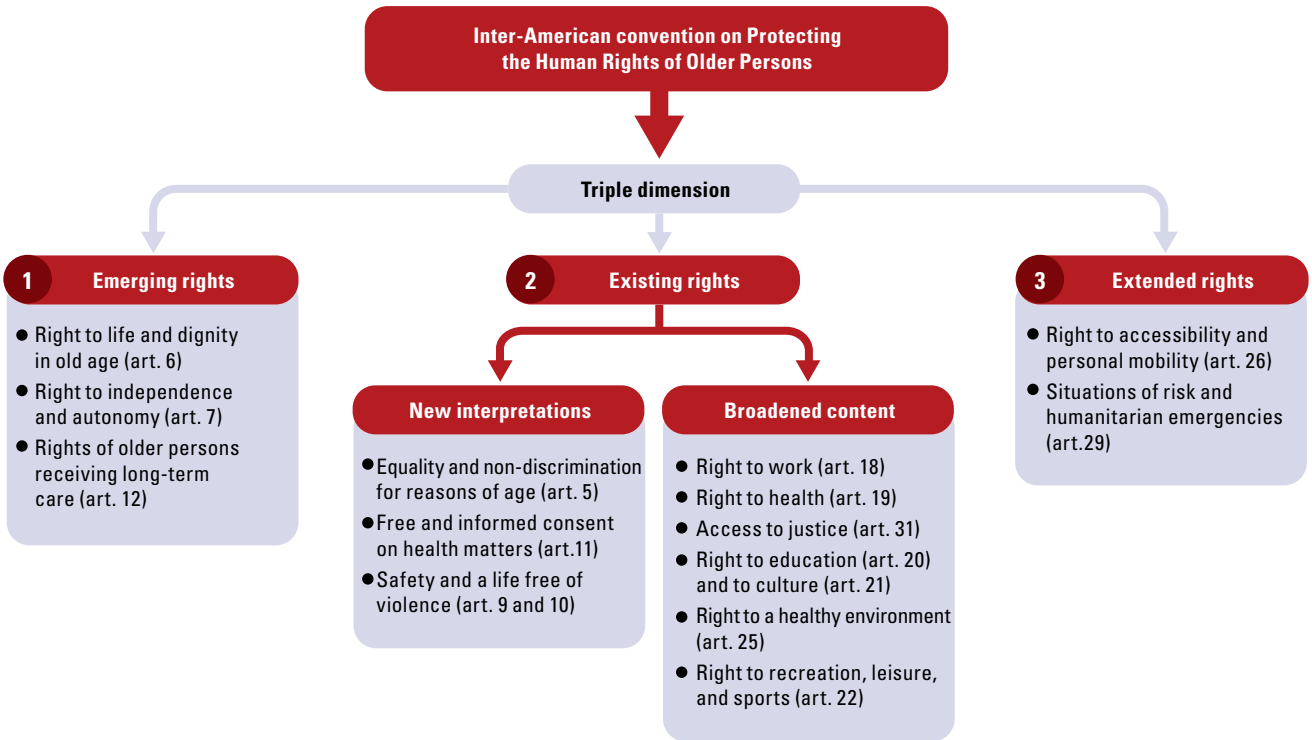
[18] The Convention on the Rights of Persons with Disabilities initiated a shift towards supported —rather than protected— decision-making, emphasizing the autonomy and independence of the individual rather than his or her dependency and incapacity. See OHCHR (2012).

[19] Article 33 of the 17 April 2012 draft convention established "judicial guarantees of older persons who are institutionalized". It stated that older persons had the right to appoint legal counsel to represent them in all judicial or administrative proceedings related to their institutionalized status and that, if they did not obtain such services, counsel would be provided to them." This language was subsequently amended and the title of the article was changed to "Rights of older persons receiving long-term care" (article 12).

C. The triple dimension of the rights protected by the Convention

For the purposes of this chapter, the contents of the Inter-American Convention on Protecting the Human Rights of Older Persons will be divided into three categories: emerging rights, existing rights and extended rights (see diagram III.1).

Diagram III.1
The Inter-American Convention on Protecting the Human Rights of Older Persons



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of E. Dussel, "Derechos vigentes, nuevos derechos y derechos humanos", *Crítica Jurídica. Revista Latinoamericana de Política, Filosofía y Derecho*, No. 29, June 2010.

- Emerging rights are new rights, or rights that have only been partially enshrined in existing international and national standards.
- Existing rights have already been included in international standards, but changes are required in order to tailor them to the specific needs of a specific group, whether via new interpretations or the broadening of their content.
- Extended rights are specifically intended for groups that have not previously enjoyed them, owing either to omission or discrimination (Dussel, 2010).

1. Emerging rights

The Convention contains three emerging rights: the right to life and dignity in old age (article 6); the right to independence and autonomy (article 7); and the rights of older persons receiving long-term care (article 12).

The first of these rights implies an interesting innovation. In reference to the right of older persons to live with dignity in old age and until the end of their life without suffering discrimination of any nature, it ensures —among other things— access to palliative care.

The second right again emphasizes the integrity and dignity of older persons, specifically in regard to their right to make decisions according to their traditions and beliefs. The third right, further analysed below could produce a conflict between the protection of individuals living in long-term care facilities and the acknowledgement of the right of older persons to live independently. Nonetheless, in practice this right is intended to address the abuse often perpetrated during the provision of long-term care services.

2. Existing rights

The Convention provides new interpretations of the right to equality and non-discrimination (article 5), the right to give free and informed consent on health matters (article 11) and the right to safety and a life free of violence (articles 9 and 10).

The Convention updates the content of all three rights by inserting new elements, thereby establishing a specific set of State obligations with respect to older persons: it forbids any discrimination against older persons for reasons of age; it lists the conditions required for older persons to be able to give their free and informed consent; it obliges the State to establish procedures enabling older persons to expressly demonstrate their prior will and instructions for any medical interventions, including palliative care; and it protects the right of older persons to live with integrity and dignity, and free from any discrimination.

Although similar articles are also present in other international instruments, such as the Convention on the Rights of Persons with Disabilities, this is the first time that the situation of older persons has been specifically addressed in relation to each of these rights.

The subcategory of "broadened content" generally applies to economic, social and cultural rights. Considering these rights have already been recognized in the International Covenant on Economic, Social and Cultural Rights —an instrument whose provisions full apply to older persons—, the Convention simply serves to adapt them to the specific situation of this group. Access to health care, the right to work and the right to education all fall into this category.

3. Extended rights

Two rights can be classified in this subcategory: the right to accessibility and personal mobility, and the right related to situations of risk and humanitarian emergencies. Both rights are included in the Convention on the Rights of Persons with Disabilities. However, unlike for women and children, no specific article was inserted for older persons in that instrument. The Convention rectifies this omission by specifying these rights in relation to older persons (Quinn, 2009).

D. The ratification process of the Convention[20]

The Vienna Convention on the Law of Treaties of 1969 stipulates that the ratification of a treaty means the international act whereby a State establishes its consent to be bound by the obligations of a treaty.[21] "International human rights law lays down obligations which States are bound to respect. By becoming parties to international

[20] The first countries to sign the Convention document were Argentina, Brazil, Chile, Costa Rica and Uruguay. The signing of the document serves as notice that a State intends to adopt the relevant measures and expresses its consent to fulfil the obligations of the treaty at a later date. Countries that sign the document also have an obligation in good faith in the period leading up to the ratification, acceptance or adoption of the treaty, during which the State will abstain from any actions whose consequences may be incompatible with the subject and purpose of the treaty. The instrument must then be domestically ratified by parliament.

[21] See article 2, paragraph 1(b); article 14, paragraph 1; and article 16 of the Vienna Convention on the Law of Treaties, 1969.

treaties, States assume obligations and duties under international law to respect, to protect and to fulfil human rights. The obligation to respect means that States must refrain from interfering with or curtailing the enjoyment of human rights. The obligation to protect requires States to protect individuals and groups against human rights abuses. The obligation to fulfil means that States must take positive action to facilitate the enjoyment of basic human rights."[22] These three obligations make up the implementation framework for international treaties.

Having been ratified by Uruguay and Costa Rica, and with the two countries' respective instruments of ratification duly submitted to the OAS General Secretariat, the Inter-American Convention on Protecting the Human Rights of Older Persons entered into force on 12 January 2017. On 21 December 2016, the Plurinational State of Bolivia had passed Law No. 872, becoming the third State to ratify the Convention, and deposited its instrument of ratification with OAS on 17 May 2017. Chile ratified the Convention on 10 December 2016 and deposited its instrument of ratification on 15 August 2017. Argentina ratified the Convention on 9 May 2017 but has yet to deposit its instrument of ratification with OAS.

On 28 July 2016, Costa Rica became the first State to ratify the Convention. The regulation —Law No. 9394— was then signed on 8 September but its instrument of ratification was not deposited with OAS until 12 December 2016.

In Uruguay, Law No. 19.430 ratifying the Convention was promulgated on 8 September 2016. The process had been initiated on 22 December 2015, when the executive requested parliament's approval of the treaty. The text was laid before parliament on 24 February 2016 and was approved by unanimous vote six months later, on 24 August. On 18 November 2016, Uruguay deposited its instrument of ratification. As the first country to do so, it became the President of the Conference of States Parties to the Convention.

The Convention document declares that its follow-up mechanism will comprise a Conference of States Parties and a Committee of Experts, to be established upon deposit of the tenth instrument of ratification or accession.

The Conference of States Parties, comprising the States parties to the Convention, is the principal organ of the Follow-up Mechanism. Its functions include monitoring the progress made by the States parties in complying with the commitments under the treaty and promoting the exchange of experiences and best practices as well as technical cooperation among the countries.

The Committee of Experts comprises experts appointed by each State party to the Convention. Among other functions, it is responsible for conducting a technical review of periodic reports submitted by the States parties on the implementation of their obligations under the Convention. The first of these reports shall be provided within a year of the first meeting and, thereafter, States parties will submit reports every four years.

Chapter VI of the Inter-American Convention, entitled "Follow-up Mechanisms to the Convention and Means of Protection", is undoubtedly one of its strengths. It creates a mechanism of dialogue and control, designed to monitor the progress made by the States parties in complying with the commitments and to encourage their effective implementation.

Any right, even if recognized internationally, that lacks a protection mechanism will inevitably be flawed, as there will be no means to ensure compliance. The mechanisms proposed by the Convention, which will enter into force once the tenth instrument of ratification has been deposited, will produce a progressive interpretation of international standards on the rights of older persons that will serve to further clarify and specify the meaning and scope of the rights contained within the treaty.

22 See [online] http://www.ohchr.org/en/ProfessionalInterest/Pages/InternationalLaw.aspx.

The Conference of States Parties and the Committee of Experts will conduct analyses and formulate recommendations on the basis of the reports submitted by the States parties. This joint effort will create a virtuous circle, serving both as a means to observe the progress made with the rights of the Convention and, chiefly, as a key tool to help each State party comprehend the legislative, political, programmatic measures required to guarantee the enjoyment of the rights at the national level.

E. The emerging rights of the Inter-American Convention and contributions to their interpretation

A State that takes the sovereign decision to ratify an international treaty assumes a series of responsibilities and obligations (to respect, to protect and to fulfil human rights). In some cases, as mentioned above, these obligations mean that States must not interfere with the enjoyment of human rights, must protect individuals and groups against human rights abuses and violations and, lastly, must adopt the appropriate legislative, political, programmatic and other measures in order to give effect to the rights, as established in article 1 of the Convention.[23]

These obligations make up the implementation framework for any international treaty, and the Inter-American Convention on Protecting the Human Rights of Older Persons is no exception.

The measures must be conceived, formulated and implemented from a rights-based perspective. In other words, they must be built around the set of political, civil, cultural, economic and social rights that contribute to human development. This means using human rights principles and standards in the analysis, planning, implementation and review of legislation, policies and programmes, with a view to improving the situation of older persons for the full enjoyment and exercise of their rights.

In other words, human rights principles and standards inform good governance practice, by steering the preparation of legislative frameworks, policies, programmes, budgetary allocations and other measures.

The measures required to implement the Convention present certain challenges in terms of the "new" rights, which differ from those "emerging" and "existing" rights. The new rights mark a departure from the way older persons have been legally treated in the region hitherto: the "emerging" rights are innovative, while the "existing" ones demand new interpretations of rights already recognized by other treaties and international standards.

These "new" rights have, in general, been disregarded by domestic law. This may continue to be the case for some time, calling into question their individual legitimacy as the new paradigm becomes established (Dussel, 2010). The creation and entry into force of the Inter-American Convention on Protecting the Human Rights of Older Persons usher in a period in which the new rights, as they become recognized by the wider political community, will become the new prevailing "normality", while, the previous legal standard will lose legitimacy and legality, at least in relation to international standards. The challenge is to bring the new rights to a status of full legality and applicability as the domestic law at the national level.

[23] "Where the exercise of any of the rights or freedoms referred to in this Convention is not already ensured by legislative or other provisions, States parties undertake to adopt, in accordance with their constitutional processes and the provisions of this Convention, such legislative and other measures as may be necessary to give effect to those rights or freedoms" (Article 1 of the Inter-American Convention on Protecting the Human Rights of Older Persons).

The Inter-American Convention on Protecting the Human Rights of Older Persons is still recent. Reference must therefore be sought in other similar processes in order to determine how the new rights may be incorporated at State level. A series of guidelines can be found in the path taken by existing human rights treaties that have already made significant progress towards full legitimization, in the form of State legislation, policies and practices; recommendations of conventional and non-conventional follow-up mechanisms to ensure compliance (concluding observations and general comments of the committee, among others); and even the jurisprudence of the inter-American and European human rights systems.

The most immediate point of reference is the process undertaken to implement the Convention on the Rights of Persons with Disabilities, which has focused on the rights of a specific social group and one that shares certain similarities regarding the presence of emerging and existing rights. To a certain degree, it can therefore serve as a guide for interpreting and implementing some of the "new" rights established by the Inter-American Convention on Protecting the Human Rights of Older Persons.

As noted earlier, the existing and emerging rights contained within the Convention include the right to life and dignity in old age (article 6), the right to independence and autonomy (article 7), the right to long-term care (article 12), the right to equality and non-discrimination (article 5) and the right to give free and informed consent on health matters (article 11).

Owing to their innovative nature, and without prejudice to the rest of the rights established by the Convention, a detailed analysis of some of these rights follows.

1. Equality and non-discrimination

The main characteristic of all human rights is their universality. This means that all people have human rights, regardless of their nationality, ethnicity or religion, or any social, cultural, economic or other conditions. The principle of non-discrimination is complemented by the principle of equality, as outlined in article 1 of the Universal Declaration of Human Rights: "All human beings are born free and equal in dignity and rights."

Equality and non-discrimination are not new concepts. They are present in all human rights treaties, as well as in the majority of the constitutional texts and domestic legislation of States. As such, all the rights recognized in human rights treaties —whether universal or inter-American in nature— can be said to be fully applicable to older persons. Non-discrimination for reasons of age is not an innovative concept; it is the fundamental principle behind the need for and existence of the Convention on the Rights of the Child.

The undeniable and innovative contribution of the Inter-American Convention on Protecting the Human Rights of Older Persons lies in the prohibition of all forms of discrimination on the grounds of age against persons aged 60 or older, as established in its preamble through the reaffirmation of the obligation of States to eliminate all forms of discrimination for reasons of age.

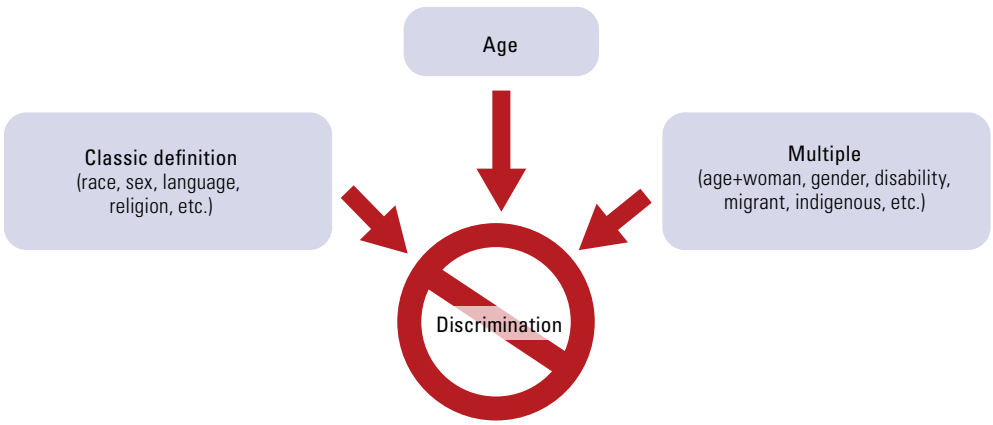
The principle of equality and non-discrimination is a recurrent and fundamental element of the Inter-American Convention on Protecting the Human Rights of Older Persons as it was in the Convention on the Rights of the Child. It is the central pillar of a process of progressive specification aimed at the materialization of equality and the removal of any social and institutional obstacles.

The importance of equality and non-discrimination is reflected in the fact that the term "discrimination" appears 19 times in the text of the Convention, and "equality" 23 times (on most of these occasions, the exact expression used is "on an equal basis"). The principle of equality and non-discrimination is therefore intimately associated with each of the Convention's substantive provisions, since the States parties are obliged

to guarantee that all the rights enshrined in the Convention are respected, protected and fulfilled on an equal basis and without discrimination.

In the Convention, the right to non-discrimination comprises three separate but complementary dimensions. First, it contains the classic definition of "discrimination": any distinction, exclusion, or restriction with the purpose or effect of hindering, annulling, or restricting the recognition, enjoyment, or exercise, on an equal basis, of human rights. Second, there is an innovation: the distinction, exclusion or restriction is based on age (or more specifically in this case, on advanced age). Lastly, the Convention establishes a definition of "multiple discrimination", or discrimination that is based on two or more factors (see diagram III.2).

Diagram III.2
Elements of the right to non-discrimination in the Inter-American Convention on Protecting the Human Rights of Older Persons



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

In addition to establishing the duty of non-discrimination as a principle (article 3), the Convention also outlines the obligation of the States parties to take affirmative measures and make reasonable adjustments for the exercise of the rights by the rights-holders, including any temporary provisions that may be necessary to expedite or attain de facto equality for older persons (article 4(b)).

Article 5 specifically prohibits discrimination on the grounds of the age of older persons. It indicates that States parties must develop specific approaches in their policies, plans and legislation on ageing and old age in relation to older persons who are vulnerable or victims of multiple discrimination.

It is evident, therefore that the prohibition of discrimination has a vast field of application. In the Convention, the terms "measures" and "reasonable adjustments" are employed in a broad and discretionary manner. Nonetheless, the possible ambiguity of these terms should not be interpreted as a weakness. Rather, this broadness means that each State has some discretion in deciding how to fulfil the obligations of the Convention. It also means that States must not restrict themselves to a single formula in the fulfilment of their obligations, but must instead take any measures that may be needed to protect older persons from all forms of discrimination.

The obligation to respect the human rights of older persons requires States parties to refrain from adopting any laws, policies, standards, programmes, administrative procedures or institutional structures that directly or indirectly deprive older persons of the full enjoyment of their civil, political, economic, social and cultural rights. The obligation to protect these rights requires States parties to protect older persons from

the discrimination of private individuals and to adopt measures to eliminate practices that fuel prejudice and perpetuate the notion that older persons are inferior or dependent. The obligation to fulfil these rights requires States parties to adopt a wide range of measures (including special temporary measures where necessary, in accordance with article 4(b) of the Convention) in order to ensure the de jure and de facto enjoyment of these rights for older persons.

Article 4 stipulates that the States parties will not be considered discriminatory by adopting affirmative measures and making reasonable adjustments to ensure equality for older persons. This article is important because it introduces the concept of substantive equality. In other words, States must not only work towards formal equality, in the form of non-discriminatory regulations, but also towards guaranteeing and promoting substantive equality; fairer starting points must be established. Special temporary measures are necessary in order to achieve this substantive equality.

As outlined in chapter II, the main cause of discrimination originates from the standard of normality upon which society has been built and its consequent inability to create decent and equal conditions for those who are different. Difference in itself neither causes nor justifies inequality; instead, it is culture that embeds a system that establishes and standardizes inequalities. In order to disentangle this web of inequalities and achieve substantive —not merely formal— equality, a selective allocation of resources, services and protections is needed for the most excluded and disadvantaged members of society, in addition to differentiated strategies tailored to the particular characteristics of such groups. Logically, substantive equality will in turn lead to equal outcomes.

Older persons, in addition to suffering discrimination for reasons of age, may also be subjected to other forms of discrimination on the grounds of their race, ethnic origin, religion, disability, class, caste or other factors.

In this regard, the States parties are faced with a complex and demanding challenge. The Convention explicitly requires that equal conditions, non-discrimination, equal treatment and equal opportunities be guaranteed in respect to the right to life and dignity (article 6); the right to participation and community integration (article 8(a)); the right to personal liberty (article 13); the right to freedom of expression and access to information (article 14); the right to nationality and freedom of movement (article 15); the right to work (article 18); the right to health (article 19); the right to education and culture (articles 20 and 21); the right to a healthy environment (article 25); the right to accessibility and personal mobility (article 26); the right to participate in political and public life (article 27); legal capacity (article 30); and access to justice (article 31).

It is not enough to adopt a general law that prohibits discrimination, or to incorporate an anti-discrimination clause into specific legislation for older persons or a national plan on ageing. The challenge the States are facing is multidimensional and extensive. They must progressively identify possible breaches of the rights of older persons in their regulatory framework and national policies. Then they must eliminate and rectify those discriminatory references, conditions, requirements or other elements in their standards, policies and programmes that have a direct or indirect impact upon the rights of older persons.

Indirect discrimination refers to laws, policies or practices that appear neutral, but have a disproportionate impact on the exercise of rights as distinguished by prohibited grounds of discrimination (United Nations, 2009).

In addition to reviewing regulation, policies and programmes, complementary efforts are also required to fight age-related stigmatization in different areas of society: at the general level, by adopting measures to achieve dissemination of the Convention; in the field of public administration, by developing codes of conduct for civil servants; in the judiciary, by training officials to apply the Convention's provisions to every judicial decision; and for government agencies and civil servants in all State spheres, by introducing specific education and training programmes on the principles and provisions of the Convention.

The creation of entities to monitor age discrimination and advocate for its elimination must be considered in all areas of public life. These entities could take various forms, such as human rights procurators, parliamentary commissions or ombudspersons. Complaint mechanisms are also required to enforce the right to non-discrimination (United Nations, 2016a).

Finally, the financial aspect must not be disregarded. No progress can be made on domestic State legislation, policies and programmes without the sufficient financial resources assigned in an accountable, effective, efficient, equitable, participatory, transparent and sustainable manner.

In this regard, the general comment on public budgeting for the realization of children's rights recently issued by the Committee on the Rights of the Child could serve as a useful point of reference. It indicates that States should take proactive measures to ensure positive outcomes by mobilizing sufficient revenue and allocating and spending funds accordingly. In order to achieve substantive equality, States parties should identify which groups qualify for special measures and then use public budgets to implement them. In particular, in order to secure budgets that contribute positively to the enjoyment of rights, States must address inequalities by reviewing and revising relevant legislation, policies and programmes, by increasing or reprioritizing certain parts of the budget, or improving the effectiveness, efficiency and equity of their budgets. (United Nations, 2016b).

2. The right to independence, autonomy and legal capacity

Autonomy and independence are two related concepts that are often used indistinctly in legal instruments and frameworks. While autonomy refers to the ability to exercise freedom of choice and control over the decisions affecting one's life, including with the help of someone else if needed, independence means to live in the community without assistance or, at least, where the help provided does not subject older persons to the decisions of others (United Nations, 2015).

Huenchuan (2012) observed that, from a human rights perspective, the concept of autonomy encompasses both a public dimension, which is linked to an individual's active participation in the organization of society, and a personal dimension, which is manifested in the possibility to formulate and carry out one's own life plans. Self-determination and the freedom to make one's decisions are the grounds for exercising both dimensions of autonomy.

Autonomy and independence are not totally new concepts. The United Nations Principles for Older Persons[24] make explicit reference to independence and indirect

[24] Adopted by virtue of resolution 49/61 of the United Nations General Assembly on 16 December 1991.

reference to autonomy. More recently, the preamble to the San José Charter on the Rights of Older Persons in Latin America and the Caribbean mentions respect for autonomy and independence in decision-making as a fundamental right. Within this Charter, the two concepts are also mentioned in relation to the right to free and informed consent prior to any medical treatment, as well as in relation to care services, the improvement of living conditions and environment, and guaranteeing accessibility for older persons by eliminating architectural barriers.

The Independent Expert on the enjoyment of all human rights by older persons, appointed by the Human Rights Council, has cited recommendation CM/Rec (2014)2 of the Council of Europe on the promotion of the human rights of older persons, in which it is stated that older persons have the right to lead their lives independently, in a self-determined and autonomous manner. This encompasses taking independent decisions with regard to all issues which concern them, such as property, income, finances, place of residence, health, medical treatment or care (United Nations 2015).

The independence and autonomy of older persons have a prominent place in the Convention, being identified both as general principles (article 3) and as standalone rights (article 7). They also receive special mention in relation to the rights of older persons receiving long-term care (article 12) and the right of older persons to recreation, physical activity, leisure and sports as a means to promote their independence and autonomy (article 22).

Article 7 establishes that the States parties shall adopt programmes, policies, or actions to facilitate and promote full enjoyment of the right of older persons to make decisions, to determine their life plans and to lead an autonomous and independent life.

Autonomy and independence are specifically linked to three aspects of the lives of older persons:

(i) Decision-making and action;

(ii) The opportunity to choose one's place of residence and where and with whom to live, rather than being obliged to live in a particular living arrangement, and

(iii) Progressive access to a range of in-home, residential, and other community-support services, including the personal assistance necessary to support living and inclusion in the community and to prevent isolation or segregation from the community.

Autonomy also involves the recognition of older persons before the law, encompassing their freedom and legal capacity to make decisions.

The concepts of independence and autonomy demand that any individual's decision be legally respected. Denial or restriction of older person's legal capacity threatens their autonomy, with negative impact on the ability to exercise the right to make decisions on civil, commercial, administrative, judicial, health-related or other issues that may have an impact on their well-being.

This leads us to the necessary interrelation between article 7 and article 30 of the Convention. The latter reaffirms the right of older persons to recognition before the law and establishes that States must ensure that all measures concerning the exercise of legal capacity will provide for appropriate and effective safeguards. Given the diversity of older persons and their needs, the nature and intensity of the support shall differ from case to case.

The most immediate point of reference on autonomy and legal capacity can be found in the Convention on the Rights of Persons with Disabilities. That experience may serve to improve understanding of the scope of autonomy as a concept, as well as the measures that may be adopted to implement it. In its general comment on equal recognition before the law, for example, the Committee on the Rights of Persons with Disabilities offers guidelines to States on how to reform their regulations, urging them to replace decision-making regimes with supported decision-making.

The following list serves as a guide to the essential measures that States must take in order to guarantee full respect for the autonomy and independence of older persons:

(i) Examine the laws that regulate guardianship and trusteeship, and formulate laws and policies that will replace substitute decision-making regimes with supported decision-making, so as to respect the autonomy, will and preferences of the individual (United Nations, 2013a).

(ii) Replace substitute decision-making regimes with supported decision-making alternatives. The old regimes must be fully replaced; it will not suffice to develop two systems in parallel (United Nations, 2013a).

(iii) Ensure that the need to receive support and reasonable adjustments in order to make decisions will never be used in legislation or in judicial or administrative proceedings to cast doubt over a person's legal capacity.

(iv) Establish a supported decision-making regime and procedures, always giving primacy to a person's will and preferences and respecting human rights norms (United Nations, 2013a).

(v) Adopt regimes based on supported decision-making. Although these may take various forms, they should all be based on certain key provisions (United Nations, 2013a):

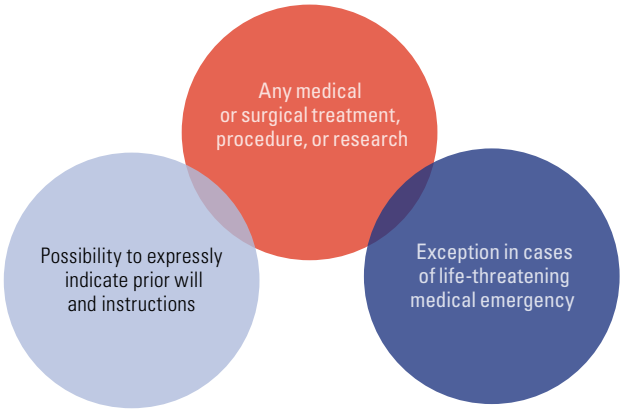
- All forms of support in the exercise of legal capacity must be based on the will and preference of the individual, not on what is perceived as being in his or her objective best interests.
- Support in decision-making must not be used as a justification for limiting other fundamental rights (such as the right to vote, the right to marry or establish a civil partnership, the right to give consent to medical treatment and the right to liberty).
- The person must have the right to refuse support and terminate or change the support relationship at any time.
- Safeguards must be set up for all processes relating to legal capacity and support in exercising legal capacity. The goal of safeguards is to ensure that the person's will and preferences are respected.

3. Free and informed consent on health matters

Autonomy, independence and legal capacity are particularly important to older persons when it comes to making key decisions on health care and, above all, on medical treatment. In order to strengthen and ensure respect for older persons' autonomy, they must be able to consent to a medical treatment, refuse it, or choose another one.

The importance of the right to give voluntary, free, prior and informed consent on health matters is reflected in the decision to devote an article exclusively to this right in the Inter-American Convention on Protecting the Human Rights of Older Persons.

Diagram III.3
Article 11 of the Inter-American Convention on Protecting the Human Rights of Older Persons: free and informed consent



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

As articulated by the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, guaranteeing informed consent is fundamental to achieving an environment that is respectful of autonomy, self-determination and human dignity. Informed consent is not merely the acceptance of a medical treatment, but a voluntary and sufficiently informed decision. It is not just the right to health that is invoked, but the right to self-determination, non-discrimination, freedom from non-consensual experimentation, security and dignity of the human person, recognition before the law, and freedom of thought and expression (United Nations, 2011).

States parties have an obligation to require all health and medical professionals (including psychiatric professionals) to obtain the free and informed consent of patients prior to any treatment. In conjunction with the right to legal capacity on an equal basis with others, States have an obligation not to permit substitute decision-makers to provide consent on behalf of an individual. All health personnel should also ensure, to the best of their ability, that assistants or support persons do not substitute or have undue influence over the decisions of their patients (United Nations, 2013a).

In his 2013 report on torture in health-care settings, the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment considered that the deprivation of legal capacity (which occurs when a person's exercise of decision-making is taken away) presupposes a situation of powerlessness, whereby the victim is under the total control of another person. Medical treatments of an intrusive and irreversible nature, when lacking a therapeutic purpose, may constitute torture or ill-treatment when enforced or administered without the free and informed consent of the person concerned (United Nations, 2013b).

The Special Rapporteur on the right to health reiterated this point when declaring that the persistent denial of the right to informed consent could constitute a form of physical and psychological abuse of older persons, who are much more prone to treatment and care without consent. This is compounded by discrimination directed against older persons, who in some cases may have a diminished capacity to consent to treatment (United Nations, 2011).

It is not enough to simply recognize informed consent as a right in legislation. It must be borne in mind that the imbalance of power, experience and trust inherently present in the doctor-patient relationship, in addition to structural inequalities, can result in the voluntary or informed nature of consent being significantly compromised. With a view to protecting the rights of older persons, States should establish appropriate support mechanisms, including community involvement and comprehensive counselling, that would help overcome subsequent challenges to achieving informed consent (United Nations, 2011).

States must adopt measures to guarantee that the right to give prior and informed consent in a voluntary, free, and explicit manner is fully respected, including:

(i) Revising legislation, regulations, policies and protocols related to health-care services in order to ensure that they comply with international standards, and in particular the Inter-American Convention on Protecting the Human Rights of Older Persons;

(ii) Defining a clear and complementary set of regulations on the subject of free and informed consent on health matters;

(iii) Ensuring that information on health-related issues is freely available on a non-discriminatory basis, accessible in view of the particular communication needs of the individual, and presented in an acceptable manner from cultural and other perspectives, so that the person granting the consent understands all the implications of the decision being made;

(iv) Instituting mechanisms to raise awareness and train medical professionals, non-medical carers and the wider community on the rights of older persons and the right to informed consent;

(v) Establishing adequate support mechanisms that help to overcome the difficulties involved in attaining informed consent, including community involvement and comprehensive counselling;

(vi) Making the protection of informed consent a key component of the evaluation of health-care services and the fulfilment of public health goals;

(vii) Establishing oversight mechanisms to detect situations that put the exercise of informed consent at risk and complaint mechanisms that can easily be accessed by older persons; and

(viii) Informing and empowering older persons, in order to strengthen their participation in health policymaking and in building networks of older persons through which health information can be more easily accessed.

4. Participation of older persons

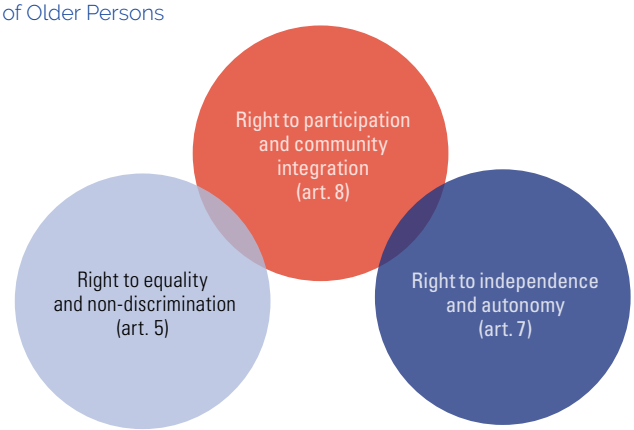
The Inter-American Convention is a valuable legal instrument for the countries of the region, chiefly because it allows older persons to defend their rights and to ensure that these rights are respected.

As far as participation is concerned, article 8 of the Convention establishes that "older persons have the right to active, productive, full, and effective participation in the family, community, and society with a view to their integration" and indicates that "States parties shall adopt measures to enable older persons to participate actively and productively in their community and to develop their capacities and potentialities".

It is essential that States parties reflect upon this right and how it can be brought into effect in such a way that, beyond a simple statement of intent, it may become an obligation that States are obliged to fulfil as a means of strengthening democracy and political pluralism, as the Inter-American Court of Human Rights has stated in reference to other OAS treaties.

The exercise of article 8 on the right to participation and community integration is both inseparable from and interdependent on certain other rights established by the Convention —for example, article 5 on equality and non-discrimination and article 7 on independence and autonomy.

Diagram III.4
Interdependence of human rights in the Inter-American Convention on Protecting the Human Rights of Older Persons



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

These three articles are of fundamental importance in ensuring the consolidation of older persons as rights-holders. On the one hand, they seek to eliminate the barriers preventing them from making their own decisions and, on the other hand, they help to give lie to the notion that human beings become perpetually dependent in old age.

Older persons and their organizations face a considerable task concerning the three articles of the Convention. Article 4(f) stipulates that States parties will "encourage the broadest participation by civil society and other social actors, especially older persons, in the drafting, implementation, and oversight of public policies and laws to implement" the Convention.

This article identifies general State obligations with respect to the rights enshrined within the Convention. Although States are obliged to provide a series of measures and services, article 4(f) also demands that action be carried out in certain areas by individuals, and not just by the authorities.

As has been said of the Convention on the Rights of Persons with Disabilities (Kanter, 2015), the success of the Inter-American Convention on Protecting the Human Rights of Older Persons will depend on how successful the countries are in enforcing their laws and changing attitudes towards older persons.

By way of illustration, older persons in Costa Rica have already made use of the Convention to protect their rights. In 2015, various applications for amparo were brought before the Constitutional Chamber of the country's Supreme Court of Justice. One of these applications for amparo was made against the Bank of Costa Rica, which, by not giving preferential treatment to older persons, had failed to comply with national legislation and the principles of the Inter-American Convention. The court ruled in favour of the older persons and ordered the Bank to guarantee the availability of a preferential option within its platform of services, enabling it to offer special attention to individuals with the right to preferential treatment.[25] Actions such as this, which contribute to a wider process of awareness-raising involving the participation of different individuals and groups around the country,[26] are becoming a part of national jurisprudence and can henceforth be referred to in cases relating to the rights of older persons.

[25] See file 15-010852-007-CO of the Constitutional Chamber of the Supreme Court of Justice of Costa Rica.

[26] One of them is the National Pension Board for Teachers of Costa Rica. In addition to promoting the ratification of the Inter-American Convention, the organization has held informative and educational events across the country featuring workshops and talks by experts on the implications of the Convention, as well as other activities raising awareness of the Conventions and its use (JUPEMA, 2016).

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Chapter

IV

Emerging issues for the protection of the rights of older persons

Introduction

This chapter addresses two issues on which the regional discussion about the human rights of older persons has made substantial contributions, whether by conceptualizing them, by recognizing rights or by identifying States' obligations when it comes to promoting, observing and protecting these.

It reviews the common ground between three regional instruments adopted in the past two years, in the Americas, Europe and Africa: the Inter-American Convention on Protecting the Human Rights of Older Persons; Recommendation CM/Rec(2014)2 on the promotion of human rights of older persons, adopted by the Committee of Ministers to member States of the Council of Europe on 19 February 2014; and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Older Persons in Africa, adopted on 26 January 2016 by the Assembly of Heads of State and Government of the African Union.

These three regional instruments represent the corpus of currently recognized rights applying specifically to older persons. Despite their differences (and the fact that the Council of Europe recommendation is non-binding), common concerns can be identified, such as equality and non-discrimination, and end-of-life palliative care.

The Inter-American Convention on Protecting the Human Rights of Older Persons is the only instrument to deal extensively with the rights of this group on the basis of the three dimensions identified in chapter III of the present document, and the one that most fully reflects the conclusions of the treaty committees and the interpretations arrived at by other human rights bodies.

The Protocol to the African Charter stands out for the specificity of the rights it guarantees older persons, including some that are not included in the other two instruments, an example being the rights of specific groups. The Council of Europe recommendation focuses on promoting the rights of older persons in certain areas, and its content is the basis for public policy.

Access to credit is the first subject presented in this chapter, as an example of the discrimination suffered by older persons. The importance of credit is recognized internationally because of its contribution to economic development and the reduction of inequalities, and it is even included in Goal 1 on poverty eradication of the 2030 Agenda for Sustainable Development.

Better access to credit allows people to manage their lives and economic activity more effectively. The benefits include using credit to take up opportunities and simplify consumption, or to improve the quality of life of individuals and their households.[1]

Credit is one of the most basic financial services from the point of view of financial inclusion, since in addition to complementing savings it allows households and individuals to spread income and spending over time and to obtain goods and services at suitable times within financial cycles, thus boosting economic productivity.

The issue of older persons' access to credit is generally overlooked, even though it contributes to their economic security and inclusion. The present document address the subject from the perspective of human rights, particularly economic, social and cultural rights, and the principle of equality and non-discrimination.

[1] For example, self-employed workers and small business owners generally use loans to invest in assets such as a sewing machine, refrigerators or agricultural implements that help them in their businesses, while households may use them to pay for education or health services (Villacorta and Reyes, 2012).

The second topic addressed in this chapter is end-of-life palliative care and dignified death. Both tie in with an increased awareness that a longer lifespan does not automatically signify good health. According to the World Health Organization (WHO), life expectancy at birth for the two sexes in the Americas region was 76.9 years in 2015, while health-adjusted life expectancy at birth was 67.3 years.

As the population grows older, an ever greater proportion of people are reaching an age (75 and over) at which they are at risk of becoming frail and developing multi-morbidity conditions that require specific continuing care (Council of the European Union, 2014). The prevalence of chronic and progressive diseases such as cancer, diabetes, cardiovascular problems and Alzheimer's means that this type of service is needed more than in earlier periods.

Almost 18 million people around the world died in unnecessary pain in 2012, and in the Americas region an estimated 365 of every 100,000 adults needed palliative care, the third-highest level in the world (Connor and Sepúlveda, 2014). A lack of training among medical personnel, limited availability of medications and the absence of facilities or support for family members to care for terminally ill older persons are a daily reality.

In response to this situation, the Executive Secretary of the Economic Commission for Latin America and the Caribbean (ECLAC) has pointed out that palliative care gives people the opportunity to regain autonomy by restoring their ability to make decisions about treatments and the way they are administered, and the right to have their wishes respected. Unfortunately, despite its importance as a humanitarian issue, palliative care is still a privilege and is not guaranteed for all (Bárcena, 2015).

The Latin America and Caribbean region has made progress over the past five years in conceptualizing dignified death as part of the right to life and dignity, and not simply as assisted suicide. As the United Nations Human Rights Committee has pointed out, dignified death is a complex issue, and associating it only with euthanasia carries the risk of trivializing something as serious as the demise of a human being.[2] Hence, palliative care is recognized as an issue of solidarity and interdependence by the Inter-American Convention on Protecting the Human Rights of Older Persons, which provides a definition of it and clearly establishes State obligations in respect of access and implementation.

A. Equality and non-discrimination in older persons' access to credit

By 2030, ensure that all men and women, in particular the poor and the vulnerable, have equal rights to economic resources, as well as access to basic services, ownership and control over land and other forms of property, inheritance, natural resources, appropriate new technology and financial services, including microfinance (Target 1.4 of Sustainable Development Goal 1).

[2] This comment by the Human Rights Committee was in response to the law authorizing euthanasia in the Netherlands. In particular, the Committee considered that application of the law carried the real risk of trivializing something as irreversible as the death of a human being. After being partly decriminalized in 1994, euthanasia was legalized in the Netherlands from 1 January 2002. The United Nations body recognized that this was a very complex issue that had arisen largely because of the evolution of medical practice, but at the same time it admitted that it felt the need to issue a statement when a State "seeks to relax legal protection with respect to an act deliberately intended to put an end to human life" (United Nations, 2001).

1. Access to credit in a human rights framework

Non-discriminatory access to financial credit is an internationally recognized human right that stems from the fundamental right to an adequate standard of living, and States must adopt special measures to secure it.

This follows from the provisions of one of the major international human rights instruments, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), article 13 of which enjoins: "States Parties shall take all appropriate measures to eliminate discrimination against women in other areas of economic and social life in order to ensure, on a basis of equality of men and women, the same rights, in particular: […] (b) The right to bank loans, mortgages and other forms of financial credit" (United Nations, 1979).

(a) The Committee on Economic, Social and Cultural Rights

Since 2001, the Committee on Economic, Social and Cultural Rights has included issues of credit access in its reviews of countries' implementation of rights, requesting information from States parties and formulating recommendations for ensuring non-discriminatory access to credit.[3] The Committee has highlighted four factors relating to this topic: first, the link between lack of access to credit and extreme poverty; second, the de facto discrimination suffered by women seeking credit; third, the importance of microcredit in overcoming poverty; and fourth, specific access to housing loans as a measure linked to the right to housing.

In its final observations, the Committee has highlighted lack of access to credit as one of the factors behind extreme poverty and has urged the development of accessible credit schemes. An example is its 2008 report on India, paragraph 29 of which alludes to its particular concern about the extreme poverty caused by the lack of access to credit,[4] recommending the adoption of measures to correct this. A similar observation can be found in its review of the report presented by the Solomon Islands: "The Committee recommends that the State party encourage […] the creation of accessible credit schemes."[5] Likewise, in its review of Senegal the Committee urged the State to provide "credit facilities at reasonably low rates".[6]

A key aspect of the human rights approach as applied to credit issues is discrimination in access as a violation of the principle of equality and non-discrimination. The Committee on Economic, Social and Cultural Rights has underscored inequality of access between men and women, and this criterion applies to other dimensions of discrimination such as age. In its report on Ecuador, it stated: "The Committee expresses its concern about the de facto inequality that exists between men and women. […] Such inequality is reflected in […] limited access to […] credit."[7] It made similar observations in its review of Guatemala: "The Committee calls upon the State party to ensure equality between women and men in all spheres of life, in particular by taking effective measures to combat discrimination in […] access to […] credit services."[8]

3 See Concluding observations of the Committee on Economic, Social and Cultural Rights, Senegal (E/C.12/1/ADD.62 (CESCR, 2001)), Benin (E/C.12/1/ADD.78 (CESCR, 2002)), Solomon Islands (E/C.12/1/ADD.84 (CESCR, 2002)), Brazil (E/C.12/1/ADD.87 (CESCR, 2003)), Guatemala (E/C.12/1/ADD.93 (CESCR, 2003)), Ecuador (E/C.12/1/ADD.100 (CESCR, 2004)), India E/C.12/IND/CO/5 (CESCR, 2008)), Nicaragua (E/C.12/NIC/CO/4 (CESCR, 2008)), Chad (E/C.12/TCD/CO/3 (CESCR, 2009)), Sri Lanka (E/C.12/LKA/CO/24 (CESCR, 2010)), Gabon (E/C.12/GAB/CO/1 (CESCR, 2013)) and El Salvador (E/C.12/SLV/CO/35 (CESCR, 2014)).

4 See Concluding observations of the Committee on Economic, Social and Cultural Rights, India (E/C.12/IND/CO/5), 8 August 2008.

5 See Concluding observations of the Committee on Economic, Social and Cultural Rights, Solomon Islands (E/C.12/1/Add.84), 19 December 2002.

6 See Concluding observations of the Committee on Economic, Social and Cultural Rights, Senegal (E/C.12/1/Add.62), 24 September 2001.

7 See Concluding observations of the Committee on Economic, Social and Cultural Rights, Ecuador (E/C.12/1/Add.100), 7 June 2004.

8 See Concluding observations of the Committee on Economic, Social and Cultural Rights, Guatemala (E/C.12/1/Add.93), 12 December 2003.

(b) The Committee on the Elimination of Discrimination against Women

The Committee on the Elimination of Discrimination against Women has developed an ongoing and systematic analysis of discrimination in access to credit, in this case for reasons of gender. In general recommendation No. 25 on article 4, paragraph 1, of CEDAW, on temporary special measures, the Committee reminds States parties that "temporary special measures should be adopted to accelerate the modification and elimination of cultural practices and stereotypical attitudes and behaviour that discriminate against or are disadvantageous for women" and includes credit and loans among these special measures (United Nations, 2004).

In its reviews, the Committee has applied article 13 of CEDAW, formulating observations and recommendations on non-discrimination in access to credit.[9] In its review of Malawi, the Committee expressed its concern about "the indirect discrimination against women because they have limited access to credit, owing to their lack of collateral".[10]

According to the Committee on the Elimination of Discrimination against Women, access to credit is among the measures for improving living conditions, along with education, employment, access to land and health services; it is also recommended as a measure for economic empowerment and participation. In its concluding observations on Costa Rica, for example, the Committee "encourages the State party to adopt concrete, targeted measures to accelerate the improvement of conditions of [...] women in all spheres of life" and "calls upon the State party to ensure that […] women have full access to […] credit facilities and can fully participate in decision-making processes".[11] A similar recommendation was made to Burkina Faso: "The Committee also encourages the State party to continue its efforts to promote the economic empowerment of women through their access to […] credit […] and other resources taking into account their social realities."[12]

9 See Concluding observations of the Committee on the Elimination of Discrimination against Women, Thailand (A/54/38/REV.1(SUPP) (CEDAW, 1999)), Burkina Faso (A/55/38(SUPP) (CEDAW, 2000)), Nicaragua (A/56/38(SUPP) (CEDAW, 2001)), Suriname (A/57/38(SUPP) (CEDAW, 2002)), Argentina (A/59/38(SUPP) (CEDAW, 2004)), Paraguay (A/60/38(SUPP) (CEDAW, 2005)), Cambodia (CEDAW/C/KHM/CO/3 (CEDAW, 2006)), Mali (CEDAW/C/MLI/CO/5 (CEDAW, 2006)), Togo (CEDAW/C/TGO/CO/5 (CEDAW, 2006)), Turkmenistan (CEDAW/C/TKM/CO/2 (CEDAW, 2006)), Guatemala (CEDAW/C/GUA/CO/6 (CEDAW, 2006)), Bosnia and Herzegovina (CEDAW/C/BIH/CO/3 (CEDAW, 2006)), Malawi (CEDAW/C/MWI/CO/5 (CEDAW, 2006)), Cuba (CEDAW/C/CUB/CO/6 (CEDAW, 2006)), Georgia (CEDAW/C/GEO/CO/3 (CEDAW, 2006)), Philippines (CEDAW/C/PHI/CO/6 (CEDAW, 2006)), India (CEDAW/C/IND/CO/3 (CEDAW, 2007)), Peru (CEDAW/C/PER/CO/6 (CEDAW, 2007)), Suriname (CEDAW/C/SUR/CO/3 (CEDAW, 2007)), Nicaragua (CEDAW/C/NIC/CO/6 (CEDAW, 2007)), Viet Nam (CEDAW/C/VNM/CO/6 (CEDAW, 2007)), Azerbaijan (CEDAW/C/AZE/CO/3 (CEDAW, 2007)), Namibia (CEDAW/C/NAM/CO/3 (CEDAW, 2007)), Mauritania (CEDAW/C/MRT/CO/1 (CEDAW, 2007)), Sierra Leone (CEDAW/C/SLE/CO/5 (CEDAW, 2007)), Vanuatu (CEDAW/C/VUT/CO/3 (CEDAW, 2007)), Mozambique (CEDAW/C/MOZ/CO/2 (CEDAW, 2007)), Niger (CEDAW/C/NER/CO/2 (CEDAW, 2007)), Serbia (CEDAW/C/SCG/CO/1 (CEDAW, 2007)), Pakistan (CEDAW/C/PAK/CO/3 (CEDAW, 2007)), Guinea (CEDAW/C/GIN/CO/6 (CEDAW, 2007)), Indonesia (CEDAW/C/IDN/CO/5 (CEDAW, 2007)), New Zealand (CEDAW/C/COK/CO/1 (CEDAW, 2007)), Hungary (CEDAW/C/HUN/CO/6 (CEDAW, 2007)), Brazil (CEDAW/C/BRA/CO/6 (CEDAW, 2007)), Belize (CEDAW/C/BLZ/CO/4 (CEDAW, 2007)), Estonia (CEDAW/C/EST/CO/4 (CEDAW, 2007)), Burundi (CEDAW/C/BDI/CO/4 (CEDAW, 2008)), Lebanon (CEDAW/C/LBN/CO/3 (CEDAW, 2008)), Sweden (CEDAW/C/SWE/CO/7 (CEDAW, 2008)), Nigeria (CEDAW/C/NGA/CO/6 (CEDAW, 2008)), Madagascar (CEDAW/C/MDG/CO/5 (CEDAW, 2008)), Mongolia (CEDAW/C/MNG/CO/7 (CEDAW, 2008)), Rwanda (CEDAW/C/RWA/CO/6 (CEDAW, 2009)), Timor-Leste (CEDAW/C/TLS/CO/1 (CEDAW, 2009)), Switzerland (CEDAW/C/CHE/CO/3 (CEDAW, 2009)), Guinea-Bissau (CEDAW/C/GNB/CO/6 (CEDAW, 2009)), Liberia (CEDAW/C/LBR/CO/6 (CEDAW, 2009)), Botswana (CEDAW/C/BOT/CO/3 (CEDAW, 2010)), Papua New Guinea (CEDAW/C/PNG/CO/3 (CEDAW, 2010)), Russian Federation (CEDAW/C/USR/CO/7 (CEDAW, 2010)), Argentina (CEDAW/C/ARG/CO/6 (CEDAW, 2010)), Fiji (CEDAW/C/FJI/CO/4 (CEDAW, 2010)), Burkina Faso (CEDAW/C/BFA/CO/6 (CEDAW, 2010)), Costa Rica (CEDAW/C/CRI/CO/56 (CEDAW, 2011)), Ethiopia (CEDAW/C/ETH/CO/67 (CEDAW, 2011)), Zambia (CEDAW/C/ZMB/CO/56 (CEDAW, 2011)), Nepal (CEDAW/C/NPL/CO/45 (CEDAW, 2011)), Chad (CEDAW/C/TCD/CO/14 (CEDAW, 2011)), Côte d'Ivoire (CEDAW/C/CIV/CO/13 (CEDAW, 2011)), Zimbabwe (CEDAW/C/ZWE/CO/25 (CEDAW, 2012)), Brazil (CEDAW/C/BRA/CO/7 (CEDAW, 2012)), Bulgaria (CEDAW/C/BGR/CO/47 (CEDAW, 2012)), Guyana (CEDAW/C/GUY/CO/78 (CEDAW, 2012)), Equatorial Guinea (CEDAW/C/GNQ/CO/6 (CEDAW, 2012)), Angola (CEDAW/C/AGO/CO/6 (CEDAW, 2013)) and the Democratic Republic of the Congo (CEDAW/C/COD/CO/67 (CEDAW, 2013)).

10 See Concluding observations of the Committee on the Elimination of All Forms of Discrimination against Women, Malawi (CEDAW/C/MWI/CO/5), 3 February 2006.

11 See Concluding observations of the Committee on the Elimination of All Forms of Discrimination against Women, Costa Rica (CEDAW/C/CRI/CO/56), 2011.

12 See Concluding observations of the Committee on the Elimination of All Forms of Discrimination against Women, Burkina Faso (CEDAW/C/BFA/CO/6), 2010.

The background to the Committee's work on this issue includes, in particular, its observations on its review of Argentina in 2010, in which it included older women specifically and made recommendations on access to credit. In its report, the Committee indicated that it remained "concerned about the situation of rural women, particularly older women and indigenous women, in view of their extreme poverty, marginalization and frequent lack of access to [...] credit facilities and community services". The Committee urged the State party to pay special attention to the needs of these specific groups of women and to ensure that they participated in decision-making and had full access to credit facilities.[13]

(c) The Special Rapporteur on extreme poverty and human rights

The Special Rapporteur on extreme poverty and human rights has complemented the observations and recommendations of the United Nations human rights treaty bodies by producing reports that address two aspects related to credit access. First, in her report on the Human Rights Council's draft guiding principles on extreme poverty and human rights, she urged States to recall their immediate and ongoing obligations with regard to the right to an adequate standard of living, to which end she recommended "ensuring access to relevant financial resources, including bank loans, mortgages and other forms of credit, by those living in extreme poverty" (United Nations, 2010a, para. 76).

Second, analysing the implications of the economic and financial crises, the Special Rapporteur pointed out: "In order for States to meet their duty to protect, the banking sector should be regulated to obligate banking institutions to serve the interests of society by, for example, ensuring access to credit without discrimination, especially those struggling under increased economic burdens" (United Nations, 2011, para. 84).

Also, in the light of emerging cases of financial abuse in lending, the Special Rapporteur warned: "States should ensure adequate means of redress for those adversely affected by the actions taken by financial sector institutions, and adopt regulations that discourage harmful practices by providing for accountability mechanisms that penalize risky behaviours and prosecute perpetrators" (United Nations, 2011, para. 84).

(d) Regional instruments

The Inter-American Convention on Protecting the Human Rights of Older Persons addresses access to credit in article 24 on the right to housing and article 30 on equal recognition before the law.

In the first case, it requires States parties to foster access to home loans and other forms of financing without discrimination, promoting, inter alia, collaboration with the private sector, civil society and other social actors.

Article 30 broadens this requirement, indicating: "States parties shall take all appropriate and effective measures to ensure the equal right of older persons to own or inherit property, to control their own financial affairs, and to have equal access to bank loans, mortgages, and other forms of financial credit, and shall ensure that older persons are not arbitrarily deprived of their property."

Access to credit was not addressed in Recommendation CM/Rec(2014)2 of the Council of Europe or in the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Older Persons in Africa. Nonetheless, these instruments do contain specific measures on equality and non-discrimination. For example, article 3

[13] See Concluding observations of the Committee on the Elimination of All Forms of Discrimination against Women, Argentina (CEDAW/C/ARG/CO/6), 2010.

of the Protocol refers to the elimination of all forms of discrimination against older persons, including those of a cultural, social and legal nature, and article II.6 of the Council of Europe recommendation states that older persons shall enjoy their rights and freedoms without discrimination on any grounds, including age.

2. Age discrimination in access to credit

Economic security is defined as independent access to stable economic resources adequate to ensure a good quality of life (Guzmán, 2002), although there are other elements that influence the well-being of older persons, several of them involving transfers from their own families, either in kind or in the form of time spent assisting and caring for them. The convergence of the two elements (economic and non-economic) allows older persons to meet their needs, preserve their autonomy and make their own decisions.

According to the United Nations, economic security is a legitimate aspiration in old age, both for people who have contributed to the social security system throughout their lives and for those who do not meet the requirements for a contributory pension because of their working history or for other reasons (United Nations, 1995).

Within this framework, older persons' financial position is of crucial importance for their economic security and thence their quality of life. The ability to obtain housing, food, supplementary health insurance and other goods and services can enhance or limit their well-being, and depends precisely on their financial position. Nonetheless, older persons often have no way of improving this.

After retirement, there are fewer opportunities to generate income through work or business. Any inheritances have already been received and bad investments cannot be undone. Moreover, even if older persons' experience is recognized as one of the assets they can use to generate new business opportunities, their limited ability or inability to access funding is a severe constraint on any initiative they may wish to undertake (National Institute of Adult Continuing Education, 2008).

Given the financial pressures facing older adults, including emergencies, access to credit can be a particularly important tool for this group.

Older persons' access to credit is still very limited and discriminatory. The size of the gap between the scale of need and the attention actually paid to it is astonishing. At best, the public authorities alone have paid attention to the problem, and it has not been researched or addressed in discussions about financial inclusion (United Nations, 2012).

The variety of older persons' income strategies has repercussions for the financial services they require, mainly because their expenses can be unpredictable and they do not always have a steady flow of income. Throughout the world, however, formal financial service providers often exclude this group. According to the Equality Commission for Northern Ireland, the main reason for this is discrimination (Fitzpatrick and Kingston, 2008), manifested mainly in two ways: (i) direct (using age as a proxy for risk) and (ii) indirect (establishing barriers to access such as requiring the use of literacy skills in application formalities, making information about credit available only in an electronic format or online, or imposing contemporary forms of money management).

A 2012 report by the United Nations Secretary-General arrives at the same conclusion, stating that there is "growing anecdotal evidence that the social integration of older persons is constrained by age limits and penalties imposed by insurance service providers and financial institutions. […] [A]ge discrimination [is] a widespread reality, particularly with regard to travel insurance, complementary health insurance, mortgages and loans.

[…] [I]n most countries, banks restrict access to long-term loans and mortgages for persons over a certain age, usually 65 or 70. In addition to being exclusionary and even discriminatory, such restrictions on older persons hinder their access to basic services, housing, home equipment and transportation" (United Nations, 2012).

Discrimination against older persons in this area affects some more than others. In the United Kingdom, a study by the International Longevity Centre and Age UK showed that in 2008 an older person from an ethnic minority was three times more likely to be excluded from financial products than a white older person. The same study revealed that older persons became more likely to be denied access to financial products with age. Between 2002 and 2008, for example, 9.3% of persons aged 80 or older were subject to this type of exclusion, compared with 2.1% of persons aged 50 to 59 (Kneale, 2012).

Discrimination against older persons in access to credit paves the way for situations of abuse by forcing them to take out expensive and sometimes illegal loans. Such borrowing increases the likelihood of becoming over-indebted and can go together with aggressive debt collection, with all the associated stress. Many also borrow from friends and relatives. When such informal debts cannot be repaid, this can lead to the breakdown of social relationships that are crucial for older persons' quality of life, especially when they are struggling financially, creating a domino effect of defaults. As an example, 5% of Europeans aged 55 and over stated in 2011 that they could not make scheduled loan repayments to family or friends (European Microfinance Network, 2012).

Such situations of abuse are also found in formal lending. In Chile, for example, a 2014 study by the National Consumer Service (SERNAC) observed that there were 13 major investor organizations claiming to offer some financial product or service specifically to pensioners or older persons. Of the financial institutions included in the study, 47% charged a total lending cost higher than the financial industry average. The difference between the cheapest and the most expensive options was about US$ 500, equivalent to almost half the net loan amount (SERNAC, 2014). In Argentina, one in three retirees, or about two million people, have taken out loans whose repayments are deducted directly from their retirement benefits through various organizations such as cooperatives, mutual societies, unions and banks. These generally carry very high interest rates, representing as much as 159% of the total financial value of the loan.

Box IV.1
Older persons' access to credit in Mexico

Older persons have little access to financial services in Mexico. According to data from the 2012 National Financial Inclusion Survey (ENIF), just 30 out of every 100 persons aged 65 to 70 interviewed said that they had some saving or payroll account, investment or other type of financial product with a banking institution. Among those with pensions or retirement benefits, 66 out of every 100 had access to banking services, while just 20 of every 100 people without pensions had bank accounts (see figure 1). Insufficient or irregular income was the main reason given by 47.2% of pensioners or retirees without access to banking services to explain why banking access in this age segment was so limited.

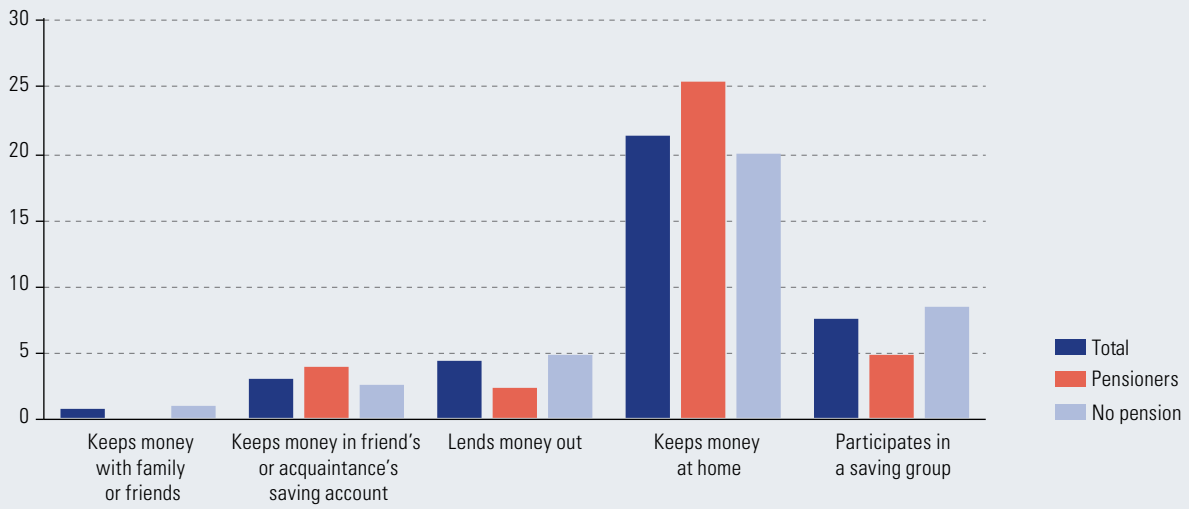
Lacking access to the banking system, 22.0% of older persons keep their money at home or with family or friends, while 25.4% of pensioners choose this option. Of informal saving alternatives, the leading choice among older persons is participation in saving groups (7.6%), while 3.0% use friends' or acquaintances' saving accounts and 4.3% decide to lend out their money. Among older persons who receive pensions, 4.8% participate in saving groups, 4.0% use saving accounts and 2.3% choose to lend out their funds (see figure 2).

Box IV.1 (concluded)

Figure 1
Mexico: persons aged 65 to 70 with bank accounts, 2012
(Percentages[a])

Source: National Banking and Securities Commission (CNBV)/National Institute of Statistics and Geography (INEGI), "Encuesta Nacional de Inclusión Financiera. El desarrollo de una encuesta de demanda: el caso de México", Mexico City, June 2012.
[a] The percentages are of those responding affirmatively in the National Financial Inclusion Survey (ENIF).

Figure 2
Mexico: saving habits among persons aged 65 to 70, 2012
(Percentages)



Source: National Banking and Securities Commission (CNBV)/National Institute of Statistics and Geography (INEGI), "Encuesta Nacional de Inclusión Financiera. El desarrollo de una encuesta de demanda: el caso de México", Mexico City, June 2012.

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of National Banking and Securities Commission (CNBV)/National Institute of Statistics and Geography (INEGI), "Encuesta Nacional de Inclusión Financiera. El desarrollo de una encuesta de demanda: el caso de México", Mexico City, June 2012.

3. Older persons' access to credit in other regions of the world

Most formal credit access programmes specific to older persons are operated by public bodies and involve small-scale lending tied to the value of borrowers' monthly pensions. One of the main barriers presented by such lending is that older persons lacking pension coverage are excluded from the system and obliged to borrow from private-sector organizations (banks or financial institutions), without preferential rates or other benefits.

The most inclusive lending initiatives for older persons originate not from the formal financial system but from microfinance programmes that do not require beneficiaries to have a bank account. These programmes reach the least well-off, provide small loans not linked to pension income and offer preferential interest rates. They tend to be partnerships between cooperatives and government bodies focused on providing lending solutions for older persons excluded from the formal credit system.

The rates, amounts and repayment schedules of loans made by formal financial institutions under programmes for older persons tend to vary with age. Interest rates range from 7% to 30%, whereas private-sector lenders may charge anywhere from 50% to 106%. A 2014 study by SERNAC in Chile, for example, compared the interest rates of different public- and private-sector lenders and found that the lowest and highest rates on a loan the same size were offered by Banco Estado and La Polar (a private-sector financial institution), respectively, with a difference of 214% between the two.

Loan amounts are another indicator that varies with borrowers' age. The older the applicant, the smaller the amount and the shorter the repayment period. Instalments generally cannot exceed 30% or 40% of the pensioner's monthly income. At the age of 90, repayment periods are capped at 10 months.

Almost all credit programmes available to older persons age-limit loan amounts. The maximum age for borrowing under programmes run by public-sector bodies ranges from 85 to 90. Another restriction is the purpose of the loan, with many going to fund home purchases or improvements. Only a few countries allow older persons to invest in other areas of their choosing, including, for example, the creation of business opportunities.

Lastly, collateral requirements are usually far stricter for older persons than for other age groups. For example, the lending programme for social housing in the Plurinational State of Bolivia requires a child of the borrower's to act as co-signer (but in no event as co-owner) to ensure the debt contracted by the older person is repaid in full. In other instances, the applicant must own a property, and its value will largely determine how much can be lent.

In practice, not only do older persons face age discrimination when applying for loans, but many of the initiatives currently available can easily cause them to forfeit their capital or assets. Besides affecting their financial capacity, this impacts their ability to bequeath assets to their descendants. The inequality inherent in such practices is clear, because poor older persons are the worst affected.

That said, it is possible to give older persons equal treatment in this area when there is the will to do so and enforcement mechanisms are in place. A study by AGE Platform Europe singled out two examples of good non-discriminatory practice. The first example was Malta, where lending decisions are based solely on an individual's capacity to repay, irrespective of age. The second example was Sweden, where, following much media discussion in August 2008, all Swedish banks voluntarily removed age-discriminatory practices in the granting of credit cards, loans and mortgages (United Nations, 2012).

4. Credit access programmes for older persons in the region

In response to the growing difficulty older persons were having in accessing credit in Argentina, the Argenta programme was created in 2012 for all pensioners in the Argentine Integrated Social Security System (SIPA), with funding from the Sustainability Guarantee Fund (FGS) of the National Social Security Administration (ANSES).

Loans ranging from US$ 65 to US$ 2,500, repayable in 12, 24 or 40 instalments, are granted under this scheme. Instalments may not exceed 30% of net monthly income.

During the early years of the scheme, funds were accessed with a card and borrowers could spend their loans with businesses participating in the programme. Since November 2015, borrowers have been able to take up to 100% of the loan as cash deposited in their bank accounts.

One of the main problems with the programme is that there are age limits for contracting a loan (89) and repaying the last instalment (under 91).

In the private sector, the age limit for taking out a personal loan or card for domestic purchases is 68. The maximum age for obtaining a credit card that can also be used abroad is 67. Provincial banks apply higher age limits of up to 83.

Another Argentine success is the Third Age Nation (*Nación Tercera Edad*) loan, which can be up to 80,000 pesos repayable in fixed instalments over up to five years, at below-market rates. What is different about this scheme is that it is open to all pensioners irrespective of the bank they are registered with, rather than just those cashing their pensions at Banco de la Nación Argentina. Loan amounts are smaller or repayment periods shorter for those unconnected with the bank, and rates are a little higher, but still below market rates.

In the Plurinational State of Bolivia, there is a social housing loan programme for retirees. The loans are for purchasing or repairing, refurbishing, extending or otherwise improving single-family homes, irrespective of the type of collateral used for the loan, provided the value of the home including improvement works does not exceed the maximum market values established for social housing. This programme is supported by article 74 of Financial Services Act No. 393, which provides that consumers are entitled to equitable access to financial services, without discrimination on grounds of age, gender, race, religion or cultural identity.

Nonetheless, only members of the middle class can access this type of loan in practice, as one of the requirements is for the family (not just the applicant and spouse) to have a total income of over US$ 900. Repayment capacity is also analysed: for an older person to obtain a loan, one of their children can co-sign, thus taking over the debt in the event of their death. Only if retirees meet these requirements can they access loans in the three interest rate brackets, as their income allows. Lending is handled by Banco Unión.

The My House My Life (*Minha Casa Minha Vida*) housing programme of the Federal Government of Brazil is designed to incentivize the building and purchase of new housing units or repurposing of urban buildings and the building or remodelling of rural housing. The programme has benefited roughly 6.8 million people, the equivalent of the entire population of Rio de Janeiro, Brazil's second-largest city. The *Faixa 1.5* component of the programme grants subsidies of up to US$ 14,285 to families with gross monthly incomes of up to US$ 750. Despite the programme's huge impact, just 6.2% of loans were to older persons as of 2016. The maximum eligibility age was raised from 75 to 80 in 2012.

In addition, the Central Bank of Brazil operates under an agreement with the National Social Security Institute (INSS) to provide loans to retirees, who may commit no more than 30% of their net income to the monthly repayments. The minimum and

maximum loan amounts are US$ 37 and US$ 14,800, respectively. Interest ranges from 1.5% to 2.4% per month, which is lower than private-sector bank rates, and loans can be repaid in 2 to 36 instalments.

Colombia has a programme called Older Colombia (*Colombia Mayor*) that operates a cash transfer plan for older persons living in poverty. It is financed by the public treasury and by a solidarity fund that deducts 1% from the pay of people earning more than four times the minimum wage. The cash transfer benefit is small at less than 5% of average income, or just US$ 32 per month. Programme benefits are paid in cash through non- banking networks such as money transfer agencies, which have 1,800 payment outlets and charge between 4% and 5% of each transaction. These outlets operate in poor neighbourhoods in remote areas and work more closely with marginalized communities than traditional banks. Payment days are announced on the radio in the community, and beneficiaries have 15 days to collect their money from a specified payment outlet.

There are two very localized private-sector organizations that lend to older persons. One is the CONFIAR financial cooperative, which offers credit lines to finance purchases of goods and services, with various requirements depending on the type of loan applied for. The other is the Department of Antioquia Staff Fund (FEDEAN), a savings and loan company in the solidarity economy that provides loans to pensioners who formerly worked in the departmental government, municipal territorial agencies and decentralized institutions of Antioquia. The fund offers four types of loans: (i) ordinary loans with a maximum repayment period of 36 months and no restrictions on use; (ii) extraordinary loans for contingencies or emergencies with a repayment period of up to six months; (iii) social loans to finance health services and purchase household appliances and other necessities; and (iv) loans specifically for affiliates aged 75 and over. Colombia's Public Pension Fund (FOPEP) also offers fixed-rate loans to pensioners aged up to 84, starting at US$ 400.

In Peru, the 2013-2017 National Plan for Older Persons of the Ministry of Women and Vulnerable Populations offers microenterprise loans to older persons not in receipt of a pension, but its interest rates are higher than those of the official banking sector.

Banco de Crédito del Perú, which is in the private sector, offers unsecured loans to older persons in receipt of pension or self-employment income. Loan amounts range from US$ 100 to US$ 6,400, with interest rates of between 13.5% and 16.08% per year. Repayments can be in up to 48 instalments. In addition, Banco de la Nación runs a programme called Préstamos Multired, which lends to clients in receipt of a public-sector pension. Maximum loan amounts are determined by clients' ability to service the loan from their pension or earnings, but decline with age. The effective rate is 16.08% per year and loans can be repaid in up to 36 instalments.

In Uruguay there is no legal impediment to older persons borrowing from private- or public-sector banks. This means that the central bank does not impose restrictions preventing financial institutions from granting mortgages whose repayment term extends beyond the applicant's seventieth birthday or from supplying older persons with credit cards. In practice, though, banks prefer not to do so for reasons of risk, and a number of organizations in the financial system place age limits on applications for loans or life insurance (65 or 70).

The Uruguayan Social Insurance Bank (BPS), in its capacity as a national social security institution, lends to anyone in receipt of monthly income from it in the form of retirement benefits, survivors', ex gratia, old age or disability pensions, special maintenance allowances or temporary disability subsidies.

The loans granted must not exceed an amount equivalent to the last six nominal monthly payments received as of the application date, with a limit of US$ 7,500 at 2011 values. The loans granted by BPS are compatible with personal loans obtained from the Banco de la República Oriental del Uruguay, as long as the total amount deducted

for repayments on both does not exceed 40% of the total nominal income received on a permanent basis from all the BPS affiliate's benefits. When there are outstanding loan arrears, the withholding rate may be as much as 60% of nominal benefit income. Interest rates range from 12% to 32% per year, depending on the number of instalments.

The repayment period may be set at 6, 12, 18 or 24 months at the borrower's choice, and loans may be renewed on completion of at least 40% of the period and repayments. Monthly instalments on loans granted by BPS are deducted from the applicant's benefits. Contracts may be voided or waived if the borrower dies or renounces the retirement benefits, if the latter are cancelled, if the debt is remitted or if there is insufficient liquidity.

In Ecuador, the Bank of the Ecuadorian Social Security Institute (BIESS) offers unsecured loans so that members and pensioners can obtain resources to meet their consumption needs. Repayment periods are up to four years and, depending on payment capacity (as determined by their retirement pension), borrowers can apply for a sum of up to 80 times the unified basic worker wage. The current annual interest rate on unsecured loans is 11.07%, although it varies depending on the repayment period. Interest rates on loans are readjusted every six months.

Box IV.2
Consumer protection for older persons in Chile

In Chile, the National Consumer Service (SERNAC) has expressed concern about the debt incurred by older persons. According to a 2014 survey it carried out on consumers' knowledge and assessment of financial matters, 65% of persons aged 60 or over had some store credit card debt, 29% had bank credit card debt and 26% had consumer credit debt.

Law no. 19496 on the protection of consumers' rights stipulates the rights of users and the obligations of companies with respect to consumer credit. SERNAC has specifically recommended that companies show consideration to older persons as consumers.

This means that the market must make provision for this group. Accordingly, it is up to companies to give older persons clear information about the products and services they offer, provide them with legible contracts, avoid arbitrary discrimination against them and enable them to consume safely.

To meet these obligations, financial institutions should follow a number of procedures, including the following:

- Providing appropriate, accurate and timely information on lending terms. The conditions described in the relevant publicity must be adhered to.
- Adhering to the conditions proposed when the loan offer is made. This offer must be valid for at least seven days, meaning that its terms cannot be altered during that time, so that older persons are in a position to compare them with other institutions'.
- Providing the summary of loan conditions in a standard format. This must go on the first page of the lending offer and the contract, stating the price and all costs associated with the loan, among other relevant information.
- Publishing the annual equivalent rate and total cost of credit in all loan publicity.
- Providing quarterly loan statements that show how much has been paid off and how much is outstanding.
- Not selling or offering products that are conditional on customers purchasing other products or services.
- Not interfering with consumers' right to terminate a consumer loan contract early if they so wish, as long as they thereby fulfil all associated obligations towards the lender.
- Providing objective reasons in writing when a loan application is rejected.

Source: National Consumer Service (SERNAC) of Chile, "SERNAC presenta radiografía de créditos de consumo para los adultos mayores", November 2014 [online] http://www.sernac.cl/sernac-presenta-radiografia-de-creditos-de-consumo-para-los-adultos-mayores/.

B. The right to end-of-life palliative care and a dignified death

1. The right to life and dignity in old age

The approach of death involves a number of activities, as different practicalities pertaining to the end of life have to be organized. It is essential for these activities —which are carried out by family members, caregivers and medical personnel, among others— to meet standards that ensure appropriate living conditions until such time as clinical and biological death supervenes.

Older persons are among the most vulnerable to death. Their position in the age structure of society becomes almost by default a predictor of their demise. This social construction of old age prompts a particular way of treating the elderly: "The social structures in which [older persons] are involved are oriented to the fact of their forthcoming death; their families have become increasingly independent of them; the scope of references to the 'future' has progressively narrowed; 'dying' is of considerably less consequence for others, e.g., it is not felt to be a matter which requires drastic revision of others' life plans, as does the 'fact' that a young adult is dying" (Sudnow, 1967).[14]

Older persons are sometimes treated like cadavers even when they are, clinically and biologically, still alive. This occurs especially in cases where they are dying or suffering from terminal illnesses, although they do not necessarily have to be in this predicament to receive degrading treatment. There is often a predisposition to treat older persons as if they were dying regardless of how serious or irreversible their condition actually is.

Thus, society turns predictions of their death into self-fulfilling prophecies. Older persons requiring emergency care often do not receive the same treatment as younger ones, they are not hospitalized along with other patients suffering from the same illnesses, they are kept on stretchers or sitting in corridors, they are physically restrained to prevent falls, they are denied the presence of a companion or they are prevented from moving about independently, among other things.[15] Moreover, according to experts, doctors uncomfortable at dealing with elderly patients' anxieties about death may choose to give them false hopes and treatments that actually shorten lives instead of improving them (Gawande, 2014).

Paradoxically, humankind is still discussing what to do about ensuring a dignified death. There is a debate about what should be protected: the conditions of death or the ability to choose when to die.[16]

The boundary between these two options is clearer in Latin America and the Caribbean than in other regions. The Inter-American Convention on Protecting the Human Rights of Older Persons plainly identifies the conditions required to maintain dignity until death: "States Parties shall take steps to ensure that public and private institutions offer older persons access without discrimination to comprehensive care, including palliative care; avoid isolation; appropriately manage problems related to the

[14] This behaviour has become so accepted that even older persons view behaviour that does not respect their dignity as conventional. For the dignity of life to be preserved until death, it is vitally important to change this way of behaving and to honour people's expectations of what the end of their lives should be like, with every effort made to fulfil older persons' wishes and provide all the support a dignified end requires.

[15] See Costa Rica, Sala Constitucional de la Corte Suprema de Justicia (2016).

[16] In the United States, the State of Oregon allows its citizens to take self-administered lethal medications prescribed by a doctor under the Death with Dignity Act (DWDA) of 1997. The state of Washington passed a similar law in 2008, followed by Vermont in 2013. In Europe, the Swiss law permitting assisted suicide has been in force since 1942. In 2014, Belgium extended its 2002 euthanasia law to children. In the Netherlands, the law enacted in 2002 went a step further, allowing both assisted suicide and euthanasia in certain circumstances.

fear of death of the terminally ill and pain; and prevent unnecessary suffering, and futile and useless procedures, in accordance with the right of older persons to express their informed consent" (article 6).

This instrument also defines palliative care as "[a]ctive, comprehensive, and interdisciplinary care and treatment of patients whose illness is not responding to curative treatment or who are suffering avoidable pain, in order to improve their quality of life until the last day of their lives. Central to palliative care is control of pain, of other symptoms, and of the social, psychological, and spiritual problems of the older person. It includes the patient, their environment, and their family. It affirms life and considers death a normal process, neither hastening nor delaying it."

The ultimate goal of the Convention in this area is not a good death, but a good life until the end. It is for this reason that the instrument addresses palliative care so extensively, not only in article 6 on the right to life and dignity in old age, but in article 12 on the rights of older persons receiving long-term care, article 19 on the right to health and article 11 on the right to give free and informed consent on health matters.

In practice, some States have recognized a dignified death as a right whose protection requires timely and appropriate access to palliative care. In Costa Rica, for example, resolution 1915-92 of the Constitutional Chamber of the Supreme Court recognizes a right to die with dignity for those who are aware that they are dying and choose to do so painlessly. The resolution also recognizes the indisputable link between the right to health and the right to life: the fundamental purpose of the former is to give effect to the latter, given that this protects not only a person's biological existence but all the other aspects deriving from it (Costa Rica, Sala Constitucional de la Corte Suprema de Justicia, 1992).[17]

2. The right to free and informed consent and advance directives

Some clarification is also needed regarding free and informed consent on health matters, as addressed in article 11 of the Inter-American Convention. The purpose of this was for older persons to be able to refuse health-care interventions that they did not desire or were forced to submit to in health-care institutions. In accordance with paragraph 2 of the International Covenant on Economic, Social and Cultural Rights and article 2 of the Universal Declaration of Human Rights, emphasis was placed on a favourable environment in which informed consent would be a priority and on guarantees of the greatest possible protection against stigmatization and discrimination.

One doubt that arises is whether article 11 favours euthanasia, specifically when it alludes to the following obligation: "States Parties shall also establish a procedure that enables older persons to expressly indicate in advance their will and instructions with regard to health care interventions, including palliative care."[18]

Advance directives are instructions whereby a person makes known their wishes regarding certain medical interventions in the expectation that these will be respected and complied with by the doctor or medical team when that person is no longer in a position to express preferences (Montiel Llorente and García Alonso, 2007).

[17] In the United States, the Supreme Court laid the foundations for a constitutional right to appropriate palliative care in its rulings on Washington v. Glucksberg and Vacco v. Quill (Quesada, 2008). In Europe, the European Court of Human Rights ruled in the case of Diane Pretty v. the United Kingdom that the response to euthanasia should be the promotion of palliative care (European Court of Human Rights, 2002).

[18] During the ratification of the Inter-American Convention by Chile's Parliament, for example, the Chamber of Deputies, prompted by a lawmaker, requested a review by various commissions to determine whether the provisions of the Convention could be interpreted as favourable to euthanasia or assisted suicide (see Boletín No. 10.777-01(C) of the Chamber of Deputies of Chile).

Article 11 of the Inter-American Convention must be interpreted in the light of article 6 on the right to life and dignity in old age. In this framework, advance directives are part of the kind of legislation that favours palliative and end-of-life care. The intention is not to prolong or shorten life but to respect the natural moment of death.[19]

According to the Supreme Court of the United States, one of the advantages of advance directives is that they give people the comfort of knowing their preferences have been stated and are available to their families and doctors, and the peace of mind that comes from knowing they will be able to communicate with their families and doctors through a directive based on their personal philosophy, so that decisions can be taken without regret or remorse.

The United States has a living will registry that allows citizens to issue these directives. By contrast with the legal situation in some countries of the region, advance directives can be issued whether a person suffers from a terminal illness or not. This testimonial from the registry reveals how helpful such an instrument can be: "I am very glad I registered my advanced [sic] directive. As caregiver for my mother, my father, and my stepmother I cannot express the peace of mind that registering gives. My husband and daughter will never go through the stress of wondering if they are acting according to my wishes. It will be very clear for them. In a way, making my advanced directive is protecting my husband and daughter, even when I am seriously ill. When a loved one is seriously ill is the worst possible time to deal with the subtleties and ramifications of hospital and legal bureaucracies. This will free them from a lot of those worries" (name withheld, Kingston, Washington).[20]

Despite the usefulness of advance directives, there is still much work to be done. There are conceptual misunderstandings that may limit the rights and freedoms of older persons, even in places where there is legislation. For example, the use of advance directives is still limited in Mexico City, with only 2,700 of these documents being registered between 2008 (when the relevant law was enacted) and 2013.

3. Palliative and other care for older persons

In 2011, over 29 million people worldwide are estimated to have died from diseases requiring palliative care, with 20.4 million of these needing it at the end of their lives. The great majority of adults needing end-of-life palliative care live in low- and very low-income countries, and the bulk of them (69%) are aged 60 or over (Connor and Sepúlveda, 2014).

In the United Kingdom, a country acknowledged to have made advances in the field, nurses and doctors who responded to a 2001 survey on end-of-life care for hospitalized patients gave it as their opinion that the care of dying older patients was characterized by a lack of emotional engagement with the patient and institutionalized non-disclosure of information about their deaths. Their responses indicated that although nurses provided individual care to dying patients, much of it was directed solely towards meeting their physical needs. The data show that death is sometimes badly managed in hospitals, with inadequate control of symptoms, insufficient support for patients and caregivers and little or no communication about prognoses or treatment (Costello, 2001). As a result, the pain associated with ageing has tended to become institutionalized and the perception that this is so has become a real obstacle to older persons receiving the care they need.

[19] See the Advance Directive Act for the Federal District [online] http://www.salud.cdmx.gob.mx/storage/app/media/Ley_Voluntad_Anticipada.pdf; current legislation in some Mexican states; and the advance directive decree in Uruguay [online] http://www.msp.gub.uy/sites/default/files/archivos_adjuntos/DECRETO%20VOLUNTAD%20ANTICIPADA%20DEL%204%20DE%20DIC.%20DE%202013.pdf.

[20] See [online] http://www.uslivingwillregistry.com/testimonials_registrants.shtm.

Palliative care also tends to be used as a substitute for curative care. Life-extending treatment is suspended by default when people are admitted to programmes of this type. In some cases, the older person's presence is not even required for their admission into a palliative care programme to be evaluated, with decisions being taken on the basis of information supplied by third parties. In other cases, it is health-care professionals themselves who suggest palliative care for older people with terminal diseases without considering other forms of treatment.

It seems to be particularly hard where older persons are concerned to distinguish between curative treatment and care, which are usually interdependent. For example, a blood transfusion may be part of a treatment to restore health or to strengthen cancer patients so that they can receive palliative radiotherapy, and the same holds for dialysis. The line between the two types of treatment is ambiguous, and the reasons for their stark separation are of various kinds.

One explanation concerns health-care professionals. As early as the seventeenth century, Francis Bacon wrote: "I esteem it the office of a physician not only to restore health, but to mitigate pain and dolors; and not only when such mitigation may conduce to recovery, but when it may serve to make a fair and easy passage" (cited in Abid, 2008).

Other reasons stem from the substantial gap between research and development investment in techniques for controlling symptoms and other aspects of palliative care and investment in life-prolonging techniques. There are also barriers within research and clinical systems that prevent many people from receiving effective palliative care where and when they need it (Foley and Gelband, 2001).

It would thus be a mistake to view the curative model and the palliative care model as the only two options available. The two models represent opposite ends of a spectrum in which limitless variations are possible, and leaping from one extreme to the other is seldom appropriate (Fox, 1997). Between the curative model and the palliative model, there is the person-centred approach. This means that when someone is suffering from a terminal illness, use must be made of the whole array of solutions offered by medicine to relieve pain and help the person live a full and satisfying life (Hadjistavropoulos and Hadjistavropoulos, 2008). According to WHO, this not only improves the quality of life of terminally ill patients, but reduces unnecessary hospitalizations and use of health services.

4. Palliative care as a State obligation

Access to palliative care is a legal obligation of States. Before the adoption of the Inter-American Convention on Protecting the Human Rights of Older Persons, this had already been recognized by the Committee on Economic, Social and Cultural Rights in general comment No. 14 (United Nations, 2000) and by the Committee on the Elimination of Discrimination against Women in general recommendation No. 27 (United Nations, 2010b). Consistently with this, the Special Rapporteur on torture established in a 2013 report that denying pain relief could constitute inhuman and degrading treatment, according to the definition of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (United Nations, 2013).

The Council of Europe has also included palliative care in recommendation CM/Rec(2014)2. Its explanatory report (CDDH-AGE, 2013) states that the legal basis for this inclusion is that human dignity must be respected at all stages of each individual's life (including terminal illness and death) and that palliative care helps to preserve this dignity, providing an appropriate environment for such patients and helping them to deal with pain and other distressing symptoms. Hence, palliative care should be provided in all areas in response to the progressive needs of older persons. Within five years of the adoption of the recommendation:

- Member States should offer palliative care for older persons who suffer from a life-threatening or life-limiting illness to ensure their well-being and allow them to live and die with dignity.
- Any older person who is in need of palliative care should be entitled to access it without undue delay, in a setting which is consistent with his or her needs and preferences, including at home and in long-term care settings.
- Family members and friends should be encouraged to accompany older persons who are terminally ill or dying. They should receive professional support, for example by ambulatory palliative-care services.
- Health-care providers involved in palliative care should fully respect patients' rights and comply with professional obligations and standards.
- Trained specialists in the field of palliative care should be available to lead education and research in the field. Programmes of palliative care education should be incorporated into the training of all health and social care workers concerned and cooperation of professionals in palliative care should be encouraged.
- Member States should ensure the adequate availability and accessibility of palliative care medicines.
- In the organization of their national palliative care systems, member States should take into account Recommendation Rec(2003)24 of the Committee of Ministers to member States on the organization of palliative care.

In relation to this last point, European countries have had a valuable directive on palliative care in place since 2003, but progress has been uneven. As this instrument is not binding, member States of the Council of Europe are not obliged to implement it fully.

Article 19 of the Inter-American Convention establishes the following State obligations regarding palliative care in addition to the guarantees mentioned previously:

- Promote and strengthen research and academic training for specialized health professionals in geriatrics, gerontology, and palliative care.
- Promote the necessary measures to ensure that palliative care services are available and accessible for older persons, as well as to support their families.
- Ensure that medicines recognized as essential by WHO, including controlled medicines needed for palliative care, are available and accessible for older persons.

Moreover, articles 6, 11 and 12 of the Convention call for non-discrimination and equality of access in the provision of palliative care.

Box IV.3
Palliative care in other regions of the world

A study conducted in 2015 by the Economist Intelligence Unit (EIU) prepared a Quality of Death Index ranking 80 countries around the world by palliative care provision, access to analgesic treatment, public policies and funds for the terminally ill, and individual and community perceptions of death. The United Kingdom, Australia, New Zealand, Ireland and Belgium took the top five places overall, while the bottom three were the Philippines, Bangladesh and Iraq.

In Mongolia (ranked 28), a notable development was the creation of the Mongolian Palliative Care Society (MPCS) in 2000. Before then, the country did not have palliative care services or programmes or a government policy in this area, and used just 1 kg of morphine per year. Beginning in 2003, palliative care was incorporated into legislation and into the national cancer control programme. In 2013, Mongolia started including palliative care in the treatment of other chronic diseases and in home care.

In China (ranked 71), there is no national strategy or law guaranteeing access to palliative care. The national Ministry of Health has officially endorsed the establishment of palliative care departments in hospitals, but outside of the country's 400 specialized cancer hospitals, only a few community health centres offer palliative care services.

Box IV.3 (concluded)

In Spain (ranked 23), palliative care has evolved since the 2007 launch of a palliative care strategy by the national health-care system. In a country where health care falls under the authority of 17 regional health systems, this national approach has increased access to services. The launch of the national strategy has led to a 50% increase in palliative care facilities and unified regional systems.

The development of palliative care in South Africa can be attributed partly to government funding and partly to the participation of non-governmental organizations, notably the Hospice Palliative Care Association of South Africa. Religious institutions also have hospitals that offer palliative care. Moreover, South Africa has made progress in training and developing the skills of health-care professionals. The first master's degree in palliative care catering to doctors, nurses and social workers was offered by the University of Cape Town.

According to research by Hospice UK, the number of people dying in hospital could be cut by 20% if care models were identified and their impact on families and communities assessed. The strategy of the United Kingdom, which tops the ranking, is based on reducing the number of people dying in hospitals every year and on providing patients with palliative home care packages that include nursing or a home carer, accompanied by the latest remote monitoring technology.

Taiwan Province of China (ranked 6) is a pioneer in technological advances, and these have a direct impact on the rights of patients and on the palliative care they receive. For example, all Taiwanese citizens have an insurance card with their medical information: older persons are encouraged to make specific end-of-life decisions about their wishes in the event that a resuscitation decision needs to be made, and this information is linked directly to their insurance card, so that it will come up when they register at any health-care facility.

Source: The Economist Intelligent Unit, *The 2015 Quality of Death Index. Ranking palliative care across the world*, 2015 [online] https://www.eiuperspectives.economist.com/sites/default/files/2015%20EIU%20Quality%20of%20Death%20Index%20Oct%2029%20FINAL.pdf.

5. Palliative care programmes for older persons in Latin America and the Caribbean

Most countries of the region do not meet the demand for palliative care and fail to recognize it as a discipline or to include it in public or private health-care systems. Fewer still have legislated for it, and funding and continuity have been impaired as a result.

The majority of national palliative care programmes in the region were created in the late 1990s, meaning the approach is fairly recent. There are isolated initiatives resulting from local efforts, but few countries have a national public policy guaranteeing access to palliative care.

In countries that do have national palliative care programmes, they are linked primarily to oncological diseases and can still be difficult to access for non-cancer patients, such as those living with HIV/AIDS or suffering from other chronic or terminal illnesses. The law does not require the provision of palliative care for these patients, and pain management with analgesics depends on whether doctors are authorized to prescribe opioids.

The lack of national policies has led to the emergence of private initiatives to provide care for the terminally ill, but at a very high cost, which debars low-income patients from access. There are also non-profit foundations that provide support and pain relief, although they lack duly accredited personnel. This situation threatens the sustainability of these activities, which are carried out mainly by volunteers and with resources from charitable and non-governmental organizations (NGOs).

A 2014 WHO study (Connor and Sepúlveda, 2014) presents an interesting classification of progress with palliative care around the world. In the region, most countries are in the early stages of developing thiscv type of programme. For example, a large number of Caribbean countries (Antigua and Barbuda, Grenada, Saint Kitts and Nevis and Saint Vincent and the Grenadines) were classified at the lowest level, with no known palliative care activity (see table IV.1).

Table IV.1
Latin America and the Caribbean: level of development of palliative care programmes, 2014

Level of development of palliative care programmes	Countries and territories
Group 1: No known activity	Anguilla, Antigua and Barbuda, Aruba, Falkland Islands (Malvinas), French Guiana, Grenada, Martinique, Montserrat, Netherlands Antilles, Saint Kitts and Nevis, Saint Vincent and the Grenadines, Turks and Caicos Islands, United States Virgin Islands.
Group 2: Capacity-building	Bahamas, British Virgin Islands, Dominica, Haiti, Honduras, Nicaragua, Plurinational State of Bolivia, Suriname.
Group 3a: Isolated provision	Barbados, Belize, Bermuda, Bolivarian Republic of Venezuela, Brazil, Cayman Islands, Colombia, Cuba, Dominican Republic, Ecuador, El Salvador, Guadeloupe, Guatemala, Guyana, Jamaica, Panama, Paraguay, Peru, Mexico, Saint Lucia, Trinidad and Tobago.
Group 3b: Generalized provision	Argentina.
Group 4a: Preliminary integration	Chile, Costa Rica, Puerto Rico, Uruguay.
Group 4b: Advanced integration	

Source: S. Connor and M.C. Sepúlveda (eds.), *Global Atlas of Palliative Care at the End of Life*, Worldwide Palliative Care Alliance/World Health Organization (WHO), January 2014.

At the second level are countries where some efforts have been made but there are as yet no established policies, such as Dominica, Haiti, Honduras, Nicaragua and the Plurinational State of Bolivia. In Honduras, for example, the available data show that there are no palliative care services or units at any of the three levels of care (Pastrana and others, 2012). There is no accredited training in palliative care, and nor is this included in the academic curriculum of the medical sciences faculty of the Autonomous National University. As a result, there are not known to be any specialists in this field. From a legal standpoint, there are still no laws or regulations on palliative care, which means that no government resources are allocated to it.[21]

After this, WHO classifies Brazil, Colombia, the Dominican Republic, Ecuador, Mexico, Panama, Peru and Trinidad and Tobago, among others, as being at the stage where progress with palliative care programmes is hindered by lack of funding, medication is not widely available and coverage is limited.

In Peru, coverage is limited despite the existence of the Home Care Programme for Older Adults and Cancer Patients (ADAMO). Fewer than 2,000 older persons received home care in 2014. As regards training, there is no professional accreditation for doctors providing palliative care. The Peruvian Society of Palliative Care, a non-profit organization, is trying to fill the gaps by raising awareness and training medical professionals in pain management and palliative care.

In 1996, Brazil established the National Cancer Institute (INCA) in Rio de Janeiro. This cancer hospital, run by the Ministry of Health, offers the most comprehensive palliative care services in the country. Palliative care training is officially recognized as a subspecialty, known officially as the Área *de Atuação em Medicina Paliativa*, but there are still too few graduates to meet demand (there were an estimated 30 or so professionals with this specialty as of 2012). Despite local initiatives, palliative care is still not recognized as part of health services (Palmeira, Scorsolini-Comin and Sanches Peres, 2011), which is why the federal government needs to establish a national health policy to consolidate palliative care in Brazil.

[21] In Honduras, a bill was presented in 2014 on palliative care for patients with terminal chronic illnesses, dealing with access to opioid medications for patients in the terminal phase or with chronic diseases and giving these the right to decide when to suspend medical treatment and obtain assistance to die.

Argentina, Chile, Costa Rica and Uruguay were classified by WHO at the most advanced levels for the region (but not the world). Although there is more awareness of the importance of palliative care and more professionals and services have become available in some of these countries, there has not as yet been any real policy consolidation.

In Argentina, palliative care services were first provided by isolated private centres in 1982, before eventually being incorporated into frameworks of health-care regulation in 2000.

Current legislation in Argentina includes the right to comprehensive palliative care as part of treatment, this being enshrined in Law 26742 on patients' rights.[22] However, this law has not been adequate, since the country's administrative code grants each province the autonomy to set its own standards and some have not incorporated palliative care services. In fact, just 10 of the 24 provinces have legislated for palliative care.

In addition to this law, commissions and programmes have been set up within the Ministry of Health and the National Cancer Institute. These initiatives are not backed up by earmarked funds or by oversight and monitoring mechanisms, and thus have been unable to universalize palliative care services.

There are at least five research centres dealing with the issue in Argentina: Pallium Latinoamérica, the Foundation of the Medical Federation of the Province of Buenos Aires (FEMEBA) at Tornú Hospital, the Palliative Care Department of Udaondo Hospital, the Alfredo Lanari Medical Research Institute of the University of Buenos Aires and the Rosario Adult Palliative Care Unit (UCPAR). Some of these centres have received subsidies from the Ministry of Health to develop research protocols.

In Chile, regulations do include palliative care, and all health-care providers in the public and private sectors are required to provide palliative care services to advanced-stage cancer patients. The National Programme of Pain Relief for Cancer and Palliative Care was set up in 1994 with the support of the Ministry of Health (MINSAL, 1999). Nine years later, in April 2003, the Programme was incorporated into the System of Universal Access with Explicit Guarantees (AUGE), a health-care improvement and affordability programme (MINSAL, 2006).

In Costa Rica, palliative care is covered by the universal social security scheme. Hospitalization, medication and specialist consultations are provided free of charge, and there are NGOs that support the uninsured.

From the legal point of view, although Costa Rica has not legislated for palliative care, the Constitutional Chamber has issued resolutions relating to the rights of terminally ill patients. One of the first and most significant was a 1994 ruling enshrining the right to a dignified and pain-free death.

The issue was institutionalized in 2008 with the creation of the National Council for Palliative Care, comprising representatives from the Ministry of Health, the Costa Rican Social Security Fund (CCSS), the National Centre for Pain Control and Palliative Care, the Costa Rican Palliative Care Federation, the Social Protection Committee (JPS) and some foundations.

Trinidad and Tobago is gradually introducing a palliative care framework. There are several centres that provide care for terminal cancer patients, and in 2014 the first government-funded palliative care hospital unit was opened, but this is still not enough to meet demand. The availability of pain control medications also continues to pose a problem. The University of the West Indies launched an MSc in palliative care medicine in 2012.

[22] See Documentation and Information Centre of the Ministry of Economy and Public Finance of Argentina, Law 26742 [online] http://www.grupoguia.com.ar/libros/medicina/LeyesMedicinaLegal/Leyes09/Ley26742.pdf.

The situation in Barbados is slightly different. Opioids and other essential medications are generally available, although the country still lacks a specialized palliative care structure. The Ministry of Health and NGOs have been working to improve end-of-life care services. The Barbados Association of Palliative Care, an NGO founded in 2011, provides support and care for the terminally ill. The Barbados Palliative Care Needs Assessment, commissioned by the Ministry of Health, reported in 2012 that a palliative care centre was needed. Plans are now afoot to build one, to be operated by the Barbados Cancer Association (BACA) along with another NGO.

In the WHO ranking, all the region's countries came below the United States, the United Kingdom, Australia, Sweden and Japan, among others. They do meet a number of the requirements for consolidating palliative care in the region (research, professional training, availability of medications, subsidies to reduce out-of-pocket spending, progressive public spending on palliative care and broad awareness of its contribution and the need for it, among other things).

Cuba is one of the countries in the region that stands out in this area. The Pain Management and Palliative Care Programme (PADCP) for cancer patients is part of the free universal national health system. The PADCP includes home care by multidisciplinary teams of doctors, nurses and psychologists. It also covers free hospitalization and medication during treatment. The Ministry of Health has made a proposal to include the palliative care component in primary health care as part of the Family Doctor and Nurse Programme in the interests of ensuring long-term management of disease and helping people cope with bereavement. The overall objective is to enhance the subjective well-being and quality of life of cancer patients requiring palliative care and their families by providing comprehensive care that encompasses physical, social, emotional and spiritual needs, while avoiding ill effects for the medical team. Palliative care training, meanwhile, has been officially accredited since 2010 in the form of a diploma in palliative care for adult patients and a national diploma in cancer management. Faculties of medicine also include palliative care content.

C. Challenges for protection

Close analysis of the conditions faced by older persons confirms that their rights need to be examined thoroughly to determine whether existing standards address their concerns.

In the case of the two issues addressed in this chapter, the conclusion is that there are still shortcomings when it comes to respect for older persons' rights. Age discrimination persists, and new areas for concern are emerging as the population ages. A few years ago, older persons were unlikely to demand greater equality in access to financial services, or to call for dying and end-of-life conditions to be treated as a public issue concerning more than the health sector.

With respect to palliative care, although programmes are being implemented, there is still much to be done. In Chile for example, public health system programmes present major operational deficiencies. The professionals who run them do not always have the right training, medication is misused to keep terminally ill patients sedated, and there is no coordination with curative care. Once older persons are admitted into palliative care programmes, it is immediately assumed that they will not survive for long. Home visits are limited and of poor quality, and not all primary care providers are properly trained. The situation is different in the private sector, where palliative care is of a much higher quality than in the public sector. However, it is costly and thus unaffordable for the most vulnerable segments of the population.

In terms of access to credit, older persons continue to be discriminated against and may face barriers at any stage of their application. In 2015, a 75-year-old in Costa Rica filed an appeal on the grounds of unconstitutionality with the Constitutional Chamber of the Supreme Court of Justice against the Costa Rican Social Security Fund (CCSS) on the grounds that as a condition for applying for a mortgage he had been asked for a credit life insurance policy for which he was turned down by the National Insurance Institute (INS). The petitioner explained that the insurer had asked him about any illnesses and sent him to take a number of medical tests. He argued that he had ailments typical of a person his age but was not unhealthy. Nonetheless, he was refused the insurance policy on the grounds that, under internal health assessment policies, his high blood pressure and other physical symptoms made him ineligible. Because he did not have this policy, the CCSS refused the loan he had applied for.[23]

In this case, the Constitutional Chamber of the Supreme Court of Justice, taking into account the San José Charter on the Rights of Older Persons in Latin America and the Caribbean, ruled in favour of the older person and requested that the institutions involved adopt the necessary measures to allow the petitioner to provide reasonable surety for the mortgage.[24]

The court's ruling is in line with other decisions favourable to older persons, but this is not always the outcome in other countries of the region. There are limitations on the exercise of rights, many stemming from institutional weaknesses in the enforcement of laws. More and better protection is needed, like that provided for women or other groups facing discrimination. For example, there are a number of bodies all working to improve women's well-being and protect their rights.[25]

The adoption of the Inter-American Convention on Protecting the Human Rights of Older Persons and the Protocol to the African Charter on Human and People's Rights on the Rights of Older Persons in Africa shows that it is possible and necessary to develop a legally binding multilateral instrument that can ensure full and effective promotion and protection of the rights of older persons (Group of Friends of Older Persons, 2016). Furthermore, the coexistence of international and regional human rights instruments has been a constant in the modern world. Their usefulness and compatibility can easily be appreciated in the issues addressed by this chapter.

In addition, duplicated but differentiated standards are justified because a global consensus sometimes requires a continental one, and this can be achieved in a regime that does not affect the global agreement but brings additional benefits in terms of promoting and protecting human rights. Again, a vital part of legal doctrine is the pro homine principle, which means that the standards most favourable to the human being will be used in the specific situation concerned (Carmona, 2009).

23 See Sala Constitucional de la Corte Suprema de Justicia [online] http://sitios.poder-judicial.go.cr/salaconstitucional/Centro%20de%20Jurisprudencia/8-BOLETIN%20MENSUAL%20DE%20LA%20SALA%20CONSTITUCIONAL%20DE%20COSTA%20RICA%20-%20AGOSTO%202015%20(3).htm.

24 See Sala Constitucional de la Corte Suprema de Justicia [online] http://sitios.poder-judicial.go.cr/salaconstitucional/Centro%20de%20Jurisprudencia/8-BOLETIN%20MENSUAL%20DE%20LA%20SALA%20CONSTITUCIONAL%20DE%20COSTA%20RICA%20-%20AGOSTO%202015%20(3).htm.

25 For example, the United Nations has UN-Women and the Commission on the Status of Women. ECLAC has the Regional Conference on Women in Latin America and the Caribbean. The Human Rights Council has the Committee on the Elimination of Discrimination against Women, the Working Group on the issue of discrimination against women in law and in practice, and the Special Rapporteur on violence against women. The Organization of American States (OAS) has the Inter-American Commission of Women, the Rapporteurship on the Rights of Women and the Follow-up Mechanism to the Belém do Pará Convention.

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CHAPTER

V

The human rights of older persons: unsolved problems and unmet commitments

Introduction

This chapter discusses two subjects whose treatment in practice presents major shortcomings in the region and other parts of the world. The first is the right to a life free of violence, and the second is long-term care.

Abuse of older persons is a violation of their human rights and a major cause of injury, illness, loss of productivity, isolation and despair (WHO, 2002). It began to be acknowledged as a social problem in the 1980s, since when its definition, typology and prevention have been debated at length (United Nations, 2002). At the end of the last century, the most commonly used definition of elder abuse was "a single or repeated act, or lack of appropriate action, occurring in a relationship where there is an expectation of trust but which causes harm or distress to an older person" (AEA, 1995). The recognized types of maltreatment ranged from physical and psychological abuse to property exploitation and self-neglect.

There are now more precise definitions of elder abuse thanks to the efforts of United Nations human rights treaty bodies and to discussions about the rights of older persons in Africa, the Americas and Europe. Nonetheless, aside from these advances, more forceful measures are needed to prevent and eradicate the problem.

The complexity of long-term care derives mainly from the environment in which it currently takes place, characterized by changing roles for women, still large numbers of children, progressive population ageing, a longer lifespan with illnesses or disabilities, and changing family models.

Women's entry into the workforce has meant that they spend less time than formerly caring without pay for people who are temporarily or permanently dependent. This change, which stems from the pursuit of gender equality, becomes a limitation when there are no appropriate replacements for traditional caregivers or when these caregivers are weighed down with domestic, non-domestic and care-related tasks (Rico and Robles, 2016).

At the same time, the number of people needing care is growing, as there are still large numbers of children —representing 26.1% of the population in Latin America and the Caribbean in 2015 (United Nations, 2015a)— even as the population aged 75 and over increases.

In 2015, persons aged 75 and over represented 27% of the older population in Latin America and the Caribbean (18,788,506 people), and this age segment is expected to grow at a rate of roughly 3.59% per year from 2015 to 2020. The number of people in this subgroup will be almost twice as great in 2030 as in 2015, and will exceed 70 million by 2050.

Epidemiological studies have shown that a large proportion of persons in this age group may enjoy only unstable independence and risk functional loss. Persons aged 75 and over tend to require hospitalization, have frequent falls, take medication and suffer from chronic illnesses that often lead to incapacity (The Family Watch, 2012; García-García and others, 2011). Meanwhile, as described in chapter I of the present document, the rapid decline in fertility rates and increase in life expectancy over the past few decades have helped bring about a hybrid situation, with different types of households emerging and the family structure of the preindustrial age coexisting with new living arrangements (Arriagada, 2007; Sunkel, 2006).

This means that the contribution of the family, the main protection network catering to the care needs of older persons with impaired autonomy, is not the same now as

This chapter addresses issues of elder abuse and long-term care from a human rights perspective, reviewing legal advances to date, the general situation around the world and challenges for the coming years.

in previous decades. However, this contribution has traditionally allowed the public sector to play a secondary role, which it retains to this day (The Family Watch, 2012).

This chapter addresses the subjects of elder abuse and long-term care from a human rights perspective. In both cases, it describes the legislative progress made to date, the overall situation at the global and regional levels, and the challenges to be faced over the next few years.

A. Abuse of older persons: a human rights issue

1. The right to a life free of violence in old age

As in the case of other social groups, violence against older persons is no longer treated as a private matter but has come under public scrutiny. Although initally addressed as part of the discussion about vulnerability, the emphasis now is very much on dealing with this from a human rights perspective. Treaty bodies and, more recently, regional instruments have supported this change in perspective.

The shift to a rights-based approach to the abuse of older persons has been supported by ECLAC. In the San José Charter on the rights of older persons in Latin America and the Caribbean, ECLAC member States rejected any type of abuse of older persons and undertook to work to eradicate it.[1]

(a) The Human Rights Committee

A life free of violence implies the exercise of all rights set out in international human rights covenants. General Comment No. 20 on article 7 of the International Covenant on Civil and Political Rights (the prohibition of torture or other cruel, inhuman or degrading treatment or punishment) laid this out in 1992 (United Nations, 1992).

The aim of article 7 is to protect an individual's dignity and physical and mental integrity. This right is based on the prohibition of acts that cause physical pain and mental suffering, including corporal punishment for crime or as a disciplinary measure. It is the duty of the State to provide everyone with the necessary protection against these acts, with no limitations.

The Human Rights Committee observed that applying this article did not just mean prohibiting such treatment or punishment or declaring it a crime, but that other measures had to be adopted to prevent and punish acts of this kind, with added safeguards for the special protection of persons at risk.

According to the Committee, the abuse of older persons should be considered a violation of their right to personal integrity, be this physical, mental or moral. This right also includes protection from economic exploitation and a requirement for them to give free and informed consent to anything that affects their autonomy, integrity or well-being.

[1] The following measures were identified: implementing policies and procedures to prevent, punish and eradicate any type of elder abuse, and penalizing those responsible; establishing mechanisms for prevention and supervision and strengthening legal mechanisms in order to prevent any type of violence against older persons; guaranteeing special protection of older persons who, because of their gender identity, health, ethnic origin or other conditions of vulnerability, are at greater risk of being abused; and providing older persons with access to legal remedies to protect them against property exploitation.

(b) The Committee Against Torture

The right to personal integrity is violated when the State (acting through its agents) or any person inflicts cruel, inhuman or degrading treatment that causes physical, psychological or moral suffering. Torture is an aggravated form of cruel, inhuman or degrading treatment.

In accordance with article 16 of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the obligations of the State apply in all situations of abuse. Personal integrity is a legal right that merits the highest level of protection. Hence, older persons must receive the same protection against abuse as people subjected to acts of torture.

This is underscored in General Comment No. 2 of the Committee Against Torture, which states that the prohibition of abuse is absolute and its prevention must be effective and non-derogable. States must ensure the protection of members of groups especially at risk of being tortured, fully prosecute and punish all acts of violence and abuse, and ensure the application of other positive prevention and protection measures, including the elimination of any legal or other obstacles that impede the eradication of ill-treatment and the adoption of effective measures to ensure that such conduct and any recurrences thereof are prevented (United Nations, 2008).

The General Comment also sets out States' obligation to continually keep under review and improve national laws and recommends that they provide data disaggregated by age, gender and other key factors that allow them to identify and compare discriminatory treatment which would remain undetected otherwise, and to adopt corrective measures (United Nations, 2008).

(c) The Committee on the Elimination of Discrimination against Women

General Recommendation No. 27 of the Committee on the Elimination of Discrimination against Women (United Nations, 2010) called just as forcefully for the abuse of older women to be addressed in a serious and decisive manner.

According to the Committee, States must pass legislation recognizing and prohibiting domestic, sexual and institutional violence against older women, particularly those with disabilities. States also have an obligation to investigate, prosecute and punish all acts of violence against older women, including those committed as a result of traditional practices and beliefs.

States should also pay special attention to the violence suffered by older women in times of armed conflict and the impact it has on their lives, and to the contribution that older women can make to the peaceful settlement of conflict and to reconstruction processes.

In addition, States should give due consideration to the situation of older women when addressing sexual violence, forced displacement and the conditions of refugees in times of armed conflict. They should take into account relevant United Nations Security Council resolutions on women, peace and security when addressing such matters.

(d) Regional instruments on older persons' rights

The Inter-American Convention on Protecting the Human Rights of Older Persons reaffirms that abuse is a violation of the right to personal integrity. Abuse is defined as "a single or repeated act or omission to the detriment of an older person that harms

their physical, mental, or moral integrity and infringes the enjoyment or exercise of their human rights and fundamental freedoms, regardless of whether or not it occurs in a relationship of trust".

The Convention also defines negligence as an "involuntary error or unintentional fault, including, inter alia, neglect, omission, abandonment, and failure to protect, that causes harm or suffering to an older person, in either the public or the private sphere, in which normal necessary precautions proportional to the circumstance have not been taken".

These two definitions set up the extensive treatment of abuse in articles 9 and 10 of the Convention. Article 9 recognizes that older persons have the right to live in safety and without violence of any kind, to be treated with dignity, and to be respected and appreciated regardless of social status. Article 10 requires States to take all necessary legislative, administrative or other measures to prevent and eradicate all forms of torture or other cruel, inhuman, or degrading treatment or punishment of older persons.

The Inter-American Convention on Protecting the Human Rights of Older Persons and a number of other regional instruments refer specifically to abuse and neglect when addressing issues affecting the rights of older persons.

Article 8 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Older Persons in Africa also calls for States to prohibit and punish abuse of older persons, including traditional practices that affect their well-being, health and dignity, with an emphasis on older women. Recommendation CM/Rec(2014)2 of the Committee of Ministers of the Council of Europe also addresses violence and abuse of older persons, but not as forcefully as the Protocol to the African Charter or the Inter-American Convention, as it only focuses on raising awareness to detect violence and abuse, and places less of a duty on States to carry out effective investigations of complaints of abuse.

The Inter-American Convention and the Council of Europe recommendation also call for the protection of older persons receiving long-term care from acts of violence, which is a sensitive issue. Many older persons, like other groups living in institutions, experience abuse, violations of privacy and even constraints on their freedom of movement. In Spain for example, an estimated 23% of dependent older persons living in care homes are physically restrained, a figure that rises to 60% for those suffering from dementia (Arraras, 2011).

According to both instruments, States' obligations include the prevention of violence through awareness-raising and training. The Council of Europe recommendation, for example, stipulates that "member States should implement sufficient measures aimed at raising awareness among medical staff, care workers, informal carers or other persons who provide services to older persons to detect violence or abuse in all settings, […] and in particular to encourage them to report abuses to competent authorities. Member States should take measures to protect persons reporting abuses from any form of retaliation."

The Inter-American Convention on Protecting the Human Rights of Older Persons goes further by specifying that States must "enact the necessary legislation, in accordance with domestic mechanisms, so that the corresponding personnel and long-term care givers may be held liable to administrative, civil, and/or criminal penalties, as applicable, for any acts they commit that cause harm to older persons".

These regional measures aimed at promoting and protecting the rights of older persons provide a clearer picture of what protection is aimed at and how it is supposed to be implemented. With the exception of the Council of Europe recommendation, they have expanded States' legal responsibilities, but greater importance should now be given to preserving, guaranteeing and restoring conditions in which older persons' integrity is likely to be respected.

2. Causes and consequences of elder abuse

The risk of abuse is not inherent in old age itself but stems from various other factors that are often interdependent. Nonetheless, older persons tend to be particularly vulnerable to situations of risk, powerlessness, abandonment or exploitation (ECLAC, 2004), whether in long-term care or psychiatric institutions, health centres or prisons, in the workplace or home, or elsewhere.

The causes of abuse in the family environment are numerous and complex. Although gender, old age and physical problems were formerly considered to be common factors in abuse cases, recent research has shown that these factors on their own do not explain violence, although they may contribute to it. The same is true of the widespread belief that victims of abuse are financially dependent on their carers or aggressors, as subsequent studies have revealed cases in which the opposite is true. Caregiver stress was also identified as a common cause of abuse, but there is increasing evidence that the quality of the relationship is actually more important than the type (WHO, 2003).

At the community level, some factors associated with abuse are the result of modernization, for example the gradual loss of functions within a changing society, the erosion of traditional family structures and the difficulties these have in providing safety and protection. In Chinese society, for example, some reasons found for abuse are younger generations' loss of respect for older persons, tensions between traditional and emerging family structures, restructuring of basic support networks, and emigration of young couples to new cities, while their elderly parents remain in increasingly dilapidated residential areas in city centres (Kwan, 1995).

One of the most visible forms of abuse in institutional settings is found in long-term care homes that fail to meet minimum quality standards. Care system deficiencies such as insufficient or substandard training of staff, excessive workloads and inadequate care for residents (which are usually manifested in overstrictness or overprotectiveness), and likewise deteriorating facilities, can make interaction between staff and residents in these care homes more difficult, giving rise to abuse, neglect and exploitation. Cases of violence against residents and by these against staff members have been recorded in centres providing psychological and geriatric care (Vásquez, 2004).

In this environment, acts of mistreatment or neglect by individuals must be distinguished from institutional abuse. The former are the result of individual acts and originate in institutional failings like some of those just mentioned, while the latter, conversely, is the outcome of an established regime in the institution as such where negligence or neglect is ingrained and staff members perpetuate abuse by applying a regimented system that admits of no questioning, established in the name of the discipline or protection enforced (WHO, 2003).

Data on the extent of the problem in institutions such as hospitals, nursing homes and other long-term care facilities are scarce. However, a survey of nursing home staff in the United States suggests rates may be high: 36% had witnessed at least one incident of physical abuse of an elderly patient in the previous year, 10% had committed at least one act of physical abuse towards an elderly patient and 40% admitted to psychologically abusing patients (WHO, 2016).

The studies that have begun to be produced on this theme have also refuted some established ideas about the prevalence of certain types of elder abuse. It is often thought that the most common form of abuse is psychological, expressed through insults, intimidation, humiliation or indifference. However, there is increasing evidence of other equally or even more testing situations.

In 2016, the World Health Organization (WHO) warned that at least 10% of older persons suffer from some form of abuse, be it physical, sexual, psychological or financial, and described this as a "significant" public health issue. Specifically, it is estimated that between 0.2% and 4.9% of older persons suffer physical abuse, between 0.04% and 0.82% sexual abuse, between 0.7% and 6.3% psychological abuse, between 1.0% and 9.2% financial abuse and between 0.2% and 5.5% some form of neglect (WHO, 2016).

Surveys of older persons living in the WHO European region revealed that 2.7% —equivalent to 4 million people aged 60 and over— had experienced maltreatment in the form of physical abuse as of 2010. The proportion affected by sexual abuse was 0.7%, equivalent to 1 million older people, while the figure for mental abuse was far higher at 19.4%, equivalent to 29 million older people, and 3.8%, equivalent to 6 million older people, were affected by financial abuse (WHO, 2011). These figures give a notion of the multiple forms of abuse experienced by older persons.

From a social perspective, the severest consequence of abuse is older persons' isolation and loss of self-esteem, which contribute to negative stereotypes of old age.

The economic exploitation of older persons has also been studied with a greater sense of urgency in the past few years. During the economic recovery following the 2008 crisis, older persons became more attractive targets for fraudsters, as many of them owned tangible assets such as real estate, cash savings, pensions and other retirement income. According to one United States senator, roughly one in five older persons in that country will be a target of some form of financial exploitation, with amounts running into the billions of dollars each year (McCaskill, 2015). The financial exploitation of older persons will probably increase as the population ages (10,000 people are set to reach the age of 65 every day over the next 15 years). Assuming the exploitation rate remains constant at one in five people, this yields a figure of approximately 73,000 new victims each year. Compounding this alarming statistic is the fact that most victims do not file complaints, for any number of reasons (embarassment, fear of pressing criminal charges against a family member or carer, fear of losing their independence) (Wotapka, 2015).

The repercussions of abuse are also diverse, being variously personal, social and financial. Physical abuse of older persons can have grave consequences, owing mainly to bone fragility, which results in longer periods of convalescence that can lead to death. From a social standpoint, the most serious effects of elder abuse are isolation, diminished self-esteem and feelings of insecurity, which in the long run encourage negative stereotypes of ageing by associating it with disengagement and a lack of personal projects.

From an economic perspective, specialized services and personnel training to prevent and address situations of abuse cost money. The costs are even higher when the losses to older persons from the exploitation or theft of cash or assets are taken into account.

The least visible aspect of this problem, however, directly concerns the right to life. A study carried out in New Haven (United States) over a period of 13 years showed that mortality rates were substantially higher for older persons who had been victims of abuse, regardless of the type, than for those who had not (Lachs and others, 1998).

3. Experience with the prevention and eradication of elder abuse in other regions of the world

Among developed countries, the United States has progressed in this area at the national level and has a fully developed system for reporting and handling cases, while initiatives in Europe vary considerably from one country to the next. Although there is a wide variety of measures, these are focused mainly on prevention and on encouraging victims to file complaints (see box V.1).

Box V.1
Programmes for the prevention of elder abuse in Europe

Although legal frameworks in this area may be inadequate and public policy not necessarily substantial or consistent, there are some examples of good practices in relation to elder abuse in many countries. Austria, for instance, has held workshops to give participants experience in counselling older persons who have been victims of violence, and has created contact points to assist those who have been abused.

In other countries, such as Belgium and France, cases of abuse can be reported via special hotlines. Local support teams conduct house calls and propose solutions to improve older persons' situations, in addition to offering counselling and free training. In Finland, an action plan to reduce violence against women in 2010-2015 also included measures that applied to older persons.

In Germany, a programme put in place to safeguard the elderly helps implement prevention measures such as housing for older women requiring protection from domestic violence and counselling centres for victims of abuse, as well as awareness-raising and training for home care workers so that they can play a preventive role. Given that older persons are probably at greatest risk of death from unnatural causes going undetected, an interdisciplinary group of experts has developed a guide for medical professionals to better detect homicide of older persons.

In the Netherlands, a protocol has been developed to fight abuse of older persons in the province of Noord-Holland. This protocol is used by those who come into occasional contact with older persons (for example in hair salons), and aims to prepare them to recognize signs of abuse, within the limits of their responsibilities. The protocol also outlines the steps to take in the light of suspected cases of abuse and how to contact specific support groups.

The national plan of action on ageing in Turkey provides professional training to those who work with older persons, with the aim of helping them detect abuse and neglect and of creating a mechanism for filing complaints.

Portugal has developed a programme to improve the safety of older persons implemented by the police, involving direct telephone lines between their homes and police stations, for example.

Legislation in the United Kingdom ensures that employers and voluntary organizations have access to information on the criminal records of those who provide care to older persons, in order to eliminate risks. The government also has a prosecution policy for crimes against older persons that allows better tracking. Special advocacy services such as the charity Victim Support cater to older persons, giving assistance that goes beyond the criminal justice system.

Source: Steering Committee for Human Rights (CDDH), *Compendium of good practices* (CDDH-AGE(2013)04), Strasbourg, 23 May [online] http://www.coe.int/t/dghl/standardsetting/cddh/CDDH-DOCUMENTS/CDDH-AGE(2013)04_moz_good%20practices.pdf.

In Canada, the government of Quebec has implemented a very innovative initiative incorporating the human rights perspective, the Governmental Action Plan to Counter Elder Abuse, which specifies that all older persons have the right to have their physical and psychological integrity respected; that elder abuse is an unacceptable act of power and domination and must be censored and denounced by society; that the eradication of elder abuse must flow from egalitarian, equitable and respectful treatment; and that all older persons in situations of abuse must have ready access to mechanisms that will let them regain control of their lives as quickly as possible.

There is another interesting programme in the Oceania region, specifically New Zealand. This is the Elder Abuse and Neglect Prevention programme run by the Ministry of Social Development, which works in four main areas: (i) strengthening collaboration among all stakeholders with a view to effective and accessible service provision, (ii) raising cultural awareness with a view to recognizing the needs of all people, including the Maori and other indigenous communities of the Pacific region,

(iii) taking a best practice approach, setting minimum standards for service provision and taking into account the local context, community, knowledge and relevant skills, and (iv) outcome-based accountability so as to ensure that the services provided are of a kind and scope to achieve the desired outcomes (Peri and others, 2009).

Not many countries have managed to adopt wide-ranging and comprehensive legislation on the abuse of older persons. Only some Atlantic provinces of Canada, a number of states in the United States and Israel have laws that stipulate mandatory reporting of abuse. In the United States, for example, 43 states require professionals and anyone else working with older persons to notify organizations designated by the State for this purpose when they have reason to believe that abuse, neglect or exploitation has occurred. The aim of these initiatives is to avoid abuse going unnoticed despite warning signs (WHO, 2003).

4. Programmes to prevent and eradicate elder abuse in Latin America and the Caribbean

Latin American and Caribbean countries have been tackling elder abuse in different ways.

Most of the region's programmes focus on prevention campaigns designed to raise awareness and increase the visibility of the issue, and only a few are more practically geared towards protection. Among the most innovative areas are services providing socio-legal guidance in situations of abuse, like those in Peru and Uruguay.

Some countries have made progress in establishing a legal framework that makes specific reference to older persons as victims of abuse, something that went unmentioned until a few years ago. In Ecuador, article 153 of the Organic Comprehensive Penal Code, which came into effect in August 2014, punishes the abandonment of older persons with prison terms that range from 1 to 3 years and from 16 to 19, depending on aggravating factors.[2]

Costa Rica has a Subcommittee on Access to Justice for Older Persons whose programme consists in a system of identification alarms for when violations of this group's rights are reported, recording mainly domestic violence cases. As well as identifying elder abuse cases so that this group can be given priority, the programme operates a special helpline for complaints, which has allowed better recording and follow-up of reported cases. Supplementing this innovation in the judiciary, Costa Rica's National Pension Board for Teachers (JUPEMA) has prepared a rights-based guide on ageing, well-being and awareness-raising to familiarize schoolchildren with the subject of preventing abuse, maltreatment and abandonment of older persons.

In Peru, socio-legal guidance services have become increasingly important. Emergency women's shelters set up as part of the National Programme against Domestic and Sexual Violence receive complaints of violence, including those presented by older persons, and carry out activities to raise awareness and to detect ill-treatment and abuse. A set of policy guidelines on securing good treatment for older persons entitled "Lineamientos de política para la promoción del buen trato a las personas adultas mayores" has also been adopted in the country.

Uruguay also offers socio-legal guidance services. The National Institute for Older Persons (INMAYORES) runs a service for victims of domestic violence which operates in the departments of Montevideo, Canelones and San José. This service aims to help

[2] Article 153 of the penal code states: "Anyone who abandons an older person [...], leaving them helpless, and places their life or physical integrity in real danger, will be punished with a prison term of one to three years. Any injuries resulting from abandonment of a person will be punishable by the penalties stipulated for criminal injury plus one third. If death ensues, the prison term will be from 16 to 19 years."

protect older persons' rights by providing a comprehensive response to and follow-up of cases of abuse and ill-treatment. It is run by an interdisciplinary technical team specializing in this area that provides direct assistance and psychological, social and legal counselling. Implementing this kind of service is a vital step in addressing the issue, and the results are not limited to the actual cases dealt with but include greater knowledge, visibility and awareness of the problem throughout society.

In the Dominican Republic, the National Council for the Elderly (CONAPE), which is responsible for national policies on ageing, has created a specialized unit for violence against older persons with a view to preventing and pursuing the increasing number of cases of violence, abuse and maltreatment experienced by this group.

The existence of these specialized bodies means that professionals can take a tailored approach to crimes of violence against older persons. Access to justice is also guaranteed for this group, with free legal assistance provided by lawyers from the Attorney General's Office. Indeed, the Public Prosecutor's Office of the National District has combined sensitivity with the knowledge, specialization and support needed to address this social scourge, becoming a pioneer in serving the needs of the older population in the country.

In Argentina, the city of Buenos Aires has passed Law No. 5420 (the Comprehensive Prevention and Protection against Elder Abuse and Maltreatment Act), whose purpose is to provide comprehensive interdisciplinary protection to older persons who have been victims of any type of abuse or maltreatment or who are extremely vulnerable, so that they are guaranteed physical, psychological, economic and social assistance. In practice however, it is very rare for older persons to initiate legal proceedings against anyone abusing them. The Ministry of Social Development has been running a national campaign for good treatment of older persons intended to encourage people to review socially entrenched prejudices and stereotypes, raise awareness of elder abuse and mistreatment and promote a culture of good treatment.

The Plurinational State of Bolivia has a legal framework in place to protect older persons. Section VII (articles 67 and 68) of the country's constitution establishes the rights of older persons and prohibits abuse, abandonment, violence and discrimination. There are also socio-legal guidance centres for older persons, which receive an average of 10 complaints of domestic abuse each day. However, there is still much work to be done to ensure that the country's protection laws are fully enforced.

Most programmes in the region for forestalling and eradicating abuse centre on preventive awareness-raising and visibility campaigns, while only a few are oriented towards more concrete protection. Among the most innovative areas are services providing socio-legal guidance for situations of abuse.

The Ministry of Economic and Social Inclusion in Ecuador also runs awareness-raising and prevention campaigns with the support of youth volunteer networks. Similar activities are carried out in centres for older persons, including those operated directly by the ministry and those managed under licence. These activities are focused on the adoption of measures against abuse and maltreatment of this population segment within families and institutions.

The Older Persons Information Centre in Trinidad and Tobago, which is part of the Division of Ageing, addresses older persons' concerns of every kind and provides information about products, services and resources. In practices, this is where abuse is reported, and in some cases officials make house calls on older persons who have reported abuse or neglect. The government is also preparing to implement a new law that will govern the granting of licences, regulation and oversight of nursing homes. The law will criminalize elder abuse by managers or employees of long-term care homes.

In Bermuda, legislation was adopted in 2008 to create a register of individuals who have abused older persons and make reporting of suspected abuse mandatory. It covers abuse committed by care workers, family members or anyone else. The purpose of the register is similar to that of child sex offender registers in some countries: to prevent

registered offenders from being employed as care workers or managers of long-term care homes. The law also requires professionals who work with older persons (in the health sector, social services and the police force) to report suspected cases of abuse. When suspected abuse is reported, the registrar is responsible for investigating the circumstances of the case and can refer them to the police, request protection for the older person by virtue of the domestic violence law or provide care or housing to guarantee the victim's safety and well-being.

In Chile, elder abuse has been a constant concern since the creation of the National Service for Older Persons (SENAMA) in 2002. A programme against abuse of older persons was launched nationwide in 2012. It is run by specialists based in the country's 15 regions and has two components: prevention and visibility, and counselling in cases of abuse. One notable outcome of the programme has been the establishment of a board responsible for preventing and dealing with abuse in each region, with these going to form a specific network of protection and prevention with jointly developed regional programmes. SENAMA also runs a programme of action to promote good treatment through mechanisms for publicizing rights and preventing abuse, operating on a comprehensive intersectoral basis with psychological, social and legal components. Elder abuse cases are also taken on, managed and coordinated as part of the programme, particularly those involving domestic violence, and a lawyer is on hand in each regional capital to provide legal assistance and advice, thanks to an agreement with the legal aid agency.

B. Long-term elderly care and State obligations

1. Definition of elderly care in regional instruments

(a) Care as interdependence

The idea of care expresses the interdependent relationship between human beings and the society in which they live, although it was always strongly tied to the notion of independence or personal autonomy (as opposed to dependence), which gradually came to be understood as self-sufficiency.

Older persons need to come to terms with their losses in a secure environment where they can strengthen their potential autonomy with assistance that reinforces whatever capabilities they retain or are able to recover.

Determining a person's degree of independence or dependence is a very difficult dilemma, and not just in the case of older persons. Human beings are at constant risk of becoming dependent on others at some point in their lives.[3] They may find themselves in need of acute or long-term care owing to a disability, chronic illness or trauma, any of which could limit their ability to carry out basic personal care activities or day-to-day tasks.

The problem is worse for older persons with borderline autonomy, as the standard of normality is to have the self-sufficiency to eat, bathe and move around, but the environment is not always supportive. Sometimes they need technical assistance to reach the desired standard, but this is unavailable to many. It is here that care should be focused, and not on the extremes, as a bridge between actual and potential autonomy. Injustice arises when the latter does not equal the former (Etxeberria, 2014).

[3] Traditionally, these activities of daily living are classified as basic (eating, dressing, bathing, getting into and out of bed, using the bathroom and sphincter control) and instrumental (preparing one's own meals, cleaning, washing, taking medication, travelling beyond walking distance, going shopping, managing money and using the telephone or the Internet). A person is dependent if their ability to carry out basic and instrumental activities is limited. Although the number of limitations qualifying someone as dependent varies from country to country, this has been generally accepted as a suitable criterion, characterizing as it does a person's inability to live independently and their need for assistance from others to carry out certain tasks.

Elder care can be defined in consideration of some basic human rights principles. In order to understand the inner meaning of what care is meant to provide, it is very important that it not be equated with the concept of adequate living standards.

There is an ethical distinction at the heart of the observation above. Care services must address the problems that arise as a person grows older. Old age undeniably leads to a genuine loss of some capacities, but this should never, even in the most severe cases, be used as justification for violating the moral grandeur of a person's dignity as a human being (Etxeberria, 2014).

Older persons experiencing loss of capacities should be supported by a secure environment where their potential autonomy is strengthened by assistance that reinforces any remaining or recoverable capacities. It is striking how the technical definition of dependence that was arrived at in developed countries, especially Spain, has ultimately narrowed the scope of the care concept in the region, and even reduced reciprocity to a mere contractual relationship.

(b) The scope and limitations of regional instruments

In the past five years, various countries and international bodies have highlighted long-term elder care and those who provide it. The Inter-American Convention on Protecting the Human Rights of Older Persons, recommendation CM/Rec(2014)2 of the Committee of Ministers of the Council of Europe and the Protocol to the African Charter have also urged countries to take action on this matter.

According to article 12 of the Inter-American Convention, older persons have "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".

The right is a broad one that encompasses components of the right to an adequate standard of living. However, it contains a restriction that should be done away with, since as it stands it covers only older persons being cared for in residential facilities, to the exclusion of home care. According to the Inter-American Convention, an older person receiving long-term care services is "one who resides temporarily or permanently in a regulated public, private or mixed establishment, which provides quality comprehensive social and health care services, including long-term facilities for older persons with moderate or severe dependency, who cannot receive care in their home".

According to the United Nations (2010), long-term care is provided in two settings: in residential facilities (this being what is protected under article 12 of the Inter-American Convention) and at home.[4] The Council of Europe recommendation also pays particular attention to older persons who receive residential care. Although institutional care is clearly important, persons who receive care at home require equally forceful protection, of the kind the Protocol to the African Charter is meant to facilitate.

Another restrictive provision is found in the Council of Europe recommendation, which stipulates that older persons who are placed in institutional care have the right to freedom of movement but that this can be restricted as long as the restriction is lawful, necessary and proportionate and in accordance with international law.

[4] Residential care refers to the housing and care of a person in a specialized care institution. Older persons who live in these institutions are often under the authority of the care provider, whose function is to assist them in their daily activities, including administering medication and providing health-care services. Home care generally refers to medical services provided by professionals in a patient's home, in contrast to care provided in specialized institutions.

This type of provision has been widely debated because it can lead to practices that violate the dignity of older persons, especially considering that the guardianship approach continues to be the most commonly used in their case. It can also encourage legal excesses that are unacceptable because they reflect only private conflicts of interest, which are not always easy to identify. For example, a declaration of incapacity can be sought in cases of mild senile dementia, lack of mobility, deafness or an administrative rather than legal ruling of disability, even though, according to existing jurisprudence, these limitations do not always constitute incapacity (SEPIN, 2015).

Despite the reservations arising with regard to the above provisions, it must be recognized that they are merely a synopsis of the current state of the debate on this issue, and certainly there is still much work to be done.

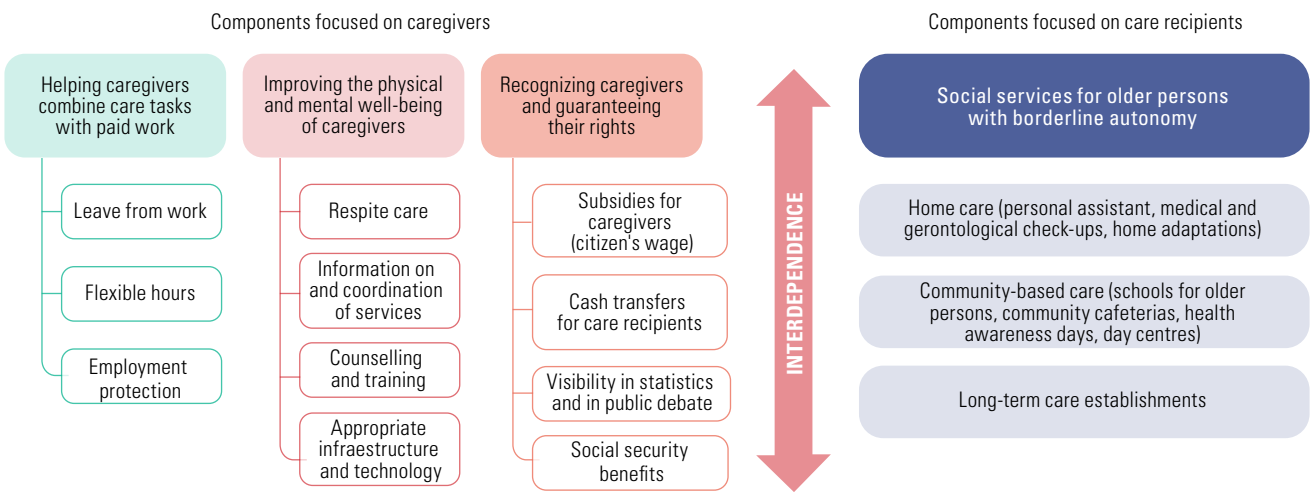
2. Care of older persons: areas of intervention

Caring for older persons involves a number of working areas, but some of the most important ones can be identified from the experience of developed countries:

- Helping caregivers to combine their tasks with paid work by ensuring they are entitled to leave of absence, flexible hours and employment protection.
- Improving the physical and mental well-being of caregivers through measures to provide respite care, information on and coordination of services, counselling and training, and availability of appropriate infrastructure and technology.
- Recognizing caregivers and guaranteeing their rights by providing them with a citizen's wage and access to social security and health-care benefits, or providing cash transfers for care recipients. It is also very important to incorporate care into the public debate so that it is given the appreciation and recognition it deserves (Colombo and others, 2011).
- Developing social services for persons with borderline autonomy: this involves progressive, non-discriminatory measures ranging from long-term home care to residential care, as well as palliative care (see chapter IV).

Diagram V.1 is a working matrix showing the actions associated with each of the care components identified above.

Diagram V.1
Long-term care of older persons: areas of intervention



Source: S. Huenchuan, "'¿Qué más puedo esperar a mi edad?'. Cuidado, derechos de las personas mayores y obligaciones del Estado", *Autonomía y dignidad en la vejez: teoría y práctica en políticas de derechos de las personas mayores* (LC/L.3942), S. Huenchuan and R.I. Rodríguez (eds.), Santiago, Economic Commission for Latin America and the Caribbean (ECLAC), 2014.

(a) Inputs for a standard of long-term care

The Council of Europe recommendation outlines some requirements that ought to be guaranteed for long-term elder care services in terms of availability, accessibility, acceptability and quality (see table V.1).

Table V.1
Essential long-term care requirements as established in international instruments

Requirement	Definition	Content of long-term care
Availability	Functioning public health facilities, goods and services and programmes should be available in sufficient quantity and should provide essential drugs, safe and potable water and adequate sanitation facilities.	• Services should be available within the community to enable older persons to stay as long as possible in their own homes.
Accessibility	Health facilities, goods and services must be accessible to vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.[a]	• States should take appropriate measures, including preventive measures, to promote, maintain and improve the health and well-being of older persons. They should also ensure that appropriate health care and quality long-term care are available and accessible.
Acceptability	All health facilities, goods and services must be respectful of ethics and the culture of the respective populations, be sensitive to gender and life-cycle requirements, and be designed to respect confidentiality and improve the health status of those concerned.	• Care providers should treat any sensitive personal data of older persons confidentially and carefully in accordance with their right to privacy.
Quality	Health facilities, goods and services must be scientifically and medically appropriate and of good quality, with good professionally trained personnel and appropriate medical equipment.	• Caregivers should receive the necessary training and support to ensure that the services they provide are of a good quality. Where older persons are being cared for at home by informal carers, the latter should likewise receive the required training and support to ensure that they are able to provide the care needed.

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of United Nations, *General Comment No. 14 (2000). The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights)* (E/C.12/2000/4), Committee on Economic, Social and Cultural Rights, 2000; Steering Committee for Human Rights (CDDH), "Draft explanatory report to the recommendation on the promotion of the human rights of older persons", fourth meeting, Council of Europe, 23-25 September 2013.

[a] There are three types of accessibility: (i) physical accessibility for all, including disadvantaged persons and groups, (ii) financial affordability for all, particularly disadvantaged persons and groups, and (iii) the right to seek, receive and impart information concerning health issues, while respecting confidentiality (United Nations, 2000).

(b) The duties and respite options of older persons' caregivers

The Inter-American Convention and the Council of Europe recommendation both make provision for support services for family members and other persons who care for older persons on an informal basis. The Protocol to the African Charter makes an important contribution by singling out caregivers in the following provisions:

- Adopt policies and laws that provide incentives to family members who care for older persons at home.
- Identify, promote and strengthen traditional support systems to improve families' and communities' ability to care for older persons.
- Adopt measures to ensure that indigent older persons who care for orphans and vulnerable children receive financial, material and other forms of support.
- Ensure that any social or other benefits for children in the care of older persons actually go to the latter.

These three regional instruments elevate long-term care to the status of an enforceable right, going a step further than the United Nations Principles for Older Persons, albeit still with limitations. Also, although the common features have been highlighted here, there are significant asymmetries between these three instruments in terms of content and the strength of the protection that they provide.

This is a cause for concern because, in practice, the support available to informal caregivers is still very inadequate. A good case in point is family respite care programmes, which are a temporary and specific solution to deal with situations arising within families so that carers can cater to the specific needs of users (UNIR, 2016).

In the United States, dementia sufferers and their informal caregivers have been receiving support from day centres and temporary care in nursing homes for several decades now. Centres that provide respite care for one or more days a week or for several weeks allow family members who act as caregivers to have a break while leaving the person with dementia in a safe and supervised environment. This contributes to the ultimate goal of supporting ageing in the communities where dementia sufferers have been living, ensuring that they receive assistance and reducing the likelihood that family carers will suffer from health problems.

In the United Kingdom, respite care programmes are designed to replace caregivers so that they can look after their own health and well-being and take a break from care duties. For example, they may be assigned a regular replacement for overnight care. In certain cases, local authorities may provide temporary care following a carer's assessment or after the person being cared for has been assessed. Carers can use a directory of local carers' services to find a replacement (NHS, 2016).

In Ireland, the Department of Social Protection grants an annual subsidy to carers. The name was changed from Respite Care Grant to Carer's Support Grant in 2016 to better reflect how the funds are used by carers. For example, recipients can use the grant to pay for respite care, but are not obliged to do so (Department of Social Protection of Ireland, 2017).

The contribution of these three regional instruments has been to elevate long-term care to the status of an enforceable right, thus going a step further than the United Nations Principles for Older Persons. However, there are great asymmetries in their content and the strength of the protection they provide.

In some Caribbean countries, day centres for older persons allow family caregivers to work, or at least take a break from their care duties. These centres also keep older persons socially and physically active, provide nutritious meals and sometimes offer other services such as health checks. They provide invaluable support to caregivers, many of whom are themselves older persons.

The above-mentioned initiatives, as well as others in Cuba, Spain and Uruguay, are some of the few currently identified. However, there is still an unresolved problem in this area: sometimes it is forgotten that older persons receiving long-term care develop a bond with their caregivers which should also be respected. Being admitted into a care home for a period so that their carers can have a break is a stressful situation for older persons and requires a meticulous evaluation beforehand, especially at certain times of the year. It has been shown that the number of older persons left on their own triples during the summer, implying that in Spain, for example, more than 3 million older persons are abandoned because their families consider them a hindrance on their vacations (Arias, 2002).

Temporary or permanent admittance into a nursing home, when unrelated to the level of care required, is a stressful situation that can manifest itself in increased distress, faster deterioration, diminished self-esteem, adaptation difficulties, increased depressive symptomatology, less frequent social contact and general activity, and even changes in time perception (Arrazola, 1999). Not all older persons who enter nursing homes react negatively in this way, as there are some who actually feel relieved and whose condition and family relationships improve. But respite options for caregivers must be evaluated so that neither party is negatively affected.

3. Older persons' experience of long-term care in other regions of the world

Various international, intergovernmental and national bodies have produced definitions for long-term care, but only some of them include medical assistance.

In the United States, long-term care refers to medical and non-medical assistance received by persons who cannot carry out basic activities of daily living. The Organization

for Economic Cooperation and Development (OECD) also defines it as encompassing both types of assistance, including prevention, rehabilitation and palliative care services, and adds that this type of care can be combined with assistance in the home and with instrumental activities of daily living.

Long-term care is fundamentally different from acute care and conventional medical treatment, as it is not intended to cure or heal an illness, but mainly aims to:

- ensure the best quality of life possible;
- minimize, stabilize or offset the loss of physical or mental capacities;
- ensure that older persons achieve and maintain the highest level of functionality possible;
- allow older persons to live as independently as possible;
- help older persons to complete tasks essential to daily living;
- maintain limited functionality, health and social and mental well-being at the highest levels possible (Carretero, Garcés and Ródenas, 2006).

The options for the development of long-term care services being discussed internationally include a number of these objectives.

Some aspects that give an idea of the content and scope of existing long-term care services will now be examined.

(a) The cost of long-term care

In OECD countries, spending on care services for dependent people between the ages of 60 and 65 is practically non-existent, but from then on it rises sharply and steadily (Wittenberg and others, 2006). It is estimated that in the United States, 70% of the population living to the age of 65 will need long-term care at some point, lasting for an average of three years (Eisenberg, 2014a and 2014b). Using this figure as a benchmark, more than 33 million people in Latin America and the Caribbean who had turned 65 by June 2015 would be expected to need long-term care.

Nonetheless, the need for spending on long-term care does not only stem from ageing. According to OECD, spending is set to increase from 1.1% of gross domestic product (GDP) in 2005 to 2.3% of GDP in 2050 because of the effect of population ageing, to 2.8% because of rising dependency (with an annual increase of 0.5%) and to 3.9% because of a decline in the number of informal caregivers (OECD, 2006).

Despite the clear need for investment in long-term care, average spending does not exceed 1% of global GDP. Most African countries spend 0% of GDP on these services, and only in South Africa is public spending as high as 0.2% of GDP. In the Americas, spending ranges from 1.2% of GDP in the United States to 0.6% in Canada and 0% in the Latin American countries. In Asia and the Pacific, New Zealand spends the most on long-term care as a percentage of GDP (1.3%) and Australia the least (0%), while countries such as China, India and Indonesia spend about 0.1% of GDP. In Europe, Denmark spent the most on long-term care between 2006 and 2010 (2% of GDP), while Slovakia spent the least (0%) (ILO, 2014).

Despite the growing needs of the population, investment in long-term care has diminished over the past few years in developed countries. In the United Kingdom, the social assistance budget has been cut by 1.950 billion pounds sterling owing to central government spending cuts in the past decade, particularly over the past five years. Coverage has also been reduced: 15.3% of people aged 65 and over received social assistance between 2005 and 2006, but just 9.2% between 2013 and 2014 (Mortimer and Green, 2015). The government's budget for fiscal year 2015/2016 suggests a reduction of 472 million pounds in social assistance spending.

Budget cuts in Ireland have weakened policies intended to promote the independence of older persons through community support. The Home Help Service budget was cut from 211 million euros in 2008 to 185 million euros in 2015, despite a 25% increase in the population aged 65 years and over and an increase of roughly 30% in the population aged 85 years and over. The number of people receiving assistance has declined by almost 2% in the past seven years: 63,245 people received Home Help and Home Care Packages in 2015, compared with 64,353 in 2008 (Donnelly and others, 2016).

Because availability of and access to public long-term care services tend to be limited and costly for users, existing plans and systems rely heavily on a co-payment system. Out-of-pocket spending on long-term care by those who need it has a significant impact on their incomes, with the worst affected being the poor, women and the very old.

In the United Kingdom, the cost of long-term care for people aged 65 and over is estimated to average more than 30,000 pounds (roughly US$ 37,648) per person per year (Comas-Herrera, Wittenberg and Pickard, 2010). In the United States, the cost of long-term residential care is estimated at US$ 87,600 per year on average for a private room and US$ 77,380 for a semi-private room. It costs US$ 45,188 per year to employ a home health aide and US$ 43,472 per year to employ someone to handle homemaker services (Eisenberg, 2014a). These amounts are more than triple the average disposable income of people aged 65 years and over (Gleckman, 2010).

In South Africa, out-of-pocket spending on long-term home care represents 100% of the total cost, as there are no public long-term care institutions. In Thailand, out-of-pocket outlays are estimated at 80% to 100% of total spending on long-term care, while in Argentina they range from 60% to 80% (Scheil-Adlung, 2015).

Where there is no care service coverage, as in most Latin American and Caribbean countries, older persons face an imminent risk of impoverishment. Dependence on informal caregivers and family members is not always sufficient, and in many cases is not even an option for older persons.

(b) Protection when long-term elderly care is needed

The International Labour Organization (ILO) estimates that 48% of the global population is unprotected by national legislation on long-term care, and where there is protection, laws tend to differ significantly from one country to the next.

In India, Singapore and China, young people are required by law to care for their parents, on penalty of imprisonment or fines. In China, the constitution and the Protection of the Rights and Interests of Older People Act of 1996 (amended in 2012) explicitly prescribe that families are responsible for caring for their elders (Wong and Leung, 2012).

Other countries are less strict in this regard, and implement different modalities of protection. In South Africa, ageing occurs in a difficult environment where older persons tend to live in poor households and there may be several generations without any income of their own. Many older persons are responsible for caring for orphans, and households without the intermediate generation are common. The Older Persons Act (Law No. 13 of 2006) contains a number of provisions to protect older persons, distinguishing between community-based care and residential care. The Department of Social Development regulates the programmes applied. As regards social security, since 2004 people already receiving old-age, disability or war veterans' benefits and unable to care for themselves have been provided with specific funding to employ a full-time carer (South Africa, Government of, 2016). The subsidy is worth US$ 26 per month and in November 2016 the number of beneficiaries stood at 157,565 people (SASSA, 2016).

At the other end of the spectrum is Japan, which has had a long-term care insurance system in place since 2001. This system was set up with a view to ensuring that society as a whole supported those in need of care and to keeping long-term care services separate from health services, which were previously provided through "social admissions" to tertiary care hospitals. In Japan's insurance scheme, municipalities act as insurers with the support of the central government, and insureds are divided into two categories: people aged 65 and over, and people between the ages of 40 and 64 with health insurance. There are two types of beneficiaries in the first group: those requiring long-term care and those needing specific support to maintain their autonomy. Table V.2 shows the benefits of the system for each type.

Table V.2
Japan: the benefits of long-term care insurance for persons aged 65 and over

	In-home services	Services at facilities
Persons requiring long-term care	• Home visit or day services: long-term care, home visit bathing and rehabilitation, rehabilitation in day care centres, home nursing care, day services, leasing of welfare devices • Short-stay services and care • In-home medical care management counselling • Care service with mutual support for the elderly with dementia • Care service provided in for-profit private homes for the elderly • Allowance for purchase of welfare devices • Allowance for home renovation (handrails, removal of level differences, etc.)	• Long-term care welfare facilities for the elderly (special nursing homes for the elderly) • Long-term care health facilities for the elderly • Long-term care medical facilities for the elderly – Sanatorium-type wards – Sanatorium-type wards for patients with dementia – Hospitals with enhanced long-term care service provision (for three years after implementation)
Persons requiring support	• Same as for persons requiring long-term care (excluding care service with mutual support for the elderly with dementia)	• Not applicable

Source: Ministry of Health, Labour and Welfare of Japan, "Long-term Care Insurance in Japan", July 2002 [online] http://www.mhlw.go.jp/english/topics/elderly/care/index.html.

This insurance is 50% funded from taxation (25% from central government, 12.5% from municipalities and 12.5% from provincial governments), with the rest coming from the two categories of insureds: 17% is contributed by the first category (insureds aged 65 and over) through a pension deduction or a direct payment, and the remaining 33% is deducted from the medical insurance of insureds in the second category (aged 40 to 64). The insurance covers 90% of the total cost of benefits and services and beneficiaries pay 10% out of pocket. In 2015, 16% of persons aged over 65 (5 million people) benefited from long-term care services. In just one decade, the number of older persons being cared for in nursing homes increased by 83% and the number of people receiving long-term care at home or in their communities by 203% (Kamiya and others, 2012). Germany, the Netherlands and Taiwan Province of China have social security schemes in place to cover the costs of long-term care. Given the complexity of needs and of the schemes on offer, older persons need to be very well versed in long-term care benefits and services to be able to apply for them. These benefits may be in cash (including financial support for family members who provide care) or in kind, such as institutional care and home care. Eligibility criteria vary widely and are frequently means-, age- and needs-tested (ILO, 2014/Scheil-Adlung, 2015).

Since the social dependence insurance scheme was introduced in Germany, all citizens have been obliged to have insurance in order to access assistance from State or private health insurance systems. Social insurance covers the risk of social

dependence regardless of age. The growing cost of care is covered directly by the insurance contributions. Social benefits can be applied for when the services provided by the dependence insurance scheme are insufficient and the affected person or their family does not have the resources to finance additional care. Among the services and benefits provided under the German dependence insurance scheme, financial compensation for families is foremost (47.4% of benefits), followed by services provided in nursing homes (28.0%), financial benefits for the purchase of services (8.8%) and a combination of both types of financial compensation (10.1%). Other options such as care for caregivers, day centres and night centres are barely reflected in the figures (Germany, Government of, 2008).

4. The growing need for caregivers and its impact on society

In many parts of the world, long-term care policies are based on the assumption that informal networks such as communities and families can provide care for older persons, and do not factor in the limitations faced by caregivers (many of whom are women) or the impact this could have on the quality of unpaid care, on the income of caregiving families or on caregivers' health and employment prospects.

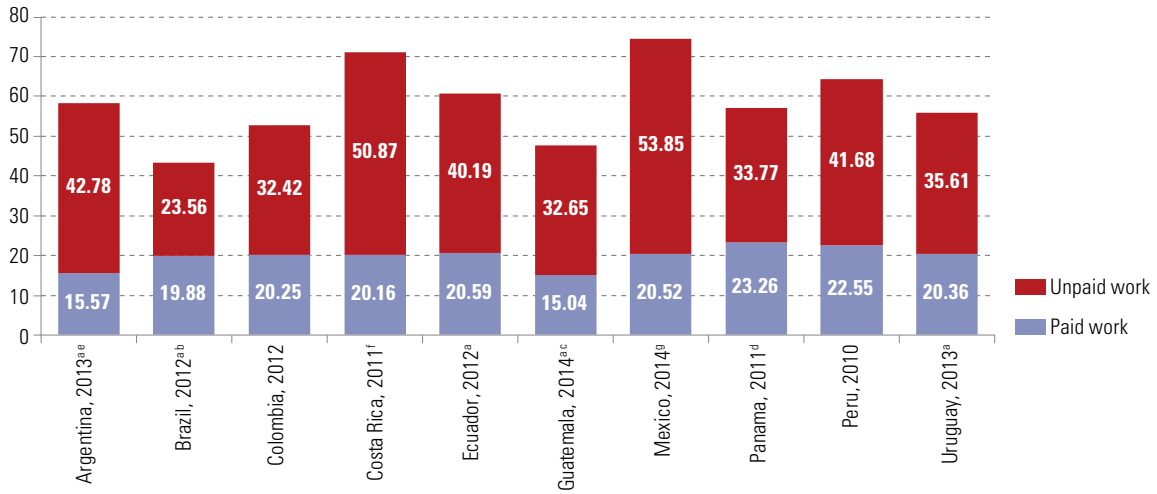
In the United States, an estimated 15 million people care for a family member suffering from Alzheimer's, 38% of them for more than 30 hours per week (Eisenberg, 2014b). In Canada, 9.6% of the population cares for individuals affected by some type of chronic illness or disability. A government-backed 2002 study found that 4% of adults provided care to a family member suffering from a mental or physical disability or a chronic or debilitating illness (Carretero, Garcés and Ródenas, 2006).

In the United Kingdom, the number of people caring informally for older persons has fluctuated slightly over the past few years, but as of 2014 around one in six people provided this type of care, a third of them for more than 20 hours per week. In Ireland, an estimated 89.5% of care for older persons living in their communities is provided by family caregivers (Care Alliance Ireland, 2015). This includes help with personal care and household tasks, and averages 30 hours per week (Kamiya and others, 2012).

The figure is much higher in Latin America and the Caribbean. Time-use surveys in some of the region's countries show that women spend a large amount of time on unpaid work (including caring for dependent persons). In Mexico, they spend more than 53 hours per week on this type of activity, while the figures are 50.8 hours per week for Costa Rica and roughly 40 hours per week for Argentina and Peru (see figure V.1). In Chile, one in four persons aged 60 and over is dependent to some extent, according to the National Service for Older Persons (SENAMA). In 86% of cases, the older person is cared for by a woman (usually the spouse or a daughter or daughter-in-law), with care time averaging more than 12 hours per day.

Many unpaid caregivers are older persons themselves, often caring for their spouses, family members or friends. In the United Kingdom, 20.5% of older persons provided unpaid care in 2014, compared with 18.2% in 2011. Older persons also tend to spend more time on care than the population of unpaid caregivers overall, with 38.8% spending 20 or more hours per week providing care and more than 25.3% doing so for more than 50 hours per week (AGE UK, 2016). In Mexico City, older persons play a prominent role in caring for their contemporaries, irrespective of their charges' risk of death, and they spend even more time caring for those at high risk of dying within the year, with 77% of elderly caregivers assisting this at-risk group (Huenchuan and Rodríguez, 2015).

Figure V.1
Latin America (10 countries): average amount of time spent on paid and unpaid work by women aged 15 and over, latest period available
(Hours per week)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of time-use surveys conducted in the respective countries.
[a] Paid work excludes time spent looking for work, as this was not asked about in the survey.
[b] Unpaid work includes only unpaid household activities.
[c] Unpaid work excludes support for other households.
[d] Survey conducted in urban areas only.
[e] Time-use module only covers persons aged 18 and over.
[f] Survey conducted only in the greater metropolitan area.
[g] The disaggregation of unpaid working activities in the 2009 survey meant that hours were overestimated, by contrast with the 2014 survey, where these activities were aggregated.

In Cuba, those caring for centenarians are often aged 60 and over (64.2%) (Selman-Houssein and others, 2012). Most of these carers are the older persons' children (66.5% of the total), followed by their grandchildren (7.1%) and non-family members (6.8%) (Fernández, 2016). In Colombia, the 2015 Health, Well-being and Ageing (SABE) survey revealed that 83.9% of those caring for older persons were women and 16.7% of these were aged 60 and over (MINSALUD, 2015).

Demand for caregivers is growing. In Australia, it is estimated that 4.4 formal carers and 83.3 informal carers are needed for every 100 persons aged 65 and over, while the figures are 17.1 and 87.2, respectively, in Norway and 6.4 and 123, respectively, in the United States. Taking these estimates as a benchmark, table V.3 shows the estimated number of informal caregivers needed in Latin America and the Caribbean between 2015 and 2030, on the assumption that older persons' care requirements remain at current levels.

Using the number of informal caregivers estimated for Norway as a benchmark, an assessment of the region's countries shows that the situation is fairly mixed. Figure V.2 shows the percentage of the economically active population younger than 65 that would be needed to care for older persons. Cuba is the most affected: assuming there is no change in the trend, 50% of the economically active population younger than 65 will be having to care for older persons by 2030, which is practically double the 2015 figure.[5] Another country faced with a testing situation is Colombia, where the economically active population required to carry out care tasks is also forecast to double.

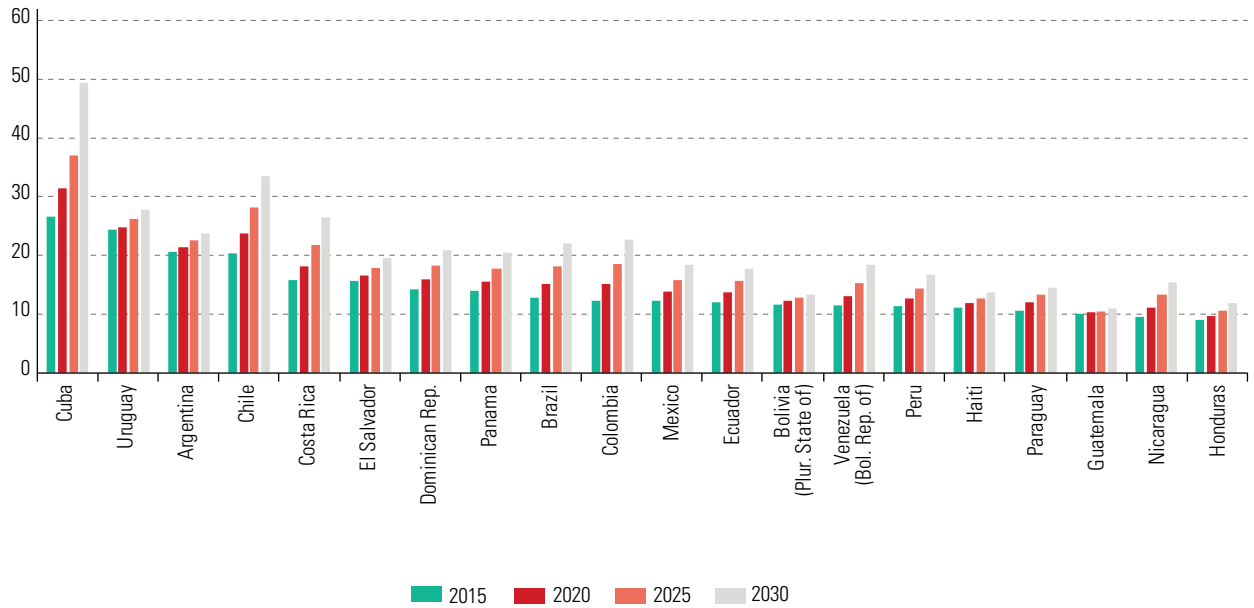
[5] In Cuba, 90% of dementia sufferers are cared for at home, which is why caregivers are so important. "Studies carried out in Cuba show that the ratio of patients to family members who care for them is one to two; 40% of these carers are forced to give up their jobs completely or partially to care for the patient and 50% are affected psychologically" (Fariñas, 2015).

Table V.3
Latin America and the Caribbean: estimated need for informal caregivers for every 100 people aged 65 and over based on estimated demand in Australia, Norway and the United States, 2015-2030
(Number of people)

	People aged over 65 in Latin America and the Caribbean	Demand for informal carers in the region based on estimated need in the reference country		
		United States[a]	Norway[b]	Australia[c]
2015	48 259 704	59 359 436	42 082 462	40 200 333
2020	58 882 203	72 425 110	51 345 281	49 048 875
2025	71 469 360	87 907 313	62 321 282	59 533 977
2030	86 609 322	106 529 466	75 523 329	72 145 565

Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of United Nations, *Probabilistic Population Projections based on the World Population Prospects: The 2015 Revision*, New York, Department of Economic and Social Affairs (DESA), 2015 [online] http://esa.un.org/unpd/ppp/.
[a] 123 informal carers for every 100 persons aged 65 and over.
[b] 87.2 informal carers for every 100 persons aged 65 and over.
[c] 83.3 informal carers for every 100 persons aged 65 and over.

Figure V.2
Latin America (20 countries): share of the economically active population aged under 65 needed to provide informal care, 2015-2030
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of United Nations, *World Population Prospects: The 2015 Revision*, and Latin American and Caribbean Demographic Centre (CELADE)-Population Division of ECLAC, population estimates and projections, 2016.

A qualitative study in six Caribbean countries confirmed major problems of coverage and access in care services (Cloos and others, 2009). Several countries face difficulties recruiting and retaining workers. In addition to addressing these issues, training and guidance for caregivers must also be strengthened, to help them identify cases of abuse or ill health, for example. Sometimes the solutions can be quite simple: in Barbados, a minibus was purchased to provide transport for caregivers attending to older persons living in remote areas.

The situation is serious not only in the countries of the region, but in the rest of the world, and this is clearly reflected in the care received by older persons in ageing countries. In Germany for example, long-term care homes suffer from a lack of personnel, and the resulting decline in care has reached a critical point. Each patient receives just 53 minutes of care each day, including feeding. One caregiver is often responsible for 40 to 60 residents (Guillán, 2013).

5. Long-term care at home: an area of intervention that must be strengthened

Research indicates that most older persons prefer to live in their own homes and to have support services that allow them to do so for as long as possible (Barry and Conlon, 2010). Evidence shows that they also want their family or friends to be their principal caregivers, which means that the main role of health and social services should be to support families so that they can meet this aspiration (Garavan, McGee and Winder, 2001).

Although many older persons would rather grow old in their own homes, few countries have developed specific programmes to facilitate this. Medical attention (including for older persons suffering from terminal illnesses), social care services and assistance can be provided to older persons at home so that they can avoid institutionalization (United Nations, 2015b).

The Independent Expert on the enjoyment of all human rights by older persons published a report on this theme (United Nations, 2015b) which contained an assessment of the concerns and difficulties raised by long-term care, as well as detailed recommendations on the adoption of appropriate measures. The assistance and support provided by family members and other informal caregivers is a key aspect of home care services which is little known and not sufficiently incorporated into human rights instruments.

Today there is greater awareness of the fact that older persons are able to remain at home thanks mainly to the efforts of an informal network and, in many countries, to the informal labour market, which facilitates access to affordable intensive care. The main consequences of this situation are:

- An excessive burden on families, especially women, which affects the latter's employment prospects and equality of opportunities with men.
- The development of an informal labour market with very substandard working conditions and wages.
- A lack of guarantees with respect to the quality of the care received by many dependent persons living in the community (SiiS, 2012).

Measures to promote informal care and recognize and support existing informal networks have recently begun to be introduced, as the weakening of these networks is seen as one of the factors that could increase demand for home care in the future.

Older persons in Spain receive a direct subsidy to arrange for their own home care. One advantage of this initiative is that it can empower them and increase their autonomy. Home care includes assistance with three types of service: (i) basic activities of daily living (for example hygiene, getting into and out of bed, dressing, eating and drinking, taking medication), including companionship; (ii) household chores (for instance, cleaning the home, preparing food, washing and ironing clothes, detecting situations of risk); and (iii) interaction with their environment (for example, help with carrying out tasks outside the home, travelling, activities to maintain cognitive functions and social relationships). Users of these services must make a monthly co-payment out of their own pocket as stipulated in their individual care plan, in accordance with the procedure established by the government or, if they use private services, by the firms or organizations managing the services.

In Turkey, there are institutions that offer free services and support to older persons living at home, funded by a combination of general budgetary spending, taxes, municipal budgets and premiums paid by employers and employees. The Ministry of

Health employs multidisciplinary professional teams to provide home services, while the Ministry of Family and Social Policies offers social support, assistance and care in different settings (including the older person's home) and municipalities provide social support, home health services, psychological support, home repairs and maintenance, help with household chores, personal hygiene and cooking, and social activities.

The responsibility for social services in the Netherlands (including certain home care and respite care services) has been transferred to municipalities, which finance them out of a tax-funded grant. The aim is for people to be able to live at home as long as possible and receive the care they need to do so. Under the most recent reforms to the system, local authorities have been assigned a larger role in providing long-term care in the community.

In Singapore, the most prosperous city State in Asia and the world, the Alexandra Health System uses a comprehensive "ageing in place" programme to reduce avoidable hospital admissions and to improve the quality of life of older people. Older people who have a high utilization of hospital services (including emergency care) receive home visits from a community nurse to review their needs and determine which of them may be unmet, develop a care plan and coordinate necessary follow-up. The frequency of visits depends on a person's needs. With this approach, the health system has reduced hospital admissions by 67% and optimized the use of hospital resources.

Globally, though, home care initiatives are still few and far between. In Ireland, for example, the lack of legislation on access to community care is controversial, and there is overreliance on the Nursing Homes Support Scheme (NHSS) owing to a failure to develop other options in the country, such as supported housing or the promotion of "ageing in place" (Donnelly and O'Loughlin, 2015). The report by Garavan, McGee and Winder (2001) concluded that community health and social care services for older people in Ireland were very limited and fragmented. Moreover, there was no official policy framework for the provision of comprehensive home care services for older persons or any corresponding legislation (Timonen, Doyle and O'Dwyer, 2012).

In China's urban areas, home care is provided in large part by paid caregivers, most of whom do not have any training. Most of these caregivers are women with limited formal education who probably migrated from rural to urban areas and who receive relatively low wages for their services (ILO, 2014).

6. Long-term care programmes for older persons in Latin America and the Caribbean

Long-term care services generally have low coverage in Latin America and the Caribbean and operate in a weak institutional framework. In most cases, national programmes that directly or indirectly involve care are incorporated into poverty reduction or social assistance programmes for families or people who are poor, vulnerable or dependent. The right to care is still not enjoyed by everyone.

(a) Home care

Many Caribbean countries have developed programmes to help older persons live independently, examples being home assistance services, nursing at home and day centres, activity centres and centres for older persons who cannot live alone. Numerous countries have launched some type of plan to provide home care services for older persons, including help with personal hygiene, household cleaning, food preparation, shopping for groceries and other necessities, and companionship. These

initiatives provide older persons with the support that they need to keep living at home, which is normally the best way to maintain autonomy. Home care for persons who live independently is also much more cost-effective than full residential care (whose costs are split between the State and the individual, however).

In some countries, such as Barbados and Saint Kitts and Nevis, the State provides basic nursing care in the home as part of a home care or other programme. This may include dressing wounds and checking blood pressure and glucose levels, or providing advice on nutrition, sanitary regulations and other health problems. Caregivers are also trained to detect and report illnesses and cases of neglect, abuse and malnutrition.

(a) Cash transfers to unpaid caregivers

The social security system in Argentina is based on the assumption that families will care for their older members if needed. The State does not offer services of this type to the middle class, which has the oldest age profile in major urban centres, but they are available for poor or neglected persons, while the classes that are better off pay for private care. The only type of care services that the middle class can afford on an ongoing basis are inappropriate, as they involve older persons being kept sedated and restrained, without any kind of stimulation. Families are also changing, with mothers working outside the home and no longer able to care for dependent older persons.

Resolution 0610-13 of Argentina's National Institute of Social Services for Retirees and Pensioners (INSSJP-PAMI) has established a programme of comprehensive financial assistance to provide care for dependent and vulnerable older persons. Its purpose is to provide financial assistance worth US$ 55 a month to members who are dependent or vulnerable because of social and health problems and cannot afford the expenditure this situation entails or lack a social support network commensurate with their needs. Although limited, this financial subsidy is normally used to hire a formal caregiver once or twice a week, which provides some respite for family members in charge of care.

The Joaquín Gallegos Lara benefit was established in Ecuador in 2010 for people with severe and profound disabilities. It is worth US$ 240 per month, which is equivalent to a basic wage, and is paid to those caring for disabled persons so that they can buy food, clothing, transport and basic supplies. The grant programme is managed by the Ministry of Economic and Social Inclusion.

In Chile, the Chile Cares programme is an initiative to lighten the workload of unpaid caregivers. It offers home care services twice a week for moderately or highly dependent older persons. This not only allows them to remain at home but also provides respite to carers, who are, in addition, given the opportunity to participate once per week in self-help groups run by mental health professionals, training workshops, specialist care training, job skills training and educational or recreational activities. To provide this assistance, local women who are unemployed or looking to supplement their income are trained and employed as formal caregivers.

Costa Rica's National Care Network for Older Persons provides basic essential goods to families caring for extremely poor older persons. The initiative aims to create a social structure comprising family members, organized community groups, NGOs and State institutions with a view to coordinating actions, interests and programmes. Those targeted are persons aged 65 and over who are poor or extremely poor, dependent, or socially at risk and who lack support networks. In the first quarter of 2016, the initiative assisted 12,086 people distributed into 53 networks, with an investment of US$ 2,700,000 (US$ 223 per person). Most help is given in the form of food, medicine, hygiene products, household appliances and devices, and payment of rent and basic services, in order to facilitate people's daily living in their own homes. Home helps are

also employed to assist families in caring for older persons, as members of many of these households do not have the time or resources to do so.

Costa Rica's Law No. 7756 creates an entitlement to leave and benefit payments for anyone in wage employment, whether a family member or not, who takes it upon themselves to care for someone in the terminal phase of illness because of an emotional tie or responsibility, with benefits being calculated on the basis of their average wage in the previous quarter.

(b) Surrogate families

In 2010, the Government of Uruguay passed resolution 863/2010 creating a working group to coordinate the planning of the National Care System within the framework of the Social Affairs Office. One component of the system is a hospital-based service for care and community integration, which carries out and encourages the reintegration of older persons into their communities within surrogate families, where one family member acts as a caregiver under a paid services contract. The older person becomes part of the family and receives multidisciplinary support and assistance (geriatric, psychiatric, nursing, social) from the Luis Piñeyro del Campo Hospital.

There is a similar initiative in Costa Rica for extreme cases in which older persons have no family support. Surrogate families agree to take full responsibility for their care, under the strict supervision and with the financial support of the Progressive Comprehensive Care Network for Older Persons and community nursing homes, which provide long-term residential care.

(c) Training in the care of older persons

In Argentina, the National Home Care Programme trains people over the age of 18 interested in providing primary care for older persons who have no family or relatives and who need help with activities of daily living. Training is provided in different care tasks such as administering oral and topical medication prescribed by medical professionals, preparing food and assisting with feeding, helping with personal hygiene and grooming, and preventing accidents. The course is geared towards people who work as caregivers and want to improve their skills or those who have a vocation for this line of work and wish to pursue a career in it. There are nine modules in total, taught by teachers, professionals and a specialist coordination team. The programme lasts four months, including 200 hours of theory and 148 hours of practical work. Once students have completed the course, they receive a certificate from the Ministry of Education that allows them to work as professional caregivers.

The Ministry of Health in Brazil runs the National Elderly Care Training Programme, which focuses on encouraging communication between older persons and their families, and offers tools and strategies to use in situations of emergency or risk.

In Cuba, the School for Caregivers is a psychoeducational programme taught by a multidisciplinary team of professionals who train family members acting as primary or secondary carers for dependent persons in the appropriate care and treatment of their charges and themselves.

The National Training Programme for Caregivers of Older Persons of the Mexican Social Security Institute (IMSS) trains voluntary workers to provide gerontological support, companionship and care for older persons. This training is part of the Institutional Geriatric Plan and the Active Ageing Programme, which aim to maintain, extend and recover the functionality and the physical, mental, emotional and social independence of this section of the population.

The Social Security Institute (IPS) in Paraguay has been offering a training course for caregivers at the Dr. Gerardo Buongermini Geriatric Hospital for the past three years, with training focused on the biopsychosocial and spiritual aspects of care. The course seeks to improve the quality of life not only of older persons, but also of caregivers. The Social Security Institute is arranging for the course to be officially recognized by the Ministry of Public Health and Social Welfare and the Ministry of Education and Culture, so that students can obtain a degree and accreditation from these official bodies.

C. Protection shortcomings and challenges

Although the subject of elder abuse can no longer be ignored, detection, visibility and appropriate intervention continue to pose challenges. Certain behaviour patterns or physical conditions in an older person are often assumed to be due solely to their advanced age or poor health.

At the same time, the vulnerability of older persons is reflected, for example, in the failure to properly tackle violence against this population segment in national legislation, which is limited to soft measures of very limited scope. This approach tends to be particularly detrimental to older women.

The progress made by the countries of the region in preventing and eradicating abuse will depend on the commitment of the various stakeholders and disciplines involved, on the development of a solid human rights base and on national legal frameworks that support the elimination of elder abuse. This legislation must be accompanied by increased awareness, or the number of older persons willing to press charges against their abusers will continue to be small, even with stricter laws. These older persons may experience contradictory feelings: powerlessness and rage towards their abusers mixed with gratitude and sometimes affection.

Many older persons are not able to file complaints of abuse, especially when it occurs in institutions, where it often develops into torture or cruel treatment. Such high incidences of mistreatment in nursing homes and hospitals may stem from cultural attitudes linked to a paternalistic and overprotective approach, but this does not excuse these crimes.

There is a need to change people's thinking and put a limit on this type of behaviour; otherwise, older persons will end up institutionalized and tied to chairs so that nothing will happen to them. According to the Spanish Confederation of Organizations for Older Persons (CEOMA), living means taking risks, and the myth that physical restraint prevents falls or improves behaviour should be discarded; if it is not, the result can be the loss of autonomy, dignity and self-esteem, as well as greater physical deterioration, because forcible restraint leads to bone atrophy and a greater risk of injury if a fall does take place (Arrarás, 2011).

Neither professionals nor laypeople will be able to detect abuse if they assume that an older person's behaviour or physical state is caused by old age or ill health alone. Without awareness, only severe cases of abuse will command attention, as abused older persons who do not utilize health care or social services are unlikely to be identified (United Nations, 2002).

Awareness-raising has been strengthened on the global agenda by United Nations General Assembly resolution 66/127, which designated 15 June as World Elder Abuse Awareness Day, a time for expressing opposition to the abuse and suffering inflicted on older persons.

In the Americas, the Inter-American Convention on Protecting the Human Rights of Older Persons provides a legal framework for the development of national initiatives to protect older persons from violence and abuse. Nonetheless, it is vital to appreciate that any action must be based on a change of perspective in the conceptualization, analysis and treatment of abuse.

Abuse must be treated as a problem for society as a whole and not just for the people affected. According to the Inter-American Convention, States have obligations towards older persons in this respect and should invest considerable public resources in services and specialized personnel to fulfil them. There continues to be a lack of information on this issue, and there is a need for educational programmes to help implement measures successfully, insurance schemes to put older persons who have been victims of domestic violence in a better position to take decisions so that they can regain their independence, priority access to housing, financial support, training, and a decent pension or a job for those able to hold one.

As long as the problem continues to be treated merely as an assistance and prevention issue, any real progress in sanctioning and eradicating violent acts against older persons is unlikely. The Inter-American Convention is the first legally binding international instrument to have established a general legal framework for preventing violence, protecting victims and calling aggressors to account. Nonetheless, it has only been ratified by three countries to date.

Although the long-term care situation has improved since 2012, there is still work to be done. Both the general and specific legal frameworks in the region's countries and the current range of social programmes for the protection of older persons reveal a growing concentration of care-related risks in families. This increases the vulnerability of those in need of care and those providing it, who as things stand are directly affected by inequality in the distribution of resources by family background.

As a result, one of the greatest challenges between now and 2030 is achieving recognition and inclusion of care in public policies within a framework of solidarity and equality. ECLAC has insisted on the need for social protection to be recast so that it can immediately respond to the consequences of demographic shifts and pre-empt the demands of a constantly changing population.

There needs to be a move towards categorizing long-term care as a collective responsibility to be met by means of benefits and services that maximize the autonomy and well-being of families and individuals within the framework of social protection systems. The public response to this issue should be considered a State responsibility entailing certain immediate obligations towards those in need of assistance and those providing it.

As documented in this chapter, demand for long-term care will continue increasing in the region. However, Latin American societies' ability to offer long-term care to their members is limited: according to estimates for the first half of the twenty-first century, provision cannot be expected to amount to one person for every member needing help. It might be enough to meet some of the demand, but not the needs of those requiring constant, intensive and specialized daily care.

A country's demographic capacity to provide assistance is determined by the sociocultural and economic context, in which three key factors stand out: the gender inequality characterizing the division of care tasks (Rico and Robles, 2016), generational differences in the exercise of solidarity, and income inequalities, which translate into vulnerability for specific population segments. The region's heterogeneity in this respect is obvious. The current demographic composition of the burden of care and the availability of potential caregivers differs from one country to the next depending

on the stage they have reached in the demographic transition, and while protection systems are well developed in some countries, they have grown weaker in others.

Against this backdrop, the establishment of a public long-term care policy is more important than ever. The reasons go beyond even demand, as care for older persons can represent a growing contribution to employment in many countries' economies.[6] In addition, the almost complete lack of provision for this type of care in social protection systems may mean that older persons may ultimately not receive the help they need in an appropriate, accessible and timely manner. The result is that a considerable percentage of the population is excluded from social services, and even their assets and income may be jeopardized as they seek help to carry out basic activities of daily living.

As can be seen, the need for care is multifaceted, but it does not essentially differ from that which humans have always had at different stages of the life cycle. Nonetheless, the context in which it is provided at present means that its social and economic implications will depend much more than formerly on the institutional arrangements of each country, both public and private, something that affects not only the sharing of responsibility for the provision of well-being between the State, the family, the market and the community, but also generational and gender compacts in this area.

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[6] For example, taking into account population ageing and the expected decline in the availability of family caregivers, it is estimated that demand for long-term care in OECD countries will require a doubling of the number of long-term care workers as a percentage of the active population by 2050 (Colombo and others, 2011).

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Chapter

VI

From lessons learned to strengthening institutions and public policies

The world is going through a period of unprecedented and probably irreversible, demographic change, leading to population ageing. There can be no disregarding the fact that the global population aged 60 years and over —currently nearly 900 million— is projected to rise to 1.4 billion by 2030. This inversion of the age pyramid is having an impact on global issues such as climate change, human trafficking, development planning, trade and well-being.

Population ageing has profound human rights implications, because it opens up new possibilities and presents unprecedented challenges for citizenship-building in the twenty-first century. First, it calls for a reconciliation of the needs and interests of all social groups within a framework of interdependence, in which all individuals have an active role to play both for their own benefit and for the benefit of others. Second, it entails a body of subjects who demand particular treatment on the grounds of age, and introduces new demands for the expansion, specification and deepening of human rights.

ECLAC has firmly upheld the idea that a human rights approach is the best way to address the situation of older persons, because it discards the classic simplification in which old age is associated with losses, placing the focus instead on equality and non-discrimination. Furthermore, it identifies State obligations to protect and empower older persons as rights-holders.

Over the past five years, regional intergovernmental organizations in Africa, Europe and the Americas have been working to prepare and adopt instruments to ensure the rights of older persons. These very efforts, however they may vary in nature, show that there is a need to standardize older persons' rights with a minimum threshold of parameters to guarantee dignity in old age. The rights protection and specification developed at the regional level must now be reflected at the national level through guarantees to ensure their observance.

Civil society organizations have played a key role in positioning the human rights of older persons on the agenda. In 2012, they petitioned the governments attending the third Regional Intergovernmental Conference on Ageing in Latin America and the Caribbean to include a reference to those rights in the meeting's title.

Accordingly, it was duly agreed in the San José Charter on the Rights of Older Persons in Latin America and the Caribbean that the name of the Conference would be changed at its next meeting. Thanks to this initiative, the fourth meeting of this intergovernmental body —to be held in Paraguay from 27 to 30 June 2017— will be entitled Fourth Regional Intergovernmental Conference on Ageing and the Rights of Older Persons in Latin America and the Caribbean, reflecting the wishes and efforts of civil society.

The change in the Conference's name has implications for the discussions and for the decisions that the countries will adopt, for the proposals that civil society will put forward, and for the mandate of ECLAC regarding ageing and older persons.

ECLAC has prepared this report in the framework of that mandate. The report outlines the advances, limitations and challenges in promoting, respecting, protecting and fulfilling the rights of older persons in the countries of the region, in a scenario where international commitments on the subject have been promising but insufficient, above all because of persistent weaknesses in the development of institutional and citizen guarantees.

In this regard, the Inter-American Convention on Protecting the Human Rights of Older Persons, developed over the past five years, represents a landmark for the region

For the first time, countries of the region have a legally binding instrument that identifies State obligations regarding older persons. The Convention also goes some way to remedying the lack of consideration afforded older persons in international human rights law.

and the world. For the first time, countries can refer to a legally binding instrument that sets forth State obligations regarding older persons. The Convention also introduces new rights and goes some way to remedying the lack of consideration afforded older persons in international human rights law.

The implementation of the Convention is just beginning. States will now have to work to establish mechanisms to guarantee the freedoms and rights it establishes. This is a task that calls for innovation, transparency, skilled personnel and the allocation of public funds.

The experience with the implementation of the Madrid International Plan of Action on Ageing and its regional translations offers useful lessons in relation to the obligations undertaken in the Inter-American Convention. Without question, one key asset of the agreements enshrined in ECLAC regional instruments is their promotion of more comprehensive approaches to government treatment of matters relating to older persons. This lesson is crucial in the current scenario.

Since 2003, several countries have made achieved notable progress. For example, the mistreatment of older persons has been established as a public issue, laws have been created to protect their human rights, action has been taken to preserve their autonomy and provide care in situations of fragility, and medium-term planning has been restored in the form of national plans and administrative reforms to bring institutions responsible for older persons within the remit of social ministries.

Some of these initiatives have withstood the test of time, others less so. Over the past five years, some have suffered from lack of adequate methodology, technical follow-up or regular evaluations. Many have suffered budgetary constraints, while others have failed to generate the political will to survive a change in administration. Consequently, various programmes that began five years ago have ceased to exist. Some national institutions serving older persons have even slipped down in the government hierarchy or been shifted to different government departments. In this regard, they have been less resilient than institutions serving women or children.

A regionwide evaluation of action in support of older persons shows that —with notable exceptions— such action has not permeated all areas of government responsibility and that issues concerning the older population tend to be confined to specific entities or sectors. The efforts of ageing-related institutions or authorities sometimes run up against structural limitations that threaten their credibility and undermine the trust invested in them by older persons.

These factors, along with the scarcity of skilled personnel and only incipient standardization of rules and processes, place severe constraints on what institutions can achieve. Unless this changes, effective implementation of the Inter-American Convention on Protecting the Human Rights of Older Persons will be a difficult task over the coming years.

Older persons and their organizations are clear on this point. Accordingly, their most frequent demands over the past five years have included a higher organizational status to be accorded to the institutions that represent them, and for their issues to be addressed from a human-rights perspective. This latter aspiration is no coincidence. Older persons and their organizations are increasingly aware that the manner in which their issues, needs and interests are treated in government discourse influences society, its understanding of their situation and its appreciation of their contributions.

Given the approaching demographic changes and the central role that older persons' institutions will be called upon to play in the implementation of the Inter-American Convention and other multilateral instruments, these trends must be reversed. Institutions must be strengthened in order to take on responsibilities that are expanding and diversifying. Older persons must also be provided with broader forums to participate in matters that affect them.

In this regard, consistent planning is crucial. Public policies must begin by treating older persons as subjects of law in order to make a real difference to their situation. They must provide decent standards of living and combat discrimination. They must also take intergenerational interdependence into account, for there can be no development if young people's wages are stagnating or falling, if women have gaps in social security contribution owing to maternity leave or time taken to shoulder the care burden, or if private pension systems widen inequality.

Now is the time to act, and to take a long-term view in our approach to ageing and older persons. Now is the time think realistically and boldly about the future; to fulfil commitments too long postponed. Above all, it is time to empower and create opportunities for all generations, and especially for older persons, in a framework of interdependence and solidarity.

Rapid population ageing in Latin America and the Caribbean brings multiple challenges and requires action to ensure the fair distribution of resources to meet the needs of all age groups in society. It also requires a change in attitudes, policies and practices to improve older persons' quality of life. In this regard, the effective inclusion of older persons has to do with equitable access to different services and social and economic benefits, as well as the guarantee of their human rights.

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