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Towards a Regional Strategy for the Implementation in Latin America and the Caribbean of the Madrid International Plan of Action on Ageing

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This document was prepared by the ECLAC Population Division – Latin American and Caribbean Demographic Centre (CELADE), with support from the agencies members of the Inter-Agency Working Group on Ageing: Pan American Health Organization (PAHO), United Nations Population Fund (UNFPA), World Bank, Inter-American Development Bank (IDB), International Labour Organization (ILO), United Nations Programme on Ageing and United Nations Population Division.

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INTRODUCTION

As the demographic transition forges ahead, Latin America and the Caribbean is gradually but inexorably ageing. This is a region-wide process, as all the countries are advancing, albeit at different speeds, towards the "greying" of their societies. Two features of this process are of urgent concern. First, the rate at which population ageing is taking place and will continue to take place in the future is faster than the rates recorded in the past by today's developed countries. Second, the environment in which this process is occurring is marked by high levels of poverty, persistent and acute social inequity, institutional underdevelopment, low social security coverage and a probable trend towards decreased family support owing to the decline in fertility.

In view of these circumstances, the countries will have to make radical changes in their public policies to adapt them to a society in which the proportion of young people will progressively shrink while that of older adults will grow. These changes will involve the readaptation of the social services infrastructure (for health care, education, housing and other components) and the restructuring of public functions in terms of technical capacities. It is also important, however, to pave the way for a cultural shift towards more inclusive societies in which older persons are valued participants and subjects of rights, in the framework of a "society for all ages".

It is true that population ageing has been recognized at an early stage, that more developed countries have accumulated experience in this regard and that the poorest countries with the most underdeveloped institutions are precisely the ones in which population ageing has advanced the least. Nevertheless, for the countries in which this process will progress the fastest, the time for action is limited and the experience of more advanced countries is of little use in helping them find viable alternatives, since those countries' economic, institutional and historical circumstances are different. In addition, the poorer countries, which have more time to act because their ageing processes are still incipient, have more serious institutional weaknesses and greater difficulty in building a long-term vision owing to the urgent need to solve immediate problems.

These considerations are not intended to imply a fatalistic view of the coming changes. Population ageing is, first and foremost, a sign of the progress and success achieved in reducing mortality and controlling fertility. Moreover, older persons are still major net contributors of support for both their families and their communities, and the vast majority of older persons are self-sufficient. Accordingly, this phenomenon should be understood in all its aspects and timely steps should be taken to plan measures for guaranteeing the right of all individuals to a dignified old age.

This document presents an analysis of the situation in each of the priority areas identified at the Second World Assembly on Ageing, held in Madrid in 2002. It also offers an analysis of legal frameworks, policies and programmes on ageing in the region and a summary of the priorities that should be taken into account.

I. THE DEMOGRAPHICS OF AGEING

1. Manifestations of population ageing

One of the most significant effects of the unprecedented changes which the region's population dynamics have produced and which will be expanded and consolidated in the first half of this century is population ageing. From a demographic standpoint, ageing has two facets. First, it is manifested as an increase in the relative proportion of people over the age of 60 out of the total population; and second, it takes the form of increased longevity. That is, the effects of the increase in average life expectancy include an increase, within the category of older persons, in the proportion of people aged 80 or over —and even the emergence of a small number who reach 100— and a lengthening of the period of time between retirement and death.

In all the Latin American and Caribbean countries the proportion and the absolute number of people aged 60 or over will rise steadily in the coming decades (see table 1). In absolute terms, between 2000 and 2025, 57 million more older persons will be added to the 41 million currently living in the region; between 2025 and 2050, this increase will amount to 86 million people.[1] This is a fast-growing population whose rate of increase (3.5%) exceeds that of younger age groups. In fact, this population group will grow three to five times faster than the total population between 2000 and 2025 and between 2025 and 2050.

Table 1
INDICATORS OF POPULATION AGEING IN LATIN AMERICA AND THE CARIBBEAN 2000, 2025 AND 2050

Indicators	2000	2025	2050
Population aged 60 or over (thousands)	41 284.7	98 234.8	184 070.7
Percentage of people aged 60 or over	8.0	14.1	23.4
Annual growth rate (2000-2025 and 2025-2050)	3.5	2.5	...
Percentage of people aged 75 or over	1.9	3.5	7.9
Median age of population	24.6	32.5	39.4
Ageing index[a]	25.2	60.7	128.2

Source: ECLAC Population Division - CELADE. Demographic projections as of 2003.

[a] Population over 60/population under 15.

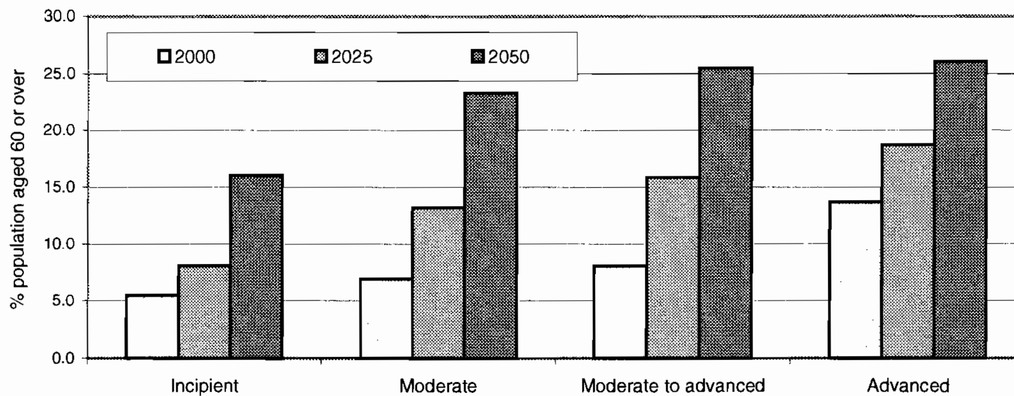
As a result of this dynamic, the proportion of people over 60 will triple between 2000 and 2050, so that by the latter date, one out of every four Latin Americans will be an older adult. Owing to the increase in longevity, the proportion of people near the upper limits of the category of older adults will grow, with the population over 75 rising from 2% to 8% between 2000 and 2050. Two indicators of age

[1] The data presented in this document are based on projections which, by their very nature, have some degree of uncertainty. The major demographic trends they predict are nevertheless unlikely to be proved wrong, since the people who will make up the older population in the next 60 years have already been born.

structure clearly illustrate some of the demographic implications of this process. First, the population's median age will rise by 15 years between 2000 and 2050, with the result that by 2050 half the population will be over the age of 40. The ratio of older persons to children will therefore change dramatically. Currently, there are 25 older adults for every 100 children; by the end of the first half of this century, older persons will outnumber children by 28%. The majority of older persons are women. They represent 55% of the group aged 60 or over, but more than 60% of the group aged 80 or over.

Within the region, the situation varies widely from one country to another. To reflect this, the countries were divided into four categories according to the current stage of their ageing processes (see figure 1).[2]

Figure 1
PERCENTAGE OF THE POPULATION AGED 60 OR OVER, BY STAGE OF POPULATION AGEING, 2000, 2025 AND 2050



Source: Table A.1, annex.

One group of countries, in which population ageing is incipient, includes Bolivia, Guatemala, Haiti, Honduras, Nicaragua and Paraguay. In these countries the percentage of people aged 60 or over ranged from 5% to 7% in 2000 and will probably be between 15% and 18% in 2050. This process could speed up if the trend towards lower fertility rates in these countries continues and intensifies.

In a second group of countries, which is experiencing moderate population ageing, the proportion of people aged 60 or over is between 6% and 8% and is likely to exceed the 20% mark by 2050. Belize, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guyana, Mexico, Peru and Venezuela are in this group. These countries saw major changes in fertility rates between about 1965 and 1990.

They are followed by the countries with moderate to advanced population ageing, whose percentages of older persons currently range from 8% to 10% and will rise quickly to reach 25% to 30%. This group includes the Bahamas, Brazil, Chile, Jamaica, Suriname and Trinidad and Tobago.

[2] The countries were grouped according to the total fertility rates and ageing indices they posted in the 1990s. Some countries may change categories if new census data result in significant corrections of the estimates.

Lastly, the group with advanced population ageing includes countries such as Uruguay and Argentina, which are on the leading edge of population ageing in Latin America, along with Cuba and other parts of the Caribbean (Netherlands Antilles, Guadeloupe, Barbados, Martinique and Puerto Rico).

In sum, the data confirm that the population ageing process, though not uniform, is taking place throughout Latin America and the Caribbean and that older persons in the region will represent an increasingly significant proportion of the total population. By 2050 the proportion of older adults in a great many Latin American countries will have equalled the proportions observed today in the developed countries (United Nations, 2002).

2. Determinants of population ageing

The factors underlying population ageing in the countries of the region are the decline in fertility and the increase in life expectancy observed in the region's population over the last four decades of the twentieth century. With regard to fertility, since the mid-1960s the region has witnessed a dramatic and steady decline in the number of children per woman (see table 2). All the countries now deemed to be at the incipient and moderate stages of population ageing had fertility rates of over six children per woman in the mid-twentieth century. While fertility had begun to decline much earlier in certain countries, such as Argentina, Uruguay and Cuba —which are now, consequently, at an advanced stage of population ageing—, it did not begin to change until the middle of the last century in the other countries, and continued to fall fairly steadily in subsequent decades.

Table 2
LATIN AMERICA AND THE CARIBBEAN: LIFE EXPECTANCY AT BIRTH AND TOTAL FERTILITY RATE, BY CATEGORY OF POPULATION AGEING, IN SELECTED PERIODS

Category of population ageing	**Life expectancy at birth**				
	1950-1955	**1970-1975**	**1995-2000**	**2020-2025**	**2045-2050**
			Life expectancy		
Incipient	42.9	52.8	64.3	72.2	77.4
Moderate	49.9	61.7	71.4	76.0	79.2
Moderate to advanced	51.7	60.3	68.6	74.6	78.6
Advanced	62.8	68.7	73.9	77.9	80.6
Total Latin America and the Caribbean	**52.1**	**61.4**	**70.0**	**75.3**	**78.9**
			Total fertility rate		
Incipient	6.8	6.4	4.5	2.6	2.1
Moderate	6.8	5.9	2.9	2.1	2.1
Moderate to advanced	6.0	4.6	2.3	2.1	2.1
Advanced	3.5	3.2	2.3	2.0	2.1
Total Latin America and the Caribbean	**6.0**	**5.1**	**2.8**	**2.2**	**2.1**

Source: Prepared on the basis of population estimates and projections by the ECLAC Population Division - CELADE (2003) and the United Nations (United Nations, *World Population Prospects,* 2000).

This decline in fertility was observed even in countries that had no family planning programmes, and withstood the recessionary cycles of the "lost decade" of the 1980s, military dictatorships, political violence and structural adjustment processes; what is more, it has held steady in a region where indices of exclusion, vulnerability and poverty are high. In the last five years of the twentieth century the total fertility rate reached a regional average of 2.8 children per woman and, while rates in the different countries still vary considerably, all of them are under 5 children per woman. Projections for the next 25 years indicate that the decline will continue and that the differences across countries will tend to even out.

For 2025 onward the hypotheses used in making the projections point to a virtual convergence in all the groups of countries towards 2.1 children per woman, which is the population replacement rate. Nonetheless, some countries (such as Cuba, Barbados and Martinique) already have fertility rates of fewer than 2 children per woman (the replacement rate), while others (Chile, Brazil, Mexico and other Caribbean countries) may, according to the most recent estimates, have lower-than-expected fertility rates in the next few years and, accordingly, faster population ageing as a result of the decline in the younger population.

Another major change in this connection is the remarkable progress made in reducing rates of premature death. Between 1950 and 2000 life expectancy at birth increased by an average of 18 years, reaching 70 years in 2000 (see table 2). By 2025 life expectancy will have increased to almost 75 years, and by 2050, to about 80 years. Differences between countries at different stages of the population ageing process are narrowing and the countries are expected to show very similar figures in the near future, to the extent that the smallest gains are made in the countries whose ageing processes have advanced the most. Moreover, gender-specific trends in life expectancy at birth consistently show that women are likely to live longer: the gap between women and men in this regard widened steadily from 3.4 years to more than 6 years between 1950 and 2000.

Life expectancy at age 60 is a more precise indicator of longevity. Data for the region show that in 2000 this indicator averaged about 20 years (17 years in Haiti and 26 years in Guadaloupe and Martinique).[3] These figures are substantially higher among women than among men: while women who reach the age of 60 in the period 2000-2005 are expected to live for another 21 years (regional average), the remaining life expectancy for men who reach the age of 60 is three years shorter. By 2045-2050 it is projected that women's life expectancy at age 60 will have continued to rise, reaching values of close to 24 years (28 years on the above-mentioned Caribbean islands). For men, however, this value will rise to only 22 years (23 years on the islands mentioned).

3. International migration, internal migration and patterns of urban-rural residence among older adults

The other demographic variable that can have an effect on population ageing is migration. The selective emigration of young people hastens the ageing of their populations of origin. Mexico's high rate of international migration, for example, has had a severe impact on the age structure of certain communities. Some Caribbean nations have experienced population ageing because of the emigration of young people and the return of older adults after retirement. In such cases, the older, non-emigrant population faces a

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[3] Latin American and Caribbean Demographic Centre (CELADE) (2002), *Los adultos mayores en América Latina y el Caribe. Datos e indicadores*, CELADE, Santiago, Chile, Boletín informativo. United Nations (2002), *World Population Ageing 1950-2050*, Sales No. E.02.XIII.3, New York.

severe shortage of family support, which may be partially offset, at least in monetary terms, by remittances received from relatives abroad.

Older adults also make up a smaller share of internal migrants than other age groups, regardless of the scale of such migration. According to the 2000 round of censuses in the region, only 2% to 6% of persons aged 60 or over were living in a major administrative division other than the one they had lived in five years before the census was taken. The observation that older persons are less likely to migrate also holds true in the case of migration between smaller administrative divisions (municipalities, parishes or districts), even though this kind of move normally involves shorter distances and lower costs.

While older persons migrate less, the emigration of the population in other age groups, especially young adults, has a significant impact on population ageing in the areas from which they emigrate. This is true of rural-to-urban migration. Population ageing is more advanced in rural areas than in urban ones, despite the rural population's higher fertility and lower life expectancy. In more than half the Latin American countries, the proportion of older adults living in rural areas is higher than the proportion living in urban areas. Older adults in rural areas are a population group that requires special attention, since rural areas have historically had lower service coverage and more pronounced economic deterioration, in addition to the shrinkage of the family support network through the emigration of children and younger relatives.

Older persons living in cities tend to be concentrated in more central areas because of the emigration of younger generations to new neighbourhoods. These micro-areas are an important focus for policies to benefit older adults, since they have a high density of older persons and, while they may in some cases offer easier access to services than do peripheral areas, in some major cities these central areas are run-down and unsafe.

4. Urbanization

Although rural areas tend to have older populations than urban areas, most older persons in Latin America and the Caribbean live in urban areas and thus do not differ significantly from other age groups in this respect. In the region as a whole over 70% of the older population currently lives in cities, and this proportion is expected to rise to over 80% by 2025. It should be noted, however, that in some countries, such as Guatemala, Haiti and Honduras, a high proportion of the population, and over half of all older adults, still live in rural areas.

5. Living arrangements of older persons

Household composition has major implications for the quality of life of older persons, especially in situations of economic hardship and poverty. Living together, while it may not necessarily be a desirable option in some cases, creates an ideal environment for the transfer of support —consisting of instrumental and emotional exchanges as well as economic ones— among family members. Towards the end of the 1990s, one out of every four households in the region included an older person,[4] and a clear majority of older adults —8 out of every 10, according to the 1990 censuses, and at least 2 out of 3, according to

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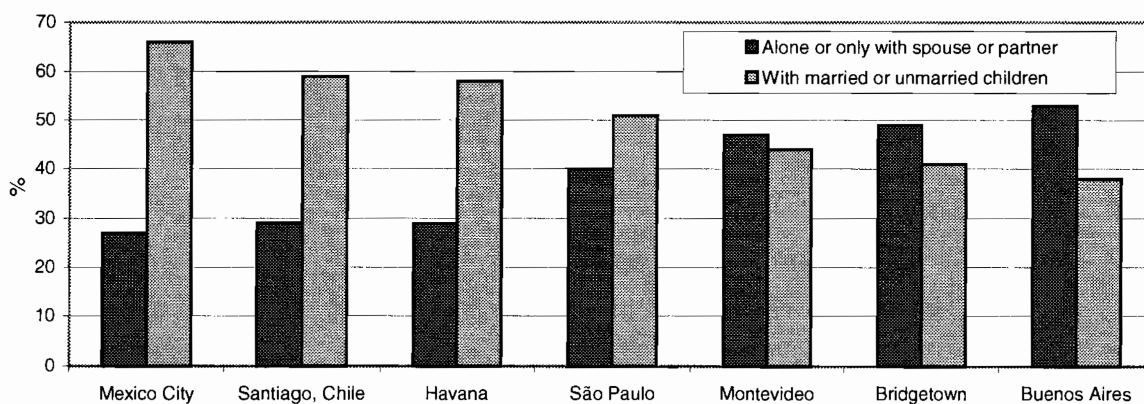
[4] ECLAC/CELADE (2002), *Los adultos mayores en América Latina y el Caribe: datos e indicadores*, Santiago, special edition.

urban household surveys from 1997— lived in multigenerational households.[5] According to recent data based on health, well-being and ageing surveys conducted in cities in seven Latin American and Caribbean countries, a large proportion of older persons (40% to 65%) live with their children, with the biggest proportions found in Mexico City, Santiago and Havana and the smallest in Buenos Aires, Montevideo and Bridgetown (see figure 2).[6] Conversely, the percentage who live alone or with only their spouse or partner shows the opposite trend, as it approaches or exceeds 50% in the latter three cities.

Figure 2

PERCENTAGE OF PERSONS AGED 60 OR OVER, BY LIVING ARRANGEMENTS, IN SELECTED LATIN AMERICAN AND CARIBBEAN CITIES, 2000



Source: Health, well-being and ageing surveys analysed by Saad (2003), "Transferencias informales de apoyo de los adultos mayores en América Latina y el Caribe: estudio comparativo de encuestas SABE", *Notas de población*, ECLAC Population Division – CELADE.

According to census data, living alone is not very common in Latin America. For the most recent years available (between 1995 and 2001), this indicator ranged from 5% to 16%, with Uruguay and —surprisingly enough— Bolivia being the countries with the highest percentages. In most of the countries more women than men tend to live alone, probably because they are less likely to enter into a new relationship after widowhood or separation. In addition, the proportion of people living alone is generally higher in rural areas than in urban ones.[7] Lastly, there does not appear to be any region-wide trend towards living alone as the population ageing process advances. For example, more or less steady increases have been observed in some countries (Brazil, Bolivia, Chile and Costa Rica), while in others (Panama, Mexico and Ecuador) the percentage of people living alone has been relatively stable or erratic.

[5] As might be expected, in the countries with the oldest populations, such as Uruguay, households with older adults represent nearly half of all households, but in no country of the region is the percentage of households with at least one older adult less than 20% (ECLAC (2000), *Social Panorama of Latin America, 1999-2000*, Santiago, LC/G.2068-P).

[6] Except in Mexico and Cuba, the proportion who live with at least one married child is much lower than the proportion who live with unmarried children only; in Cuba, this may be related to housing shortages.

[7] Brazil is an exception, since its non-contributory rural pension programmes have made older adults the rural residents with the most stable incomes, attracting other family members to their households.

6. Partnership status

According to recent census data, between 70% and 85% of older adult men and between 55% and 60% of older adult women report that they are married or living with a partner. This difference between the sexes in terms of partnership status reflects a combination of women's higher rates of widowhood (because the husband is usually older) and men's greater tendency to find a new partner after a relationship has been dissolved by widowhood or separation. This profile of partnership status changes at older ages, with widowhood, especially among women, increasing to the point of representing the majority status among people aged 85 or over. The proportion of widowed older women is significant in some countries, especially those with higher past mortality rates among men. In Bolivia and Mexico, for example, one out of every four older women is widowed, in contrast to rates of 6% and 9%, respectively, among older men in those countries.

7. Education

Older persons are among the population groups with the lowest levels of education, since their formative years date back to a time when the coverage of the region's formal educational system was far less extensive than it is today. Illiteracy rates are highest among people aged 60 or over, ranging from about 50% in Bolivia to about 13% in Chile. Nearly all the countries show gender disparities unfavourable to women, with the exception of Costa Rica, where the illiteracy rate is lower among women because of less gender inequality in access to Costa Rica's educational system in the first half of the twentieth century. The gap is enormous in some countries, such as Bolivia, and very small in others, such as Chile and Panama. Lastly, illiteracy rates are much higher in rural areas, exceeding 80% among older adult women in rural Bolivia. The main point to bear in mind, however, is that in all the countries new generations of older persons will be considerably better educated than the current generation thanks to the progress made in the field of education over the past four decades.

II. SITUATION IN THE THREE PRIORITY AREAS

The Madrid International Plan of Action on Ageing adopted at the Second World Assembly on Ageing put forward policy recommendations for improving the quality of life of older persons in three priority directions: older persons and development, advancing health and well-being into old age and ensuring enabling and supportive environments. In the following sections, the situation in the region in each of these areas is analysed and the most important issues are identified.

A. ECONOMIC SECURITY

Rapid population ageing has economic impacts at both the aggregate and individual levels. Older populations put strong pressure on pension systems, making it harder for countries to keep them solvent and sustainable, especially in the case of pay-as-you-go systems. Because of these difficulties, people may not have enough economic resources to meet their needs in the final stage of life. The problem of how to guarantee economic security in old age, which is considered the most important component of the priority direction termed "older persons and development" in the Madrid Plan of Action, is one of the most complex policy challenges currently faced by the countries.

A person's capacity to obtain goods in general, both economic and non-economic, is a key factor in determining his or her quality of life in old age. The economic security of older persons can thus be defined as their capacity to independently and regularly obtain and use a sufficient amount of economic resources to enjoy a good quality of life in their old age.[8] Economic security enables older persons to meet objective needs for creating a good quality of life and to enjoy independence in their decision-making. It also enhances their self-esteem by enabling them to play significant roles such as supporting younger generations and relatives who cannot fend for themselves and participating in daily life as citizens with full rights.

The amount of resources needed is not standard and depends on the person's age, state of health, living arrangements, previous consumption patterns and enjoyment of State benefits in the form of free services or subsidies. Economic security can be provided in a variety of ways: through income-generating work, savings (physical and financial assets), social security systems and support networks, primarily those consisting of family members.

1. Situation of economic security in the region

Economic security conditions in Latin America and the Caribbean are deficient, unequal and inequitable. As shown in figure 3, more than a third of the region's inhabitants aged 65 or over, including both urban and rural residents, have no income, pension or retirement plans or paid work. Two out of every five older persons in urban areas have social security income, whereas the proportion is just one out of five in rural areas. Work is therefore the primary source of income for older persons in rural areas.

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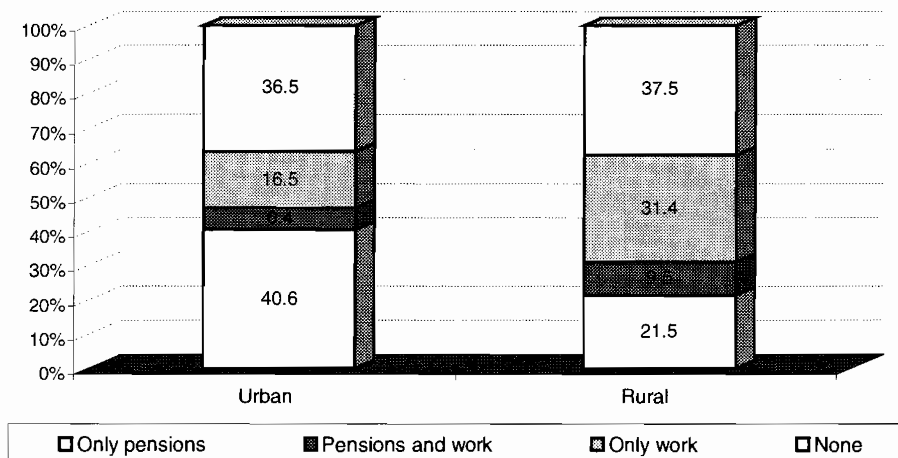
[8] Guzmán (2003), "Seguridad económica en la vejez: una aproximación inicial", paper presented at the IDB/ILO/ECLAC meeting of experts on the economic security of older adults, Panama City, 9-11 April 2002.

Figure 3
INCOME SOURCES OF THE POPULATION AGED 65 OR OVER, URBAN AND RURAL AREAS OF LATIN AMERICA, CIRCA 1997



Source: ECLAC, on the basis of data presented in the *Social Panorama of Latin America, 1999-2000* (LC/G.2068-P), Santiago, Chile. United Nations publication, Sales No. E.00.II.G.18, August 2000.

These figures differ widely from one country to another. In urban areas, in 8 out of the 16 countries for which information is available (see annex table A.2), half or more of the population aged 60 or over has no income of any kind. The situation is more or less the same in rural areas, since older persons continue to work and receive some income as a result of this economic participation.

2. Economic participation in old age

A significant proportion of the region's older adults are economically active, in contrast to the trends observed in developed countries. For example, in the United States in 1999, only 17% of men and 9% of women over 65 were still working; in Mexico, data from the 2000 census showed that 67% of men over 60 and 43% of those over 65 were still active. Among women, economic activity declines as age increases, and only 10% of women aged 65 or over are still active.[9] Activity rates are systematically higher in rural areas; in Bolivia, for example, over 60% of rural inhabitants aged 60 or over are still active, whereas the proportion is only 38% among city dwellers in this age group.

While participation rates among older persons were falling steadily at one point, over the past decade they have risen in many of the countries. Out of a group of 11 countries in the region, most saw an increase in participation rates among people aged 60 to 64 and among those aged 65 or over (see table 3). This trend is probably due to a combination of factors related to pension reform, specifically increases in the legal retirement age and in the number of years of contributions required in order to receive a pension. Other factors may also prompt people to stay economically active for as long as they can. For example, a person's pension benefits may be very modest or unavailable because he or she has not made the necessary social security contributions.

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[9] Guzmán (2002), op. cit.

Table 3
ECONOMIC ACTIVITY RATES OF THE POPULATION AGED 60 TO 64 AND 65 OR OVER IN SELECTED LATIN AMERICAN COUNTRIES, 1990 AND 2000

Country	Years	Age 60-64		Percentage change	Age 65 or over		Percentage change
		1990	2000		1990	2000	
Argentina	1990-2001	33.1	48.5	46.5	9.9	13.0	31.3
Brazil	1990-1999	41.8	47.1	12.7	19.7	25.5	29.4
Chile	1990-2000	36.9	42.6	15.4	14.5	17.5	20.7
Colombia	1992-2000	43.1	40.3	-6.5	21.3	19.2	-9.9
Ecuador	1994-2001	52.7	67.7	28.5	34.1	44.6	30.8
Honduras	1990-2000	57.2	56.7	-0.9	36.9	41.9	13.6
Mexico	1990-2001	40.5	42.5	4.9	21.7	21.3	-1.8
Panama	1991-2000	33.9	41.2	21.5	21.4	20	-6.5
Paraguay	1990-2001	47.2	60.4	28.0	34.3	39	13.7
Uruguay	1991-2000	38.1	40.3	5.8	10.7	10.1	-5.6
Venezuela	1990-2001	41.7	51	22.3	25.2	28.5	13.1

Source: Bertranou (2003), "Tendencias en indicadores de empleo y protección social de adultos mayores en América Latina", Santiago, Chile, ILO. Preliminary version.

This hypothesis is supported by the observation that economic activity rates for older persons are directly related to rates of social security coverage, decreasing in line with increases in the proportion of the population receiving pension benefits.[10] A high workforce participation rate among older adults therefore does not necessarily mean that these people have freely chosen to work; it may mean that they must work in order to obtain the minimum amount of economic resources they need to survive. Unfortunately, in relatively less developed countries, older persons tend to engage in informal employment that does not alleviate their socio-economic vulnerability. An analysis of the number of hours worked by those who remain in the labour market shows no significant difference between older adults and persons approaching retirement in terms of the number of hours worked, yet the income earned by the former is significantly less than the income earned by the group aged 50 to 59.

This does not mean that older persons' economic activity never has positive effects on income. In at least nine countries of the region the poverty rate among households with older adults would be close to or more than 20% higher if this earned income were eliminated. Accordingly, support for the economic endeavours of older persons could be a good way to promote active ageing in sectors which are not engaged in, or have been displaced from, dependent employment in the labour market.

[10] ECLAC (2000), *Social Panorama of Latin America, 1999-2000*, Santiago, Chile.

3. Social protection systems

In the 1980s the region witnessed a wave of retirement and pension system reforms, which in Chile resulted in the introduction of a new social security regime intended to eventually replace the system in force up until that time. Under the new system, retirement pensions are financed solely through individual capitalization, while disability and survivor's pensions are financed from a combination of personal savings and collective life and disability insurance. Social security resources are managed by a number of specialized private firms, and each worker may choose which firm is to manage his or her pension. The State, meanwhile, acts in a regulatory and supervisory capacity and as the system's guarantor of last resort.[11]

In the 1990s structural reforms were introduced in the retirement and pension systems of Peru (1992), Argentina (1993), Uruguay (1995), Bolivia (1996), Mexico (1996), El Salvador (1997) and Costa Rica (2000). Each of these reforms has specific features; for example, in Peru a new system of private retirement and pension fund managers competes with the old pay-as-you-go system, while in Argentina, Costa Rica and Uruguay the individual capitalization system is complemented by public pay-as-you-go systems, giving rise to integrated social security systems. In Bolivia and El Salvador, as in Chile, the reformed capitalization systems will eventually replace the old pay-as-you-go systems. Lastly, Ecuador, Nicaragua and the Dominican Republic have enacted social security reforms introducing individual capitalization, but have not yet put the new systems into operation.

The progression towards fully funded social security schemes has led, in some cases, to non-solidarity-based systems that rely on individual social security saving. In other cases the operation of fully funded schemes is integrated with and balanced by the operation of mechanisms such as minimum or basic pensions. One feature of the new systems is that they have tended to make a clear distinction between contributory components and redistributive ones. As a result, when redistributive components are not properly implemented, the accessibility and quality of old age, disability and survivor's benefits come to depend largely on each individual's work history. One exception to this trend is the reform enacted recently in Colombia (Law No. 797), which incorporates some redistributive components into the pension system itself for purposes such as the financing of minimum pensions.

Another element which nearly all of the region's retirement and pension systems have in common is their focus on formal-sector workers in dependent employment arrangements. Although the systems in Argentina and Uruguay include mandatory coverage for self-employed or own-account workers, compliance rates among such workers are limited, especially in Argentina. Generally speaking, the low rate of protection for self-employed or own-account workers is a problem that was not addressed by the social security reforms of the 1980s and 1990s. Owing to the high rate of informal-sector employment and to self-employed workers' limited capacity to pay social security contributions, a sizeable proportion of the population has effectively been left out of the contributory system, meaning that people in this category will not be self-sufficient in terms of income unless they have enough resources of their own.

The degree of economic security provided to today's older adults through formal social security systems reflects the way these systems were designed three or four decades ago and the labour market conditions prevailing at that time. Accordingly, a prospective analysis of the systems' future potential to

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[11] It should be noted that in Chile, the State-guaranteed minimum pension is just one (albeit the best known) of the fiscal guarantees provided. The State also guarantees life annuities, work-related disability and survivor's pensions and, as a last resort, the minimum profitability of pension funds.

provide older persons with economic security must be based on indicators of the coverage of current workers and on the new conditions being imposed for access to retirement benefits. While a wide range of structural reforms have been introduced in retirement and pension systems, as described above, all of them have tended to "toughen" the eligibility requirements for retirement benefits.

With respect to the coverage of current workers, out of 10 countries analysed, only Uruguay and Chile currently cover more than 50% of the economically active population (EAP), while five countries (Argentina, Brazil, Colombia, Ecuador and Venezuela) have participation rates of about 30% of the EAP and the rest (Bolivia, Paraguay and Peru) have rates of about 10%. This indicator, though static and aggregate, is useful for highlighting the need for a more in-depth assessment of the degree of retirement coverage which social security systems will be able to offer in the future. In other words, the young people and young adults who do not currently pay into the social security system will one day be older adults with insufficient or non-existent retirement benefits. Consequently, unless corrective measures are taken, the proportion of older adults receiving retirement and other pensions could be smaller than it is today. If this situation is not recognized and corrective steps are not taken in time, assistance-based or non-contributory benefit systems and formal and informal support networks for older adults will come under tremendous pressure. In fact, non-contributory and assistance-based pension programmes have been gradually but insufficiently expanded to fill in the gaps in coverage that occur in contributory systems.[12]

Thus, while the newly reformed social security systems will be in a better position financially than they were in the past, they can also be expected to provide less coverage in terms of benefits than they do today. The countries should therefore carefully monitor resource accumulation by workers in order to anticipate pressures either on the fiscal resources needed to provide non-contributory benefits to persons not covered by the contributory system or on the capacity of the labour market and families to make up for shortcomings in the social security system. These problems may be more serious in countries such as Bolivia, El Salvador and Peru, whose reforms have a bigger personal-saving component and where the informal sector accounts for a large proportion of the labour market.

The new pension systems based on individual saving are undeniably interesting as a way of providing income security in old age to workers who are regularly engaged in formal employment. These systems do not, however, have the necessary tools to prevent poverty among older persons who do not work in the formal labour market or are forced to stop working without having accumulated enough resources. Preliminary assessments of the new fully funded systems indicate that, in countries where such systems have been implemented in a context of macroeconomic stability and fiscal discipline, the reforms have tended to alleviate medium-term fiscal problems, partly because they reduce the amount of expected fiscal obligations and partly because they transfer some of the financial risk to individuals.

4. Family and community support networks

Family support is a major source of income in old age. For the third of the older population that did not receive income of any kind in the late 1990s (see figure 3), the family probably represented the sole source of support.[13] Data from health, well-being and ageing surveys conducted in Latin American and

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[12] Bertranou, Solorio and van Ginneken (2002), *Pensiones No Contributivas y Asistenciales: Argentina, Brasil, Chile, Costa Rica y Uruguay*, ILO, Santiago, Chile.

[13] Saad, 2003 (op. cit.).

Caribbean cities show that a large proportion of older persons receive support, primarily from relatives. This proportion ranges from 82% of the people surveyed in Barbados to 93% in São Paulo and Havana. The most important types of support are those involving services, goods and money. In almost all the countries, the proportion of older persons receiving such support was over 60%. Another important observation is that most of this support comes from family members who live with the older person, followed by support from children who live in separate households; support from siblings, though not negligible, is less significant.

The data also reveal flows of support from older persons to others. The proportion of older persons who provide some type of support ranges from 70% in Bridgetown, Barbados, to 88% in São Paulo and Santiago, Chile. These figures not only illustrate the intensity with which transfers of support involving older adults are taking place in Latin America, but also show that such transfers are made in both directions.

The current situation in terms of the extent to which older persons can obtain support and economic security from their descendants is a product of the demographic circumstances prevailing three or four decades ago, which have undergone substantial changes.[14] On the one hand, the sharp decline in fertility will reduce the potential size of older persons' family support networks. The situation of older persons will be especially difficult in the next few years, since they must prepare for their own old age under unfavourable circumstances such as those described above, while at the same time helping older relatives, knowing that they will not necessarily enjoy the same degree of family support that they themselves are offering their elders. On the other hand, women's full integration into the world of work outside the home will require a redistribution of caregiving functions between men and women; regardless of whether or not this occurs, however, women's participation in the workforce will reduce the availability of a source of support which, for reasons of gender, has traditionally been assigned a disproportionate share of caregiving tasks. Lastly, increased longevity and its effect in terms of reducing the proportion of widowed spouses, together with changes in patterns of formation and dissolution of unions, are changing family structures in ways that could limit families' capacity to provide support in the future.

B. AGEING AND HEALTH

The Latin American and Caribbean countries have made extraordinary progress in reducing mortality at all ages, thereby increasing life expectancy and improving the population's health. Nonetheless, acute social and age-related inequalities in terms of older persons' health status and access to adequate health care are still in evidence.

Much of the future increase in the proportion of older persons out of the total population can be traced back to changes in mortality patterns between 1930 and 1990. The speed of these changes was due to the rapid decline in mortality associated with infectious diseases in the first 10 years of life. The relatively short period of time in which the age structure of the region's population has shifted reflects —at least in part— the medical and public health revolution that triggered the decline in mortality half a century ago. Older persons who reach the age of 60 after the year 2000 are those who experienced the benefits of the medical technology introduced after the Second World War. The gains that have increased

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[14] Ibid.

their life expectancy resulted largely from the success achieved in reducing exposure to infectious diseases, developing better treatments and raising rates of recovery.[15] This has led to the hypothesis that, in the near future, the health status and functional limitations of older adults in Latin America could worsen. Should this prove to be the case, the ageing process in the region will sharply increase the demand for health care services. Even if this hypothesis is not borne out, however, the absolute and relative increase in the population aged 60 or over, especially at the upper limits of this age group, will have the effect of steadily increasing this demand.

The sections below present analyses of the factors considered in relation to the problem of health among older persons in the region.

1. Cause-specific mortality profiles of older persons

Below is an analysis of changes in cause-specific mortality patterns among people aged 60 or over. The analysis was based on available data for various countries of the region[16] from the early 1980s and the late 1990s. In terms of communicable infectious diseases, the standardized mortality rate among adults aged 60 or over dropped by 16% among men and 19% among women. In this category, the most common cause of death among older adults of both sexes continues to be respiratory infections, the rate of which dropped by 8% among men and 15% among women over the period considered. The most significant reduction was in mortality caused by tuberculosis, which declined sharply for both sexes: by 49% among men and 54% among women.

The standardized mortality rate for neoplastic diseases increased slightly among men (4%) and fell slightly among women (5%). Among men in this age group, the most striking trend was the 52% increase in the risk of death from prostate cancer and the 6% increase in the incidence of death from lung cancer, which were not offset by the reductions in the risk of death from stomach cancer (-25%) and other neoplastic diseases (-1%). Women in this age group saw increases in their risk of death from lung cancer (25%) and breast cancer (15%), which were partly offset by decreases in the risk of death from stomach cancer (-34%), uterine cancer (-14%) and other neoplastic diseases (-3%). Overall, cancer is still the second most common cause of death in this age group after cardiovascular disease.

The risk of death from diseases of the circulatory system fell by about 21% among men and 29% among women aged 60 or over. This was the most striking aspect of the change in the mortality profile of older adults in Latin America and the Caribbean in the last two decades of the twentieth century. Indeed, the decline in mortality from circulatory diseases was the biggest contributor to the increase in life expectancy for both sexes. The most significant reductions in region-wide standardized mortality rates were in the areas of cerebrovascular disease and ischaemic heart disease. The risk of dying from hypertensive disease, on the other hand, fell by 2% among women and rose by 8% among men, although it declined among both men and women at the lower end of this age group. There was a marked reduction in the risk of death from other diseases of the circulatory system (-42% among women and -38% among men). This category includes rheumatic fever, valvular heart disease, congestive heart failure, cardiomyopathy and many other cardiovascular conditions.

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[15] Alberto Palloni, Susan DeVos and M. Pelaez, "Ageing in Latin America and the Caribbean", CDE Working Paper No. 99-02, Center for Demography and Ecology, University of Wisconsin-Madison.

[16] Argentina, Barbados, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Jamaica, Mexico, Panama, Paraguay, Puerto Rico, Trinidad and Tobago and Venezuela.

The standardized rate of mortality due to external causes fell by almost 16% among men and 19% among women aged 60 or over. The main external cause of death for both sexes is transport accidents. Men are three times more likely than women to die in such circumstances, despite a reduction of 19% among the former and 21% among the latter. Accidental falls are the second most common external cause of death among older adults, although the mortality rate declined by 43% among women and 22% among men. Among older adult males, homicide is still a major external cause of death and homicide rates have remained relatively stable. Suicide is almost six times more frequent among older adult males than among women in the same age group.

The standardized rate of mortality among older adults due to all other causes increased over the period considered. Diabetes mellitus increased considerably during that time and the absolute risk of mortality increased sharply by 57% among men and 39% among women, thereby reducing excess risk among women from 25% to 10% over the period.[17] Mortality from chronic obstructive pulmonary disease went down, whereas mortality from liver cirrhosis remained at much the same level.

2. Morbidity profiles and risk factors among older persons

Data from health, well-being and ageing surveys show that most older persons report that they are not in good health and that this indicator is higher among women in all the cities surveyed.[18] In Mexico City, Havana and Santiago, Chile, more than 60% of women and more than 50% of men aged 60 or over rate their state of health as poor or fair. These percentages are almost twice as high as the ones for Buenos Aires, Montevideo and Bridgetown, Barbados. In the United States and Canada, the figures are only 35% and 40%, respectively, for persons aged 70 or over. This is an indication of the enormous health disparities that exist between countries that have very similar life expectancies at age 60 but that have had very different experiences in terms of population ageing and economic processes.

Non-communicable diseases are caused by a wide variety of risk factors, in addition to genetic factors. Even in old age, it is never too late to change bad habits and control or avoid risk factors which, in most cases, bring on or cause complications in certain chronic diseases that can result in disability. The prevalence of risk factors among older adults is alarming. In all the cities surveyed except Bridgetown, nearly one in two older adults at the younger end of the spectrum (between the ages of 60 and 69) had at least two risk factors, such as tobacco use, overweight or lack of vigorous physical activity. Most people who have some difficulty with the basic activities of daily living (BADL) have at least one of the above-mentioned risk factors.

The prevalence of hypertension fluctuates around 48% in all the cities surveyed. On the basis of that figure, it may be surmised that at least 20 million older persons in Latin America and the Caribbean, of whom two thirds are women, suffer from hypertension. Since these figures include only people whose hypertension has already been diagnosed, the real prevalence could be even higher. As far as diabetes is concerned, the prevalence among older persons is over 22% in Mexico City and Barbados and over 10% in the other cities.[19] In almost all the cities, the prevalence of diabetes tends to be higher among people

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[17] The relative risk of dying was measured on the assumption that both men and women can live to the age of 85.

[18] The five possible answers were excellent, very good, good, fair or poor.

[19] In Mexico City the survey respondents were also given glucose tests on an empty stomach; for every older adult who had already been diagnosed with diabetes, another was identified as having undiagnosed diabetes.

with less than three years of schooling and is associated with obesity and the perception of fair or poor health. Cardiovascular disease is the main cause of morbidity and mortality in older adults. Among persons aged 60 or over, the risk of suffering from a disease of the cardiovascular system is about 18% for men and 20% for women. Nearly one in two women aged 60 or over suffers from arthrosis, which is one of the most disabling diseases suffered by older adults. Its prevalence is considerably higher in a number of cities, such as Buenos Aires and Havana, where it affects almost two thirds of older women. In some Latin American cities, the proportion of adults over 75 who suffer from cognitive deterioration can easily exceed 20%. Of the total number of people suffering from cognitive deterioration, almost half are older adults with low levels of education. In the cities surveyed, an average of 18% of the respondents reported that they had depressive symptoms; the figure was systematically higher among women.

With reference to falls, the survey showed that approximately 30% of older adults had suffered a fall in the 12 months prior to the study. The relatively similar figures across several countries suggest that approximately 13 million older adults may suffer from falls and their consequences every year. In the area of malnutrition, the main problem is obesity. In Mexico City, Santiago and Montevideo, three out of every four women aged 60 or over have a body mass index (BMI) of over 30 kg/m^2. With respect to ocular and oral health, there is a high demand for services that must be met, since the limitations that could otherwise result have repercussions on the quality of life of older persons.

3. Functional ability and disability

The quality of life of older persons is closely linked to their functional capacity and the set of conditions that enable them to care for themselves and take part in family and social life. Although there are no fully comparable data for measuring disability in Latin America and the Caribbean, estimates based on census information suggest a high incidence of disability.

It is clear that the prevalence of disability increases with age. For instance, available figures suggest that, if the incidence of disability remains stable for the next few years, by 2010 almost a million of the people aged 70 or over in Mexico will be disabled. These people will need either a relative or a professional home caregiver to assist them in their daily activities.

A more appropriate way of assessing the phenomenon is to measure physical functionality by evaluating older people's ability to carry out basic activities of daily living (BADL), such as crossing a room, bathing, eating, dressing and getting into and out of bed, without limitations. About 20% of the older persons who took part in the survey, and 26% of those aged 70 or over, reported having difficulties with BADL.

The three cities in which the prevalence of disability was lowest were Bridgetown, Buenos Aires and Montevideo. These are also the cities that have the most nursing homes for chronic, long-term care.[20] In places that are thought to have fewer such residences —such as Mexico City, Havana, São Paulo and Santiago, Chile— the percentage of people with four or more BADL limitations is almost double the percentage in Buenos Aires, Bridgetown and Montevideo.

[20] Residents of such institutions were not included in the surveys, which were based solely on samples of private homes.

4. Caregiving arrangements for older persons

(a) Caregivers for disabled older persons

One important aspect of the problems concerning disability and mobility is the responsibility that falls on caregivers. In Latin America and the Caribbean family members are the primary caregivers for older persons, with a high proportion (almost 90%) of such family caregivers being women. Most caregivers are over 50 years old and are subject to emotional and financial problems. Over 60% of the caregivers surveyed said they felt unable to cope and, in some countries, up to 80% said they had difficulty in making ends meet financially. Despite this, none of the countries has a caregiver support policy or a plan for developing options for providing day care to disabled persons.

(b) Long-term care

Although the ideal situation is for older persons to remain in their homes, there will always be a need for appropriate long-term care services for people who wish or need to choose that option. In the region, however, giving the private sector sole responsibility for meeting families' needs can lead to a culture of abuse and mistreatment that violates the human rights of persons with disabilities. To prevent this, consistent policies are needed to support families and provide community options that extend the time for which older persons can remain independent and active. The institutions developed in industrialized countries are not viable for countries in Latin America and the Caribbean.

The information collected in the survey shows that no country in the region has a reliable registry of long-term care institutions or residences. This not only makes it hard to calculate the real number of institutionalized older persons, but also indicates the lack of priority given to the issue. Countries that do have legislation in this regard lack the capacity to enforce it. The institutions and residences concerned employ caregivers with no training or qualifications, who usually work without any professional supervision. Some 90% of the countries have no laws for the regulation or supervision of these institutions.

There are two main kinds of long-term care institutions: geriatric hospitals or public or private institutions that are identified as such in public records, and private residences that offer long-term care but are not listed in any public record. Data from population censuses can be used to identify —at a minimum— hospitals, nursing homes and group homes. Calculations show that 1% to 2% of people aged 60 or over live in institutions identified as group homes. It is likely that these figures represent the minimum percentage and that the real proportion is considerably higher.

(c) Home care

Home care can replace or supplement the care provided by institutions and families. This option enables older persons to continue to live in their homes and guarantees appropriate attention in terms of functionality and health. A holistic model of home care includes family members as a fundamental part of the health-care team. In most countries where home care programmes are being developed, they are designed as a direct extension of hospital programmes. However, for older adults with functional losses and chronic illnesses, home care must be designed as a special type of long-term care model rather than simply post-hospitalization follow-up. Long-term home care has not been developed as part of the countries' service policies. It must, however, be viewed as an integral part of a national policy on long-term care for people with disabilities and chronic illnesses.

5. The supply of health-care services

There is increasing awareness in the region of the importance of readapting health-care services to meet the needs of a growing older adult population. To that end, the following problems must be addressed:

- *Lack of staff trained to care for older persons:* All older persons have the right to be treated by health-care workers who have received appropriate training in managing the health problems most commonly associated with old age. However, 80% of the management staff of national health programmes for older persons lack training in public health and ageing or in gerontology/geriatrics. Although geriatrics is beginning to develop as a specialization, the majority of older adults will never be treated by a doctor or nurse specialized in geriatrics. Health-care workers should receive at least ongoing training under the supervision of doctors specialized in medicine for older persons. This factor must be given priority as a means of respecting the right of older persons to receive the same standard of care as other population groups. Most health-care professionals are not trained to recognize the health needs of older persons. Today's health-care workers, who are mainly trained in maternal and child health, are unable to manage the health needs of older persons with complex medical conditions.

- *Problems in financing health-care systems:* The financing of health-care systems is an essential part of social reform processes. However, the sustainable systems to be developed will have to be able to meet the needs of the swelling ranks of older persons, which will increase by one million people each year for the next 10 years and by twice that number in the following 10 years. Social protection for most of this population group will have to be financed by means of solidarity-based health plans, which are not easy to introduce in fragile economies. Yet the alternative is an ageing population with higher rates of illness which, even when not fatal, could cause disabilities that increase the economic and social burden on families.

- *Failure to include health promotion:* Less than 2% of the countries have set wellness targets for the population aged 60 or over. Public health authorities have not incorporated into national plans the priorities established in the Madrid International Plan of Action on Ageing, 2002, and in resolution CSP26.R20 of the Pan American Health Organization's Pan American Sanitary Conference. That resolution urges States to develop gender- and ethno-specific targets, as well as surveillance strategies in the areas of nutritional health, physical activity, unintentional injury and fall prevention, mental health and prevention of aggression against older persons. Developing a community health approach that promotes active ageing is one of the main challenges faced by States as a result of increased life expectancy in the region. Although pilot experiences in community health promotion for older persons have been implemented in a number of locations, the fact that most of them have not been evaluated or systematized makes it impossible to take full advantage of them.

- *Failure to inform older persons of their rights:* Most older persons do not know what rights they have in relation to health, particularly if they have a disability or a low level of education and live in a rural community. In all the countries, older indigenous persons find it even more difficult to participate in community health programmes owing to language barriers and problems in adapting to different cultural norms.

- *Limited and unsupervised development of long-stay institutions:* Most of the region's long-term care institutions and services were developed by the private sector and civil society in response to a market need. It is estimated that 80% of the residents of such homes or institutions have some kind of dementia, suffer from incontinence and have difficulty in carrying out at least one BADL function.

- *Fragmentation of services and lack of comprehensive care:* Older persons who have access to professional health care have steadily rising rates of hospitalization and consume more medications than the rest of the population. However, the service network is fragmented. Instead of receiving coordinated assistance suited to their needs, older persons who are new to the health-care system are expected to adapt to an approach designed to address the acute health problems suffered by younger users rather than the more chronic problems suffered by older persons.

- *Lack of research and monitoring:* Although most of the countries have research capacity in the area of public health, they lack the capacity to study the epidemiology of ageing or the repercussions of age-related diseases on individuals, families and services. None of the region's surveillance systems are capable of analysing the nature and magnitude of the dangers of malnutrition, falls, arthropathy and dementia as people grow older. No research is being done on risk factors or on changing unhealthy behaviour among people aged 60 or over. With the exception of the health, well-being and ageing survey and the national ageing surveys carried out in Mexico and Puerto Rico, over the last three years few large-scale population studies have been done on the older population's health status and the determining factors behind it.

C. ENABLING ENVIRONMENTS

The promotion of an environment conducive to the social development of older persons was one of the issues dealt with in the Madrid International Plan of Action on Ageing, 2002. Laying the essential groundwork by strengthening participatory political systems, eliminating violence and discrimination and promoting material conditions that facilitate community life, among other actions, is a crucial means of enhancing the role played by older persons. In the region, the situation of social environments (elder abuse, the image of ageing and participation) and physical environments (housing and the use of urban space) are also considered essential areas in which action for change is needed, since the existing gaps between generations and among older persons themselves must be reduced as a matter of urgency. The following section presents analyses of certain aspects of these issues.

1. Enabling social environments

(a) Elder abuse

Since the 1980s, when abuse of older persons was recognized as a social problem, a long-standing debate has emerged on the definition and typology of this phenomenon and on ways of preventing it. Currently, the most widely accepted definition is the following: "Elder abuse is a single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation

of trust, which causes harm or distress to an older person".[21] The types of abuse recognized range from physical and psychological abuse to financial abuse and self-neglect.

At the family level, there are two key factors that underlie almost all types of abuse: gender and socio-economic status. Most victims are female, over the age of 75 and living with family members, while the abuser is usually a relative, a son or daughter or an adult acting as caregiver. The dependency of the abuser rather than that of the victim appears to be a major factor in cases of elder abuse.

At the community level, some of the variables associated with abuse have emerged as a consequence of the modernization process: the progressive loss of functions, relations of dependency between generations and the erosion of traditional family structures. One of the most important factors in this respect is forced displacement, which takes place for different reasons and may cause older persons to feel uprooted and depressed.

At the institutional level, one of the most visible forms of abuse occurs in long-stay institutions (residences, homes, etc.) that do not meet basic quality standards. This situation may result in inadequate care, loss of individuality, fraud, suicide or other consequences.

The prevalence and incidence of elder abuse in the region are not yet fully understood. Nevertheless, certain conclusions can be drawn from case studies conducted in some countries of the region:

- The causes of abuse are multiple and complex. It is generally agreed that the likelihood of abuse is increased by certain conditions, such as a shortage of resources for meeting the victim's needs, caregivers who are under stress or not properly qualified and situations of economic crisis and unemployment.

- The most common type of abuse is psychological, expressed in insults, intimidation, humiliation or indifference, which can make older persons feel insecure and become withdrawn and increasingly isolated.

- There are significant differences between the sexes in relation to abuse. Most victims and abusers are women. This is because women are usually responsible for caregiving tasks and older women are more likely to require care owing to the physiological deterioration they suffer in the course of their longer lifespans.

Abuse has personal, social and economic repercussions. Physical abuse can have serious consequences, mainly because older persons have frail bones and require longer recovery periods that may even lead to death. From a social perspective, the most severe consequence of abuse is that it isolates older persons, erodes their self-esteem and makes them feel insecure, thereby contributing, in the long run, to negative stereotypes of old age. The economic repercussions include the costs of meeting the demand for specialized services and training staff to prevent and deal with situations of abuse. If older persons' financial losses as a result of the exploitation and theft of their money and property are also included, the economic costs are even higher.

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[21] Action on Elder Abuse (1995), "Action on Elder Abuse's Definition of Elder Abuse", Action on Elder Abuse Bulletin, London, May/June.

(b) The image of ageing

Studies have shown that the dominant image of ageing in today's Western societies is negative and is expressed in the social representation of older persons as passive, ill, deteriorated, burdensome or cut off from society. One of the possible causes of the problem is the cultural construct of old age as a phase of losses, of all types. This representation of old age as a time of deterioration is combined with the way each culture's collective imagination perceives the passage of time and its effects on the body. This process generates ideas, prejudices and assumptions about older persons in which physical and biological changes are construed as losses in terms of social life.

Societal values influence this situation, since ideas about old age are part of a typology based on productivity and the technological advances that have occurred with dizzying speed, in which the dominant archetypes are young people and adults who are in their productive years and who have power. Another important factor is the culture of appearance, in which beauty, strength and fitness, as attributes of eternal youth, are overrated features that displace any other type of aspiration and operate to the detriment of communication through words rather than images.

One of the consequences of this situation is that old age has become a source of vulnerability (both social and economic) which can lead to the exclusion of older persons as a group. Another important consequence is the invisibility of old age in public policies, research and academia.

The communications media play a fundamental role in perpetuating or changing this situation. They generally present stereotyped images of the "third age". Indeed, in recent years the image being projected has changed from that of a dependent, inactive person to the stereotype of older men as retired urban consumers with purchasing power. However, this image does not always reflect the variety of situations experienced by older persons. Negative stereotypes of old age must be altered, since, as will be shown below, they do not correspond to reality. Older persons have potential, resources and the capacity to oppose the status quo and effect change.

(c) Participation by older persons

Participation consists in promoting the organization of individuals on the basis of interests and creating conditions in which the community can articulate and defend those interests and make demands, form alliances or determine public policy on that basis.[22] For the older population, personal fulfilment involves playing a more active role in public affairs, defending their demands for equitable access to employment opportunities and occupying a central rather than a marginal place in society. In Latin America and the Caribbean organized groups of older persons carry out a broad spectrum of activities that range from lobbying for health-care services and microenterprises to providing legal advice or defending rights.

- *Participation in designing and monitoring policies and programmes*: Since the last decade of the twentieth century, structures have been set up in different countries to enable organizations of older persons to participate in the design and implementation of policies and programmes. No information is available for assessing the effectiveness of existing

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[22] I. Licha (2000), *Participación comunitaria. Conceptos y enfoques de la participación comunitaria*, Washington, D.C., Inter-American Institute for Social Development.

mechanisms, but they are known to represent valuable opportunities for learning and exercising negotiation skills.

- *Community participation*: In almost all the countries of the region, there are two main types of organization in which older persons participate: (i) community organizations that grow old along with their members and are replenished by new generations, and (ii) organizations consisting exclusively of older persons. In addition, older persons participate in a variety of informal networks of various types (family, neighbourhood, community) in which they take part in exchanges. The structure and content of the networks vary according to context, but they generally tend to be headed and financed by men, while women are to a greater extent "members" and exchange services and assistance.

- *Volunteering*: In many countries of the region older persons participate in volunteer activities. The availability of free time after they have stopped working and/or their children have become independent encourages them to engage in this type of socially productive work.

The comparative analysis of practices with regard to volunteer work is complex because the value and meaning of exchanges vary both within and between countries of the region. Nevertheless, certain trends can be identified on the basis of data from health, well-being and ageing surveys.

São Paulo and Bridgetown are the cities with the highest levels of volunteering by older persons. Santiago, Buenos Aires and Montevideo have intermediate levels of volunteering, while Mexico City and Havana have low levels. Most of this volunteer work is performed in churches and temples; these are followed by other places such as centres for older persons (Santiago, Buenos Aires and Havana), social welfare services (Mexico City, Montevideo and São Paulo) and children's homes (São Paulo and Montevideo). A smaller proportion of older persons volunteer at universities, schools or hospitals. The type of institution in which volunteer work is carried out varies by sex, as does the type of activity (see table 4).

Table 4
PERCENTAGE DISTRIBUTION OF THE PLACES WHERE OLDER PERSONS PERFORM VOLUNTEER WORK: SELECTED CITIES IN LATIN AMERICA AND THE CARIBBEAN

Type of assistance	Buenos Aires	Bridgetown	São Paulo	Santiago	Havana	Mexico City	Montevideo
Social welfare services	8.5	6.7	12.5	4.0	4.2	36.7	14.2
Centres for older persons	13.1	3.3	6.8	12.5	8.3	4.8	10.0
Children's homes	7.9	1.6	10.1	4.3	2.4	1.3	20.1
Schools/universities	6.5	0.3	0.8	1.1	5.0	2.9	4.2
Health-care centres	5.1	1.0	0.0	2.2	14.6	3.9	3.5
Churches or temples	36.2	73.5	57.1	37.6	22.0	38.1	25.1
Hospitals	6.5	0.8	2.5	1.3	15.4	0.0	3.4
Other	16.3	12.8	10.2	37.1	28.1	12.3	19.5
Total assistance	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Health, well-being and ageing surveys. Special processing carried out by the Population Division of ECLAC - CELADE, 2003.

- *Kinship networks*: The family is the setting for the intergenerational transfer of resources —material goods, care, emotional goods— that are extremely important in the daily lives of older persons. While such exchanges fall within the private sphere, in many communities the boundaries between relationships with members of the same family and relationships with members of the same neighbourhood or community are blurred or permeable. According to the health, well-being and ageing surveys, the assistance provided by older persons within kinship networks varies according to socio-economic level; the provision of childcare, however, is a generalized practice. Between 17% (in Bridgetown) and 25% (in Montevideo) of older persons provide childcare services, thereby contributing to the socialization of new generations and to the transmission of knowledge and customs.

- *Education*: Lifelong learning poses challenges to formal educational systems by creating a demand for training in the use of new technological developments, the completion of unfinished basic schooling or access to studies in subject areas of special interest. Since the 1980s some countries of the region —Costa Rica, Chile, Uruguay, Argentina and Brazil— have shown an increase in the number of universities for the "third age", which address the training needs of older persons in the middle socio-economic strata. In general, a higher percentage of women than men take part in these activities. This phenomenon is attributable not only to women's longer life expectancy, but also to the need to close generation gaps.

All these trends demonstrate that older persons carry out a variety of activities for their own benefit and the benefit of the community. However, these practices are not always coordinated and do not always bring about changes in the status and position of older persons. It is to be hoped that these trends will help to generate conditions for the greater empowerment of older persons in the years to come.

2. Enabling physical environments

Housing influences the quality of life in numerous ways, from objective considerations of living conditions and resources to subjective considerations of well-being. The housing situation of older persons must be analysed in terms of family structures, and the diversity of older persons' needs and preferences, including the option of "growing old at home", must be taken into account. Below is a description, based on census data, of the housing conditions of this social group in various countries of the region.

- *Household composition*: Multigenerational households consisting of a nuclear family plus an older family member living with persons of different generations are a very common form of co-residence in all the countries under consideration; they account for 20% to 40% of all residential arrangements. The exception is Uruguay, where this type of arrangement accounts for 18.4% of all households and is less common than households consisting of an older adult couple living alone. Conversely, households consisting of a couple living alone in which at least one of the members is over 60 are less common except in Uruguay (24.4%). Census-to-census data for five countries (Bolivia, Brazil, Chile, Ecuador and Panama) show that, except in Bolivia, households with older persons have been increasing faster than those without older members. According to projections, households headed by persons between the ages of 60 and 74 will increase significantly in absolute terms, while those headed by persons over 75 will grow faster in relative terms.

- *Home ownership*: One striking finding is that home ownership is more common among households that include older persons than among households that do not (see table 5).

Table 5

PERCENTAGE OF HOUSEHOLDS IN OWNER-OCCUPIED DWELLINGS, BY PRESENCE OR ABSENCE OF OLDER PERSONS, IN SELECTED LATIN AMERICAN AND CARIBBEAN COUNTRIES; LAST AVAILABLE CENSUS

Country	Year	Households with older persons	Households without older persons	Total
Bolivia	2001	92.9	76.1	80.3
Brazil	2000	84.9	72.4	75.2
Chile	2002	85.0	67.5	72.8
Costa Rica	2000	83.9	68.0	71.7
Ecuador	2001	79.7	62.6	67.2
Mexico	2000	86.3	72.4	75.6
Panama	2000	81.7	64.0	68.6
Venezuela	2000	89.3	74.5	78.1

Source: Annex table A.3.

- *Access to quality housing*: In most of the countries for which information is available, older persons are more likely to live in dwellings with dirt floors and substandard walls, although this increased likelihood is not always significant. The most critical situations are found in Bolivia and Nicaragua, where nearly half of all households with older persons live in dwellings with dirt floors. In Bolivia more than 65% of all households with older persons live in dwellings with substandard walls; in Nicaragua the percentage is about 50%. In terms of basic sanitation and drinking water, available data show that households with older persons have a coverage rate slightly higher than the national average, except in Mexico and Chile. The situation with respect to indoor plumbing is similar, with coverage of up to 90% in Chile and Costa Rica. In three countries (Bolivia, Chile and Ecuador), the census-to-census variation in the percentage of houses with easy access to drinking water shows that the situation of households with older persons improved, albeit more slowly than the national average.

- *Overcrowding*: Defined as an occupancy rate of more than three persons per bedroom, overcrowding is less common in households with older persons. Nicaragua ranks first in this regard (44.6%), with Ecuador a distant second (20.7%).

Older persons' use of urban space is strongly influenced by the shape that the city takes and the ways in which it facilitates or hinders access to urban services and amenities. Data from the health, well-being and ageing surveys show that 10.8% of older persons in Montevideo and 17.4% of those in Santiago, Chile, no longer leave their homes for fear of falling. In Chile, for example, a number of risk factors have been identified, including the lack of railings, irregular steps, inadequate banisters and poor lighting. In terms of traffic accidents, older persons are a high-risk group; in Venezuela and Argentina, for example, 21% and 12.4%, respectively, of pedestrians hit by cars are over 60 years old. In terms of public

safety, older persons are highly vulnerable. A study conducted in Mexico on the basis of the National Victimization Survey (2000) revealed that there were more crime victims in the over-60 group than in any other age group.

The type of urban segregation that affects older persons is not the traditional spatial segregation that occurs when different groups are concentrated in different areas, but segregation from the use of public spaces. The failure to adapt public spaces to the needs of older persons discourages their use by this age group. If older persons are to become integrated and exercise their citizenship in the region's urban areas, these areas must have physical and spatial characteristics that provide a safe and accessible environment. What is needed is a new generation of public space design aimed at enabling older persons to move about with autonomy and security. The unavailability of transport systems suited to the needs of older persons is a common characteristic of most of the region's cities and is one of the factors that limit the use of public space. In addition, high rates of crime and violence in some city neighbourhoods tend to discourage older persons from leaving their homes. This limits their social integration and physical mobility and, in turn, contributes to the development or worsening of disabilities.

The physical environment of the region's cities was created on the basis of a pattern that is actually appropriate for only one segment of the population: average adults. Thus, the design of cities where streets, urban fixtures, parks, paths, gardens and public transport systems are fit for older persons is a major challenge for municipal and other governmental authorities.

III. LEGAL FRAMEWORK, POLICIES AND PROGRAMMES FOR OLDER PERSONS

Human rights are inherent in the human condition and all persons must be able to exercise them without any form of discrimination. Older persons have rights as individuals and also as a group. Accordingly, it is necessary not only to recognize their fundamental freedoms, but also to enable them to exercise social rights in order to live in safety and dignity. The State, society and older persons themselves must work actively to achieve this. Below is an outline of the current situation with regard to the rights of older persons in the region, based on an analysis of legal instruments of different types and descriptions. It is followed by an overview of State initiatives for older persons, specifically policies and sectoral programmes designed for this social group.

1. The international human rights framework for older persons

Since no international convention has yet been adopted on the rights of older persons, a review of the current situation in this regard must include an analysis of the various existing global and regional instruments. There are two main sources which establish —either directly or by extension— the rights of older persons. The first consists of the following United Nations instruments:

- The International Covenant on Economic, Social and Cultural Rights does not refer explicitly to the rights of older persons, although article 9 deals with the "right of everyone to social security". Like the Universal Declaration of Human Rights, it does not expressly prohibit discrimination based on age. Nevertheless, the rights established in those two instruments may be reviewed in terms of their application by extension to older persons. Such a review was carried out by the Committee on Economic, Social and Cultural Rights in 1999.

- The two International Plans of Action on Ageing provide a political foundation at the international level and offer guidance on how the international community can deal with the challenges of ageing. The Plan of Action adopted in Madrid in 2002 identifies as central themes the realization of all human rights and fundamental freedoms of all older persons and the need to ensure older persons' full enjoyment of economic, social and cultural rights and civil and political rights.

- Since 1973 the United Nations General Assembly has adopted a number of resolutions concerning older persons. One of the most significant is resolution 46/91 of 1991, in which the United Nations Principles for Older Persons were established under five clusters: independence, participation, care, self-fulfilment and dignity.

- Recommendation No. 162 of the International Labour Organization (ILO) concerns older workers, and ILO Convention No. 102 on social security contains recommendations that apply to the entire population, but affect in particular the well-being of older persons.

At the regional level, the American Convention on Human Rights includes age in its reference to "any other social condition" and in the chapter on political rights, and refers to older persons explicitly in the article on the right to life. The OAS Additional Protocol in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador) is the only binding instrument that contains provisions directed

specifically at older persons, in its article 17 on protection of the elderly. Lastly, Pan American Health Organization (PAHO) resolution CE130.R19 focuses specifically on the topic of health and ageing and provides recommendations for member States.

In general, all the instruments establishing the rights of older persons, whether directly or by extension, acknowledge that today the goal is not only to provide them with protection and care, but also to ensure their involvement and participation in society. The Latin American and Caribbean countries have one binding instrument that establishes the basic rights of older persons: the Protocol of San Salvador, whose implementation, though progressive, should lay the appropriate groundwork for guiding government actions. This is not to suggest that the region should give priority to basic rights alone, but to draw attention to an instrument that can be useful for ensuring that rights in old age are guaranteed and exercised pending the adoption of an international convention on this subject, for which the United Nations Principles for Older Persons provide the best possible framework.

2. The juridical and legal framework for older persons in Latin American and Caribbean countries

Constitutions are the basic pillars of any democracy; they are the supreme law of the national juridical order, and their provisions are mandatory. Thus, they always deserve special attention. This section contains a comparative analysis of the constitutions and most recent constitutional amendments of 21 countries. The rights included in the United Nations Principles for Older Persons provide an analytical framework for identifying points of comparison between such diverse constitutions.

In 19 of the 21 countries considered, specific rights are established for older persons (see table 6).

Table 6

RIGHTS OF OLDER PERSONS, AS ESTABLISHED IN THE CONSTITUTIONS OF 21 SELECTED COUNTRIES

Right	Number of countries	Countries
Independence	15	Bolivia, Brazil, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Uruguay, Venezuela
Care	13	Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, Guatemala, Honduras, Nicaragua, Panama, Paraguay, Peru, Puerto Rico, Venezuela
Participation	3	Brazil, Colombia, Ecuador
Dignity	5	Brazil, Costa Rica, Ecuador, Mexico, Paraguay

Source: The constitutions of Argentina (1853), Bolivia (1994), Brazil (1988), Chile (1980), Colombia (1991), Costa Rica (1949), Cuba (1976), Dominican Republic (1994), Ecuador (1998), El Salvador (1983), Guatemala (1993), Honduras (1982), Mexico (1971), Nicaragua (1995), Panama (1972), Paraguay (1992), Peru (1993), Puerto Rico (1952), Trinidad and Tobago (1997), Uruguay (1997) and Venezuela (2000), with their most recent amendments.

Similarly, in the middle ranks of the pyramid-shaped hierarchy of laws in some countries of the region (Brazil, Costa Rica, Mexico, Paraguay and El Salvador), there are special general laws that regulate nationwide initiatives in relation to ageing. Table 7 describes these provisions by thematic area.

Table 7
PROVISIONS ESTABLISHED IN SPECIAL GENERAL LAWS CONCERNING OLDER PERSONS IN SIX SELECTED COUNTRIES

Thematic area	Provisions
Economic security	The issues covered range from preparation for retirement to measures to eliminate age discrimination at work. In Costa Rica the law provides for advisory services on access to sources of financing and the creation of organizations of production units of older persons, flexible working hours, etc.
Health	All the laws include health as a basic right. They not only guarantee the provision of health-care services, but also promote the prevention and treatment of disease in old age, with special emphasis on persons who are to some degree dependent. Some laws include special provisions on long-stay institutions.
Housing and urban development	In general the laws provide for the creation of housing programmes directed specifically at older persons or for the improvement of their housing conditions, and for the elimination of architectural and urban barriers.
Participation	All the laws refer to the value of older persons' participation and establish rights to that effect. In some cases they encourage older persons' participation in the formulation and implementation of actions that affect them.
Violence and discrimination	On the whole, the laws include specific measures to eliminate elder abuse. Age discrimination is also a recurring theme in all the laws considered, and some of them protect older persons' right not to be portrayed in terms of negative stereotypes, both in the media and in the areas of culture and education.

Source: Law No. 8,842 of 1994 (Brazil), Law No. 7,935 of 1999 (Costa Rica), Rights of Older Adults Act of 2002 (Mexico), Law No. 1,885 of 2002 (Paraguay) and Decree No. 717 of 2002 (El Salvador).

As may be inferred, the issues dealt with in these laws are broad and include some of the rights established at the international level. Except in Brazil, most of these laws were enacted following an extensive awareness-raising campaign carried out in 1999 in the context of the International Year of Older Persons.

With regard to constitutionally guaranteed rights, the special general laws represent considerable progress. Of course, it is one thing to adopt a law and quite another to secure its observance and enforcement by governments and their institutions. The recognition of certain rights and obligations, however, transforms vague aspirations into legal obligations and commitments, and makes the question of their observance a legitimate focus of international action and internal political debate. In this case, their observance requires the active cooperation of society as a whole, but also the individual and group contributions of older persons themselves.

3. Policies concerning older persons in Latin America and the Caribbean

Policies on ageing are understood to mean the set of actions undertaken by the State in response to the social, economic and cultural consequences of the ageing of the population and of individuals, and cannot be properly analysed without taking into consideration elements such as the definition of the issue, the

actors involved and the areas in which policy initiatives are carried out.[23] Below is an analysis of policies on ageing in six countries of the region: Bolivia, Brazil, Chile, Costa Rica, El Salvador and Peru.

The policies in question focus on addressing the needs of the current generation of older persons and promoting, in the long term, the creation of conditions in which people can age with dignity, defined from the individual point of view as autonomy or independence, and from the collective point of view as the creation of an enabling environment for the exercise of rights in old age. Moreover, the policies recognize that ageing challenges current forms of social organization and that action in this regard should include not only measures to improve older persons' living conditions today, but also actions of a structural and strategic nature that lead to changes in society.

In contrast to the public policy practices of two decades ago, the policies analysed propound shared responsibility for public practices as an alternative to the State's unalterable hegemony in policy design, implementation and evaluation. It is important to note, however, that families and civil-society organizations in general have traditionally played a leading role in meeting the needs of the older population in the countries of the region, so that their explicit inclusion in actions directed at that social group is simply a way of acknowledging their contribution and involving them in the modern practice of public affairs. It is also important to highlight the role assigned to older persons as a group, since they too have obligations to meet in achieving well-being and exercising their rights.

The contents of the policies are very similar in the countries considered, and can be grouped into different spheres of action (see table 8).

Table 8

SPHERES OF ACTION OF POLICIES ON AGEING IN SIX SELECTED COUNTRIES

Economic security	Promotion of economic participation, protection of labour rights in old age, elimination of age discrimination in the labour market, preferential assistance for older persons living in indigence and poverty, improvement of the social security system, etc.
Health	Promotion of self-care and healthy lifestyles, access to health-care services, human resources training, regulations for the operation of long-stay institutions, access to essential drugs, etc.
Enabling physical environments	Access to public spaces, access to housing.
Enabling social environments	Promotion of a realistic image of ageing, strengthening of solidarity between generations, access to continuing education, participation and exercise of rights.

Source: National Plan for Older Adults (Bolivia, 2001), Law No. 8,842 regulating the National Policy for Older Adults (Brazil, 1994), National Policy for Older Adults (Chile, 1996), National Policy on Services for Older Adults: 2002-2006 action plan (Costa Rica, 2002), National Policy on Services for Older Adults (El Salvador, 2001) and Policy Guidelines for Older Persons (Peru, 2002).

In general, all these policies reflect the paradigm of active ageing. Although they aim to generate appropriate conditions for ageing, they propose few mechanisms for achieving this. Another striking feature is that both the problems on which the policies are based and the measures proposed for addressing them are extremely similar in all the countries. This points to problems in their formulation, as

[23] S. Huenchuan (1999), "De Objetos de Protección a Sujetos de Derecho: Trayectoria y Lecciones de las Políticas de Vejez en Europa y Estados Unidos", *Revista de Trabajo Social Perspectivas: Notas sobre Intervención y Acción Social*, No. 8, December 1999, Universidad Católica Cardenal Raúl Silva Henríquez, Santiago, Chile.

it is not possible that such different countries could have identified the same problems and devised such similar solutions. One explanation may be that the policies were generally formulated on the basis of international recommendations, without regard to each country's particular conditions and characteristics.

In fact, most of these policies purport to follow both the guidelines adopted at the World Assembly on Ageing held in Vienna in 1982 and the United Nations Principles for Older Persons. But these recommendations were not acted upon in the light of national circumstances, perhaps because of the lack of regional instruments to guide the formulation of policies on ageing or the lack of a fund of knowledge on the particular situation of older persons and ageing within each country.

The policies considered are nevertheless significant because they are the outcome of a degree of national consensus which enabled the State to take a position on the issue and to regard it as an area for action. This is all the more praiseworthy in that the countries studied are pioneers in explicitly establishing this type of policy, from which lessons can be learned that will be useful not only for the other countries of the region, but also for improving these countries' own initiatives.

4. Sectoral programmes for older persons: social security, health and housing

Although only some of the countries of the region have policies designed specifically for older persons, this does not always mean that this social group is absent from public affairs in the other countries. Older persons are included in sectoral programmes under other categories defined on the basis of criteria other than age (vulnerable groups, indigent groups, high-risk groups, etc.). This does not mean that the perspective of generational equity is taken into account in these public policies and sectoral programmes, but that older persons are regarded as part of the target population they serve. Classic examples in this connection are social security programmes, specifically non-contributory pension programmes, and housing programmes.

(a) Non-contributory pensions

These schemes for providing social security coverage are most highly developed in the countries that pioneered these systems (Argentina, Brazil, Chile, Costa Rica and Uruguay). All these countries have institutionalized non-contributory pension systems with a significant level of coverage, and although these programmes have some defects with regard to management and targeting, they are quite effective in reducing the incidence of poverty among older persons, at least with regard to poverty in terms of income.[24] These countries' non-contributory pension programmes have a number of features in common:

- They are designed as entitlements available to all those who meet the eligibility requirements established by the programmes. In Chile welfare pensions are subject to a quota.

- Applicants must provide proof of income to receive this entitlement, so that the programme resources can be channelled to persons in need.

[24] F. Bertranou (2003), "Tendencias en indicadores de empleo y protección social de adultos mayores en América Latina", preliminary version, International Labour Organization, Santiago, Chile.

- The value of the non-contributory pension is substantially less than the value of the minimum pension, which reduces the disincentive for subscribing to contributory schemes.

- The programmes are financed from general tax receipts.

One important innovation in Brazil's non-contributory rural pension programme is that entitlement to benefits is based not on means testing, but on the completion of a required number of years of work in the rural sector.

(b) Housing programmes for older persons

These programmes come under general policies on housing and urban development, and deal with issues relating to housing or households via instruments targeting vulnerable groups of older persons. Some interesting experiences in this respect are the following:

- In Chile the Special Programme for Older Adults allocates up to 2% of the resources of the basic housing programme to needy persons over the age of 65. No savings are required and the housing is provided on a loan-and-restitution or rental basis in specially designed condominiums with communal facilities and functional interior fixtures (hot water heaters, air extractors and handrails in bathrooms, wide doorways and carpeting). The housing subsidy system also has a special programme for older persons, which gives priority to households headed by women or disabled persons.

- In Mexico the programme for the physical improvement of the housing stock targets not only the low-income population, but also older and disabled persons who own land and need improvements in flooring, roofing, walls or sanitary facilities. For its part, the National Housing Institute offers loans for which older persons are given priority under multi-family and single-family housing programmes.

Countries such as Argentina, Costa Rica and Uruguay also have housing programmes for older persons. It may be concluded in general that the improvement of housing services systems for older persons requires that housing policies consolidate stable models of housing services for low-resource sectors, improve their capacity to offer plans targeting poor and vulnerable sectors and generate mechanisms for coordinating low-income housing initiatives with urban development.

IV. ACTIONS SUGGESTED BY THE INTER-AGENCY WORKING GROUP ON AGEING FOR THE IMPLEMENTATION OF THE MADRID INTERNATIONAL PLAN OF ACTION ON AGEING

The Madrid Plan of Action is structured around three priority directions: older persons and development, advancing health and well-being into old age and ensuring enabling and supportive environments. In the region, priority has been given to certain issues that are considered important in the light of the characteristics of the countries' population ageing processes and levels of development, which to a large extent determine the resources and opportunities they can offer to persons at this stage of life.

A. PRIORITY SPHERES OF ACTION

1. Economic security

(a) Employment of older persons

The increase in life expectancy, together with the increase in the age of retirement and in the number of years of work required for access to old-age pensions, have made it necessary for people to continue working up to a more advanced age. Mechanisms are therefore needed to eliminate age discrimination in the workplace. People who work or have worked more or less continuously in the informal sector must be given access to contribution mechanisms or, if their income is insufficient for that purpose, to non-contributory pensions. Lastly, it is important to create conditions conducive to the development of microenterprises by improving access to credit and training in income-generating activities.

(b) Development of solidarity-based, non-exclusionary social security systems

This involves designing and implementing policies based on universality and non-exclusion: in other words, opting for solidarity instead of the selective protection of those who are in a better socio-economic situation or can contribute more, and guaranteeing the efficient financial management of these systems in accordance with a realistic view of each country's actual capacity. The first step in this direction is to define the entitlements of older persons and to determine which of them can be effectively guaranteed by the State and how they will be provided. As this is a matter of State policy, each country should develop its own answers on the basis of a nationwide consensus. If individuals are to be able to live in decent conditions in their old age, an attitude of solidarity is necessary in order to avoid reproducing inequalities in the provision of health care and social security services. Each country can define its own system; the point is to begin from a foundation of solidarity, regardless of individuals' capacity to contribute. Accordingly, the non-contributory system must be strengthened.[25] Second, the countries must decide how these entitlements will be financed. The solutions devised must be realistic and conservative with respect to the amount of resources required. Third, the system's organization must be defined with a view to avoiding management problems and maximizing efficiency while preserving the element of solidarity.

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[25] Clearly, in deciding what services to offer or establishing the value of non-contributory pensions, policy makers must take into account the possibility that disincentives to saving or contributing may be generated.

(c) Encouraging networks of family and community assistance for older persons

There is strong evidence that older persons play a crucial role in transferring resources to younger generations and that making resources available to older generations creates positive externalities in terms of family and social cohesiveness. This being the case, the discussion on financing should include an effort to measure the economic impact of these externalities. Social protection policies must take into account the existence of transfers within families and between families and the community, and the fact that these flows may change in the future as a result of economic factors (crisis, unemployment, etc.) or demographic ones (reduction in the number of children).

2. Health

(a) Access to appropriate, non-discriminatory health care

In order to evaluate older persons' access to health care, barriers to access must be identified. Most of the countries do not have this information and, where it is available, it is not broken down by geographical location, gender or socio-economic level. The little information that does exist shows that older people of indigenous and rural origin encounter various kinds of barriers that hinder their access to health-care services (language, culture, belief system, etc.). Within this group, rural indigenous women who are poor and live alone have the greatest difficulties of access. Discrimination, however, affects all older adults. It is therefore necessary not only to provide adequate services, but also to ensure that older people in general, and the most vulnerable groups in particular, have access to appropriate health-care services without age discrimination. It is also important to implement programmes that address the social, economic, geographical and cultural factors that affect the health of older persons, in order to enhance the relevance of the actions taken.

(b) Human resources training in the field of health and ageing

Priority must be given to the inclusion of geriatrics in the curricula of schools of medicine, nursing, social work, technical studies and all fields of study related to health care. A national strategy must therefore be devised for training human resources in the field of health and ageing, including ongoing medical education and the development of a regional network of geriatric education centres to meet immediate needs. Such training should cover all levels, including the level of primary care in the community.

(c) Institutional capacity for the regulation of long-term care institutions

Long-term care services in the region for older persons who have disabilities or complex health problems are operated by the private sector in response to a market need. Public health legislation should be enacted to protect the health of residents of geriatric care institutions. Establishing a system of laws and regulations, however, requires knowledge, skills and resources. As most of the countries of the region lack experience in this area, international cooperation must be sought in order to learn from the experiences of other countries and adapt existing models to the local culture and needs.

(d) Monitoring the health of older persons

The main objective of public health interventions for older populations is to reduce ill health and postpone the onset of disability in older persons. Research must be carried out on both the factors that facilitate active ageing and the ones that threaten the autonomy or independence of older persons in order to set priorities and allocate resources. Information should be generated on the state of health of older persons in order to identify trends, evaluate their health and functional risks and assess the demand for services. A health profile for the population group aged 60 or over must include: social and demographic variables; mortality and morbidity data; risk factors for illness and disability; modifiable behaviours; functional ability and disability; access to and use of health-care services, including the use of medicines and appliances; expenditure on health care and medicines; and barriers to health-care access.

3. Enabling environments

(a) Participation

- *Enabling conditions for the exercise of rights in old age*: Efforts should be made to promote the adoption of a convention on the rights of older persons, as a means of promoting the adjustment of national legislation to comply with international standards and creating a monitoring body to ensure compliance with those provisions.

- *Associativity and participation of older persons*: Self-managed organizations of older persons should be promoted in order to enhance older persons' autonomy and civic development, and steps should be taken to encourage the practice of including older persons in opportunities for participation other than organizations of older persons.

- *Availability of social support networks*: Informal support networks are part of the social capital accumulated by older persons in the course of their lives. Measures should be taken to raise society's awareness of the importance of maintaining or generating family, neighbourhood or community networks in order to prevent loneliness or uprootedness at this stage of life.

(b) The image of ageing

- *Media initiatives*: Extensive and ongoing awareness-raising campaigns should be waged through the mass media to promote a positive social image of ageing and old age and to mitigate negative stereotypes associated with older persons.

- *Intergenerational solidarity*: The creation and full use of opportunities for older persons to serve the community and the strengthening of opportunities for intergenerational dialogue at the local and national levels are examples of initiatives that could be taken to encourage solidarity and promote a realistic image of old age.

(c) Elder abuse

- *Prevention*: As part of a broad range of preventive measures, priority should be given to awareness-raising and the creation of support mechanisms for persons who act as caregivers for dependent older persons.

- *Legal treatment*: There is a need to define acts of abuse which are not currently characterized as offences because of their less serious nature, yet which are the most common forms of abuse and potential signs of the onset of a cycle of violence that escalates until it reaches the level of a recognized offence. A successful system of referral to legal aid services is essential in this regard.

(d) Housing and urban integration

- *Adaptation of housing programmes to the diversity of households with older persons*: Housing programmes should comprise measures for diversifying their plans of action to include initiatives targeting both indigent or abandoned older persons and multigenerational households.

- *Promotion of senior citizen-friendly urban design*: Care should be taken to ensure that new constructions and public spaces are designed to accommodate older persons, as a way of improving cities' efficiency.

- *Adaptation of public transport systems*: Government regulations aimed at reducing the accident rate and facilitating the mobility of older persons through a more accessible public transport system should be strengthened and enforced. In addition, road signs and signals and road design should be adapted, training should be provided on issues of road safety and road signs and signals to protect pedestrians should be installed.

B. IMPLEMENTATION STRATEGIES

The implementation in Latin America and the Caribbean of the International Plan of Action on Ageing will require concerted efforts by different social actors in both the public and civil-society spheres. At the national level, the following steps could be taken:

- Inclusion of issues related to ageing and the problems of older persons in national development frameworks to guarantee that older adult women and men have equitable access to the benefits, resources and opportunities offered by development, and mainstreaming of the intergenerational equity approach in all public policies, especially poverty reduction policies.

- Formulation of policies for older persons to establish a frame of reference for providing support and coordinating initiatives for older persons, and promotion of the establishment of institutional mechanisms for implementing, monitoring and evaluating such policies.

- Inter-ministerial coordination, which involves mainstreaming the consideration of age differences, either through the participation of the different ministries in the institutional framework responsible for older persons' issues at the national level or through commissions or agreements to incorporate the consideration of age issues into sectors such as education, employment, health care, justice, etc.

- Monitoring of policies and programmes for older persons through the conduct of studies to identify and analyse the problems of older persons and to gauge their scale, in order to guide priority-setting at the national level, provide input for policy and reform proposals and measure progress towards established goals.

The role of civil society, meanwhile, should take the form of civil-society organizations' commitment to and involvement in the regional implementation of the Plan of Action and the development of mechanisms for citizen follow-up and oversight, on the one hand, and, on the other, coordination and cooperation with the State in carrying out initiatives to further common aims and in formulating strategies for empowering older persons. Academic institutions also have an important role to play, especially in the areas of training and research on the subject of ageing.

At the international level the following measures should be implemented:

- Inclusion of ageing-related issues as priority items on the agenda of the United Nations and Organization of American States (OAS) systems in the region, both at the level of technical cooperation and in terms of generating studies and specialized information.

- Strengthening of international cooperation to support the countries of the region in developing sectoral policies and programmes on ageing, building national technical capacities, promoting the exchange of experiences and best practices, generating knowledge and disseminating information.

ANNEX

Table A.1

LATIN AMERICA AND THE CARIBBEAN: RELATIVE POPULATION DISTRIBUTION BY AGE GROUP 2000, 2025 AND 2050

	Percentage of population aged 60 or over		
Countries	**2000**	**2025**	**2050**
Total for region	**8.0**	**14.1**	**23.4**
Incipient ageing	**5.5**	**8.1**	**16.0**
Bolivia	6.4	9.0	16.7
Guatemala	5.3	6.9	14.4
Haiti	5.7	8.1	16.2
Honduras	5.2	8.6	17.6
Nicaragua	4.6	7.6	16.3
Paraguay	5.3	9.4	16.1
Moderate ageing	**6.9**	**13.2**	**23.3**
Belize	6.2	9.9	21.4
Colombia	6.9	13.5	21.9
Costa Rica	7.6	15.7	26.4
Ecuador	6.9	12.6	22.6
El Salvador	7.2	10.5	20.5
Guyana	7.0	15.2	31.0
Mexico	6.9	13.5	25.1
Panama	7.9	14.1	22.3
Peru	7.1	12.4	21.9
Dominican Republic	6.6	12.9	22.0
Venezuela	6.6	13.2	22.1
Moderate to advanced ageing	**8.1**	**15.8**	**25.5**
Bahamas	7.9	15.6	23.3
Brazil	7.9	15.6	25.6
Chile	10.2	18.2	24.1
Jamaica	9.6	14.5	24.0
Suriname	8.2	14.2	29.0
Trinidad and Tobago	9.6	20.0	33.3
Advanced ageing	**13.7**	**18.7**	**26.1**
Netherlands Antilles	11.5	22.9	26.6
Argentina	13.3	16.7	24.2
Guadeloupe	12.4	23.2	31.3
Barbados	13.5	25.0	35.4
Cuba	13.7	25.0	33.6
Martinique	14.9	24.1	32.6
Puerto Rico	14.3	20.7	27.9
Uruguay	17.2	19.7	25.4

Source: CELADE, demographic projections, 2003; United Nations, *World Population Prospects*, 2000.

Table A.2
LATIN AMERICA: INDICATORS OF INCOME RECEIVED BY THE POPULATION AGED 60 OR OVER

Country and area	Percentage receiving income				Total
	From retirement or other pension only	From retirement or other pension plus work	From work only	No income of any kind	
Urban areas					
Argentina (1994)	63.9	3.5	10.5	22.1	100.0
Bolivia (1997)	21.9	4.4	34.3	39.4	100.0
Brazil (1996)	51.9	9.9	10.0	28.2	100.0
Chile (1996)	52.7	8.6	14.4	24.4	100.0
Colombia [a] (1997)	16.2	4.1	20.9	58.8	100.0
Costa Rica [a] (1997)	39.4	-	22.2	38.4	100.0
Ecuador (1997)	14.7	2.4	34.6	48.4	100.0
El Salvador (1997)	10.2	8.2	30.6	51.0	100.0
Honduras (1997)	7	0.8	37.4	54.5	100.0
Mexico (1996)	19.6	3.6	24.8	52.1	100.0
Nicaragua [a] (1997)	16.8	-	29.6	53.7	100.0
Panama (1997)	42.7	4.9	14.9	37.5	100.0
Paraguay (1996)	17.1	4.3	31.9	46.8	100.0
Dominican Republic (1997)	13.8	1.9	24.6	59.7	100.0
Uruguay (1997)	75.3	6.0	9.7	9.0	100.0
Venezuela [a b] (1997)	10.8	-	31.0	58.2	100
Rural areas					
Bolivia (1997)	2.0	1.6	59.2	37.2	100.0
Brazil (1996)	52.4	22.5	11.5	13.6	100.0
Chile (1996)	42.4	6.0	17.0	34.6	100.0
Colombia [a] (1997)	4.1	4.4	37.5	53.9	100.0
Costa Rica [a] (1997)	18.7	-	26.2	55.1	100.0
El Salvador (1997)	1.6	1.2	43.2	54.0	100.0
Honduras (1997)	1.0	0.8	47.7	50.5	100.0
Mexico (1996)	4.6	2.9	43.6	49.0	100.0
Panama (1997)	15.4	3.4	34.4	46.8	100.0
Dominican Republic (1997)	4.8	1.6	43.9	49.7	100.0

Source: ECLAC, *Social Panorama of Latin America, 1999-2000*, on the basis of household surveys conducted in the countries.

(-) Information not available

[a] Income from retirement and other pensions refers to total transfer income received by persons identifying themselves as "retirees and pensioners" under the heading "activity status".

[b] Nationwide total.

Table A.3

SELECTED COUNTRIES OF LATIN AMERICA: PERCENTAGE OF HOUSEHOLDS IN OWNER-OCCUPIED DWELLINGS, BY TYPE OF HOUSEHOLD WITH OLDER ADULTS

		Older adult living alone	Older adult with spouse or partner only	Older adult with spouse or partner plus another or others who are not older adults	Older adult without spouse or partner plus another or others who are not older adults	Older adult who is a secondary member of the household	Older adult who is head of household plus other older adults	Households with older adults	Households without older adults	Total
Bolivia	2001	91.4	95.5	95.1	92.7	89.7	95.7	92.9	76.1	80.3
Brazil	2000	76.8	87.5	88.0	85.8	81.2	87.4	84.9	72.4	75.2
Chile	2002	77.7	88.6	89.6	87.3	77.9	86.7	85.0	67.5	72.8
Costa Rica	2000	71.8	85.9	89.4	85.5	79.1	87.7	83.9	68.0	71.7
Ecuador	2001	73.4	83.9	85.5	82.6	71.9	83.4	79.7	62.6	67.2
Mexico	2000	76.8	87.0	89.9	86.4	84.5	88.5	86.3	72.4	75.6
Nicaragua	1995	78.0	86.7	90.6	90.2	87.5	90.9	88.9	82.7	84.2
Panama	2000	75.5	83.6	87.4	84.1	72.8	85.0	81.7	64.0	68.6
Uruguay	1996	63.0	79.6	81.0	76.2	71.4	78.8	74.2	56.7	63.7
Venezuela	2000	81.7	89.4	92.7	92.8	82.7	92.6	89.3	74.5	78.1

Source: Prepared using census information from the REDATAM database, available from the Population Division of ECLAC (CELADE).