

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



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The focal points on ageing of the countries of the region provided inputs through their replies to the survey on programmes for older persons in Latin America and the Caribbean, as did the Country Offices of the United Nations Population Fund (UNFPA) and of the Pan American Health Organization (PAHO).

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INTRODUCTION

This document was prepared by the Latin American and Caribbean Demographic Centre (CELADE)-Population Division of ECLAC in compliance with ECLAC resolution 616(XXXI) of 2006, which instructs the secretariat to prepare the relevant substantive documentation for the Second Regional Intergovernmental Conference on Ageing, to be held in Brasilia, Brazil, from 4 to 6 December 2007.

The purpose of this document is to present and analyse the available information on the process of population ageing, the status of the older adult population and the advances made by countries in applying the Regional Strategy for Implementation in Latin America and the Caribbean of the Madrid International Plan of Action on Ageing.

The Regional Strategy contains targets, goals and recommendations for action for the benefit of older persons in three priority areas: older persons and development, advancing health and well-being in old age, and enabling environments. The Strategy was adopted at the First Regional Conference on Ageing in November 2003 and ratified by ECLAC in resolution 604(XXX) of 2004.

The Latin American and Caribbean region is witnessing a slow but inexorable ageing of its population. This is an across-the-board phenomenon, since all of its societies are ageing, although at different rates from country to country. Predictably, a demographic transformation of this sort will have far-reaching repercussions on society and in specific public-policy spheres, such as social cohesion, human rights and the role of the State.

Two features of this phenomenon are arousing great concern: first, population ageing in the region has been occurring more rapidly than it did in what are today's developed countries; second, it is taking place within a context of high poverty levels, persistent inequality, weak institution-building, low coverage and quality of social protection systems, and an overburdened family structure. Indeed, in addition to taking charge of the needs of elderly members, the family is filling the vacuum left by the scant presence of other institutions in the areas of protection and cohesion.

In their efforts to address the challenges of ageing, countries are taking steps to create and develop laws, policies and programmes designed to improve the living conditions of the older adult population. Since 2003, new public policy niches have taken shape and further interventions have been taken in this area, although differences in the status of the situation and achievements still persist across countries and subregions due, in some cases, to a lack of homogeneity within societies and to the characteristics of their development processes. Thus, while countries with an older population usually have more extensive coverage, in nations still in the midst of the transition, the challenges posed by the older adult population exist alongside with problems associated with the poverty and exclusion of other social groups.

Governments have become more conscious of the importance of the rights of older persons, and for some years now, have been demonstrating this concern by creating legal frameworks for protection. However, there is a wide gap between the *de jure* and the *de facto* situations, since there are still insufficiencies in the effective exercise of these rights and, today, a significant proportion of the older adult population still lacks access to social security, health care or basic services. In most cases, this vulnerability is not age-related, but instead stems from the generally precarious nature of the protection mechanisms provided by the State. In other cases, it is attributable to blatant inequality in income or scant

regard in public policy for the requirements of this social group due to the deep-rooted notion that problems of ageing are a matter for the private sphere rather than an issue calling for collective solidarity.

In Latin America and the Caribbean, the poorest and least institutionally developed countries are those where the population ageing process is the least advanced. The change in the age structure may bring tangible benefits for these countries by creating opportunities through an increasingly favourable ratio between the population of dependent ages and the working-age population. The challenges for these countries are, first, to develop a long-range vision which will direct attention towards the current agenda relating to the process of population ageing, without neglecting the urgent need to solve short-term problems and, second, to build up human capital and job-related skills and expand the capacity of production sectors in order to ensure their effective performance and thus make certain that these opportunities are not allowed to slip by.

In countries where population ageing is imminent (which means that the time for action is limited), authorities cannot simply replicate the solutions applied in developed countries because the economic, institutional and historical realities are different. Thus, they face the challenge of developing alternatives of their own to address this phenomenon, without losing sight of basic issues relating to different generations' harmonious coexistence and inter-generational solidarity.

Population ageing must not be regarded as a matter that concerns only the current generation of older persons. As discussed in this document, the steps taken to address this issue in all areas of the public agenda and in all relevant laws and policies, as well as the corresponding budget allocations, will have an impact throughout society. The essential point, from this standpoint, is to determine what steps need to be taken in order to build more cohesive, democratic and inclusive societies.

In this, as in any other sphere of public policy, the way forward depends on the mechanisms adopted and the scope for social cohesion within society, on how the reciprocal relationship between current generations is strengthened and on how this is accomplished without jeopardizing the future of coming generations. Authorities must take stock of the existing situation, deal with persistent lags and gradually move forward, expanding social protection to encompass the entire population.

ECLAC has placed special importance on this issue and has drawn attention to the need to expand coverage and increase the quality of social protection systems to cover risks of illness, old age, disability and death, among other situations of vulnerability. Entitlement to social rights embodies genuine belonging to society, since it implies that all citizens are included in the development and can enjoy the well-being that such growth provides (ECLAC/SEGIB, 2007). In old age, in particular, this curbs the inequalities that accumulate over a lifetime and, at the same time, reduces the probability that disadvantages will be transmitted from one generation to the next.

Chapter I of this document, "Heterogeneous ageing of the region's population", provides an overview of the demographic transition and ageing in the region, identifies the determinants of this process and considers some of the differences to be observed within the older adult population.

The second chapter, entitled "Ageing in the context of a rights-based approach to development", presents the social protection policy approach proposed by ECLAC at its most recent session and discusses how it applies to the specific situation of the elderly population. An assessment is made of the progress achieved in terms of constitutionalization and protection through the passage of special laws on the rights of older persons in the region. Obstacles to advances in protecting and enforcing the rights of older persons are also identified.

Chapter III, “Income protection and ageing in Latin America and the Caribbean” analyses the sources of economic security, including participation in economic activities by older persons, and looks at how social security systems perform in providing long-term old-age support. It concludes with a section on advances in the implementation of the Regional Strategy in the areas of social security, employment, and individual and community undertakings.

Chapter IV, entitled “Health protection and ageing in Latin America and the Caribbean”, addresses the relationship between demographic and epidemiological transition as well as its effects in terms of health requirements and coverage of the health system. It concludes with a section that describes achievements in the implementation of the Regional Strategy in the areas of health benefits, staff training and long-term care.

The fifth chapter, “Enabling environments and ageing in Latin America and the Caribbean”, looks at social environments, specifically residential arrangements and care systems, and physical environments, in particular housing, access to basic services and public areas. The concluding section reviews advances in implementing the Regional Strategy as it applies to the issues of abuse, participation, support networks, education, housing, transport and accessibility.

The sixth and final chapter, “Challenges to be met in implementing the Regional Strategy”, looks at the main challenges identified during the first cycle of the review and appraisal of the Regional Strategy, with emphasis on the diverse range of situations and the need to broaden labour perspectives in this area in order to bring government responses into line with demographic changes within the framework of a society for all.

Chapter I

HETEROGENEOUS AGEING OF THE REGION'S POPULATION**A. DEMOGRAPHIC TRANSITION AND THE AGEING PROCESS
IN LATIN AMERICA AND THE CARIBBEAN**

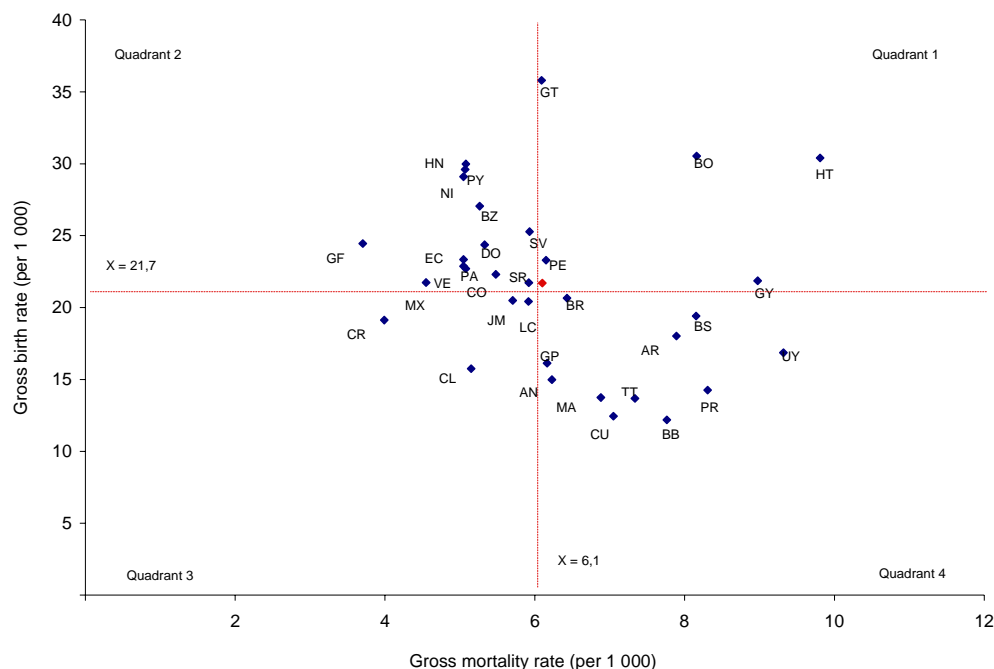
Demographic transition, which is a concept used to describe the basic characteristics of countries' population changes, consists of several stages. In the first stage, birth and mortality rates are high, which produces low population growth. In the second (truly transitional) stage, a reduction in mortality and a continuing high birth rate lead to an increase in population growth rates. In the third phase, known as advanced transition, mortality rates have already fallen and birth rates decline too, which results in increasingly lower rates of population growth. In the post-transition phase, birth rates drop below the level of mortality rates, thus resulting in extremely low or even negative natural population growth (Chackiel, 2004; Schkolnik, 2007; Villa and González, 2004).

The initial stage of the demographic transition process consists of a sustained decline in mortality and subsequently in fertility; this is followed by a phase in which the levels of both variables are low (Chackiel, 2004; Schkolnik, 2007; Villa, 2005). Although this concept was formulated to explain the sociodemographic transformation of European countries from the mid-eighteenth to the mid-twentieth centuries (Villa and González, 2004), Latin America and the Caribbean has undergone a similar process, albeit one with certain differences. In Europe, the transition process lasted over a century, while the duration has only been 50 years in this region.

The region's countries are moving towards more advanced stages of demographic transition, with this process consolidated by much lower birth and mortality rates than in previous decades: the average birth rate is no higher than 22 in 1000 and the mortality rate 6.1 in 1000. Even so, the situation is far from uniform among and within countries, as shown in figure I.1, which shows each country's position on the Cartesian graph according to its birth and mortality rates for the period 2000-2005. The countries in the first quadrant are at the earliest stage of transition, as they still have higher birth and mortality rates than the regional average (notwithstanding differences between them in terms of their natural growth rate). In Bolivia and Haiti, a high mortality rate contributes to slower population growth (around 2.2%), while high fertility in Guatemala is reflected in a higher rate of population growth (3%).

In the countries located in the second quadrant, mortality has declined considerably, although the birth rate remains relatively high or close to the regional average, thereby resulting in growth rates of between 1.8% and 2.5%. These countries are therefore in full transition. The steady fall in infant mortality in Belize, Honduras, Nicaragua and Paraguay is reflected in a gross mortality rate below the regional average, although the birth rate remains high. Figures for El Salvador, Peru, Dominican Republic, Panama, Colombia, Bolivarian Republic of Venezuela and Suriname are all very close to the regional average. The third quadrant contains countries where the birth rate and mortality rate are considerably lower than the regional average, with a growth rate that has fallen, in some cases quite recently and suddenly (as in Costa Rica and Chile).

Figure I.1
**LATIN AMERICA AND THE CARIBBEAN: THE STATUS OF COUNTRIES IN TERMS OF
 DEMOGRAPHIC TRANSITION, 2000-2005**

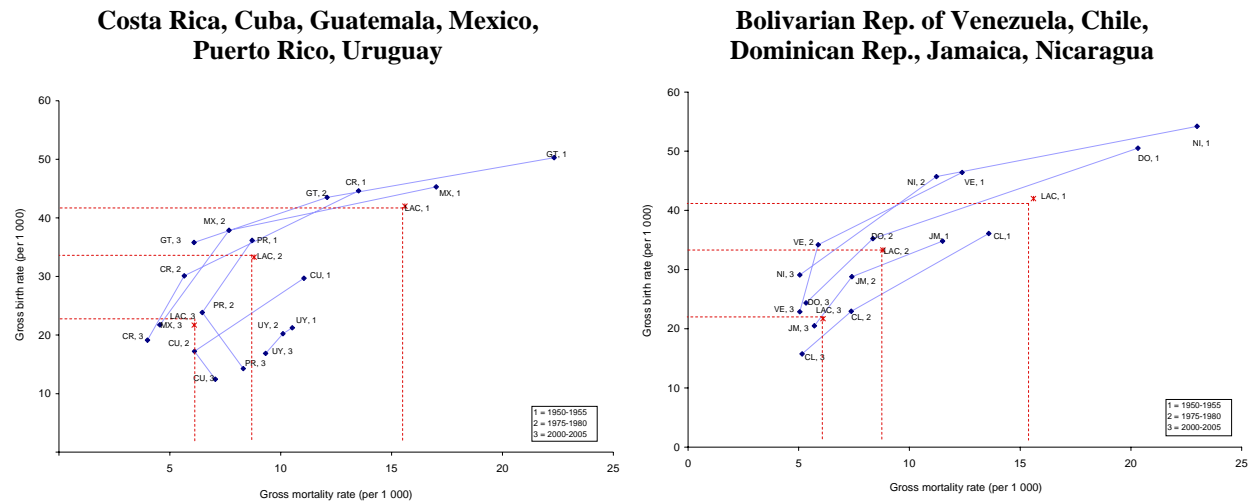


Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, population estimates and projections [online] www.eclac.cl/celade/proyecciones/basedatos_BD.htm.

Located in the fourth quadrant are those countries at a very advanced stage of transition or even in post transition, with low birth rates and rising mortality rates (typical of an aged population). Cuba and other Caribbean countries show signs of being in a post-transition phase, while Argentina and, to a lesser extent, Uruguay show signs of a longer transition. The growth rates in these countries range from 0.4% (Cuba and Barbados) to 1% (Guadeloupe and Argentina).

The current position of the region's countries in terms of the demographic transition process is the result of various experiences over the course of the last 50 years, which have in turn been influenced by many factors. To demonstrate these trajectories, 11 countries at various stages of the process were selected, with the regional average used as a reference point (see figure I.2). There are distinctly heterogeneous patterns in the demographic development of countries that, in some cases, already had vital rates way below the regional average between 1950 and 1955. In Uruguay, a forerunner in this process, the mortality rate during the 1950s was only equalled by the regional average 25 years later, while the region only caught up with the Uruguayan birth rate as recently as 2000. However, the decline in Uruguay's rates slowed down during the following decades, mainly as a result of gradual upward shift in the age structure. Cuba has also had much lower vital rates than the regional average, although the trends have followed different patterns to those of Uruguay. At the beginning of the 1950s, Cuba had moderate vital rates; mortality rates plummeted between 1950 and 1980, while the birth rate began to drop suddenly during the 1970s. This change, which has intensified in recent decades, has resulted in a slowdown of the rate of population growth, a rapid ageing of the population and, therefore, a very advanced stage of demographic transition.

Figure I.2
LATIN AMERICA AND THE CARIBBEAN (SELECTED COUNTRIES): DEMOGRAPHIC TRANSITION PATTERNS, 1950-2005



Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, population estimates and projections [online] www.eclac.cl/celade/proyecciones/basedatos_BD.htm.

Chile and Costa Rica display fairly similar trends, although in 1950 the latter's gross birth and mortality rates were higher than those in Chile and the regional average. Both countries' vital rates declined considerably during the first period (1950-1980) and remained below the regional average between 1980 and 2005. The pace of change was faster than in Argentina and Uruguay, whose natural growth rates were very close to 1%.

Mexico and the Bolivarian Republic of Venezuela are intermediate cases, with trajectories similar to the regionwide pattern. The demographic transition process began later in Guatemala and Nicaragua, with both countries' vital rates only reaching the regional average from the beginning of the period as late as 1975-1980. The gap was slow to close and, during the second period (1980-2005), mortality rates dropped to moderate levels and birth rates began to decline.

1. Fertility and mortality: a widespread and steady decline

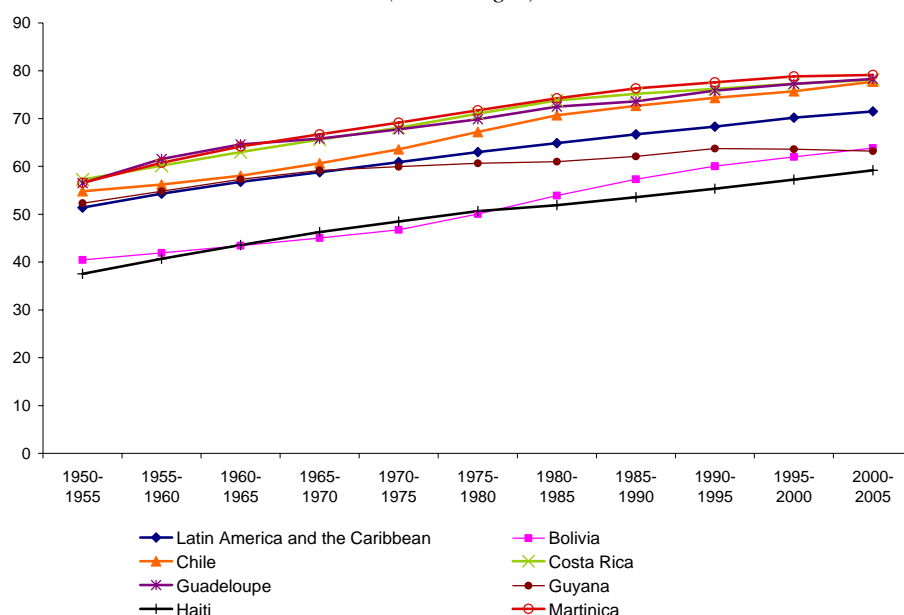
Changes in fertility and mortality in the region, irrespective of their intensity and duration, have resulted in profound demographic changes, most notably a reduction in population growth and a gradual upward shift in age structures (ECLAC, 2004).

Although falling mortality rates are a factor in population ageing, they have a different effect depending on a country's stage of transition. A decline in mortality, particularly in young age groups, is what initiates the demographic transition process and results in longer life expectancy for the region's population.

Over the past 50 years, regional mortality has dropped by 10 percentage points to give a gross mortality rate of 6.1 deaths for every 1,000 inhabitants between 2000 and 2005. Haiti has the highest gross mortality rate (9.8 in 1,000) and French Guyana has the lowest (3.7 in 1,000). Declining mortality has raised

the life expectancy at birth of the Latin American population to 71.5 years in the period 2000-2005. The increase in life expectancy at birth has occurred across the board in the region: the figure is almost 80 years for both sexes in four countries (Martinique, Guadeloupe, Costa Rica and Chile). Having said that, there remain differences among countries (see figure I.3).¹ In the five year period 1950-1955, the maximum difference in life expectancy at birth was between Uruguay (66.3 years) and Haiti (37.6 years). For the period 2000-2005, the maximum difference was between Martinique (79.1 years) and Haiti (59.2 years).

Figure I.3
LATIN AMERICA AND THE CARIBBEAN (SELECTED COUNTRIES): LIFE EXPECTANCY AT BIRTH, BOTH SEXES, 1950-2005
(Percentages)



Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, population estimates and projections [online] www.eclac.cl/celade/proyecciones/basedatos_BD.htm.

Female mortality is lower than male mortality throughout the region, which means that women's life expectancy is longer than that of men. This is due to, inter alia, the reduction in deaths related to pregnancy and labour, as these causes are usually controlled more successfully than those that affect men such as cardiovascular disease, external causes, violence and certain kinds of malignant tumours (ECLAC, 2004; CELADE, 2006a).

Chesnais (1990) identified three distinct phases in the mortality reduction process. The first phase is characterized by a general decline in mortality and an increase in life expectancy, mainly due to lower infant mortality and a resulting rise in the number of survivors in the base of the age pyramid. Although population growth is observed in all age groups, this is proportionally greater in the younger age groups as reduced risk of death in infancy and childhood initially promotes a rejuvenation of the population. In Latin America and the Caribbean, the average infant mortality rate has fallen from 126 deaths per 1,000 live births per year between 1950 and 1955, to 26 deaths per 1,000 in the period 2000-2005. However, progress has been

¹ Life expectancy at birth is the most efficient indicator of a population's level of mortality, as it is free from the distortive effect of differences between age structures, while remaining sensitive to levels of mortality in infancy and childhood.

uneven despite the improvements recorded in many countries: 10 countries (Nicaragua, Belize, Honduras, Peru, Dominican Republic, Paraguay, Guatemala, Guyana, Bolivia and Haiti) still have child mortality rates above the regional average, whereas four countries and territories (Cuba, Martinique, Guadeloupe and Chile) have fewer than 10 deaths per 1,000 live births. Persistently high infant mortality is empirical evidence of the risks of a demographic backlog both among and within countries (ECLAC, 2005).

The second stage of the process identified by Chesnais is a more evenly spread reduction in mortality across all age groups. The population structure shifts to accommodate a higher proportion of young people and adults as a result of the large cohorts born in the past with higher survival rates. This is the case of countries in an advanced state of demographic transition (see figure I.1), where the gross mortality rate for the period 2000-2005 is less than 10 in 1,000 and the infant mortality rate has declined considerably.

The third and final stage begins when there are reductions in the high mortality rate among young children and in mortality caused by degenerative diseases that affect mainly those aged over 50 (thereby increasing the probability of survival among older adults and intensifying population ageing). During this stage, a longer average lifespan is reflected in a higher proportion of the very old, who tend to have a greater need for medical, institutional and family support. Practically none of the region's countries are at this stage, although mortality is rising as a result of population ageing in some places such as Cuba, Puerto Rico, Bahamas, Guyana and Trinidad and Tobago, which all registered slight increases in their gross mortality rates in the period 2000-2005, with an even higher rate predicted by 2025 (see table I.1). By 2050, the mortality rates of several of the region's countries are expected to be higher than their present levels, mainly as a result of population ageing. This is due to older adults making up a higher proportion of the total population. In other words, there are relatively more people in age groups at greater risk of death.

Table I.1
LATIN AMERICA AND THE CARIBBEAN (SELECTED COUNTRIES): DIFFERENCES IN SURVIVAL YEARS AT THE AGE OF 60 FOR MEN AND WOMEN, 1950-2050

Countries	Differences in survival years at age 60 for men and women				
	1950-1955	1975-1980	2000-2005	2025-2030	2045-2050
Argentina	2.9	4.1	5.0	5.4	5.5
Bolivia	1.1	1.2	1.9	2.8	3.6
Brazil	0.6	0.8	3.0	3.7	4.3
Chile	2.3	3.0	3.7	4.3	4.7
Colombia	1.1	1.6	2.2	3.1	3.4
Costa Rica	1.0	2.3	2.7	3.4	3.8
Cuba	0.7	2.0	2.3	3.1	3.4
Dominican Republic	1.1	1.8	2.4	3.3	3.7
Ecuador	1.3	1.3	2.1	3.1	3.7
El Salvador	1.1	2.9	3.1	3.9	4.4
Guatemala	0.4	1.0	0.0	2.8	3.8
Haiti	0.3	0.6	1.1	2.3	3.2
Honduras	0.9	1.6	2.6	3.2	3.7
Mexico	1.0	1.9	1.8	2.8	3.2
Nicaragua	1.4	2.2	1.7	3.3	3.7
Panama	1.1	1.9	2.0	3.2	3.9
Paraguay	1.9	1.9	1.9	2.7	3.0
Peru	0.9	1.7	2.6	3.2	3.8
Uruguay	3.6	4.1	5.3	5.0	4.9
Venezuela (Bol. Rep. of)	1.2	2.6	2.1	3.2	3.9

Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, estimates and projections.

One of the most significant demographic transitions undergone by the region has been the intense and steady decline in fertility (Rodríguez, 2003). This profound shift in reproductive behaviour goes hand in hand with sociodemographic and cultural changes (Villa and Rivadeneira, 2000). This process is taking place to a greater or lesser extent in all countries, although individual national experiences have been far from uniform (Schkolnik and Chackiel, 2003). As fertility falls, so the population gradually ages (Chackiel, 2003). Ever-declining fertility therefore heightens differences in the age structure, in what is a key feature of the process of population ageing.

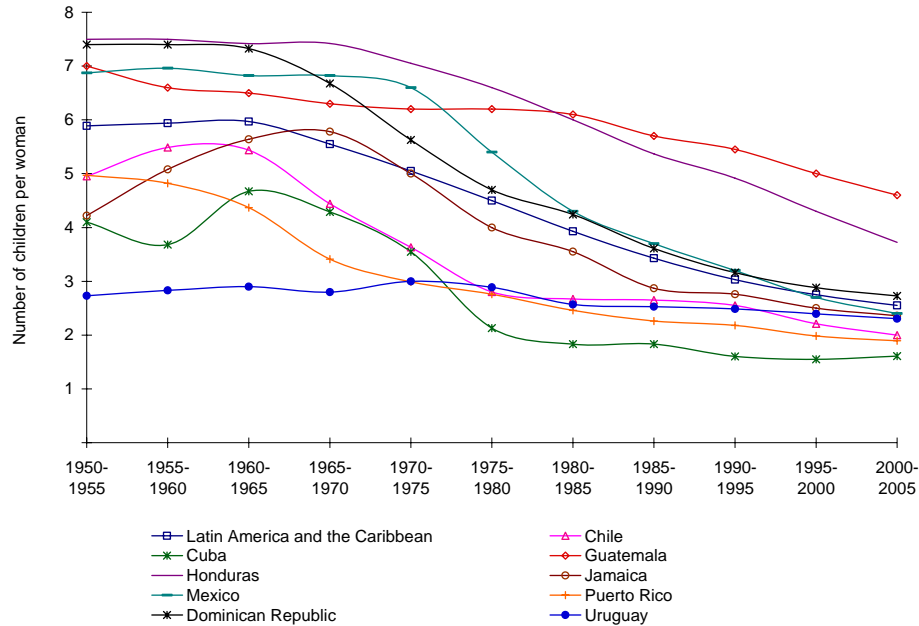
When the global fertility rate goes into steady decline, the base of the age pyramid narrows. This change in the pyramid shape occurs during demographic transition, which results in ageing from the pyramid base upwards. The link between low fertility and ageing is that the relative significance of other age groups increases in direct proportion with the decrease in those aged 0 to 4 years. There is therefore a higher proportion of older people, and the lowest level of the age pyramid shrinks. With a steady decline over time, ageing originates in the middle of the pyramid, as there are proportionally more people of intermediate age than young age (which makes the pyramid more of a rectangle). Subsequently, the combination of low fertility and falling mortality among older people results in a wide tip and a narrow base (Villa and Rivadeneira, 2000). Falling fertility clearly has more of an effect than changes in the mortality rate, as the latter only has a more direct impact at the most advanced stages of ageing (Chesnais, 1990).

Fertility has fallen in all the region's countries due to a range of factors. During the last four decades of the previous century, couples in Latin America and the Caribbean changed their reproductive patterns from a widespread tendency to have large families to a new model of approximately two children per woman. Changes in economic and social structures led to a series of cultural transformations that contributed to the adoption of reproductive behaviour in line with the ideal of a smaller family. This was in turn facilitated by the availability of contraception.

Despite this, the region's countries differ wildly in terms of when fertility began to fall and the intensity of the process. The global fertility rate (the average number of children that would be born per woman if all women lived to the end of their childbearing years and bore children according to a given age-specific fertility rate) ranges from below the replacement level (2.1 children per woman) in Cuba, Barbados, Puerto Rico and Trinidad and Tobago, to over 4 children per woman in Guatemala and Haiti (ECLAC, 2004; Villa and González, 2004; Chackiel, 2004).

Fertility first began to decline in Argentina and Uruguay. This early decline was mainly due to the fact that both countries underwent considerable economic and social development in the first half of the twentieth century and the sociocultural influence of European immigration. Although the total fertility rate in these countries was around three children per woman in 1950, the two countries displayed the region's smallest decrease in fertility between 1950 and 2005 (less than 25%). Total fertility was slower to drop in the region's other countries. In 1950, total fertility rates were over four children per woman in these countries (over seven in some countries), but have dropped by between 30% and 70% over the past 50 years. The case of Cuba is particularly striking, as fertility soared in the early 1960s before plummeting to below the replacement level in 1980. In the five year period 2000-2005, the average number of children per woman in Cuba was just under 1.6. Following high or very high fertility rates in 1950, Guatemala, Haiti, Bolivia and Paraguay (countries with the highest current levels of fertility) have seen fertility levels drop to below 45% of those initial figures in last 50 years (see figure I.4).

Figure I.4
LATIN AMERICA AND THE CARIBBEAN (SELECTED COUNTRIES): GLOBAL FERTILITY RATES, 1950-2005



Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, population estimates and projections [online] www.eclac.cl/celade/proyecciones/basedatos_BD.htm.

There is uncertainty surrounding what the characteristics of fertility will be in the next 50 years in the region, which has given rise to various questions and hypotheses (Villa, 2005; Chackiel and Schkolnik, 2004; CELADE, 2004). Although the rate of reproduction may well continue to drop or indeed be pushed to below the replacement level in all of the region's countries, there is uncertainty about how long this will take and the level that the fertility rate will reach. Several studies (Villa 2004; Chackiel and Schkolnik, 2004; CELADE, 2004; Schkolnik, 2004) suggest possible trends for fertility in Latin American and Caribbean countries. One possibility is that the region will follow the Cuban fertility trend and reach a level similar to that of Southern European countries, or, follow in the footsteps of Argentina and Uruguay where the global fertility has dropped slowly without dipping below the replacement level.

2. Changes in the population age structure

The components of demographic change (fertility and mortality) have as much impact on the age distribution of the population as on population growth. As the demographic transition process progresses and mortality and especially fertility decline, the population gradually ages (Chackiel, 2004; Villa and González 2004; ECLAC, 2004). This is defined as a progressive increase in the proportion of people aged 60 and above within the total population. This phenomenon gradually alters the profile of the age structure, whose conventional characteristics (a pyramid with a wide base and narrow tip) morph towards a more rectangular shape and subsequently an inversion of its initial form, with the top wider than the base (Chesnais, 1990).

Changes observed in age structures over the last 50 years confirm the effects of fertility and mortality patterns (see figure I.5). In countries at a more advanced stage of demographic transition (quadrants 3 and 4 of figure I.1), the pyramid structure was modified sooner than in those countries at an earlier stage in the process, which only began to show changes in the year 2000. Therefore, most countries posted a slight rejuvenation of the population in the period 1950-1975, as the fall in infant mortality increased the proportion of children aged under 15 to 41% of the regional population in 1975 (Villa and Rivadeneira, 2000).

The share of the population made up of people aged 60 and over edged up slightly to 6.5%, while there was a decrease in the proportion of working-age people (15 to 59 years). Of course, the nature of the changes depends on the stage of transition of countries: in those at the most advanced stage, those aged 60 and over already represented 7.4% of the population in the 1950s, while the average was 5.1% in countries at a less advanced stage. In 1975, those aged 60 and over represented 11.2% of the population in countries in quadrant 4, while the proportion of children under the age of 15 remained constant. At the other extreme, in countries at a much earlier stage of transition (quadrant 1), children under the age of 15 still represented 40% of the population and the proportion of older adults had hardly risen.

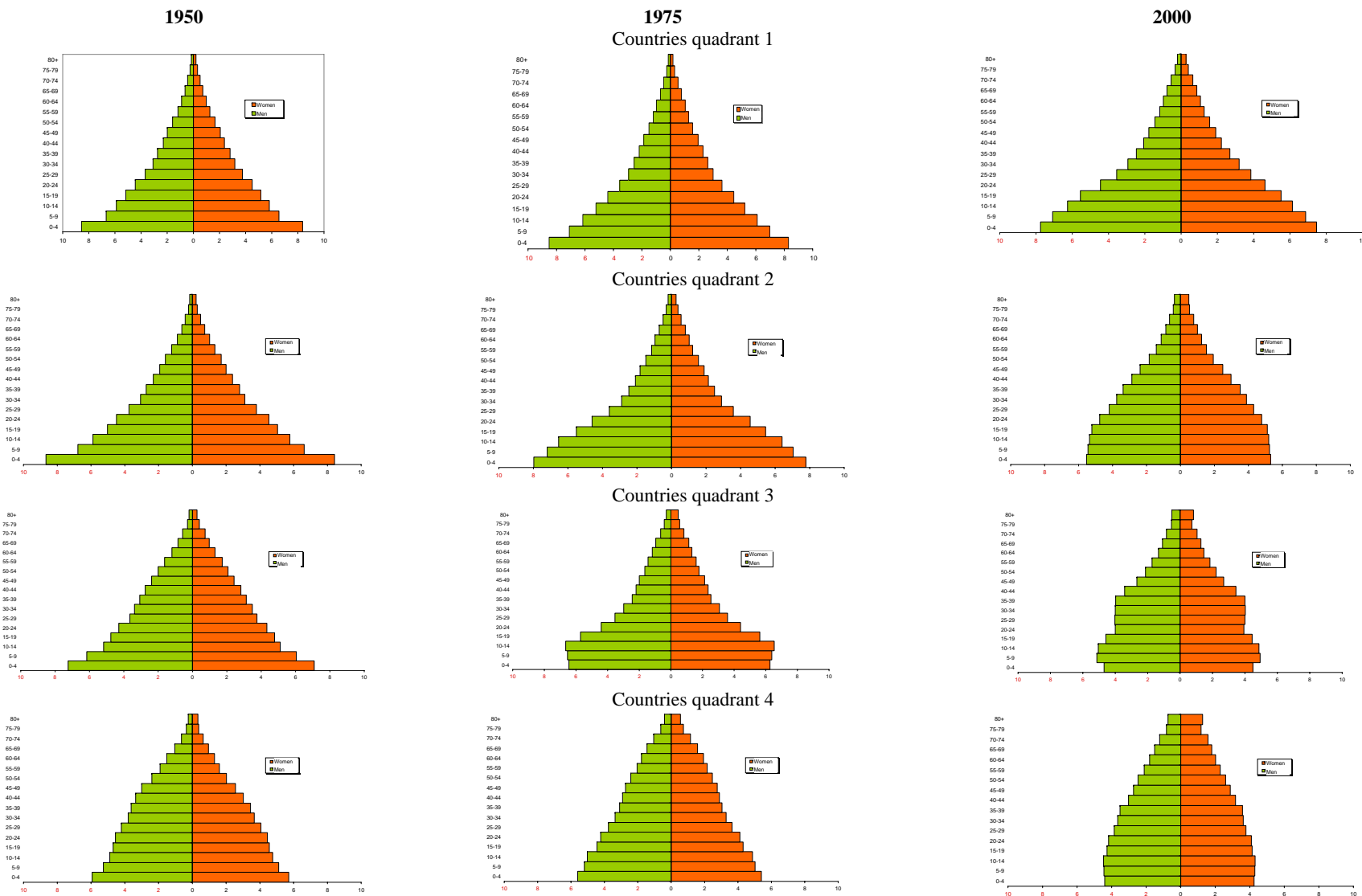
In the year 2000, the traditional pyramid shape began to alter: the steady fall in fertility rates brought down the proportion of children under the age of 15 in all countries to an average of 31% of the regional population. This proportion was only above 40% in the least advanced countries, while it was below 27% in the countries at the most advanced stage of the process. This means that ageing was taking place in the pyramid base, as the number of children aged 0 to 14 dropped, while the central and top areas became wider while the number of children under 5 continued to fall (see figure I.5). The proportion of older adults therefore increased in almost all countries. In the year 2000, the regional population included 8.3% of people aged 60 and over, with the figure rising to 14% in countries at an advanced stage of transition and falling to 6.1% in those at the least advanced stage. Furthermore, the population aged 15 to 59 rose to 60% in 2000, as a result of falling fertility and the stagnant growth of previous decades.

According to a recent review of the population projections of the Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, changes in the pyramid structure will pick up pace in 2025: children under 15 will only represent 23% of the population, while older adults will make up almost 15% of the regional population. Also, the larger cohorts born in previous decades will gradually be reaching adulthood, thereby broadening the central bands of the pyramid as part of an “era of departure” (resulting from the past “era of expansion”) that will continue for decades to come. The new age profile is shaping a pyramid with a narrower base and wider central sections, which means that the population is older (see figure I.6). Around 19% of the population in countries at the most advanced stage of demographic transition will be aged 60 or over, while the percentage of children under the age of 15 will drop to 20%. Countries that are the least advanced in the process will have a lower proportion of older adults (8%), which will slowly increase in line with the decrease in the population aged 0 to 14 years (31.7%).

By 2050, the classic pyramid structure will be completely replaced by a rectangular shape where each age group represents practically the same proportion of the population. Children under the age of 15 will represent 18% of the total regional population, and older adults will represent 24.3%. Countries that were already displaying population ageing in 2000 will have the highest proportion of older people (27%), while the least advanced countries in the transition will have considerably increased their proportion of people aged 60 and above to 14.7% of the total (see figure I.6).

Figure I.5

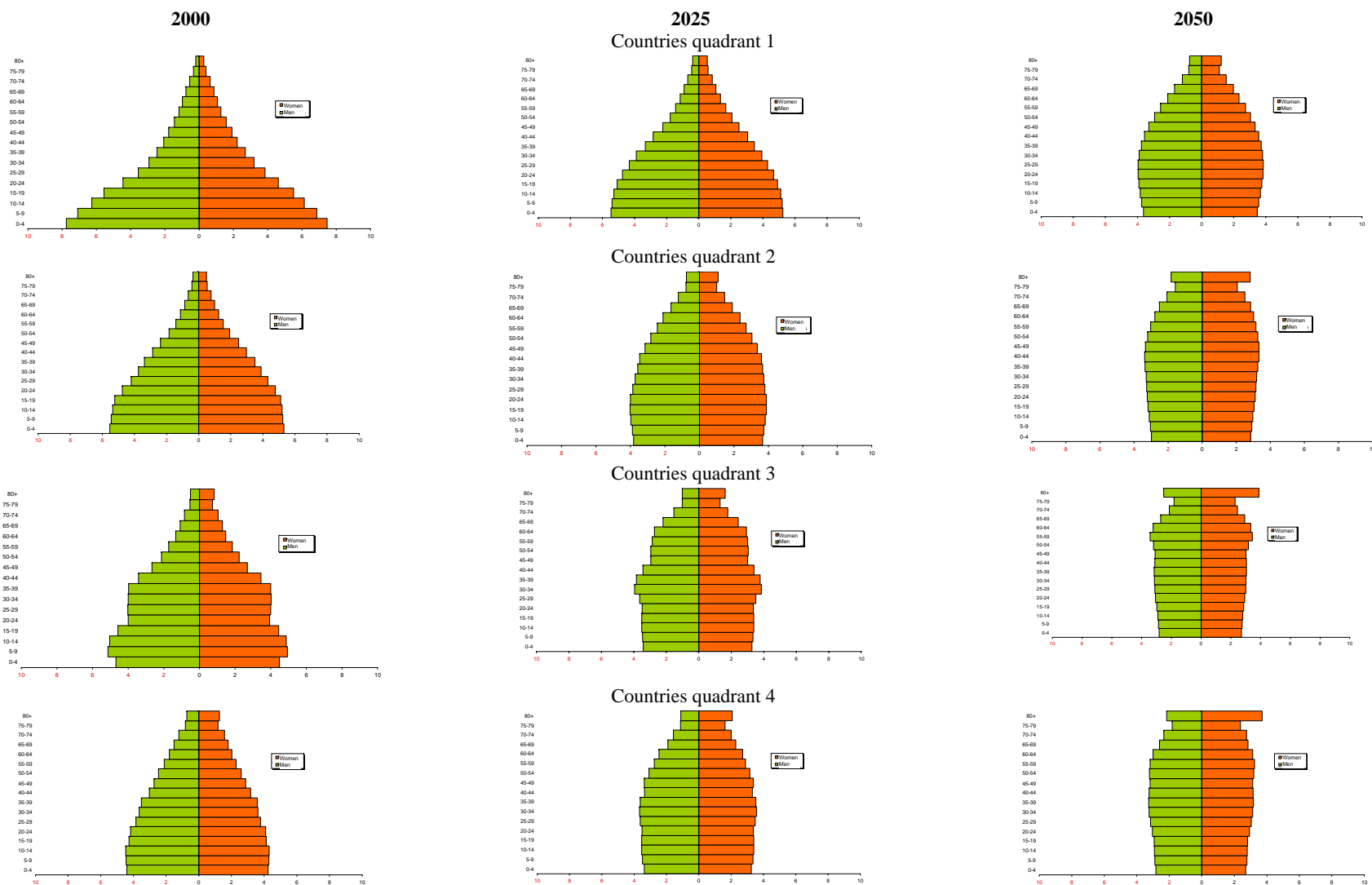
LATIN AMERICA AND THE CARIBBEAN: AVERAGE AGE AND SEX STRUCTURES OF THE POPULATION, BY STAGE OF DEMOGRAPHIC TRANSITION OF THE REGION'S COUNTRIES, 1950-2000



Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, population estimates and projections [online] www.eclac.cl/celade/proyecciones/basedatos_BD.htm.

Figure I.6

LATIN AMERICA AND THE CARIBBEAN: AVERAGE AGE AND SEX STRUCTURES OF THE POPULATION, BY STAGE OF DEMOGRAPHIC TRANSITION OF THE REGION'S COUNTRIES, 2000-2050

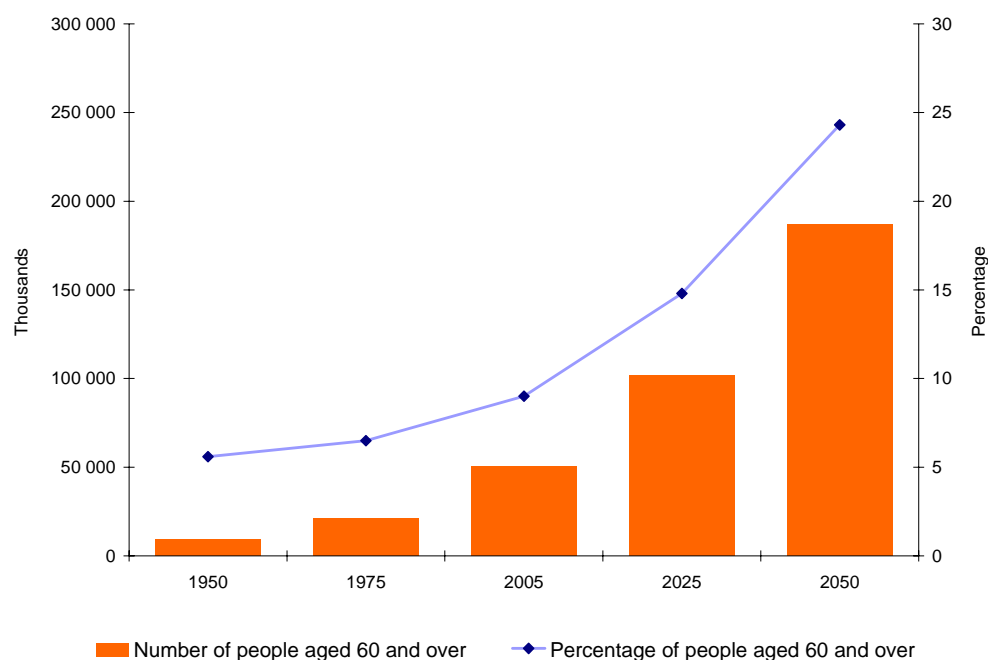


Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, population estimates and projections [online] www.eclac.cl/celade/proyecciones/basedatos_BD.htm.

B. POPULATION AGEING: A GRADUAL AND INEXORABLE PROCESS

As a result of demographic transition, the population of Latin America and Caribbean is gradually but inexorably ageing. The next few decades will see steady increases in both the proportion and the absolute number of people aged 60 and over (see table A.1 of the annex). In absolute terms, the number of people aged 60 and over (currently 41 million) will grow by 57 million between 2000 and 2025, and by 86 million between 2025 and 2050. This population group is growing at a faster pace than other younger groups (average annual growth rate of 3.5%). The rate of change within this age group will be between three and five times higher than among the total population in the periods 2000-2025 and 2025-2050. As a result, the proportion of people aged 60 and over in the total population will triple between 2000 and 2050, such that one in every four people in Latin America and the Caribbean will be an older adult in the year 2050 (see figure I.7).

Figure I.7
LATIN AMERICA AND THE CARIBBEAN: POPULATION AGED 60 AND OVER, 1950-2050
(Thousands and percentages)



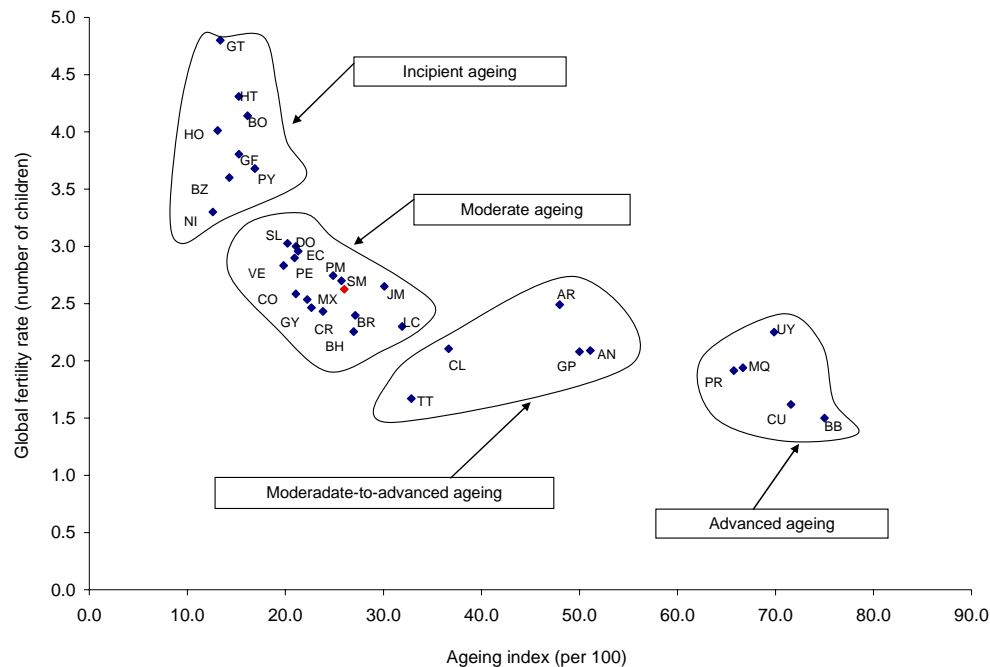
Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, population estimates and projections [online] www.eclac.cl/celade/proyecciones/basedatos_BD.htm.

1. National differences in the proportion of older adults and the growth rate of the older population

The fact that countries are at various stages of demographic transition means that the ageing process is different in each one. In order to classify the region's countries according to their stage in the process of population ageing, the global fertility rate was combined with the ageing index (ratio between the number

of people aged 60 and over and the number of children under the age of 15) for each country in the year 2000 (see figure I.8). As explained in the first section, the total fertility rate is used because it is key to the ageing process: declining fertility in the short-term produces ageing at the base of the pyramid as the proportion of children as a percentage of the total population falls. The ageing index is an indicator of the population structure by age: an increase in this indicator can mean that people are either living longer or having more children.

Figure I.8
LATIN AMERICA AND THE CARIBBEAN: POSITION OF COUNTRIES ACCORDING TO STAGE OF POPULATION AGEING PROCESS, 2000



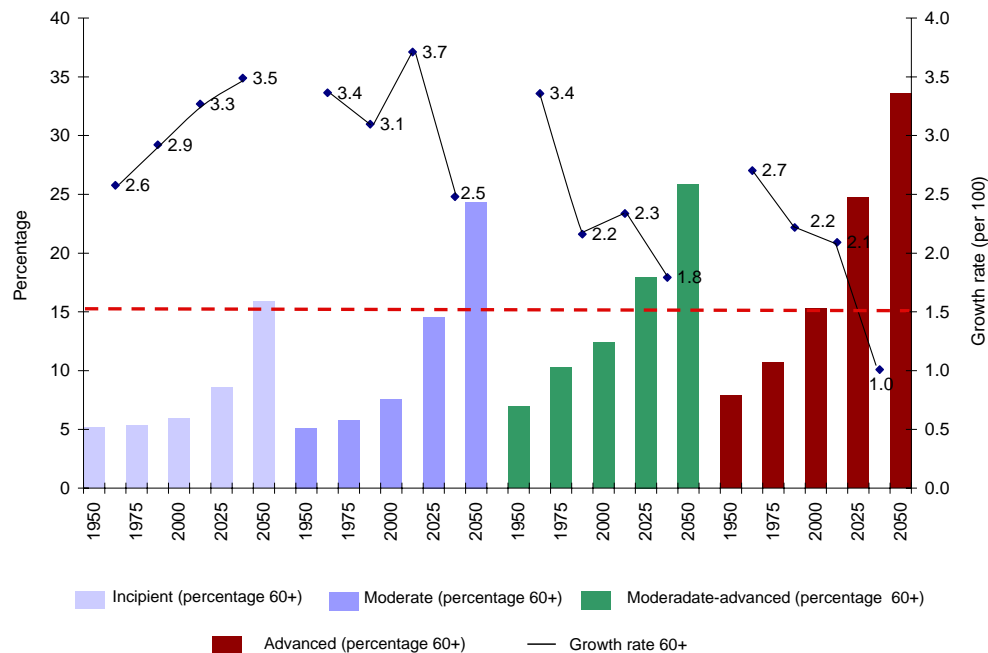
Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, population estimates and projections [online] www.eclac.cl/celade/proyecciones/basedatos_BD.htm.

Figure I.8 shows that there are four distinct groups of countries. The first group has relatively high levels of fertility (over 3.3 children per woman) and an ageing index lower than 17 older adults for every 100 children under the age of 15. These countries are at the incipient stage of the demographic transition process (eight countries). The second group consists of 15 countries with lower fertility rates (between 2.3 and 3 children per woman) and an ageing index that ranges between 19.8% and 31.9%, which means they are at the moderate stage of ageing. The five countries in the third group are at a moderate-to-advanced stage of ageing, as their fertility rates vary between 1.7 and 2.5 children per woman and their ageing indices range from 32.8 to 51 older adults per 100 children under the age of 15 (five countries). The fourth and final group of countries has lower levels of fertility (below the replacement rate) and ageing indices over 65% (five countries) (see figure I.8 and table A.2 of the annex).

The groups of countries shown in figure I.8 are directly linked to their stage in the process of demographic transition (see figure I.1). In other words, the ageing process intensifies as countries

progress through demographic transition. Having said that, the process has not been uniformly intense throughout the region, as some countries have quickly exceeded levels of 10% of the population aged 60 and over, while other countries have taken longer to surpass that percentage (see figure I.9).

Figure I.9
LATIN AMERICA AND THE CARIBBEAN: PERCENTAGE OF PEOPLE AGED 60 AND OVER AND GROWTH RATE OF THAT POPULATION, BY COUNTRIES' STAGE IN AGEING PROCESS, 1950-2050



Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, population estimates and projections [online] www.eclac.cl/celade/proyecciones/basedatos_BD.htm.

In 2000, older adults represented an average of 6% of the population in countries with incipient ageing, and 7.6% in countries with moderate ageing. The proportion of older people had already exceeded 10% in the other two categories: countries with moderate ageing posted 12.4% and in those at the most advanced stage of the process, people aged 60 and above accounted for 15% of the population. Between 1950 and 1975, countries where fertility and mortality had already begun to fall at the beginning of that period saw the population of those aged 60 and above grow at an average annual rate of 2.7%. As a result, in 1975 one in 10 people was aged 60 or over. In 2000, this age group made up 15% of the population, although the growth rate had slowed to 2.2% by that time (see figure I.9).

During the first 25 years of the period 1950-2000, although countries with moderate-to-advanced ageing recorded a similar percentage of older adults (10.3% in 1975), the average annual growth rate of 3.4% was higher than in countries with advanced ageing, as they started off with a lower proportion of older persons in 1950 (7%). Between 1975 and 2000, the older population in moderate-to-advanced countries grew at the same speed as in countries with advanced ageing (2.2%). Despite this, the percentage of older adults only rose to 12.4%.

Countries with incipient and moderate ageing entered the period 1950-2000 with the same proportion of older adults (5.1%). However, this percentage did not increase at the same rate (see figure I.9), mainly because fertility declined more sharply in countries with moderate ageing, which resulted in an average growth rate of 3.4% for older adults, who came to represent 5.8% of the population in 1975.

In countries where fertility was slower to fall, on the other hand, the percentage of older adults only rose by 0.2%, with an average annual growth rate of 2.6%. In some countries, the population aged 60 and over even fell as a result of the rejuvenation caused by declining mortality (especially among infants) and persistently high fertility. In the period 1975-2000, the number of older adults increased at the same rate in countries with incipient and moderate ageing. However, the proportion of older adults in the two categories of country is not the same as in 1950, as older adults represent 6% of the population in countries with incipient ageing, and 7.6% of the population in countries with moderate ageing (see figure I.9).

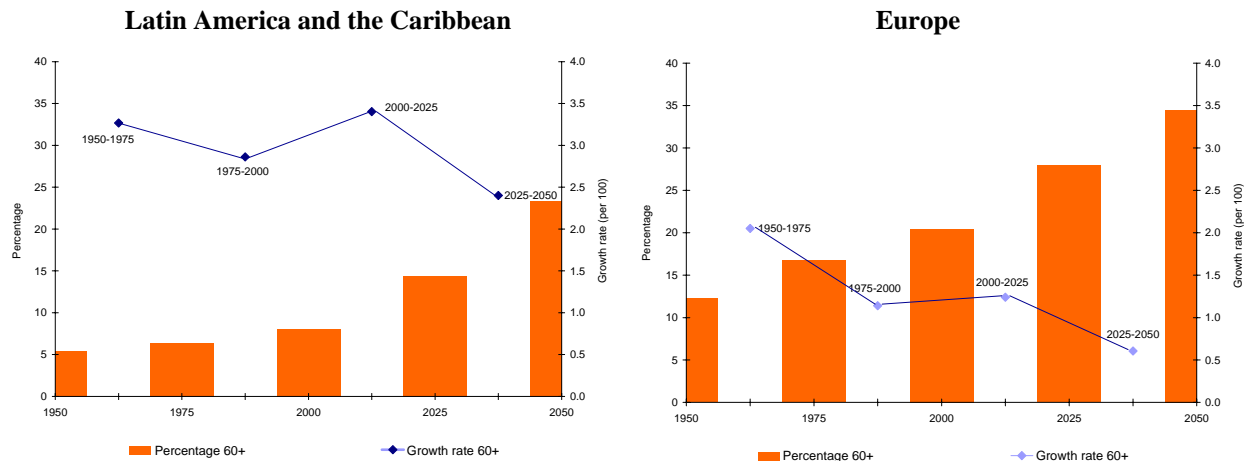
According to population estimates and projections, the number of older adults will continue to rise in the region, despite the persistence of differences among countries. In countries with advanced ageing, older adults will represent 25% of the total population in 2025. In 2050, 34 in every 100 people will be aged 60 or over. The growth rate will nonetheless be much slower, as the older population will increase at an average annual rate of 2.1% in the period 2000-2025, with the growth rate falling to as low as 1% over the following 25 years (2025-2050).

In countries with moderate-to-advanced ageing, the number of older adults will continue to grow by 2.3% between 2000 and 2025, which means that this age group will represent 18% of the total population by the end of the period. Although this growth rate will drop to 1.8% over the 25 years following 2025, those aged 60 and over will nonetheless represent 26% of the total population by 2050. In countries with moderate ageing, on the other hand, the growth rate of the population aged 60 and over will continue to rise and will even exceed the percentages recorded by more advanced countries at some stage in the process. The older population in these countries is therefore expected to increase by 3.7% between 2000 and 2025, and by a slightly lower 2.5% in the period 2025-2050. In countries with incipient ageing, growth rates of the older population will always rise, reaching 3.5% between 2025 and 2050, although older adults will still only represent 15% of the population by 2050 (see figure I.9).

One of the most striking differences between the ageing process in Latin America and the Caribbean as opposed to that experienced in Europe is that the former has moved along much more quickly and has therefore been played out over a shorter period of time. This indicates that the demographic transition process started much earlier in European countries, and that the shift from high to low levels of fertility and mortality was much slower than in Latin America and the Caribbean. In other words, the population aged more gradually.

In the mid-twentieth century, around 12.3% of Europe's population was aged 60 or over, while older adults represented 5.5% of the total population in Latin America and the Caribbean. A quarter of a century later, older adults represented over 15% of the total population in Europe, thanks to an average annual growth rate of 2.2% in the period 1950-1975. In Latin America and the Caribbean, between 1950 and 1975 fertility was already falling and the base of the age pyramid was gradually narrowing as a result. During this time, the proportion of older adults grew by an average annual rate of 3.3%. In 2000, the percentage of older adults in Europe was 2.5 times higher than in Latin America and the Caribbean, although the proportion has grown at a faster rate in the latter than in the former (2.9% compared with 1.1% in the period 1975-2000). Although the proportion of older adults in Europe will be twice that of Latin America and the Caribbean in 2025, this region's older population will post the highest growth rate in its history (3.4%) for the period 2000-2025 (see figure I.10).

Figure I.10
**LATIN AMERICA AND THE CARIBBEAN AND EUROPE: PERCENTAGE AND GROWTH RATE OF
 THE POPULATION AGED 60 AND OVER, 1950-2050**



Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, population estimates and projections [online] www.eclac.cl/celade/proyecciones/basedatos_BD.htm.

There is one feature of ageing in Latin America and the Caribbean that goes beyond the realm of demographics. Many authors agree that demographic transition in Europe was associated with a structural socio-economic shift that resulted in long-term increases in the standard of living and economic activity. As a result, the two processes interacted in a positive way by reinforcing each other.² The structures and institutions of European countries had sufficient time to adapt to the emerging demographic scenarios and to produce the resources needed to tackle the new challenges involved (Villa and Rodríguez, 2002). In Latin America and the Caribbean, on the other hand, the pace of demographic transition and population ageing has been faster, which means that there has been less time to make the necessary socio-economic and institutional adjustments to adapt to the emerging demographic situation. One manifestation of this asymmetry is the rapid demographic transition process compared with slower and more volatile economic and social development.

C. THE OLDER ADULT POPULATION AND INTERNAL DIFFERENTIATION

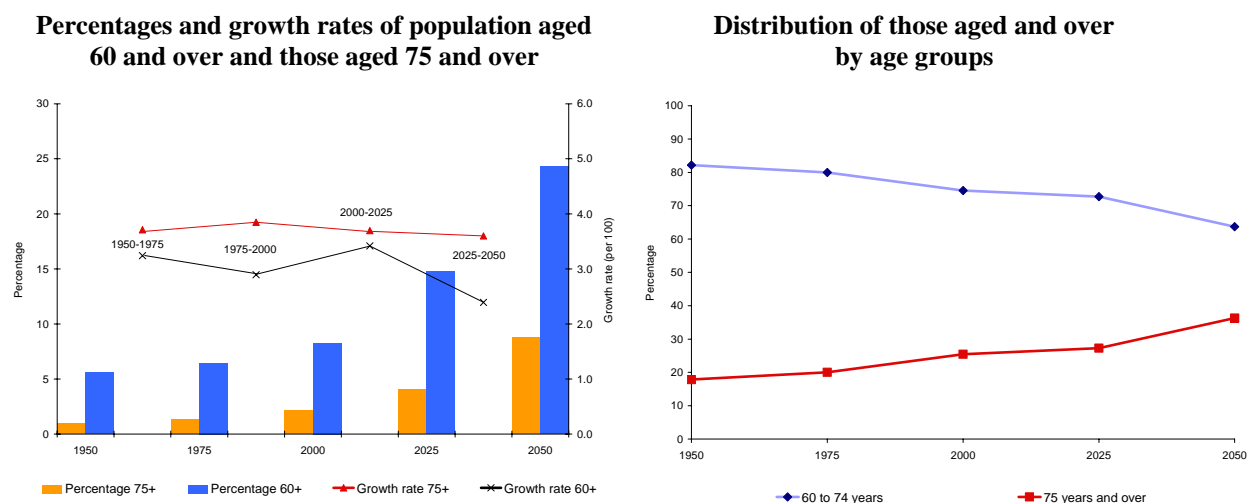
The population of those aged 60 and over is not a homogenous group, hence an analysis of some sociodemographic characteristics shows up some differences according to age (60-74 years or aged 75 and over), sex and place of residence, which are all factors that influence access to economic security, as well as health, environment and poverty.

² For further information on this issue, see Hill, Morelos and Wong (1999), Kirk (1996), Livi-Bacci (1994), Vallin (1994) and Rodríguez (2001).

1. Ageing within the older adult population

In addition to the projected increase in the older population as a whole in the region over the next few decades, the proportion of very old people within the older population is also set to rise. Over the next 50 years, older adults will age rapidly, as the age group that will expand most dramatically corresponds to those aged 75 and over (see figure I.11). The growth rate of the population aged 75 and over is expected to remain above that of the population aged 60 and over during the period 1950-2050 (see figure I.11). In 2025, this age group is expected to have doubled to represent 4% of the population, before expanding to almost 9% of the total in 2050.

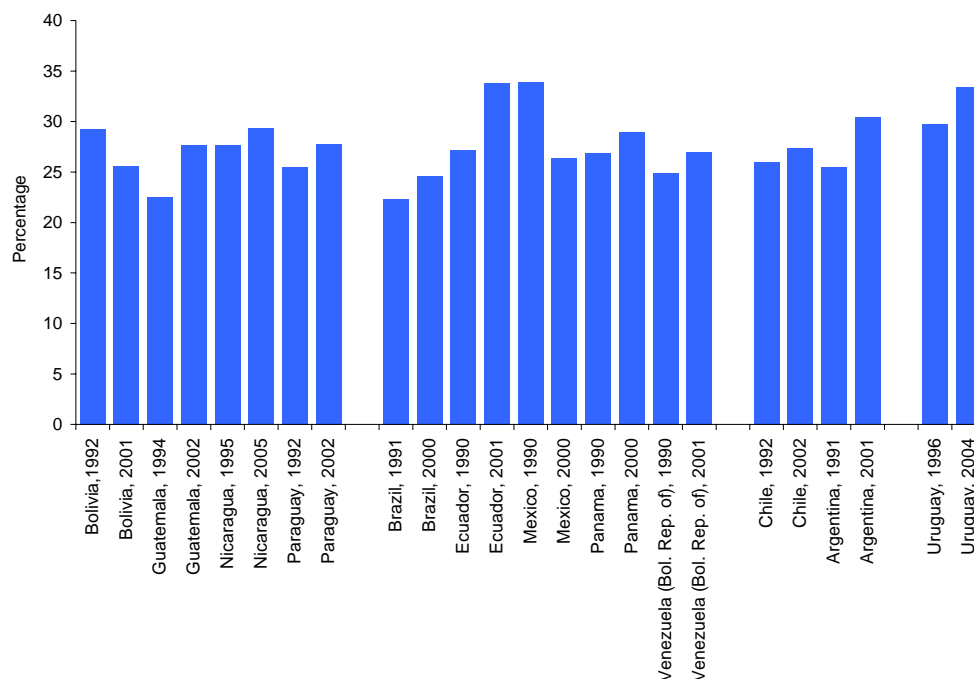
Figure I.11
LATIN AMERICA AND THE CARIBBEAN: PERCENTAGE AND GROWTH RATE OF THE POPULATION AGED 60 AND OVER AND THOSE AGED 75 AND OVER, AND DISTRIBUTION OF THE OLDER POPULATION BY MAJOR AGE GROUPS, 1950-2050



Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, population estimates and projections [online] www.eclac.cl/celade/proyecciones/basedatos_BD.htm.

Data from the two most recent census rounds in some of the region's countries do not show a clear trend in the pace of ageing among the older population. Even so, 10 of the 12 countries analysed have seen increases in the proportion of people aged 75 and over compared to those aged between 60 and 74. In the 1990 round of censuses, Brazil was the country with the smallest proportion of people aged 75 and over among the older population (22.3%), while Mexico had the highest percentage (33.9%). In the first decade of the twenty-first century, Brazil continued to have the lowest proportion (24.6%), with Ecuador now laying claim to the highest percentage (33.9%) (see figure I.12). The lack of clarity in terms of ageing within the older population seems to be explained by the incorporation of larger cohorts than in the past during the period between the two census rounds (1990-2000). This affects the demographic dynamics within the older population and may even give rise to relative rejuvenation, as in the case of Mexico.

Figure I.12
**LATIN AMERICA AND THE CARIBBEAN (SELECTED COUNTRIES): PERCENTAGE OF
 POPULATION AGED 75 AND OVER AS A PROPORTION OF TOTAL OLDER ADULTS,
 CENSUSES OF 1990 AND 2000**



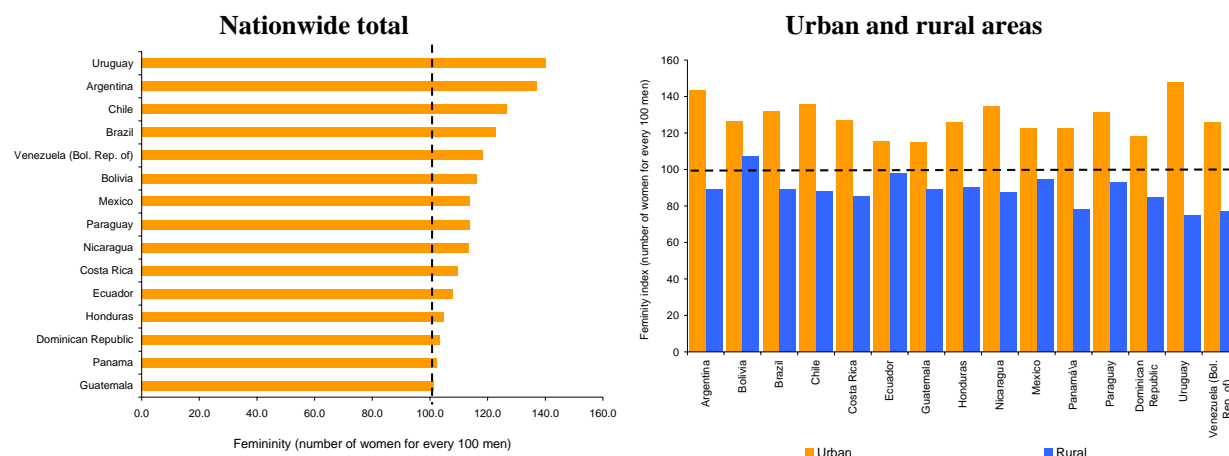
Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, population estimates and projections [online] www.eclac.cl/celade/proyecciones/basedatos_BD.htm.

Ageing within the population aged 60 and over may increase the need for medical, institutional and family support. It is therefore necessary that policies targeting this age group take into account the change in the age structures within the older adult population.

2. Gender differences in the composition of the older adult population

In Latin America, there are currently 116 women for every 100 men in the population aged 60 and over. Women tend to be even more predominant in countries with a greater life expectancy at the age of 60, combined with the fact that the gap between men and women gets wider as the population ages. According to the 2000 round of censuses, Uruguay, Argentina and Chile have the highest proportion of women in this age group (between 130 and 140 women for every 100 men). Panama and Guatemala, on the other hand, have the lowest proportion of women in this age group, although they still outnumber men (see figure I.13). There are also gender differences based on the area of residence of older adults: there are more women in urban areas and more men in rural areas (where there were fewer than 100 women for every 100 men in almost every country analysed) (see figure I.13). The difference between urban and rural areas is related to the economic activities typical of rural areas, which tend to be carried out by men. As cities have been more attractive to women for some time, the rural-to-urban migration of the past had a large female component, thereby increasing the proportion of women in cities.

Figure I.13
LATIN AMERICA AND THE CARIBBEAN (SELECTED COUNTRIES): FEMININITY INDEX OF THE POPULATION AGED 60 AND OVER, NATIONWIDE, URBAN AND RURAL TOTALS, 2000 ROUND OF CENSUSES



Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, on the basis of census microdata from the relevant countries.

The predominance of women is directly related to the fact that women tend to have greater life expectancy at the age of 60. In the past, men and women would have a similar number of years remaining at the age of 60. However, the decline in mortality (particularly maternal mortality) and increase in life expectancy widened the gap between men and women. This difference is not the same in all the region's countries. According to estimates and projections for the period 2000-2005, Uruguay and Argentina have the widest gap (with women living on average five years longer than men from the age of 60 to reach 83 years). In Guatemala, on the other hand, there is no difference between men and women (with both sexes living for 19.8 years from the age of 60), while in Haiti older women only live an average of one year longer than men. Although this difference will continue over the next few decades, there is no single identifiable trend in the region, as some countries will see the gap widen even more while in others the discrepancy could become less apparent (see table I.1).

It is vital to explicitly consider the gender dimension in population ageing, as older women in developing countries are particularly affected by this process. Women's situation in old age is aggravated by a lifetime of inequality and social exclusion. Women's longer life expectancy implies that a high percentage will be living as widows, which is often associated with loneliness and abandonment. Older women tend to have fewer years of schooling, receive lower incomes than men during their working lives and reach old age economically and socially disadvantaged. Nonetheless, many older women continue to play an important role in the family (as heads of household or raising grandchildren) and, even when very old, are the only source of caregiving in the event of illness or disability in most countries.

3. The urbanization of ageing and ageing in the countryside

Population ageing manifests itself differently depending on the territory. Each country's ageing process is unique because of the stage reached in terms of demographic transition. These distinctions tend to be stylized, as the fact that the process occurred earlier in industrialized countries resulted in more advanced ageing. International migration patterns certainly influence the differences in ageing between countries, especially in terms of the process in industrialized countries being weakened by waves of young immigrants from developing countries. Nevertheless, the effect of international migration on ageing has been secondary in comparison with the effect of demographic transition, and the former may be a temporary effect as migrants will eventually age too.

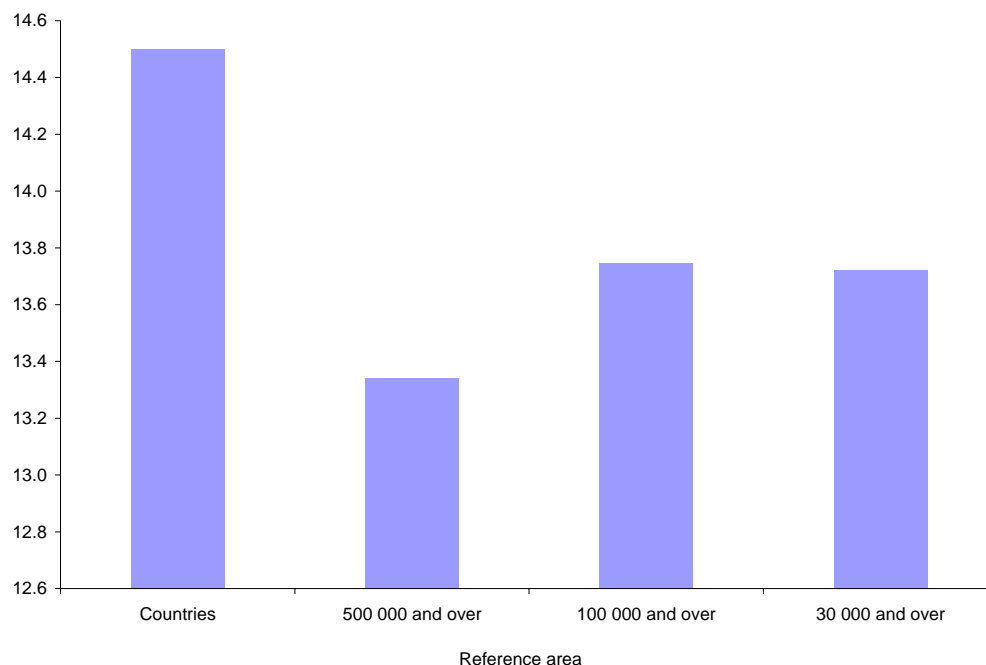
The differences in the ageing process are often expected to be as apparent within countries as among them, such that areas with more advanced socio-economic development and demographic transition should show higher levels of ageing. Given the well-known socio-economic and demographic differences between urban and rural areas, the former are expected to have a larger proportion of people aged 60 and over than the latter. However, this is not always the case, given the powerful effects of internal migration (especially from rural to urban areas).

In industrialized countries, internal migration tends to be extremely selective and different according to life cycle. Cities, which have become areas of net emigration due to outflows towards suburbs and the countryside, become home to young people seeking educational, employment and leisure opportunities, while the countryside attracts certain kinds of families and especially older people. The net result of these patterns is that ageing is more marked in rural areas.³ According to data from the Statistical Office of the European Communities (EUROSTAT), almost 15% of the population in the 25 European Union countries were aged 65 or over at the beginning of the twenty-first century. In cities in general, this percentage is around 14%, with the proportion being nearer to 13% in cities with a population of 500,000 or more (see figure I.14). However, there are some European countries where the largest cities have the highest ageing indices (see figures for Spain and Italy in table A.3 of the annex). The predominant effect nonetheless remains that three of the main European countries (Germany, the United Kingdom and France) all feature the above-mentioned pattern of lower levels of ageing in cities (see table A.3 of the annex).

In Latin America and the Caribbean, the striking unevenness in the demographic transition between urban and rural areas has resulted in a more intense ageing process in the former. However, this phenomenon is less defined due to the effect of internal migration, in particular rural-to-urban flows. Even though rural-to-urban migration is not the main form of migration in the region (as flows between cities also take place on a large scale), there is nonetheless more migration into than out of cities, which results in a net transfer of population from the countryside.

³ Presentation by professor Paul Gans, at the International Seminar "Migration and Development: The Case of Latin America", Santiago, Chile, 7 and 8 August 2007.

Figure I.14
EUROPEAN UNION: PERCENTAGE OF POULATION AGED 65 AND OVER,
NATIONWIDE TOTAL AND THREE TYPES OF CITY BY SIZE
(Percentages)

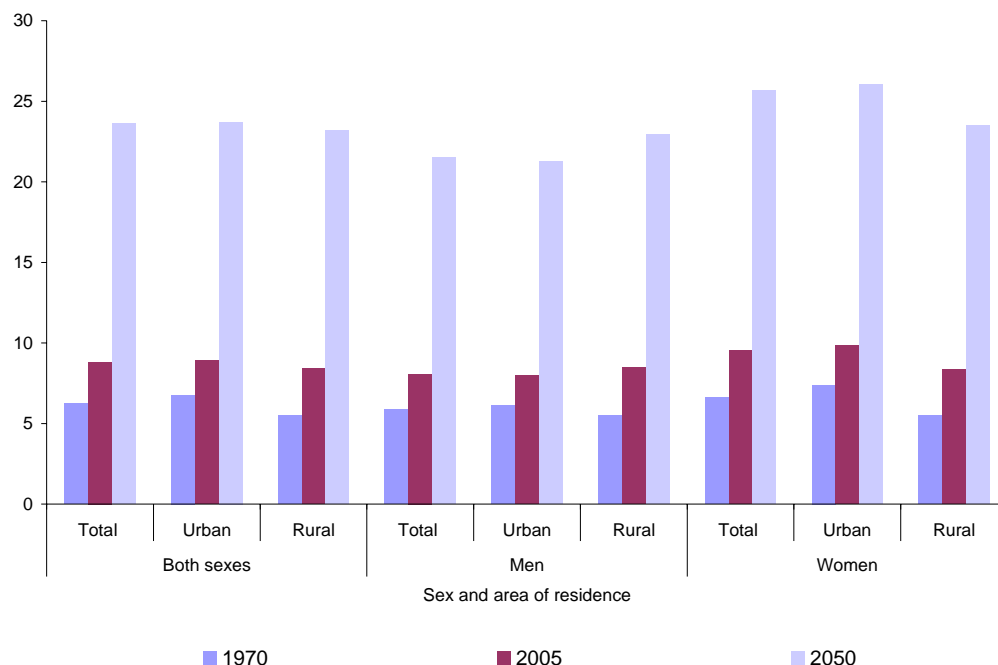


Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, on the basis of information from the Statistical Office of the European Communities (EUROSTAT) [online] <http://epp.eurostat.ec.europa.eu>.

As this migrant population tends to be mainly women of working age, the result is premature ageing in rural areas (strictly speaking, there is a much higher dependency ratio than there would be in the absence of rural-to-urban migration) and a dramatic expansion of intermediate age groups and an overrepresentation of women in cities (CELADE, 2003). This does not mean that urban areas have a lower level of ageing than rural areas. Indeed, figure I.15 shows that urban ageing is similar to the nationwide total and is expected to remain at similar levels up to 2050. The much more advanced stage of demographic transition in urban areas should result in a higher proportion of older adults. However, this is not the case because of the inflows of young people into the city from the countryside.

Because women have constituted a majority of the internal migrants in Latin America and the Caribbean (Rodríguez, 2004), there are major differences between urban and rural ageing in terms of men and women. While the ageing index has been systematically higher among men in rural areas (an estimated 23% of the rural male population will be aged 60 or over by 2050, compared with 21% in urban areas), the opposite is true for older women, who will represent 26% of the population in cities and 23% in rural areas by 2050 (see figure I.15).

Figure I.15
**LATIN AMERICA AND THE CARIBBEAN: PERCENTAGE OF POPULATION AGED 60 AND OVER,
 BY AREA OF RESIDENCE AND SEX**
(Percentages)

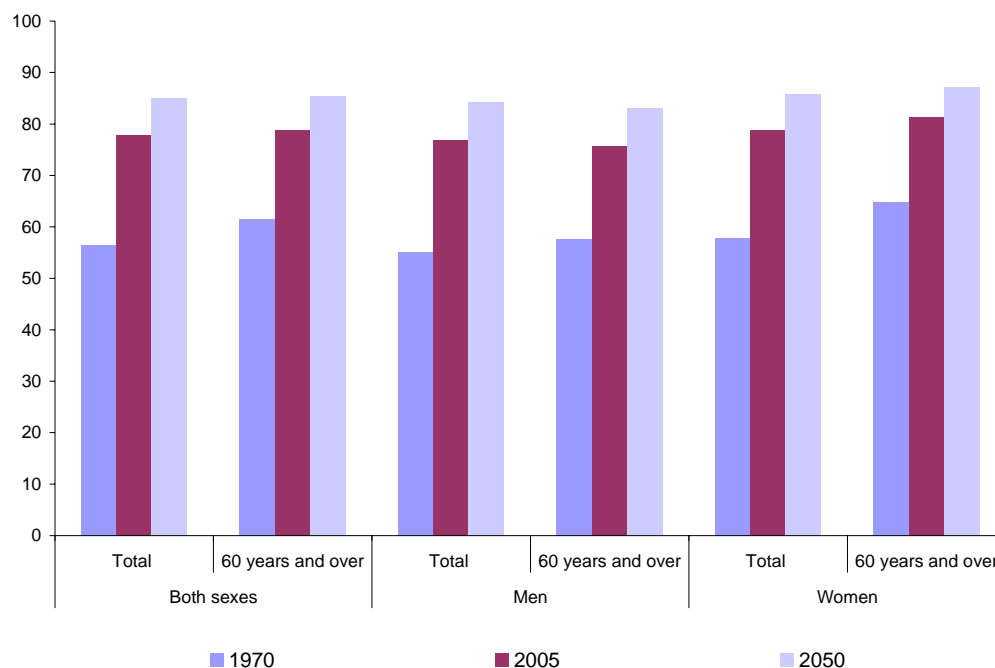


Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, population estimates and projections [online] www.eclac.cl/celade/proyecciones/basedatos_BD.htm.

The premature ageing of the population in the Latin American countryside is the result of very different factors than those at work in the European Union. In European countries, rural ageing is a result of the migration of older people who prefer to live in the countryside (particularly middle- and high-income retired people seeking a better standard of living in rural settings that tend to be well served and connected). In Latin America, on the other hand, rural ageing is the result of strong push factors that drive young people out of the countryside (Guzmán et al., 2006 and 2007; CELADE, 2003). In other words, rural ageing in Latin America is the result of the countryside being abandoned rather than selected as a lifestyle choice.

Early ageing in the countryside does not alter the long-term trend of urbanization among all age groups. According to figure I.16, the percentage of older people in the region living in urban locations rose significantly between 1970 and 2005 from 60% to 80% (77% among men and 81% among women), with the figure expected to reach 85% by 2050 (83% for men and 86% for women).

Figure I.16
LATIN AMERICA AND THE CARIBBEAN: PERCENTAGE OF THE TOTAL POPULATION AGED 60 AND ABOVE LIVING IN URBAN AREAS, BY SEX, 1970, 2005 AND 2050



Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, population estimates and projections [online] www.eclac.cl/celade/proyecciones/basedatos_BD.htm.

The region will therefore have two territorial features of ageing: a predominance of urban locations among older adults (which will influence their living conditions and requirements) and premature ageing in the countryside (which will impact on the development and needs of rural areas). The regional situation obviously differs from country to country, as some have an older rural than urban population (Bolivia, Chile, Ecuador, Mexico and Panama), while others have a similar level of ageing in urban and rural areas (Honduras, Paraguay and the Bolivarian Republic of Venezuela) and yet others have an older urban than rural population (Argentina, Brazil, Costa Rica and Guatemala) (see table A.4 of the annex). This lack of uniformity can also be observed in cities, some of which have levels of ageing higher than the nationwide average (Greater Buenos Aires, Rio de Janeiro, San José and Guatemala City), while other cities have below average levels of ageing (São Paulo, Quito and Panama City).

Box I.1
POPULATION AGEING AND INDIGENOUS POPULATIONS

Except in the case of Chile, indigenous peoples have a young or very young demographic profile with high fertility and mortality levels (ECLAC, 2007b). This applies even in countries with more or less advanced levels of population ageing. Within the relative “youthfulness” of indigenous age structures, there are four types that range from the “youngest” to the “most mature” or “aged”:

(i) Group 1. “Very young” structure with a “very wide” base: Panama, Paraguay, Guatemala and Honduras. These coexist with less youthful non-indigenous populations, with the non-indigenous population in Panama being distinctly “mature”.

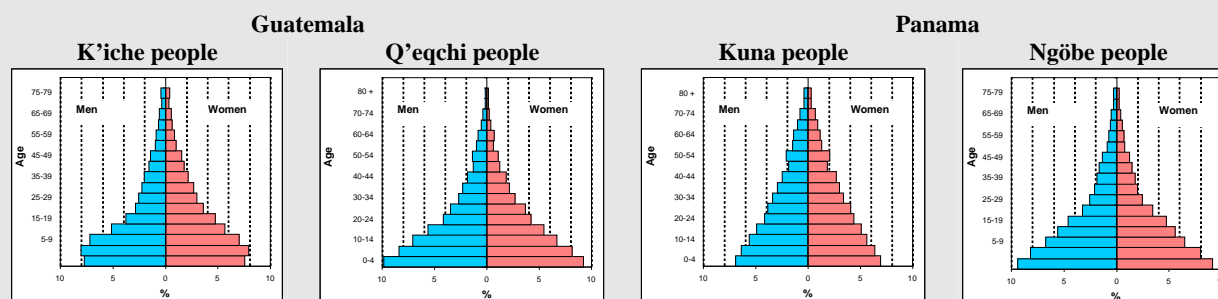
(ii) Group 2. “Young” structure with a “wide” base: Bolivia, Costa Rica, Ecuador and Mexico. All three countries have “mature” non-indigenous populations typical of an advanced stage of demographic transition except Bolivia, where the non-indigenous population remains young.

(iii) Group 3. “Mature” structure with a “stable” base: Brazil. The indigenous population combines with a non-indigenous population that is also “mature” but with a narrowing base.

(iv) Group 4. “Aged” structure with a “narrowing” base: Chile. The indigenous population structure is similar to that of the non-indigenous population, which results in an age pyramid that is somewhat rectangular.

Examining the age structures of indigenous populations in relation to data concerning specific peoples shows that there is a range of situations in each country. The figure below demonstrates that some peoples, such as the Ngöbe in Panama and the Q’eqchi in Guatemala, follow the general pattern of a younger structure. In these countries, there are also peoples with less youthful structures, such as the Kuna and the K’iche, whose fertility is reportedly lower.

**POPULATION PYRAMIDS OF SELECTED INDIGENOUS PEOPLES OF LATIN AMERICA,
2000 CENSUS ROUND**



Source: Economic Commission for Latin America and the Caribbean (ECLAC), *Social Panorama of Latin America 2006* (LC/G.2326-P), Santiago, Chile, 2007. United Nations publication, Sales No. E.06.II.G.133.

The age structure of the indigenous peoples is reflected also in two other indicators: the ageing index and the potential dependency ratio.^a While in Costa Rica, Guatemala, Honduras, Panama and Paraguay there are approximately 10 indigenous persons of 60 years of age or older per 100 young indigenous persons under the age of 15, in the case of non-indigenous peoples, this index ranges from 14 to 30 older adults per 100 children and young people. In Bolivia, Ecuador and Mexico, the index for the indigenous population is approximately 20%. Chile presents the maximum (37%) and is the country with the highest percentage of older indigenous persons (9.8%).

Box I.1 (concluded)

In terms of demographic interpretations and their policy implications, it is interesting to note that for indigenous peoples, old age does not have negative connotations but is associated rather with cultural continuity. A person's status and role in society may be enhanced with age, since it is considered that older persons are founts of wisdom and collective memory, which must be transmitted to the young people to ensure that the culture of the group or people is carried on (Ibacache and Painemal, 2001; Huenchuán, 2006). Whether and to what extent these conceptions are maintained must be determined, however, by the territorial, cultural and demographic realities of each people. For example, a case study of the Zoque people in Chiapas (Mexico) shows how the force of modernity, combined with poverty and marginalization, has eroded the social status and respect shown towards the elderly, which results in a loss of traditional roles and the appreciation they once commanded and affects their living conditions (Reyes Gómez, 2002).

From the point of view of economics, any interpretations of the dependency ratio must be placed in their sociocultural and territorial context as, to a greater or lesser extent, indigenous peoples live in subsistence economies, in which each family member has a specific task to perform (Descola, 1986).

In short, while the fast pace of ageing in the region is the most significant demographic phenomenon of the current century, for the indigenous population the challenges are still centred on the population of children and young people. This means that States must consider setting differential priorities in public policies, not only in terms of the allocation of resources to expand education and health-care coverage, but also, in terms of measures whose content, management and administration are relevant for the indigenous peoples themselves (ECLAC, 2007b).

Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, on the basis of Social Panorama of Latin America 2006 (LC/G.2326-P), Santiago, Chile, 2007. United Nations publication, Sales No. E.06.II.G.133.

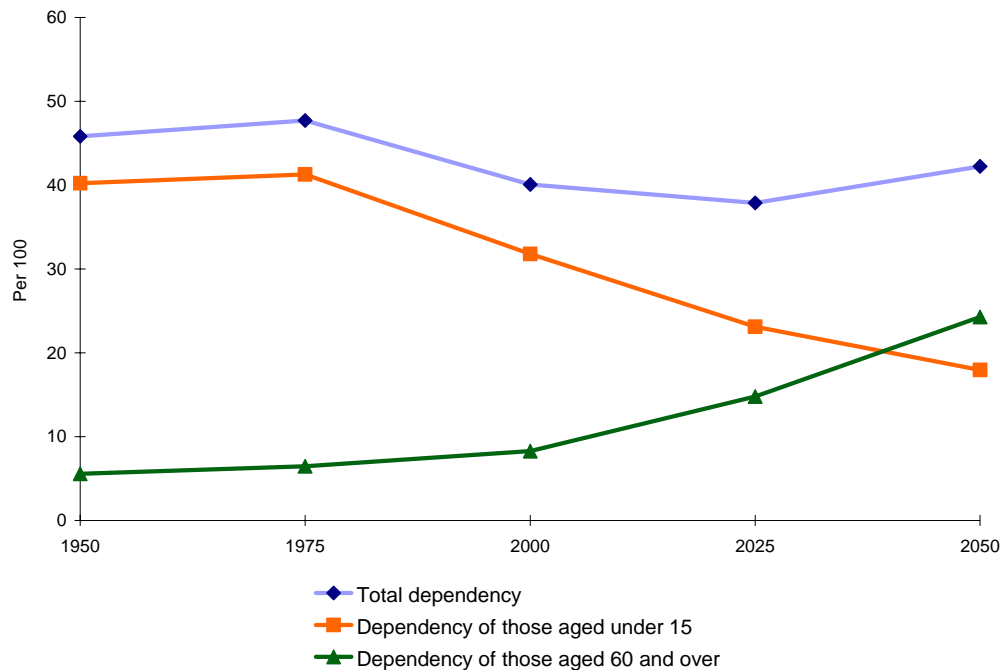
^a Refers to the number of children aged 0 to 14 and the number of people aged 60 and over for every 100 adults aged 15 to 59.

D. DEPENDENCY RATIO AND DEMOGRAPHIC BONUS IN LATIN AMERICA AND THE CARIBBEAN: AN OPPORTUNITY AND CHALLENGE

The total dependency ratio is a synthetic index of the population's age structure (CELADE, 2006a), that facilitates an analysis of the effects of ageing on the generation structure, in the light of the ratio between those who are most likely to be dependent (older adults and children) and the working-age population (see table A.5 of the annex). However, any analysis and interpretation should be carefully carried out, as both young and aged populations present high demographic dependency indices. In the first instance, this index falls with declining fertility, which reduces the proportion of children before a steady rise in the older adult population (see figure I.17).

At different times, in accordance with each country's stage of demographic transition, the dependency ratio rises again (see table A.5 of the annex). To differentiate if the greater economic burden is represented by children or older adults, the children's dependency ratio (also called the youth ratio) can be differentiated from the old age ratio. The old age ratio is used to measure the older population's potential need for social support from the working-age population. As shown in figure I.17, an increase in the dependency ratio in the region is increasingly determined by the proportion of those aged 60 and over, which has greater repercussions in terms of economic costs than those involved in youth dependency. This is mainly due to health care and social security requirements.

Figure I.17
**LATIN AMERICA AND THE CARIBBEAN: TOTAL DEPENDENCY RATIO FOR CHILDREN AND
 OLDER ADULTS, 1950-2050**



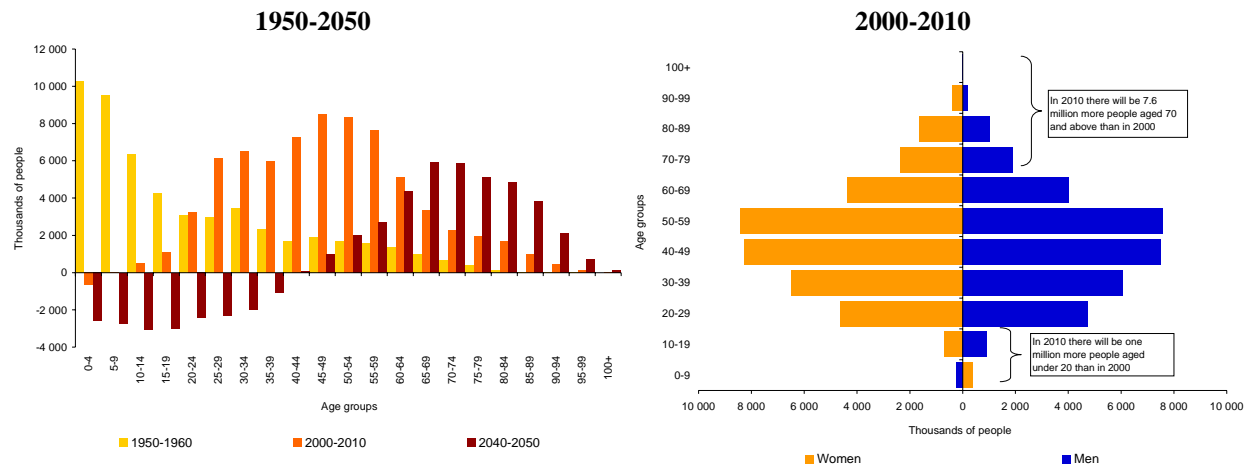
Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, on the basis of United Nations, *World Population Prospects: The 2006 Revision*, New York, 2006.

At the beginning of demographic transition, the high growth rate of children aged 0 to 14 years resulted in a high dependency ratio in the region, which placed demands on health systems, especial in terms of maternal and infant health care and education (see figure I.18). Progress in the demographic transition process combined with low fertility to reduce the total dependency ratio to below 60 people under the age of 15 and older people aged 60 and over for every 100 people aged 15 to 59. The change has been particularly striking in countries at a more advanced stage of transition (Uruguay, Cuba, Argentina and Chile). Currently, higher absolute population growth can be seen in those aged 15 to 59, who constitute the demographic group in the most productive stage of their lives (see figure I.18). Given that total dependency ratios will tend to fall during a given time, most of the region's countries will be able to take advantage of the opportunities provided by this demographic bonus to extend their productive potential and prepare for the final stage of demographic transition characterized by a relative increase in the older adult population.

Reduced pressure from the demands of the child population (which initially occurs in the absence of a striking rise in the number of older people) forms the basis for the demographic bonus and offers the chance to carry out productive investments, increase social investment in combating poverty, improve the quality of education and promote health reforms. This would also help to anticipate the measures needed to tackle the increase in the older adult population, whose demands will be more costly. The demographic bonus is also referred to as a "window of opportunity" for capitalizing upon the initial effect of the drop in fertility, since this is when the age structure of the population offers the most advantageous conditions. This is because the dependency rate during this stage is low, as the proportion of children and adolescents

has declined but the proportion of the population represented by older age groups has not yet risen significantly (ECLAC, 2004).

Figure I.18
**LATIN AMERICA AND THE CARIBBEAN: ABSOLUTE ESTIMATED AND PROJECTED
 POPULATION GROWTH BY DECADE AND AGE GROUPS, SELECTED PERIODS**
(Thousands)



Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, on the basis of United Nations, *World Population Prospects: The 2006 Revision*, New York, 2006.

However, in order to benefit from this temporary demographic bonus or dividend, measures must be implemented to raise the skills of human resources by systematically improving the quality of education and employment training. There must also be an increase in the capacity of productive sectors to ensure that these resources are used effectively. Not all of the benefits of this bonus are guaranteed, as they depend partly on the capacity of the region's economies to generate employment while the window exists. Otherwise, the bonus will simply represent an additional burden for the countries, in the form of strong pressure from the population seeking employment in a context of limited growth of work (Villa, 2003).

The demographic bonus ends as the dependency ratio rises, it is therefore limited in time. As fertility continues to fall and life expectancy rises, the proportion of older adults increases. This in turn pushes up the dependency ratio once again, which generates more demands in terms of health care and economic security. It is therefore vital to take advantage of the demographic bonus and prepare for the huge challenges of population ageing for the region's governments and for civil society, families and the older adults themselves (who have a major role to play in the process). Promoting solidarity pension financing; increasing health care services for older people with trained personnel, appropriate infrastructure and an emphasis on preventive care; and providing support mechanisms for families with elderly members —these are some of the areas that must be incorporated into the region's public policies. (Jaspers, 2007).

Chapter II

AGEING IN THE CONTEXT OF A RIGHTS-BASED APPROACH TO DEVELOPMENT**A. THE RIGHTS-BASED APPROACH, DEVELOPMENT AND THE CHALLENGE OF A SOCIETY FOR ALL AGES**

At its thirty-first session (March 2006), the Commission stated that “a rights-based approach should be used in framing public policy. The civil, political, economic, social and cultural rights enshrined in binding national and international agreements should form the normative framework for development”. This perspective alters the logic on which laws, policies and programmes are based, since the starting point is the existence, not simply of persons with needs who require assistance, but of subjects with rights, and these rights impose obligations on the State and the rest of society (Abramovich and Courtis, 2006; OHCHR, 2004; ECLAC, 2006). The individual is therefore the central subject of development, and the guarantees enshrined in the universal system of human rights protection constitute the conceptual framework accepted by the international community and capable of providing a coherent set of principles and rules for guidance (Abramovich, 2004; ECLAC 2006). This approach is also useful for defining the obligations that States must assume with regard to the economic, social, cultural, civil and political rights to be enforced as part of their long-term strategy (see box II.1).

Box II.1

OBLIGATIONS ASSUMED BY STATES WITH RESPECT TO HUMAN RIGHTS

- Obligation to respect rights: the States parties must refrain from interfering in the enjoyment of the economic, social and cultural rights enshrined in human rights instruments.
- Obligation to provide protection: the States parties must prevent third parties from infringing economic, social and cultural rights; for example, they must promote environmental protection by companies or punish any discrimination practised in private institutions.
- Obligation to promote rights: the States parties must take affirmative action to ensure that the exercise of rights is not illusory. This obligation implies organizing the entire government apparatus to ensure that it is capable of ensuring by law the free and full exercise of human rights (Inter-American Court of Human Rights, Velásquez Rodríguez case, 29/7/1988).

Source: Sandra Huenchuan and Alejandro Morlachetti “Derechos sociales y envejecimiento: modalidades y perspectivas de respeto y garantía en América Latina”, document prepared for the Expert Meeting on Population, Inequalities and Human Rights, Santiago, Chile, 26-27 October 2006.

The human rights-based approach has gained importance relatively recently in Latin America and the Caribbean, as a normative and programmatic dimension for development (ECLAC, 2006). An increasing number of laws have been enacted establishing certain rights or social and institutional initiatives for the formulation of rights-based public policy (Guendel, 2000). In addition, States in the region have ratified at least three of the seven main human rights treaties that were in force in 2006, thereby assuming binding obligations under international law.

The integration of human rights in development means that special provisions are made for the specific situation of vulnerable, marginal, underprivileged or socially excluded individuals and groups (OHCHR, 2004; ECLAC, 2006). This will help to overcome the logic of conceptual and normative frameworks used to design public policies and development institutions which have traditionally been based on stereotypical conceptions of what constitutes a human being, where the identity and status of individuals and citizens are determined by certain core attributes: belonging to the male sex, being of adult age and belonging to a particular ethnic group. Such frameworks fail to take fully into account the specificities of women, indigenous peoples, persons with disabilities or older persons. The rights-based approach to development, on the other hand, recognizes the human rights of all social groups, thus helping to ensure that those who were excluded in the past will henceforth be treated on an equal basis with respect and dignity. This will certainly enhance social integration and contribute to the construction of “a society for all” (United Nations, 1995b).

In its studies on human rights and population, CELADE-Population Division of ECLAC pays special attention to specific groups such as migrants, young people and persons with HIV/AIDS and reaffirms that the human-rights approach is the most appropriate for addressing demographic phenomena, such as international migration, spatial distribution of the population, fertility and ageing (Martínez and Ferrer, 2006). The process of population ageing opens up new possibilities for this approach and, as a corollary, for the construction of citizenship for the twenty-first century. First, it helps to reconcile the needs and interests of all groups in society in the advance towards full social integration, in which every individual, each with rights and responsibilities and regardless of age, has an active role to play (United Nations, 1995b). Second, a new social actor emerges who claims special treatment on the basis of age, introducing new demands for expanding, specifying and deepening human rights.

Both points of view are clearly legitimate, since explicit de facto and de jure inequalities have meant that older persons, like other social groups, have only been able to exercise their rights to equality and freedom in a limited way. Moreover, public policies have often failed to take their needs into account (United Nations, 1995a).

From this viewpoint, one of the central challenges of rights-based development is to contribute to the construction of a society that caters for all, male and female alike, and in which persons, irrespective of their age or other social differences, have the same opportunities to command full respect for, and exercise, their fundamental human rights and freedoms.

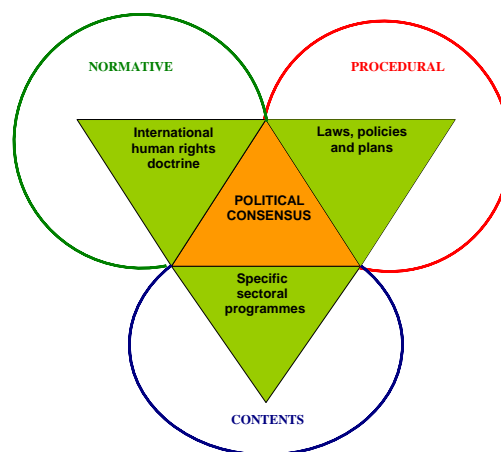
B. THE CONSENSUS WITH RESPECT TO RIGHTS, SOCIAL PROTECTION AND MODALITIES FOR INCLUSION OF OLDER PERSONS

At its most recent session, ECLAC underscored the need to reach a new political consensus regarding the society it wishes to construct in order to reconcile the well-known economic constraints and institutional weaknesses with the demands of the social groups whose rights are under discussion.

This proposal was well received by the member countries of the Commission as indicated in resolution 626(XXXI) of 2006, which recognizes that “a different approach to social protection in Latin America and the Caribbean should be adopted in response to changes under way at the global level that affect our societies, and that improving social protection leverages positive synergies among social equity, participatory democracy and economic growth”.

In order to harmonize a human rights agenda with the current exigencies to which countries are subjected, ECLAC proposes moving forward towards a new social protection covenant with three dimensions (normative, procedural and content) in order to progress towards the exercise of citizens' rights for all social groups. The specific demands of particular sectors, which, so far, have been invisible for the development agenda, must now be highlighted so that this new covenant encompasses them fully. In the case of older persons, the strategy includes the development and application of particular criteria and contents in each of the above-mentioned dimensions.

Figure II.1
DIMENSIONS OF THE NEW RIGHTS-BASED SOCIAL PROTECTION COVENANT



Source: Economic Commission for Latin America and the Caribbean (ECLAC), *Shaping the Future of Social Protection: Access, Financing and Solidarity* (LC/G.2294(SES.31/3)/I), Santiago, Chile, March 2006.

1. Normative dimension

Public actions and the institutions responsible for caring for older persons must be explicitly based on international human rights standards. Older persons are protected by binding human rights instruments including the Universal Declaration of Human Rights; the International Covenant on Civil and Political Rights; the International Covenant on Economic, Social and Cultural Rights; the American Declaration of the Rights and Duties of Man; the American Convention on Human Rights and the Additional Protocol in the Area of Economic, Social and Cultural Rights (referred to below as the San Salvador Protocol).

Article 17 of the San Salvador Protocol makes special provision for the protection of older persons. The States parties pledge to gradually supply suitable facilities as well as food and specialized medical care for older persons who lack them; to set up work programmes specifically designed to give older persons the opportunity to engage in a productive activity; and to foster the establishment of social organizations aimed at improving their quality of life. To date, the Protocol has been ratified by 14 countries in the region (Argentina, Bolivia, Brazil, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Mexico, Panama, Paraguay, Peru, Suriname and Uruguay).

There is, however, no specific binding instrument embodying the rights of older persons, such as exist for other social groups including women, children and persons with disabilities. In this regard, case law and the doctrine of the treaty committees have an important part to play in promoting understanding of the rights of older persons.

Through their general comments or recommendations, the committees define more precisely the main obligations relating to the human rights covenants as well as the rights protected by these instruments. This was done by the Committee on Economic, Social and Cultural Rights in 1995 in its General Comment No. 6, which addresses the economic, social and cultural rights of older persons (see table II.1). This document enables States parties to better understand their obligations vis-à-vis the elderly, when applying different provisions of this instrument (United Nations, 1999).

Table II.1
**COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS CONTENTS
OF GENERAL COMMENT No. 6**

Article of the International Covenant on Economic, Social and Cultural Rights	Interpretation of the Committee on Economic, Social and Cultural Rights
Equal rights for men and women (article 3)	States parties should pay particular attention to older women and should institute non-contributory old-age benefits or other assistance for all persons, regardless of their sex, who find themselves without resources on attaining an age specified in national legislation
Right to work (articles 6, 7 and 8)	The States parties should adopt measures to prevent discrimination on grounds of age at the workplace, ensuring that older workers enjoy safe working conditions until their retirement; it is desirable to promote employment of older workers in places where they can make the best use of their experience and know-how, and to set up retirement preparation programmes
Right to social security (article 9)	States parties must establish general regimes of compulsory old-age insurance, establish a flexible retirement age, provide non-contributory old-age benefits and other assistance for all older persons, who, when reaching the age prescribed in national legislation, have not completed a qualifying period of contribution and are not entitled to an old-age pension or other social security benefit or assistance and have no other source of income
Right to protection for the family (article 10)	Governments and non-governmental organizations should establish social services to support the family when there are elderly people at home, and should also implement special measures especially for low-income families who wish to keep elderly people at home
Right to an adequate standard of living (article 11)	The basic needs of older persons in terms of food, income, care, self-sufficiency and others should be met. In addition, policies should be designed to enable older persons to continue to live in their homes by improving and adapting their accommodation
Right to the highest attainable standard of physical and mental health (article 12)	Maintaining health into old age implies investment in health during the entire life span
Right to education and culture (article 13)	This right must be approached from two different and complementary viewpoints: (i) the right of elderly persons to benefit from educational programmes; and (ii) making the know-how and experience of elderly persons available to younger generations

Source: United Nations, The economic, social and cultural rights of older persons, General Comment, No. 6 (E/C.12/1995/16/Rev.1), Geneva, Committee on Economic, Social and Cultural Rights, 1995.

2. Procedural dimension

Legislation and policies on ageing must promote and protect fundamental rights and freedoms during old age. To ensure this, political authorities must supply the necessary instruments and resources to implement them, for example, by providing for these rights in the constitution, by enacting special laws for the protection of such rights or by guaranteeing the rights of older persons in policies or plans of action. Furthermore, the necessary resources must be obtained to fund the regulatory and political provisions which the country has pledged to fulfil.

There are three fundamental criteria that must be met if this instrumental dimension is to be effective: non-discrimination, progressiveness and participation. As defined in different international human rights instruments, discrimination against older persons means any differentiation, exclusion or restriction based on age which has the intention or effect of preventing or nullifying the recognition, enjoyment or exercise of their fundamental human rights and freedoms (Vásquez, 2004).

The Committee on Economic Social and Cultural Rights has identified older persons as one of the groups vulnerable to discrimination in terms of rights and therefore has recommended that States: (i) review their legislation and eliminate any *de jure* or *de facto* discrimination; (ii) approve rules that protect older persons from discrimination; and (iii) establish affirmative action measures whenever they bring opportunities for older persons in line with those provided to other social groups in the enjoyment of given rights (Abramovich and Courtis, 2006).

While the criterion of progressiveness recognizes that all the rights cannot be fully enforced in a short space of time, this does not mean that the State can indefinitely postpone fulfilling this commitment or that it should fulfil it only after achieving a given level of economic development. Progressiveness also implies a results-based obligation, so that the State should demonstrate quantitative and qualitative advances in the process of achieving the full realization of rights. It also entails a restriction on the adoption of regressive measures based on the principle of non retrogression in the area of human rights.

In short, States should plan the necessary measures to enforce the rights of older persons, since progressive realization requires targets, indicators and points of reference with respect to the realization of such rights (OHCHR, 2004). The opinion of older persons should be taken into consideration when determining these points of reference, and persons of this age group should moreover be encouraged to participate and should be incorporated into the accountability bodies in relation to the advances. Thus, it is necessary to provide and disseminate information on the rights and freedoms so that they become known to, and exercised by, older persons and the organizations that represent them (Vásquez, 2004). This calls for concrete mechanisms to enable older persons to exercise their right to participation and for access to the appropriate information to enhance their influence.

3. Content dimension

The content dimension is expressed in concrete actions put into practice through sectoral programmes or programmes that specifically target older persons (health and housing, among others), and whose orientation, benefits or services are geared towards advancing towards fulfilment of rights for older persons. Basically, these programmes must be universal and have mechanisms for enforcing the benefits and services (ECLAC, 2006).

Associated with this dimension are responsibility and enforceability, features that are peculiar to a rights-based approach and refer to the creation and development of mechanisms whereby the State can fulfil its obligations. These mechanisms may range from legal and quasi-legal provisions to administrative and policy instruments (OHCHR, 2004). For example, they may be institutions such as the ombudsman (as in the case of Guatemala), at the domestic level, or those within the Inter-American system (Inter-American Commission on Human Rights and the Inter-American Court of Human Rights), at the international level. These instruments must be accessible and comprehensible to older persons so they can make use of them should the need arise.

International human rights standards are an essential tool for promoting and protecting the rights of older persons in a positive and comprehensive way. In order to move forward towards a social protection covenant that fully encompasses this social group, it is crucial to recognize that older persons have general and specific rights within the framework of the principles of universality and solidarity.

C. CONSTITUTIONAL PROTECTION OF RIGHTS IN OLD AGE IN LATIN AMERICA AND THE CARIBBEAN

The international agreements and regulations on human rights serve as the regulatory frame of reference for a rights-based approach; nevertheless, the Constitution of each country is the instrument which establishes the hierarchy of those treaties within its domestic legal system (ECLAC, 2006). Ever since the first steps were taken towards establishing democracy in the region, the tendency has been to incorporate these international instruments in domestic law.¹ As a rule, the rights recognized in international treaties are translated into constitutional texts through their interpretation or explicit incorporation.

While all the rights and guarantees recognized in constitutional texts are, of course, applicable to older persons, there are cases in which the rights of this social group are specifically recognized; this is extremely important, since the Constitution—as a legal set of regulations—is the paramount expression of the country's entire legal, social, economic, political, civil and cultural system. The National Constitution, therefore, takes precedence over the provincial constitutions, laws in general, decrees, regulations and administrative orders. In federative countries, however (Argentina, Brazil and Mexico), the states or provinces reserve certain powers under the Constitution and do not delegate certain powers to the national Government; thus, adopting a law on the rights of older persons would require the support of each of the provinces or states to ensure that these rights are enforceable nation-wide.

Furthermore, strictly speaking, there should be a logical correlation between constitutional rights, public organization and budgetary decisions. While administrative structures and budgetary legislation are means by which rights are enforced, the protection of constitutional rights is an end in itself. Many of the

¹ Some constitutions specifically list the main human rights treaties (Argentina, Bolivarian Republic of Venezuela and Nicaragua), stating explicitly that they have a constitutional hierarchy, which gives them greater enforceability in domestic law. Others consider human rights treaties as a guide for the interpretation of established rights (Colombia). Moreover, some constitutions state that international treaties take precedence over domestic law, which, in principle, could be interpreted as meaning that they come under the Constitution, but are above domestic legislation (Brazil, Costa Rica, Honduras and Guatemala). In the Chilean and Ecuadorian constitutions, on the other hand, international treaties have a more general character, promoting and conferring respect for human rights.

constitutions in the region have provisions that give priority to respect for the rights of older persons, protect older persons against violence or condemn discrimination based on age.

The constitutional charters of the Bolivarian Republic of Venezuela, Brazil, Colombia, Costa Rica, Dominican Republic, Honduras, Nicaragua, Panama and Paraguay state expressly that older persons have the right to special protection from the State. Some charters guarantee the integral protection of older persons, recognizing some economic and social rights, ranging from health care, food, decent living conditions and housing to the more general concept of the welfare State (the Bolivarian Republic of Venezuela, Brazil, Guatemala, Ecuador and Panama). In all of these cases, it is the duty of the State to promote and implement policies or programmes for the effective exercise of rights. In other countries, the onus is on the State to adopt legislative measures for the protection of older persons; in Argentina, for example, there is the obligation to enact legislation and promote affirmative action to guarantee true equality of opportunities and treatment for older persons, as well as the full enjoyment and exercise of rights recognized in international treaties.

In addition to the above, specific social rights are ensured, such as the right to social security, present in all the constitutions examined, although the scope of the provisions varies from country to country. The Brazilian Constitution explicitly guarantees a minimum income for older persons in need, irrespective of their contribution to social security. The Colombian Constitution states that the State shall guarantee a food subsidy for indigent older persons and the Cuban constitutional document provides explicitly for social assistance to the elderly who are without resources and without protection.

Under the Brazilian and Ecuadorian Constitutions, older persons are identified as a vulnerable group and are granted priority care, with the additional stipulation that such assistance is mandatory in cases of domestic violence. The constitutional charters of Brazil, Ecuador and Mexico condemn age-based discrimination in general, while, those of the Bolivarian Republic of Venezuela, Panama and Paraguay forbid age-based discrimination in the labour field. Lastly, the right of older persons to participation and integration in the community is expressly set out in the case of Colombia and Brazil.

Explicit recognition of the rights of older persons in the Constitution implies obligations for their enforcement by the established authorities. While it would be desirable to adopt specific laws, the fact that these rights are contained in the constitutional document makes them operational and therefore directly applicable and binding on all public authorities, whose role it is to ensure that they are not infringed by either action or omission.

In short, the enshrinement of the rights of older persons in the Constitution means that the legal system, public policies, institutions and official government acts should be adapted accordingly.

D. SPECIAL LAWS FOR PROTECTION OF THE RIGHTS OF OLDER PERSONS: ADVANCES AND CHALLENGES

States must promote the full enjoyment of the rights of older persons, establishing the legal, political, economic, social and cultural conditions that will allow the integral development of the human individual. In this regard, a country must not only refrain from interfering in the exercise of individual rights, but must also provide positive benefits, that is, adopt administrative and legislative measures to ensure that these rights are in fact enforced.

Regarding legislative measures, countries may recognize some rights of older persons by including them in general laws (as in the case of Nicaragua, where this age group is considered to be vulnerable and is treated as a priority group under Health Act 423) or by enacting laws that protect these rights fully. In the following section, reference is made to the latter type of “special laws”, which are adopted within the regulatory framework of actions relating to ageing in countries that have such legal instruments.

1. The objectives and contents of legal coverage in special laws

Most countries have special legislation designed to promote and guarantee the human rights of older persons (see appendix 1). This means that the standards recognized in human rights treaties and constitutional provisions will be incorporated into the law, at least in terms of interpretation.

Some civil and political rights are protected under existing legislation (see table II.3). In all cases, the rights are specified in order to give a concrete form to the provisions of the Constitution or treaties. With respect to economic, social and cultural rights, the different laws provide for the right, inter alia, to work, to social security, education, health care, housing and social welfare (see table II.2).

Table II.2
SELECTED LATIN AMERICAN AND CARIBBEAN COUNTRIES: ECONOMIC, SOCIAL AND CULTURAL RIGHTS GUARANTEED IN SPECIAL LAWS DESIGNED TO PROTECT OLDER PERSONS

Countries/ Economic, social and cultural rights	Education and culture	Work	Social security	Physical and mental health	Housing	Adequate standard of living	Family protection	Equal rights for men and women
Brazil	●	●	●	●	●	●	●	
Costa Rica	●	●	●	●	●	●	●	
Ecuador	●			●	●	●		
El Salvador	●	●	●	●	●		●	
Guatemala	●	●	●	●	●	●	●	
Mexico	●	●	●	●	●	●	●	●
Paraguay		●		●				
Peru	●	●		●		●	●	
Puerto Rico		●		●	●		●	
Dominican Rep.	●	●	●	●	●		●	
Uruguay	●		●	●	●		●	
Venezuela (Bol. Rep. of)	●	●	●	●	●		●	

Source: Latin American and Caribbean Demographic Centre (CELADE) – Population Division of ECLAC, on the basis of special laws of the countries included in the table.

Table II.3
**SELECTED LATIN AMERICAN AND CARIBBEAN COUNTRIES: CIVIL AND POLITICAL RIGHTS
 GUARANTEED IN LAWS FOR THE SPECIAL PROTECTION OF OLDER PERSONS**

Countries/ Civil and political rights	Right to life	Personal freedom and security	Freedom of thought, conscience or religion	Association	Non- discrimination
Brazil	●	●	●	●	●
Costa Rica	●	●	●	●	●
Ecuador					
El Salvador				●	●
Guatemala					
Mexico	●	●		●	●
Paraguay					●
Peru	●				
Puerto Rico		●			
Dominican Republic				●	
Uruguay		●			
Venezuela (Bolivarian Republic of)				●	

Source: Latin American and Caribbean Demographic Centre (CELADE) – Population Division of ECLAC, on the basis of special laws in force in the countries included in the table.

2. Institutions created by special laws

Special councils have been set up under the law as governing bodies for public-policy formulation and implementation in several countries: Costa Rica (National Council for Older Persons), El Salvador (National Council for Comprehensive Care for Programmes for Older Persons), Guatemala (National Council for the Protection of Senior Citizens and the National Committee for Protection of the Aged, which acts as advisor to the former), Mexico (Citizens' Council for Older Adults) and Dominican Republic (National Council for the Elderly). In all of these institutions, the board of directors consists of officials from the different ministries or State departments, as well as from academic organizations and civil society organizations of older persons.

In Brazil, law 8.842 (4 January 1994) provides for the creation of a national council and similar institutions at the state and municipal levels. Decree 5.109 (2004) regulates and sets out the composition, structure, scope and functioning of the national council, conferring on it the role of defining the regulations and priorities for national policy and controlling their fulfilment. This Council is bipartite in composition, consisting on the one hand of the State and, on the other, of civil society organizations. The latter enjoy much broader prerogatives than in other countries in terms of their participation in the Council, including the opportunity of directing it for a specific period.

Some countries, for example, the Bolivarian Republic of Venezuela and Mexico have legislation setting up special institutions for the care of older persons. In the former, a governing body, the National Social Services Institute (INASS), established under the Social Services Act, is responsible for executing policies and plans, exercising the functions of control, follow-up and evaluation, and taking the necessary measures to ensure that the rights of older persons are respected. In the Bolivarian Republic of Venezuela, as in Brazil, State and municipal agencies, designated Social Services Centres, have been legally created and are operated by the states and municipalities under the coordination of INASS.

In Mexico, the National Institute for Older Adults (INAPAM) was set up by law. As the governing body for national policy, it is designed to coordinate, promote, support, foster, monitor and assess public measures, strategies and programmes, in accordance with the principles, objectives and provisions contained in the law.

Lastly, the third institutional modality is an arrangement whereby a specific ministry acts as governing body. In Ecuador, the Ministry of Labour and Social Welfare is established by law as the entity responsible for the protection of older persons. The Bureau for the Elderly, which comes under this ministry, is designed to protect the economic and social rights of this group and process legal claims on behalf of older persons. In Paraguay, the Ministry of Public Health and Social Welfare is the State agency responsible for implementation of the law through the Social Welfare Institute, whose sphere of duties was recently established by decree 10.068 (2007).

Most of the special laws grant responsibilities to different ministries or State departments in relation to the issues of health, work, education and transport, among others. Mexican legislation lists the obligations of each of the departments indicating their areas of competence and the older persons to whom their sectoral policies should apply.

3. Guarantees established in special legislation

The crucial question is whether the legislation establishes guarantees that ensure the effective exercise of the rights it proclaims, that is, whether tutelage mechanisms or techniques have been instituted for this purpose (Abramovich and Courtis, 2006); this may be done by setting up administrative or constitutional control or monitoring mechanisms, such as human rights ombudsmen, to ensure access to justice or by making provision in the budget for fulfilment of rights (see box II.2).

Brazil has the greatest number of mechanisms for guaranteeing the rights of older persons. The Statute on Older Persons establishes that the Office of the Attorney General or the Judicial Authority has the power to order protection measures in cases where the rights of older persons are infringed by act or omission by the State or the family. In addition, the Councils and the Office of the Attorney General have the power to oversee the policies and actions of government and non-governmental bodies and to set fines for non-compliance. The Office of the Attorney General is competent to initiate judicial actions for the protection of individual and collective rights for older persons.

The Venezuelan Social Services Act states that the Office of the Attorney General must have specialized investigating magistrates who can initiate proceedings to establish the penal, civil or administrative liability of individuals who commit offences against persons or institutions, which, by deed or omission, infringe or jeopardize individual, collective or third-generation rights of the persons protected under this Act.

In terms of the competence of the judicial power or office of the ombudsman to deal with infringements of these rights, law 7.935 of Costa Rica establishes sanctions of a criminal, civil or administrative character for cases of physical or psychological aggression, sexual harassment, or other offences, and disqualifies the perpetrator from performing duties in centres that care for older persons. It even provides for different sanctions —implemented by a civil magistrate, in case of abandonment, ill-treatment or lack of care on the part of the family or private or public institutions.

Box II.2
BUDGET AND GUARANTEE OF RIGHTS IN OLD AGE

Ensuring that the necessary budget appropriations are available for advancing progressively towards effective rights coverage constitutes another form of guarantee. Most of the special laws for the protection of older persons fail to mention the budgetary provisions required to guarantee the rights in question. Only a few laws incorporate the usual norms, stating that the State will determine the funds in the budget act for the fiscal year, or empower institutions to manage or use resources, for example, from donations or from the proceeds of fines or lottery sales.

In El Salvador, the governing body is authorized to approach public and private organizations in national and international spheres for funding. Meanwhile, the law states that the governing body or members of the Council must include in their budgets the appropriations required to comply with the provisions of the law. The relevant Dominican regulation states that an annual allocation equivalent to no less than 0.5% of the budget of the Secretariat of State for Public Health and Social Welfare will be provided as support for enforcement of these rights. It also stipulates that in the provinces where there are homes for the elderly and day centres duly registered and recognized by the Council, at least 10% of the town council's health budget must be distributed equitably among the centres in question; the town councils must therefore coordinate with the Council. Lastly, the National Fund for the Elderly, established under Ecuadorian law (article 16), is entitled to 10% of the budget of the Ministry of Health and the Environment of Ecuador; of this amount, 10% will be used to operate the National Institute for Gerontological Research.

Costa Rica has a different financing mechanism. Law 7.972 on the establishment of taxes on liquor, beer and cigarettes provides for the allocation of economic resources to the National Council for Older Persons for its operation and maintenance with a view to improving the quality of care in publicly- or privately-run homes, shelters and day centres; these funds will also be used to finance programmes for care, rehabilitation or treatment of older persons that are indigent or in need as well as for organization, promotion, education and training programmes that develop the skills of older persons, improve their quality of life and enable them to remain in the family and the community.

Funding is crucial for advancing towards enforcing the rights of older persons; the rights contemplated in the national legislation and the services or benefits that they imply cannot be provided without the requisite budget appropriations. The rights of older persons should be incorporated in the budget in order to finance social protection within the framework of the new covenant proposed by ECLAC. This implies, moreover, that the necessary mechanisms must be implemented to ensure that there is no retrogression in the services or benefits required for the effective exercise of rights within a framework of solidarity and universality.

Source: Latin American and Caribbean Demographic Centre (CELADE) – Population Division of ECLAC.

In the Bolivarian Republic of Venezuela, the Office of the Ombudsman has specialized officials who are qualified to take legal action for the defence and protection of the rights of older persons and whose duty it is to inspect public or private care institutions and report to the competent authorities any violations of the rights and interests of the persons protected by the law, in order to determine civil, criminal or administrative liability with a view to disciplinary action.

In Guatemala, there is an Office of the Ombudsman for Older Persons, set up by the Human Rights Procurator, under Agreement with the General Secretariat No. 15/98. This Office has played an active role in the defence of the rights of older persons, as well as in promoting these rights by organizing educational and awareness-building activities in the community (CELADE, 2006a).

Lastly, in Mexico, reports may be made of any deed, act or omission that may impair or affect the rights and guarantees established by law; if the report is against a federal authority, it may be presented before the National Human Rights Commission and if it is against state or municipal authorities, it may be filed with the States' Human Rights Commission.

In short, in countries where the rights of older persons are enshrined in the constitution or where laws have been adopted for the special protection of this group, a fundamental step has been taken in the advance towards a new covenant for social protection. First, the domestic legal framework has been adapted to include rights for older persons. Second, the obligations that the State and the rest of society must assume in order to move forward towards the effective exercise of the rights of older persons have been identified. Thus, a minimum standard has been set in these countries within which the States are committed to work. As will be seen later, however, the challenges of this standard are enormous, since in practice, most of the countries have not adapted their public policies to the new demographic reality. This is compounded by the lags in social protection for other sectors of the population and the inequities that derive from the type of development of the countries in the region. Population ageing will impose new and greater challenges, so that in this context legal protection will be effective only when the rights established by law have the proper coverage and actually protect rights-holders.

Chapter III

INCOME PROTECTION AND AGEING IN LATIN AMERICA AND THE CARIBBEAN

Despite progress, the entitlement and guarantee of rights to lifelong income security are issues still pending on the social agendas of most Latin American and Caribbean countries. Economic uncertainty continues to dominate the day-to-day lives of much of the region's population. While social protection should play a key role in reversing this situation, the imbalances between social protection systems and the realities which they are meant to address have worsened in recent decades. As a result, protection is unequal and the risks of illness, unemployment, disability and old age lead to a reduction in or loss of economic income for satisfying basic needs, which any society should guarantee as a fundamental right.

The demographic, social and economic bases on which social protection systems were founded have changed. As a corollary, with the exception of a handful of countries, the main problem in the region is low benefit coverage. In the specific case of transfers from the social security system, more than half of the older adult population has no access to retirement or other pensions to mitigate the risks arising from loss of income in old age. This is because social security schemes have been heavily contributions-oriented, which excludes a large segment of the population, mostly women, peasants, informal workers and migrants. In general, these groups end up without sufficient guaranteed economic income in old age despite their lifelong social contribution to society, increasing their need to obtain income from employment. Even so, there is still less poverty in households with older members than in any other type of living arrangement because, despite the poor coverage of retirement and pension systems, they are still the most important policy instruments for alleviating poverty and vulnerability in old age. At the same time, they contribute to the welfare of other generations.

Ideally, social protection systems should ensure income security during old age for all, and they need to provide benefits that place recipients above the socially acceptable minimum living standards (United Nations, 2007b). However, the way in which social protection systems operate at present means that only people who began accumulating pension entitlements from an early stage in their career have a good chance of escaping poverty in old age (ILO, 2002a).

These unprecedented demographic changes facing Latin American and Caribbean countries call for new thinking regarding the formulation and implementation of income protection policies. This new thinking requires that we view ageing as a lifelong and society-wide phenomenon.

ECLAC believes that, in order to build a more solidarity-based system of social protection, ways must be sought to strengthen the capacity of national economies for creating decent work for the entire economically-active population, and to turn labour markets into a gateway to social protection. In addition, ECLAC proposes that employment-based protection should be supplemented with non-contributory solidarity-based mechanisms (ECLAC, 2006). The challenge, therefore, is to develop a concept of social rights that not only includes but also transcends the labour market (Abramovich and Courtis, 2006).

This chapter examines the information available in the region on income generation in old age and analyses the influence of biographical, generational and protection-system factors. It also describes the measures which Latin American and Caribbean countries are taking to improve the economic conditions of older adults, in the light of the recommendations of the Regional Strategy on Ageing in

Latin America and the Caribbean. One of the main conclusions of this review is that the economic status of the elderly is gradually being included in government agendas. However, the challenge of raising social protection thresholds remains. A rights-based analysis reveals that the challenges are even more demanding because current actions should be guided by two basic human rights principles: universality and solidarity.

A. INCOME AND POVERTY IN OLD AGE: REGIONAL TRENDS

1. Income composition and economic strategies in old age

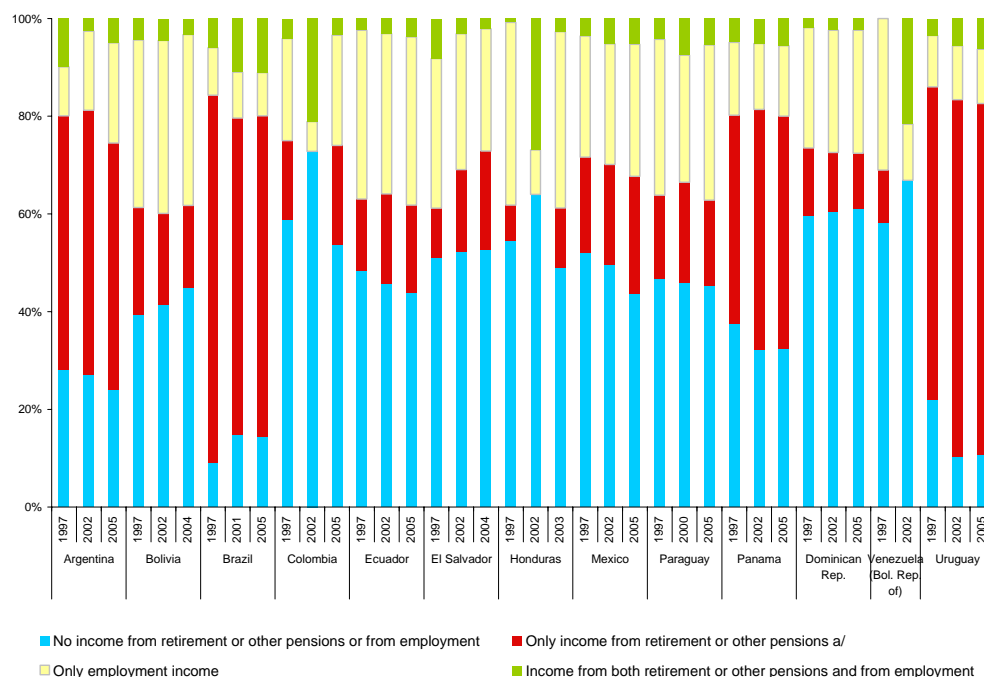
Economic participation, social security and family support are the main sources of income in old age (Guzmán, 2002a). The relative importance of each mechanism varies from one country to another depending on the level of economic and institutional development, labour market characteristics and the phase of demographic transition. The older age group tends to derive its economic income from sources other than those of other generations. In developed countries with more evolved social security systems, a large proportion of the elderly obtain their income solely from retirement or other pensions, and, as people get older, employment income becomes less important. In Latin America and the Caribbean, the economic strategies of today's older generation follow a pattern: in contexts of low retirement or other pension coverage, the labour-force participation of older adults increases and, when they receive no income of any kind, family support is vital.

Figure III.1 shows the percentage of older persons living in urban areas and receiving income from two of the most important income sources in old age —retirement or other pensions and employment income— at three points in time. In a number of countries there was an increase in the percentage of older persons receiving income solely from retirement or other pensions over the period (Colombia, El Salvador, Honduras, Mexico, Ecuador, Panama and Paraguay). However, with the exception of two countries (El Salvador and Uruguay), the increase was less than five percentage points.

During the same period, there was a decline in the percentage of older persons receiving only employment income and in those receiving both types of income, although countries did not all follow the same pattern. For example, between 1997 and 2002, in the Bolivarian Republic of Venezuela there was a 20 percentage point increase in the number of older persons receiving a combination of retirement or other pension income and employment income. At the same time, the percentage of those receiving only social security income fell by 10 percentage points.

Furthermore, the percentage of older persons receiving no income at all fell slightly in the latest year for which figures are available, although it is still the largest of all the groups analysed. An average of 43% of older persons received no income of any kind in 1997, a figure which increased slightly in 2002, before falling to 39% in the latest year analysed. The averages mask differences, and a glance at countries with weak social security systems reveals that the percentage of older persons with no income at all ranged from 40% to 66% in 2005. Not only does this population segment suffer acute economic vulnerability, it is also prey to the risks associated with poor health, disability and declining social support networks.

Figure III.1
LATIN AMERICA AND THE CARIBBEAN (SELECTED COUNTRIES): SOURCES OF INCOME FOR OLDER PERSONS LIVING IN URBAN AREAS, AROUND 1997, 2002 AND 2005
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of data from household surveys conducted in the relevant countries.

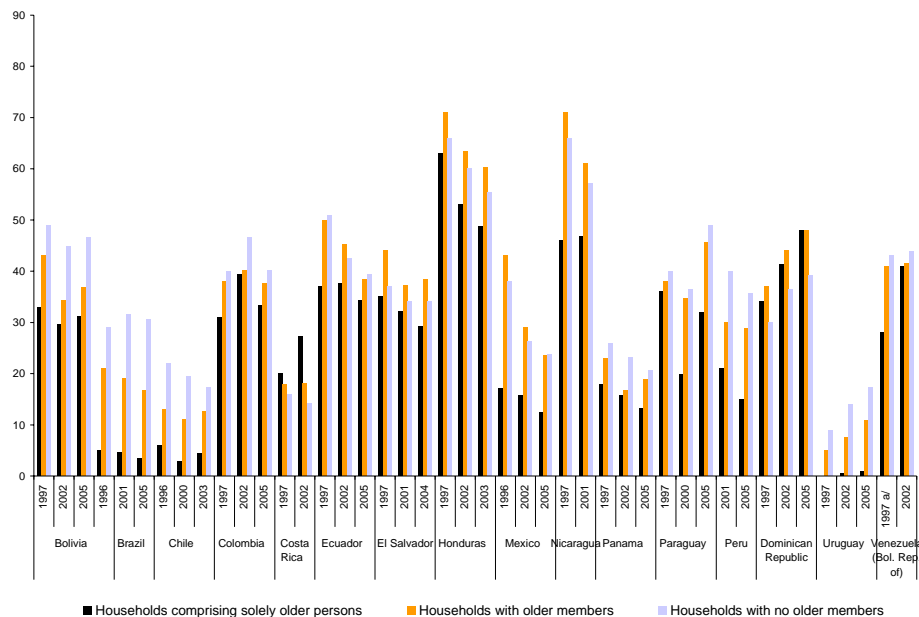
^a Income from retirement or other pensions corresponds to total income transfers to people in the variable “active population” category declaring themselves to be “persons receiving retirement or other pensions”.

2. Poverty in households with older members and protection against risks

The latest poverty and indigence figures available show significant progress in terms of both poverty alleviation in households with older persons and protection against risks in old age. Having remained broadly unchanged between 1997 and 2002, the proportion of people living in poverty and indigence fell in most countries in the region (ECLAC, 2007b). Echoing this trend, the incidence of poverty in households with older members also declined and, in 2005, both urban and rural households with older members continued to be less poor than households without older members, although the gap between the two types of household varies widely from country to country.

In Bolivia and Brazil, the incidence of poverty in urban households with no older members is more than 10 percentage points greater than in households with older members; these differences increase by more than 35 percentage points in rural areas of Brazil. By contrast, in Costa Rica, El Salvador, Honduras and the Dominican Republic, poverty is greater in households with older members and, with the exception of a couple of countries, the differences between the two types of household are fairly small (see figures III.2 and III.3).

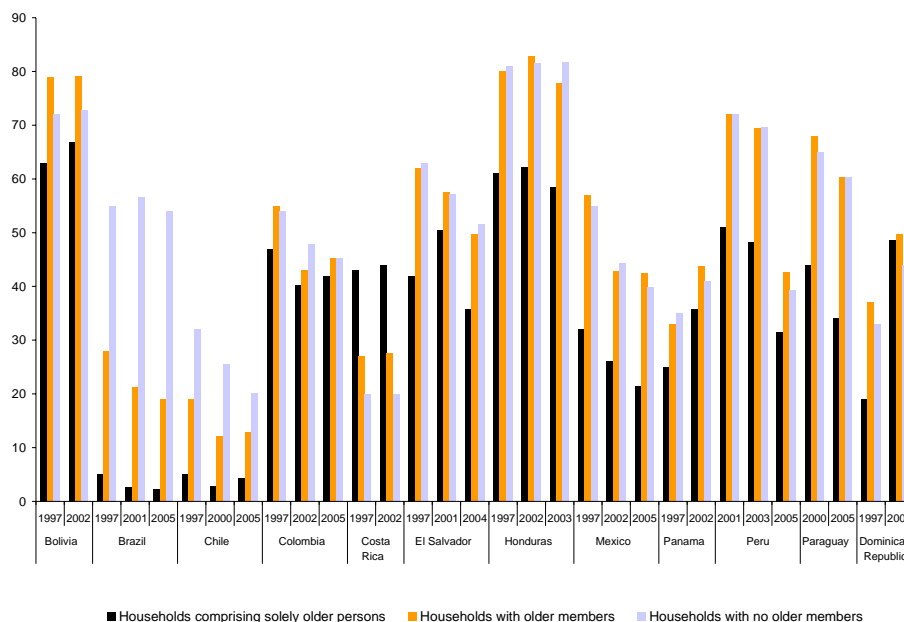
Figure III.2
**LATIN AMERICA AND THE CARIBBEAN (SELECTED COUNTRIES): INCIDENCE OF POVERTY
 ACCORDING TO TYPE OF HOUSEHOLD (URBAN AREAS), AROUND 1997, 2002 AND 2005**



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of data from household surveys conducted in the relevant countries.

^a National total.

Figure III.3
**LATIN AMERICA AND THE CARIBBEAN (SELECTED COUNTRIES): INCIDENCE OF POVERTY
 ACCORDING TO TYPE OF HOUSEHOLD (RURAL AREAS), AROUND 1997, 2002 AND 2005**



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of data from household surveys conducted in the relevant countries.

In developed countries, there is a lower poverty incidence in households with older members and in households composed solely of older persons because pensions are the main source of livelihood and protection in old age (United Nations, 2007b). However, the pattern cannot easily be replicated in Latin America and the Caribbean where, in countries with high poverty levels, older persons and their households replicate the national pattern. For instance, in Honduras, Nicaragua and Paraguay, there is no marked distinction between households with older persons and those without. By contrast, in countries like Chile, Brazil, Panama and Uruguay, where there is wider social security coverage and the household poverty rate is lower than the regional average, the differences between households with and without older members are more sharply defined (ECLAC, 2007b).

Box III.1 AGEING AND INTERGENERATIONAL TRANSFERS

The demographic transition being experienced by Latin American countries is changing the age structure of the population, with major consequences for long-term economic growth. One such consequence is a higher dependency rate arising from population ageing. This could have the effect of increasing capital in the economy, in turn boosting potential for economic growth. However, the demographic effect will depend crucially on the age structure of consumption and employment income, as well as on the type of income received from society to offset lack of employment income during the dependent years, which can come from intergenerational transfers or from earnings on capital accrued during the years of economic independence.

A study of three Latin American countries (Chile, 1997, Costa Rica, 2004 and Uruguay, 1994), conducted as part of the national transfer accounts project, presents the age profiles for economic dependency (defined as the point at which a person's consumption exceeds his or her employment income), divided into three phases: (i) youth dependency; (ii) independence in mid-life and (iii) old-age dependency, when a person again becomes dependent on non-employment income (see figure 1). However, there are interesting differences among countries in terms of both the length of time people spend in each of these phases and the average ages of consumption and employment income. In Chile in 1998, an average person could expect to make net positive transfers or accumulate capital for a period of 30 years, meaning that he or she spent around two thirds of their lifetime in a state of economic dependency. In Costa Rica, an average person's employment income exceeds his or her consumption for a period of 33 years, meaning that economic dependency lasts an average of 57 years. In Uruguay, the periods are 30 and 60 years respectively.

Figure 1
AGE PROFILE FOR NET TRANSFERS (AVERAGE OF SELECTED COUNTRIES)

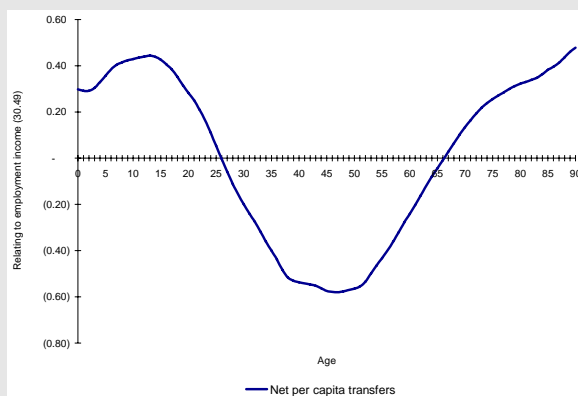
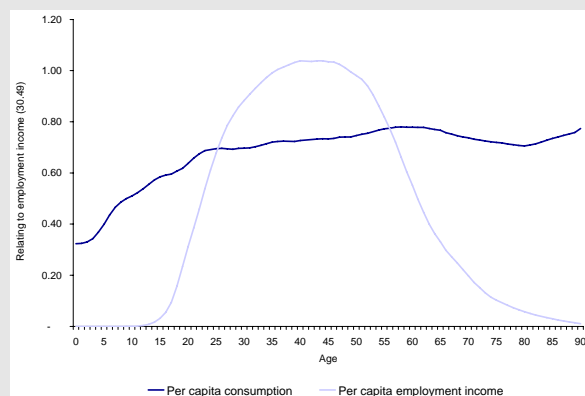


Figure 2
AGE PROFILE FOR CONSUMPTION AND EMPLOYMENT INCOME (AVERAGE OF SELECTED COUNTRIES)



Source: Latin American and Caribbean Demographic Centre (CELADE)-Population Division of ECLAC, on the basis of information from the National Transfer Accounts Database [online] <http://www.schemearts.com/proj/nta/web/nta/show>.

Box III.1 (concluded)

The average periods of economic dependency and independence are important indicators in the analysis, although they provide no information on the direction of flow of most surplus income during the economic independence phase. In the case of Chile, the average age when people are most likely to earn employment income is 46 and the average age for consumption is 47. In Costa Rica, the average age for earning employment income is 43 and the average age for consumption is 50. In Uruguay, the ages are 48 and 42 respectively. The difference between the average ages in these countries would indicate that, during a person's economically independent years, surplus income tends to flow mostly towards the oldest adults.

Intergenerational transfers could replace capital as a source of future financing, if such transfers flow towards the oldest adults. The average age for receiving and making transfers was calculated by estimating public and private sector transfers in the three selected countries (see figure 2). It was concluded that, in Chile, intergenerational transfers flow marginally more towards older adults, whereas in Costa Rica and Uruguay they flow towards the younger people. When the majority of transfers flow towards the younger people, the assumption is that investment earnings play a major role in financing older people's consumption. While there is no evidence for Uruguay, in Chile and Costa Rica around one third of the employment-income deficit of the over-65 group is funded by net reallocations of assets.

This means that if capital income continues to finance older adults' consumption to a large extent, the growing share of older persons in the population's age structure could lead to greater capital accumulation and, all else being equal, to greater potential growth in the economy.

Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, on the basis of Jorge Bravo and Mauricio Holz, "Inter-age transfers in Chile 1997: economic significance", Santiago, Chile, Economic Commission for Latin America and the Caribbean (ECLAC), unpublished; Luis Rosero-Bixby and Arodys Robles, "Los dividendos demográficos en Costa Rica a partir del mapeo de la economía del ciclo vital del individuo", document presented at the second Congress of the Latin American Population Association (ALAP), Guadalajara, 3-5 September 2006; Marisa Bucheli, Rodrigo Ceni and Cecilia González, "Intergenerational transfers in Uruguay", *Documento de trabajo*, No. 5/7, Universidad de la República, July 2007.

Some studies show that cash transfers to older persons, especially from social safety net protection programmes, are key in reducing the risk of poverty and mitigating the negative effects of vulnerability (Tabor, 2002). In addition, they benefit other generations (Schwarz, 2002; Hoskins, 2002).¹ This is because "when older adults live with younger family members, the former provide a considerable proportion of the household income, including what they receive from social security. Private and public transfers within families could thus be said to complement each other by contributing to intergenerational solidarity and social protection in the broad sense of the word" (Machinea, 2006).

B. INCOME PROTECTION AND PENSION SYSTEMS

Retirement and other pensions form part of the social security system and have probably been one of the most intensive and controversial areas of public policy reform in recent decades, with the result that pensions have a long history and are highly diverse in terms of organization, financing and performance (Mesa-Lago, 1978) (see box III.2).

¹ An exercise conducted in Brazil showed that, if transfers to older persons were discounted, poverty incidence would increase significantly, especially among the oldest old (Ricardo Paes de Barros, cited by Goldani, 2006).

Box III.2

RETIREMENT AND PENSION SYSTEMS: REFORMS AND IMPLICATIONS

At least 10 Latin American countries have initiated structural reforms since 1981, that is to say, reforms that not only change the pension financing regime by introducing advance funding wholly or partially, but also include privately managed pension funds. In addition, these changes established or embedded reforms considered to be parametric, meaning that the reforms improved the financial viability of systems by changing the conditions for benefit entitlement (such as the retirement age) or the financial parameters (such as contribution rates). In other countries, the reforms were non-structural, although they did introduce major changes involving a political economy and negotiation process between key stakeholders that was as important as the structural reforms.

**TYPE OF RETIREMENT OR OTHER PENSION REFORM DEPENDING ON THE TYPE OF CONTRIBUTION
SCHEME UNDER THE REFORMED SYSTEM**

	Type of system		Type of system		
	Compulsory contributions	Pay-as-you-go pensions	Advance-funded pensions	Pay-as-you-go pensions	Advance-funded pensions
	<div> <div>Advance-funded pensions</div> <div> Bolivia Chile El Salvador Mexico Dominican Rep. </div> <div>All contributions are paid into pre-funded individual accounts</div> </div>	<div> <div>Pay-as-you-go pensions</div> <div>Colombia Peru</div> <div>There is an option to pay contributions either into a funded scheme or into the pay-as-you-go pension scheme</div> </div>	<div> <div>Advance-funded pensions</div> <div> <div>Pay-as-you-go pensions</div> Argentina </div> <div>Contributions are paid into a pay-as-you-go system that provides a basic pension. The supplementary pension is optional</div> </div>	<div> <div>Advance-funded pensions</div> <div> <div>Pay-as-you-go pensions</div> Costa Rica Uruguay </div> <div>Contributions to the minimum pension are paid for under the pay-as-you-go system, while the supplementary pension is paid for on an advance-funded basis</div> </div>	

Source: Fabio Bertranou, *Envejecimiento, empleo y protección social en América Latina*, Santiago, Chile, International Labour Organization (ILO), 2006.

The countries with structural reforms are: Chile (1981), Peru (1992), Colombia (1993), Argentina (1994), Uruguay (1996), Mexico and El Salvador (1997), Bolivia (1998), Costa Rica (2000) and the Dominican Republic (2003). Although Nicaragua (2000) and Ecuador (2001) introduced structural changes in legislation, the changes failed to be implemented for various legal and administrative reasons. Among the countries with non-structural changes, the highest-profile case, owing to its regional representativeness, is Brazil, with its reform for private sector workers in 1999 and for public sector workers between 2003 and 2004. Other countries with non-structural changes include Panama, which incorporated the changes in 2005, although the new legislation was later amended. In addition, Colombia refined certain aspects of its reform in 2003 and Peru introduced additional changes in 2004. In recent years, therefore, the trend in countries other than the 10 that adopted structural reforms has been away from extending structural reforms and towards a continued process of parametric change, which has extended to countries that introduced the private component in the 1990s (Colombia and Peru).

Box III.2 (concluded)

In many respects the structural reforms have followed Chile's 1981 reform, with their common denominator being the model of changes in the 1990s promoted by the World Bank, with its multi-pillar system proposal (1994). Even so, characteristics have varied widely from one country in the region to another. From a structural standpoint, the reforms have pursued different paths and, according to Mesa-Lago's characterization in numerous studies (2004), three models could be said to have emerged: substitutive, parallel and mixed models. In the substitutive model, pre-funded individual accounts entirely replaced defined-benefit pay-as-you-go (PAYG) pension systems, meaning that workers entering the labour market pay all their contributions into the new advance funded scheme. In the parallel model, workers can choose between contributing to a funded scheme or to a publicly-managed defined-benefit pay-as-you-go pension scheme. Mixed schemes are a combination of the previous two models. The latter's financing and benefit parameters were also reformed.

One important aspect of all these reforms is that, while they have radically altered the financing and organizational aspects of pension systems, they reserve major responsibilities for public institutions, chiefly in the area of regulation, control and management, with the result that the reformed systems are mixed in character. What is more, in the case of Chile, which opted for the purest substitutive model, in addition to regulatory, control and management responsibilities, the State is also in charge of managing the old system during the transition phase and maintains a strong presence, particularly in the provision of non-contributory benefits and in guaranteeing basic or minimum benefits.

Source: Fabio Bertranou, *Envejecimiento, empleo y protección social en América Latina*, Santiago, Chile, International Labour Organization (ILO), 2006.

Retirement and other pensions afford protection against the risk of loss of income in old age, guaranteeing older people's economic self-sufficiency. However, according to a World Bank study, "Latin America's more than decade-long experience with pension reform has delivered significant fiscal, social and financial benefits, but the failure to extend access to formal financial protection for old age to a broader segment of society has been a major disappointment" (Gill, Packard and Yermo, 2004).

In English-speaking Caribbean countries, defined-benefit pay-as-you-go pension systems have hardly been altered (see table III.1) and, given their relatively short history and low demographic dependency rate, they remain solvent. In fact, these countries have managed to accumulate reserve funds amounting on average to 19% of regional GDP. Nonetheless, the long-term financial sustainability of these regimes is threatened by projected changes in their demographic structures (less imminent but faster than in the rest of the region), high rates of unemployment, rising indices of informality and emigration from the region to the rest of the world (ECLAC, 2006).

Table III.1
CHARACTERISTICS OF NATIONAL SOCIAL SECURITY SYSTEMS IN ENGLISH-SPEAKING CARIBBEAN COUNTRIES

Country	Maximum contributable earnings ^a	Pension to average insurable wages (percentages)		Replacement rates (percentages)			Minimum contribution period (weeks)	Retirement age		Administrative expenses as a percentage of contribution income (2003)	Life expectancy at birth (years)			Rate of return on reserves		Investment as a percentage of reserves
		Average	Minimum	10 years	30 years	Maximum		Normal	Early		2000-2005	2025-2030	2045-2050	10 years	5 years	
Anguilla	2.02	30.6	26.3	30	50	60	250	65	...	22.8	...	...	...	2.5	1.5	91.8
Antigua and Barbuda	1.88	22.2	6.3	25	45	50	350	60	...	17.7	...	...	...	0.8	1.5	44.4
Bahamas	1.36	25.4	16	30	55	60	150	65	60	19.9	69.4	75.7	77.3	4.8	4	92.4
Barbados	2.09	49	30.6	40	60	60	500	65	63	6.1	77.2	79.8	81.4	5.2	5.2	82.4
Belize	1.52	25.3	22.4	30	55	60	500	65	60	30.5	74.4	77.5	79.7	7.4	7.5	94.5
Dominica	3.15	28.3	6.8	30	55	70	500	60	...	16.7	...	...	...	4.7	4.6	77
Grenada	2.07	24.5	12	30	50	60	400 ^h	60	...	12.4	...	...	...	5	4.9	92.1
Guyana	2.1	28.5	27.3	40 ^b	55	60	750	60	...	15.8	62.4	64.1	71.2	4.8	4.1	95.3
Turks and Caicos Islands	1.69	19	14.1	30	55	60	500	65	60	21.1	...	...	...	1.6	0.9	87.5
British Virgin Islands	1.42	21.4	7.5	30	50	60	500	65	...	11.9	...	...	...	2.2	2.8	92.8
Jamaica				^f				70 ^e	65 ^e	13	75.7	79	80.8	3.5	9.8	95.5
Montserrat	1.26	17.1	8.4	30	50	60	350 ^c	60	...	48.8	...	...	...	2.4	2.4	96.7
Saint Kitts and Nevis	3.07	28.4	11.8	30	55	60	500	62	...	14.6	...	...	...	3.2	4	94.9
Saint Lucia	3.41	39	13.7		58	60	576 ^d	61	60	13.3	73.8	77.2	79.5	3.8	4.1	96
Saint Vincent and the Grenadines	3.08	29.9	19.4	30	50	60	325 ^c	60	...	16.7	...	...	...	4.3	5.6	91.6
Trinidad and Tobago	1.25	15.8	37	^g			750	65	60	6.9	74.8	78.6	80.5	4.7	4.7	93.4

Source: Oliver Paddison, *Social security in the English-Speaking Caribbean* (LC/CAR/L.64), Port of Spain, ECLAC subregional headquarters for the Caribbean, December 2005.

^a Ratio between the maximum insurable wage and the average insurable wage.

^b After 15 years.

^c Increasing to 500 in annual steps of 25.

^d 144 months, increasing by 12 months every 3 years until 180 is reached on 1 January 2012.

^e The retirement age for women is 60.

^f Flat-rate pensions plus earnings-related proportion.

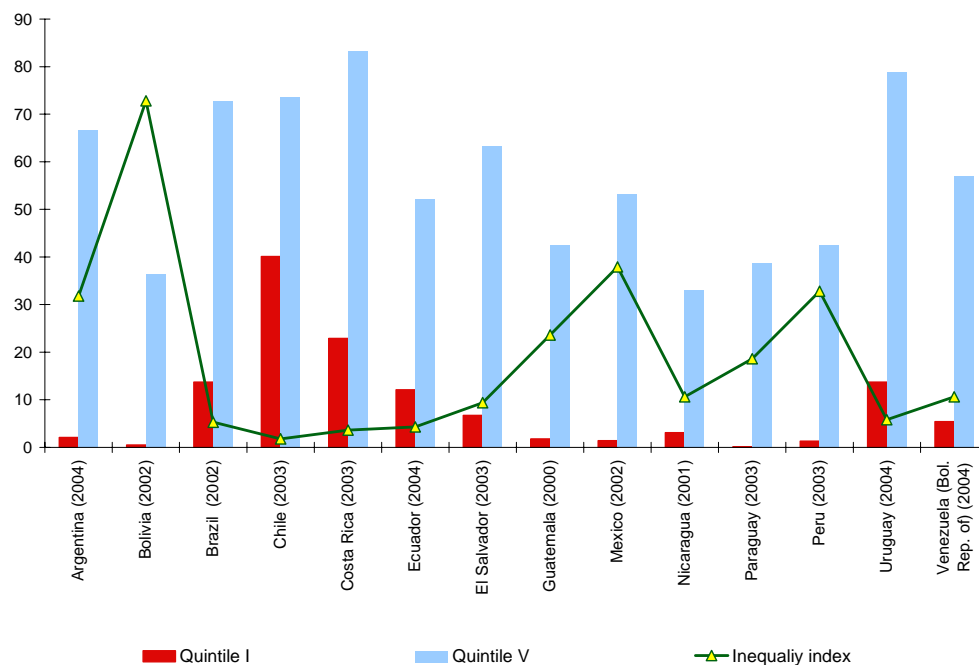
^g Pension based on average class in which contributions made over career (non-indexed career earnings approach).

^h Increasing to 500 in 2008.

1. Long-term pension coverage and the protection paradox

With the exception of one group of countries, the chief problem with retirement and pension systems in Latin America and the Caribbean is low coverage (ECLAC, 2006). This stems from a variety of factors, including problems with access to the social security system during working life. Figure III.4 shows the employment-based pension coverage for each household income quintile, together with each country's coverage inequality index.

Figure III.4
**LATIN AMERICA (SELECTED COUNTRIES): CONTRIBUTION COVERAGE FOR EACH
 HOUSEHOLD INCOME QUINTILE, AROUND 2003**
(Percentages)



Source: Fabio Bertranou, *Envejecimiento, empleo y protección social en América Latina*, Santiago, Chile, International Labour Organization (ILO), 2006.

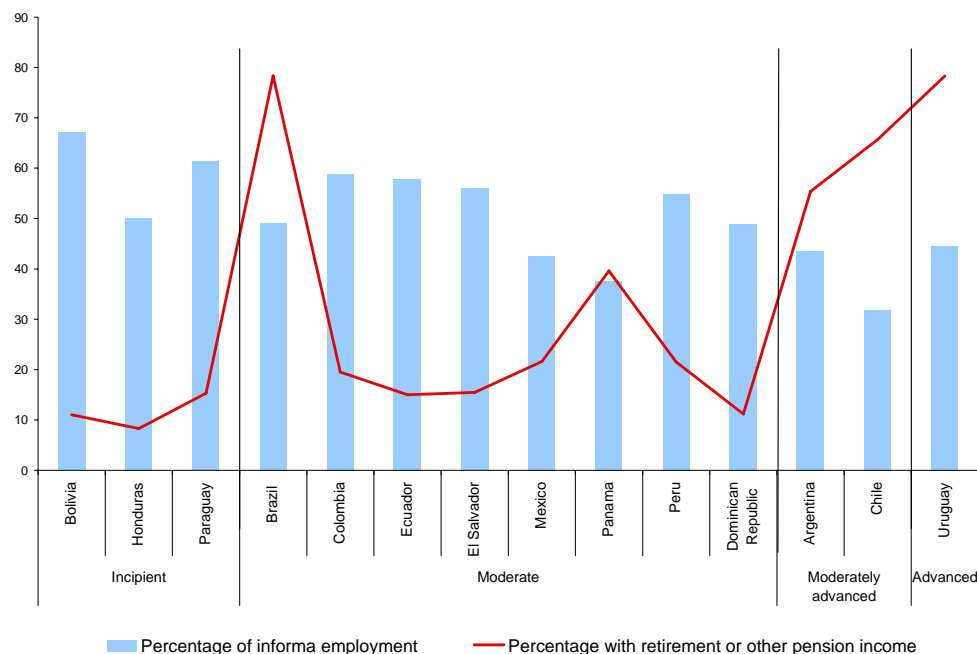
There are wide variances across the region as a result of the countries' different social and employment situations, causing disparities in employment-based pension coverage between people in the first and fifth household income quintiles. In some countries the gap is extremely large. These discrepancies in coverage therefore reflect unequal conditions of access to benefits, in addition to the inequalities and inequities affecting income protection in old age. In general, there is less inequality between the first and fifth household income quintiles in countries with high employment-based pension coverage, higher per capita income and well-established social security systems. By contrast, the disparities are most marked in countries where employment-based coverage is low or very low (Paraguay, Bolivia, Mexico and Peru). In equity terms there is a powerful protection paradox at work, as a variety of factors result in the least vulnerable groups gaining access to greater and better protection. One important

factor is the labour market, where workers with better quality jobs (employees of large companies or public sector corporations) also have better and more extensive pension coverage.

The region's employment dynamics in recent years have included greater job instability, the informalization and precarization of employment, labour-market deregulation and greater participation by women. These factors are expected to have a negative impact on retirement and pension system coverage in the future. In fact, contribution coverage shrank between 1990 and 2003 and it is doubtful that the labour market dynamic can be reversed in the short to medium term (ECLAC, 2006).

In 2005, a general review of the percentages of informal employment and social security coverage in the various phases of population ageing revealed that the situation is complex in a number of countries in which the process is incipient or moderate (Bolivia, Honduras, Paraguay, Ecuador, El Salvador, Peru and the Dominican Republic) because their informal employment percentages are currently above the regional average and they have a low level of retirement or other pension coverage (see figure III.5).

Figure III.5
LATIN AMERICA (SELECTED COUNTRIES): INFORMAL EMPLOYMENT AND PENSION COVERAGE,^a AROUND 2005
(Percentages)



Source: International Labour Organization (ILO) and Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of data from household surveys conducted in the relevant countries.

^a Pension coverage corresponds to the percentage of people aged 60 or over receiving retirement or other pension income.

If employment trends in these countries continue, they will lead to major inequalities and inequities. Also, unless there are reforms to strengthen the non-contributory components of pension systems, the most vulnerable groups will be excluded from contribution systems or will receive poor

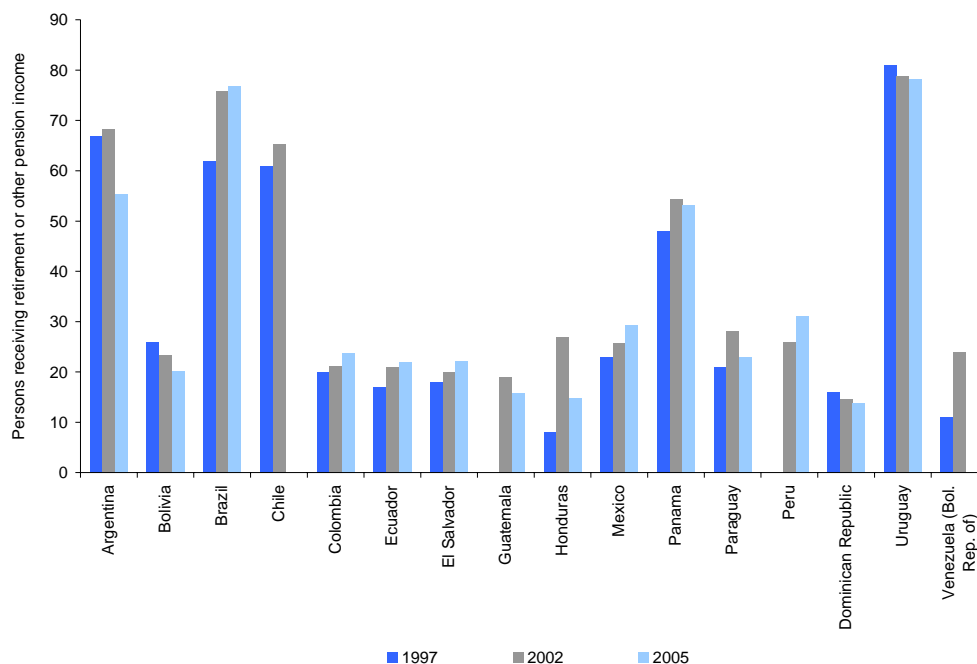
quality pensions due to their irregular contributions, while those in the poorest quintiles will tend to defer their contributions until late in working life.

2. Limited and unequal protection from retirement and pension systems in old age

Structural reforms of pension systems have undermined the solidarity inherent in traditional systems. The majority of Latin American and Caribbean countries today have limited capacity to provide older people with means of subsistence. The result is that the inequalities marking people's working lives persist as social protection inequalities in old age (ECLAC, 2000).

A clear measure of the limited capacity of pension systems to provide means of subsistence to older adults is the proportion of this population group receiving retirement or other pension income (ECLAC, 2006). Figure III.6 shows the values for this indicator in 16 Latin American and Caribbean countries around 1997, 2002 and 2005. While there are significant variations, on average the percentage of people receiving retirement or other pension income has remained relatively stable (around 4 in every 10 older adults). This is because, even though countries like Brazil expanded pension coverage for older adults by more than 15 percentage points between 1997 and 2005, in other countries the increases were smaller and, in some cases, coverage decreased.

Figure III.6
**LATIN AMERICA (SELECTED COUNTRIES): RECEIPT OF RETIREMENT
OR OTHER PENSION INCOME**
(Percentages)

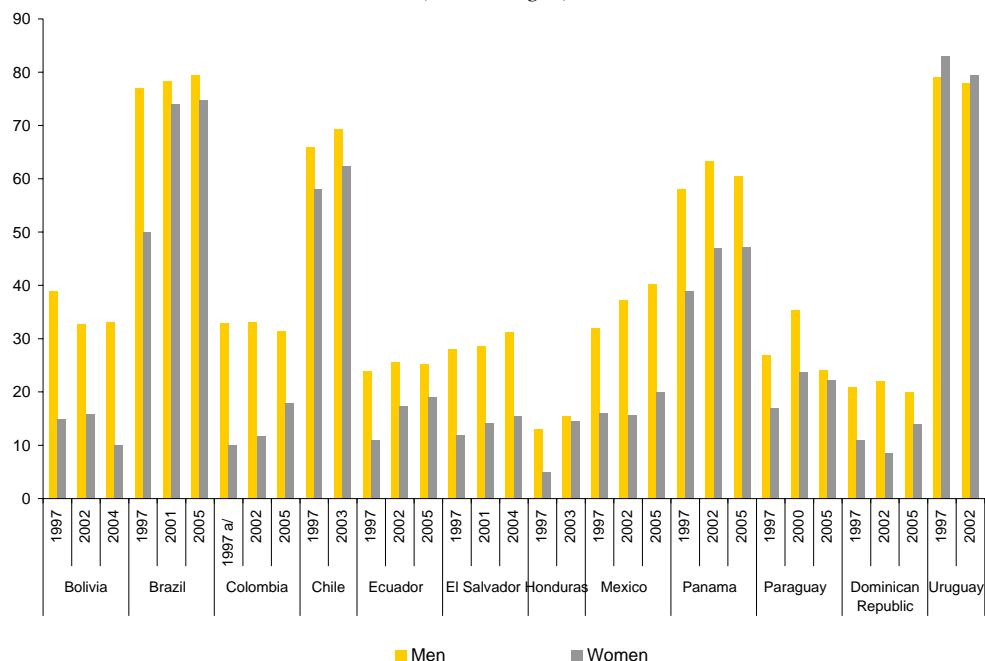


Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of data from household surveys conducted in the relevant countries.

With regard to retirement and other pension coverage, two countries (Argentina and Brazil) have high levels of coverage in old age despite having only average levels of employment-based pension coverage (between 30% and 50%). As can be seen below, this is a direct result of having non-contributory pension programmes. In both Argentina and Brazil, as in other Latin America countries pioneering social security systems (Chile, Uruguay and Costa Rica), gaps in old-age coverage have been lessened by non-contributory pension programmes. Colombia and Bolivia have also introduced non-contributory pension schemes in recent years.

The weak gender perspective in public policies partly explains why old-age social protection in Latin America (calculated on the basis of pensions received) tends to be poorer for women than for men (see figure III.7). Even though female labour force participation increased considerably in the 1960s, it was faster and more extensive in the late 1980s and early 1990s. This means that women became regular participants in the labour market during a period of worsening employment conditions (greater job insecurity and informality) when social security systems were being reformed, which heavily affected women's terms of access and contribution coverage. This made women invisible in reform processes, which entirely failed to address the gender inequalities that had historically marked women's participation in the economy and in social protection systems. On the contrary, inequities continued to worsen (Pautasi and Rodríguez, 2006). As a corollary, women have had, and continue to have, fewer pension savings, as well as limited rights to benefits and State guarantees (Bertranou, 2006).

Figure III.7
LATIN AMERICA (SELECTED COUNTRIES): RECEIPT OF RETIREMENT OR OTHER PENSION INCOME IN URBAN AREAS, ACCORDING TO GENDER, AROUND 1997, 2002 AND 2005
(Percentages)

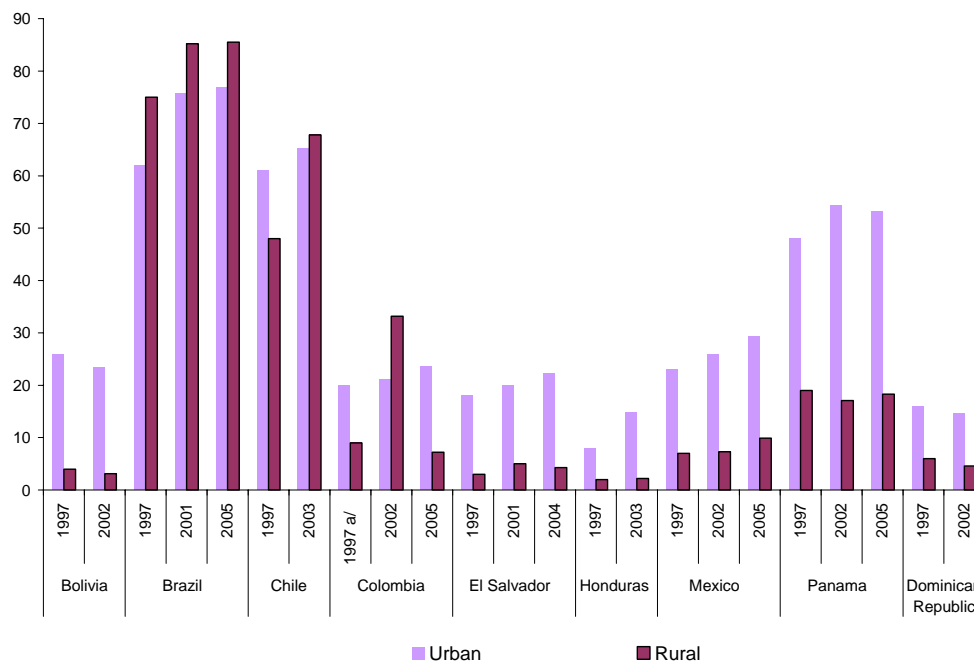


Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of data from household surveys conducted in the relevant countries.

^a Income from retirement or other pensions corresponds to total income transfers to people in the variable "active population" category declaring themselves to be "persons receiving retirement or other pensions".

Retirement and other pension coverage in rural areas has traditionally been low (see figure III.8), except in Brazil, whose rural pension system is one of the main examples in the region of the extension of pension coverage through non-contributory mechanisms (ECLAC, 2006). In the first half of 2007, Mexico also introduced a non-contributory programme based on area of residence. This consists of a monthly grant of 500 Mexican pesos (approximately US\$ 46) to all those reaching the age of 70 prior to 1 January 2007 who live in rural communities with fewer than 2,500 inhabitants and receive no similar benefits from other federal programmes (INAPAM, 2007).

Figure III.8
**LATIN AMERICA (SELECTED COUNTRIES): PROPORTION RECEIVING RETIREMENT OR
 OTHER PENSION INCOME, ACCORDING TO AREA OF RESIDENCE,
 AROUND 1997, 2002 AND 2005**
(Percentages)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of data from household surveys conducted in the relevant countries.

^a Income from retirement or other pensions corresponds to total income transfers to people in the variable “active population” category declaring themselves to be “persons receiving retirement or other pensions”.

All in all, as ECLAC predicted in 2000, the region’s pension coverage has not increased significantly in recent years because benefits continue to be heavily dependent on people having worked in the formal sector of the economy for their entire working lives. This compels families to become one of the main sources of protection for the elderly, to whom they also provide other services, such as care, when levels of dependency increase. Another consequence of poor pension coverage is to increase the labour force participation of older adults and this, in a context of population ageing, can disrupt the operation of the labour market.

C. EMPLOYMENT IN OLD AGE: TRENDS AND FORMS OF ECONOMIC PARTICIPATION

Trends in the labour force participation of older adults have focused attention on the developed regions of the world in recent years. In numerous member countries of the Organisation for Economic Co-operation and Development (OECD), the rising trend towards early retirement from the labour market and reduced working hours in old age has slowed to a halt. This, together with the new “active ageing” paradigm, has opened the debate concerning the most appropriate public policies to support the active ageing process. By contrast, in Latin America, concerns have focused on population ageing and its consequences for pension system financing, with the result that the employment status of older adults has only recently become a subject of public concern and State intervention.

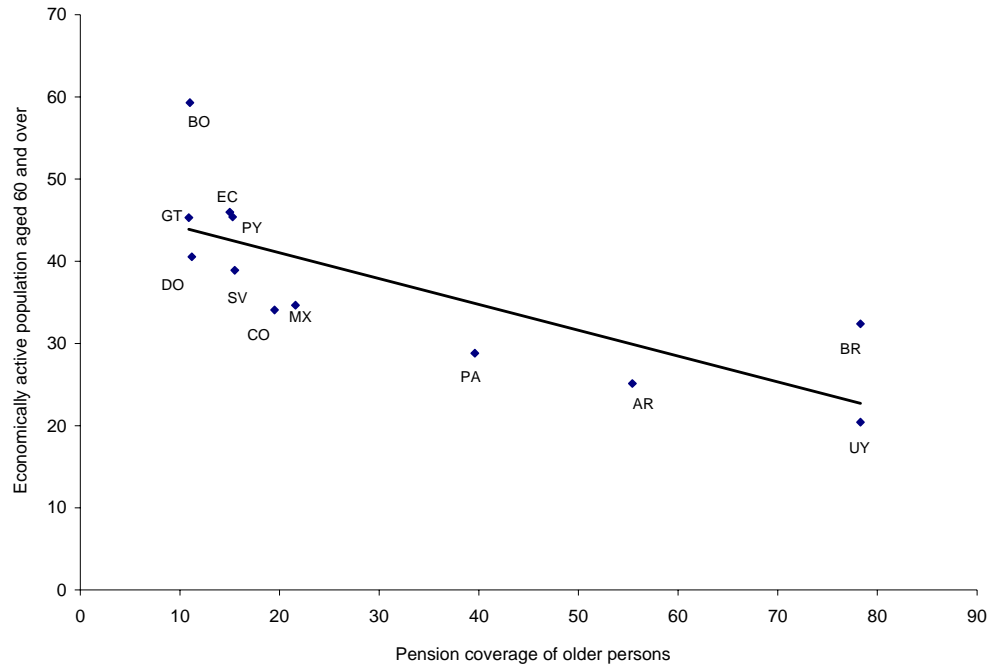
1. Factors influencing economic participation in old age

The labour force participation of older adults has undoubtedly been prompted by a number of factors, in particular demographics and health, the size and quality of social protection coverage, the macroeconomic environment and labour market performance. With respect to demographics, life expectancy has increased in most countries and is expected to continue doing so in the coming years. Furthermore, older people’s state of health, which is a critical factor determining their ability to work in old age, has been improving. Advances in medical science give reason to expect disability to decrease in almost every country in the world, suggesting that this age group will live longer and healthier lives. Together with longer lives, the gross number of working years is also increasing: it is expected to increase from 39 years for both sexes in 2005 to 42 years in 2030, with an additional seven years for women over the same period (CELADE, 2007).

A comparison between older persons and the rest of the working population confirms that older adults’ economic participation rates are growing in Latin America and the Caribbean. This could be a result of the pension system reforms in the 1990s, which introduced tougher conditions of access to benefits. This means that people are not allowed access to benefits until a later age or with a low replacement rate, which encourages retirement and other pension recipients to remain in employment for as long as possible. As a result, older workers in countries with lower social security coverage have higher labour force participation rates (see figure III.9) whereas, in countries with greater coverage, the participation rates of the elderly fall, irrespective of whether the system is contributory or non-contributory. The exception is Brazil, where the labour force participation of older adults has different characteristics than the rest of the region.

As regards the macroeconomic environment, the 1990s were a period of general economic growth in the region. Over the past four years, Latin American and Caribbean economies have been enjoying a highly favourable cycle (ECLAC, 2007a). Economic growth has led to a scenario conducive to employment, which favours older adults seeking to remain in work or find a job (Bertranou, 2006). Even so, the labour market provides precarious and insecure conditions of employment.

Figure III.9
LATIN AMERICA (SELECTED COUNTRIES): ECONOMIC PARTICIPATION RATE AND PENSION COVERAGE^a AMONG PEOPLE AGED 60 OR OVER, AROUND 2005
(Percentages)



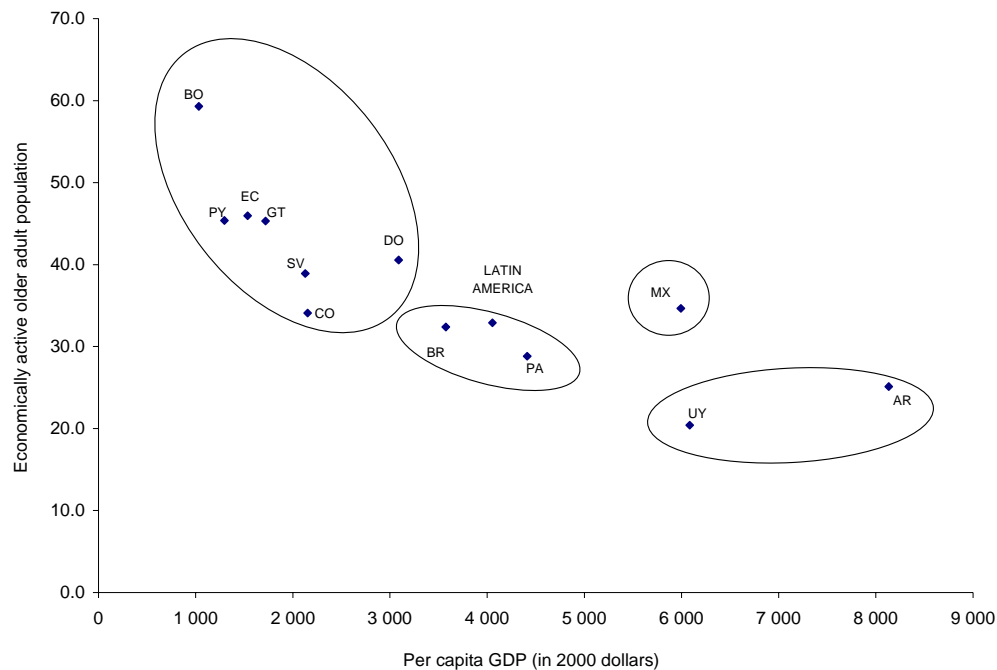
Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, *Demographic Observatory*, No. 2 (LC/G.2337-P), Santiago, Chile, 2007. United Nations publication, Sales No. E/S.07.II.G.28 and Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of data from household surveys conducted in the relevant countries.

^a Pension coverage corresponds to the percentage of people aged 60 or over receiving retirement or other pension income.

The economic participation of older persons is greater in the poorest countries than in the rest of the region (see figure III.10). In 2005, the older adult population of El Salvador, Paraguay, the Dominican Republic, Guatemala, Ecuador and Bolivia (which have lower per capita GDP rates than the regional average) had a higher economic participation rate than the forecast regional average for 2030 (CELADE, 2007).

In these countries, the increase in the economic participation of older persons has arisen in a context of labour market deregulation and the introduction of new contractual forms, including subcontracting of services and fixed-term contracts. Such practices have tended to reduce labour costs and to casualize employment for the entire population, raising informal employment to high levels in all age groups (ILO, 2006).

Figure III.10
LATIN AMERICA (SELECTED COUNTRIES): ECONOMIC PARTICIPATION RATE OF THE OLDER ADULT POPULATION AND PER CAPITA GDP IN 2005



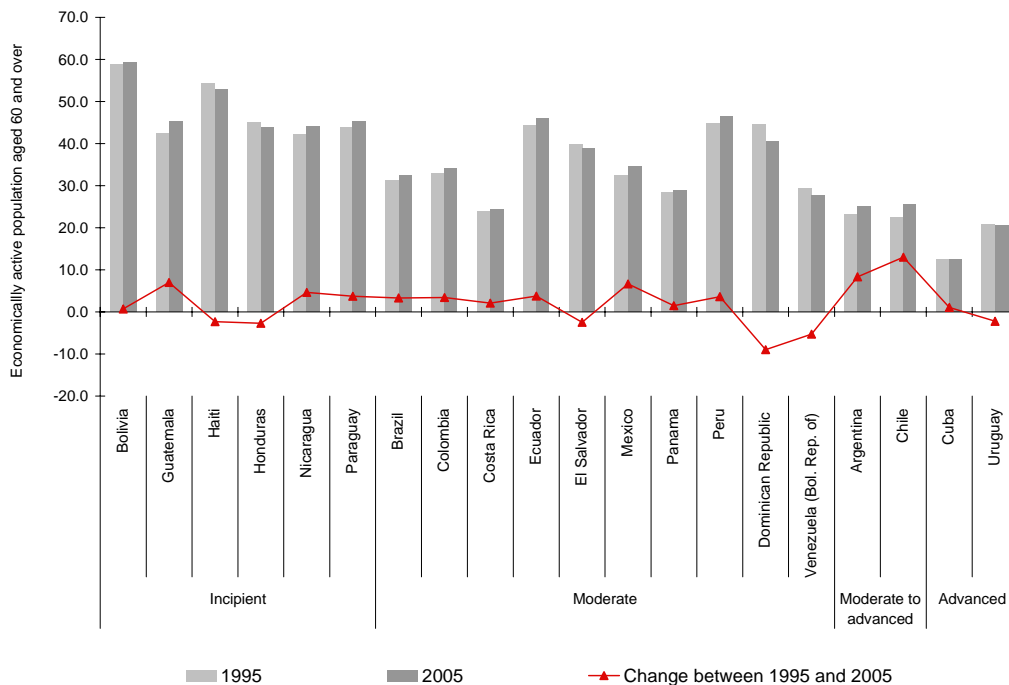
Source: Economic Commission for Latin America and the Caribbean (ECLAC), *Social Panorama of Latin America 2006* (LC/G.2326-P), Santiago, Chile, 2007. United Nations publication, Sales No. E.06.II.G.133 and Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, *Demographic Observatory*, No. 2 (LC/G.2337-P), Santiago, Chile, 2007. United Nations publication, Sales No. E/S.07.II.G.28.

2. The economic participation of older persons is tending to grow irrespective of the phase of demographic ageing

The labour force participation rate of people aged 60 years and over increased markedly in 2005, with a little more than 3 in every 10 older persons either in work or actively seeking employment. This trend is contrary to that in the majority of OECD countries, where the decline in the participation rate of older workers is associated with factors such as early retirement, higher per capita income, better education and improved health. In OECD countries, the current debate centres on how to increase the economic participation of older adults to reduce pressure on pension systems.

In the early years of the twenty-first century, nearly half the older persons in Paraguay, Ecuador and Honduras declared that they were working or seeking employment (see figure III.11). Only in Uruguay and Costa Rica was the trend the same as in OECD countries, where the labour force participation of people over the age of 60 decreased by around 10% in the 1990s.

Figure III.11
LATIN AMERICA (SELECTED COUNTRIES): PARTICIPATION RATE OF PEOPLE AGED 60 OR OVER IN 1995 AND 2005, SHOWING THE CHANGE BETWEEN 1995 AND 2005



Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, *Demographic Observatory*, No. 2 (LC/G.2337-P), Santiago, Chile, 2007. United Nations publication, Sales No. E/S.07.II.G.28.

Although Latin American and Caribbean countries are in different phases of demographic ageing, older persons join the labour force for similar reasons to people in other social groups, such as women. Older persons, like other family members, are a resource that can be drawn upon to boost the household's economic resources in times of crisis, family shortage or if the head of household's conditions of employment deteriorate (whether or not the head is an older adult).

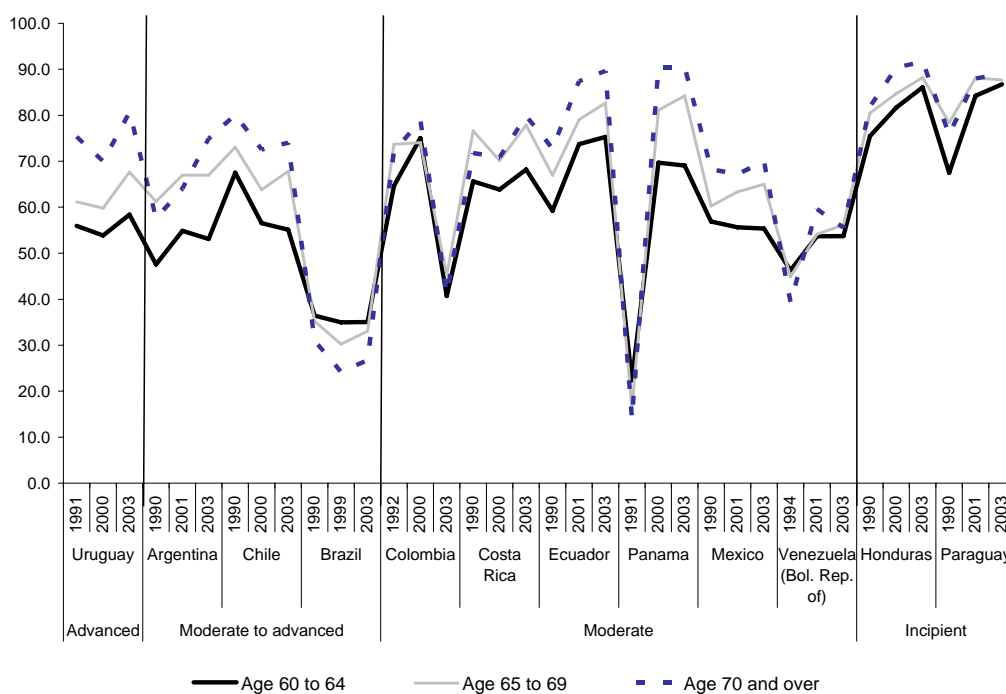
Women account for much of the large increase in the number of people over the age of 60 in the labour force. In Argentina, Brazil and Paraguay, for example, the size of the female labour force over the age of 65 doubled during the 1990s. This could stem from the inability of social security systems to provide income protection to elderly women, who receive less economic income than men despite their widow's pensions.

3. Informal employment and age and gender differences

With the exception of Chile, Panama and Brazil, where the proportion of older persons in formal employment grew by 8.7, 2.4 and 2.7 percentage points respectively in the 1990s, people in other countries tend to move into informal employment when they exceed 60 years of age (see figure III.13). Brazil presents a different profile, with nearly 70% of employed persons in the over-60 age group working in the formal sector, giving Brazil the highest proportion of older wage and salary earners in the

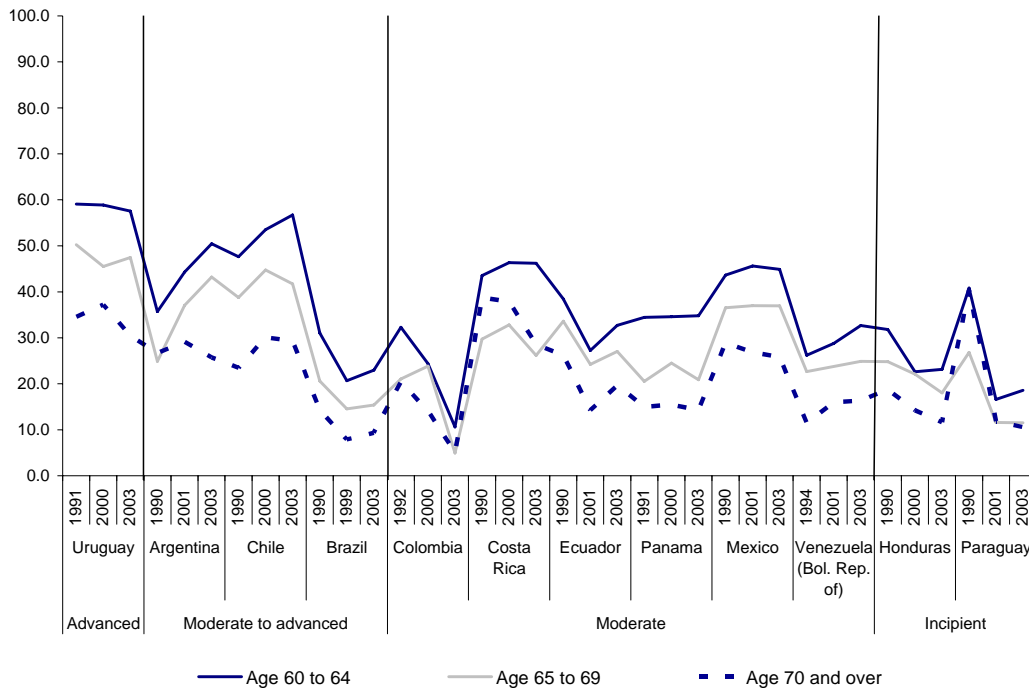
region. It is interesting to note that, in most Latin American and Caribbean countries, informal employment increases as workers get older, irrespective of the country's phase of demographic ageing (see figure III.12). There are also gender-based differences among countries in terms of informal employment. In Argentina, Paraguay and Uruguay, informality among people aged 65 or over grew between 1990 and 2003, chiefly as a result of a decline in the number of formal jobs for men, whereas in Brazil and Chile, the proportion of informality diminished mainly because the share of women in formal jobs increased. In spite of this, a comparison of statistics for women's informal employment during the latest period for which figures are available shows that more women aged 60 or over are in informal employment than women of other ages (ILO, 2006).

Figure III.12
**LATIN AMERICA (SELECTED COUNTRIES): PROPORTION OF THE OLDER ADULT POPULATION
 IN INFORMAL EMPLOYMENT, AROUND 1990, 2000 AND 2003**



Source: Fabio Bertranou, *Envejecimiento, empleo y protección social en América Latina*, Santiago, Chile, International Labour Organization (ILO), 2006.

Figure III.13
**LATIN AMERICA (SELECTED COUNTRIES): PROPORTION OF THE OLDER ADULT POPULATION
 IN FORMAL EMPLOYMENT, AROUND 1990, 2000 AND 2003**

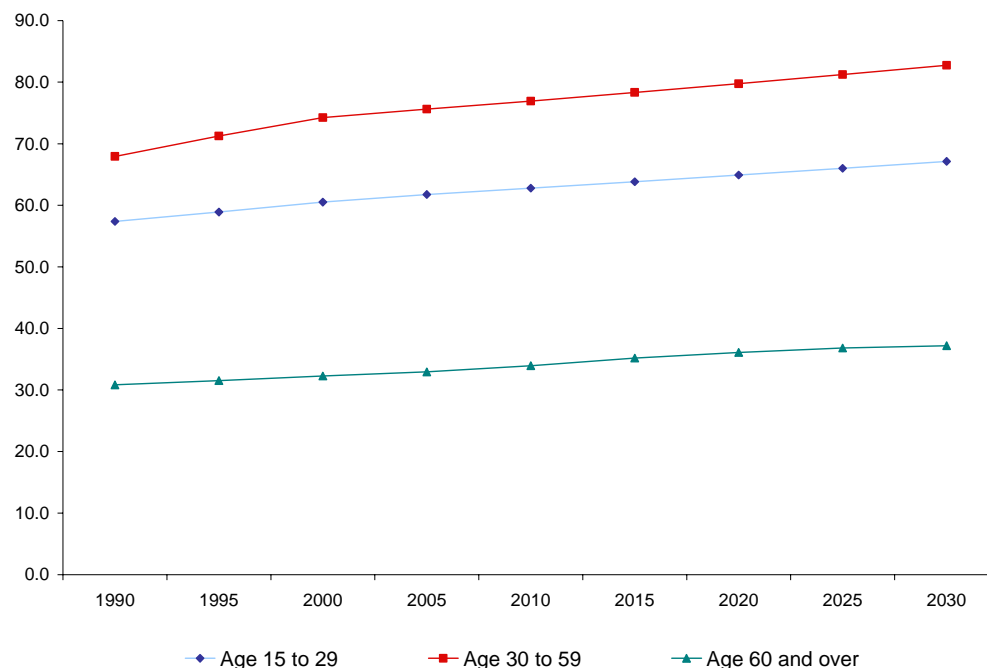


Source: Fabio Bertranou, *Envejecimiento, empleo y protección social en América Latina*, Santiago, Chile, International Labour Organization (ILO), 2006.

All in all, the economic participation rates of older adults in Latin American and Caribbean countries are growing and, as figure III.14 shows, this rising trend will continue in the future, albeit less steeply than in the 30-59 age group. This means that older persons' participation in the labour market is increasing, while the economically-active population will continue to expand for the next few decades.

Given the shortage of jobs in the labour market, it is a common perception that the old should make room for the young, who should be spared the frustration and possible psychological harm of feeling rejected by the world of work at the very start of their working life. In developing countries, where formal employment is very scarce, it is difficult for the numerous young unemployed to find a job in the formal sector. It is believed that if older workers were to stay longer in activity, it would be even worse. In many developed countries, early retirement is often encouraged, in the hope that it can improve job prospects for the young unemployed. However, whether these early retirement schemes really do create employment for the young remains doubtful (ILO, 2002b).

Figure III.14
**LATIN AMERICA AND THE CARIBBEAN: ECONOMIC PARTICIPATION RATES
 BY BROAD AGE GROUP BETWEEN 1990 AND 2030**



Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, *Demographic Observatory*, No. 2 (LC/G.2337-P), Santiago, Chile, 2007. United Nations publication, Sales No. E/S.07.II.G.28.

The problem of income insecurity in old age should not be resolved at the expense of other social groups. In its 1980 Older Workers Recommendation (No. 162), the International Labour Organization (ILO) adopted the principle that strategies and policies should ensure that employment problems are not shifted from one group to another (ILO, 2002a). This is particularly important at a time when Latin American and Caribbean countries are facing the challenge of educating and employing large and growing numbers of children and young adults (aged 15 to 24) to enable them to take advantage of this demographic window of opportunity for economic development (United Nations, 2007b).

Under this scenario, public responses must evolve and adapt to the demographic reality, which means expanding decent employment opportunities for the young and reconciling demand for income protection with the risks of old age (United Nations, 2007b). Proposed measures are to strengthen the non-contributory subsystem and solidarity mechanisms in social security systems (ECLAC, 2006).

D. NON-CONTRIBUTORY PENSIONS AND PROTECTION AGAINST THE RISK OF LOSS OF INCOME IN OLD AGE

As a matter of overarching principle, all retirement and pension systems should aim at providing at the minimum some form of basic income security to all persons in old age. This objective could be achieved by creating, or expanding where it already exists, a basic pillar providing a minimum pension benefit

(United Nations, 2007b). Any real expansion of pension coverage in the region necessarily involves, at least in the short and medium terms, the establishment or consolidation of non-contributory schemes that provide basic pensions to people who reach old age without the income or assets needed for their subsistence, irrespective of their record of contributions to the contributory regime (ECLAC, 2006).

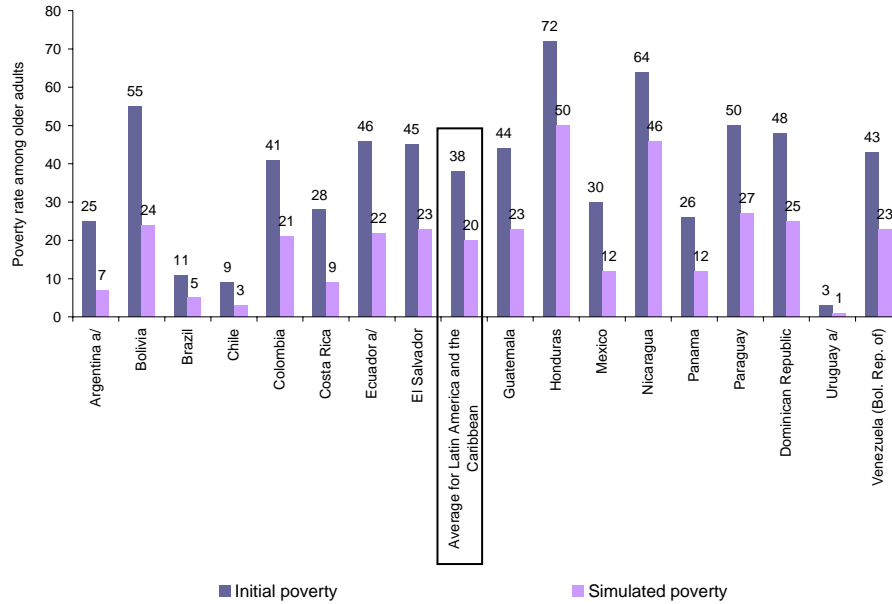
Non-contributory pension programmes grant modest and fairly uniform cash benefits to cover the risks of old age, disability and death, that is to say, they are welfare benefits targeted at poor people with little or no ability to pay contributions. Although Argentina, Bolivia, Brazil, Chile, Costa Rica and Uruguay have been implementing non-contributory programmes for decades, their coverage is still limited, with the result that they have gone only a little way towards closing the gap left by contributory programmes. Even so, countries like Chile, Bolivia and Brazil have made considerable efforts to assist vulnerable older adults.

Based on the various assessments of the effect of non-contributory pensions on poverty and extreme poverty compiled by Bertranou and others (2004), publicly-funded pensions have proven to be a powerful means of both poverty reduction and social reintegration of vulnerable people who have traditionally been excluded from social security and are prey to economic insecurity.

After conducting a simulation to gauge the potential effect on 17 countries in the region of introducing a universal non-contributory pension or a pension targeted at people aged 65 or over, ECLAC concluded that both programmes reduce poverty among older adults by an average of 18 percentage points (see figures III.15 and III.16). The average cost of the targeted pension is 0.93% of GDP, while the universal pension requires resources averaging around 2.2% of each country's GDP (ECLAC, 2006).

In a context of population ageing, limited social protection coverage and labour market regulation, non-contributory pensions provide a useful means of reducing inequalities and providing the most vulnerable segments of the population with more economic independence. Although a cash income does not in itself guarantee social integration or the recovery of important solidarity-based relationships (Pisarello and de Cabo, 2006), its development and extension would be a major step towards ensuring greater dignity and security in old age for current and future generations.

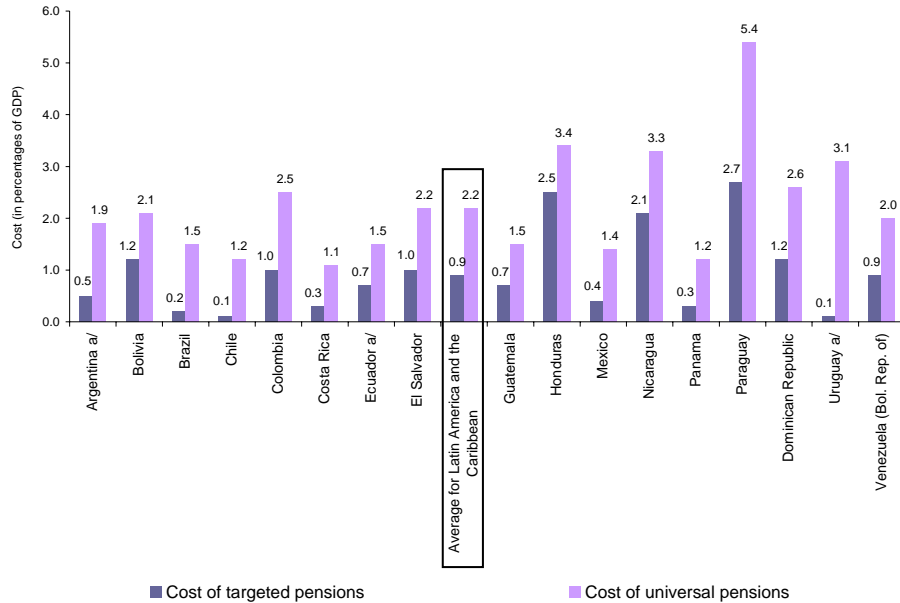
Figure III.15
LATIN AMERICA: EFFECT OF NON-CONTRIBUTORY PENSIONS ON POVERTY
(Poverty rate among older adults)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of household surveys in 2002, except in the cases of Paraguay (2000), Brazil, Nicaragua and El Salvador (2001) and Chile (2003).

^a Urban surveys.

Figure III.16
LATIN AMERICA: COST OF TARGETED AND UNIVERSAL PENSIONS
(Percentages of GDP)



Source: Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of household surveys in 2002, except in the cases of Paraguay (2000), Brazil, Nicaragua and El Salvador (2001) and Chile (2003).

^a Urban surveys.

E. PROGRESS IN IMPLEMENTING THE REGIONAL STRATEGY ON AGEING IN LATIN AMERICA AND THE CARIBBEAN: SOCIAL SECURITY, EMPLOYMENT AND NEW BUSINESS CREATION

The International Covenant on Economic, Social and Cultural Rights recognizes work and social security as human rights (articles 6 to 8, and 9 respectively), placing obligations on the signatory States in terms of compliance, protection and guarantee of rights. The majority of countries in the region have therefore included both work and social security rights as a priority in old-age legislation, policies and action plans.

In spite of widespread support for these rights, in practice, countries' legislative measures and policies have not always led directly to a set of allowances, assets and benefits to which all citizens are entitled. Indeed, in some cases there is a gulf between legislative measures on the one hand, and regulatory, administrative and political, economic and social decision-making measures guaranteeing full enjoyment of those rights, on the other. This is what the United Nations Committee on Economic, Social and Cultural Rights (CESCR) pointed out in relation to social security when it expressed its concern at unequal access to and quality of pensions. In cases where credit is due, it has also praised the efforts of the poorest countries to improve the economic conditions of the older adult population.²

In recent years, countries in the region have progressed at differing rates in establishing the right to social security and the right to work in old age. Achievements have been disparate, in terms of target population, areas and type of intervention and amount of funding earmarked.

A number of initiatives currently being undertaken by Latin American and Caribbean countries to improve the economic conditions of older persons are described below. The information has been drawn from countries' answers to a survey on Latin American and Caribbean programmes targeted at older adults, which CELADE-Population Division of ECLAC conducted between June and August 2007. Following the Strategy on Ageing recommendations, intervention alternatives have been divided into three categories: (i) social security; (ii) employment and (iii) new business creation (see table III.2).

² For example, in 2004 the Committee made the following comments about Chile: "The Committee is deeply concerned that the private pension system, based on individual contributions, does not guarantee adequate social security for a large segment of the population that does not work in the formal economy or is unable to contribute sufficiently to the system, such as the large group of seasonal and temporary workers. The Committee notes that women are particularly affected in this regard: 'housewives' and about 40% of working women do not contribute to the social security scheme and are consequently not entitled to old-age benefits. Moreover, the Committee is concerned at the fact that working women are left with a much lower average pension than men as their retirement age is five years earlier than that of men" (United Nations, 2004). In 2001 it made the following comments about Honduras: "The Committee takes note with appreciation of the family subsidy programmes that are intended to benefit the poorest and most vulnerable groups of the population, in particular children under five years of age, pregnant women and nursing mothers, and elderly persons" (United Nations, 2001).

Table III.2
**PRINCIPAL AREAS OF INTERVENTION OF LATIN AMERICAN AND CARIBBEAN ECONOMIC
 SECURITY PROGRAMMES TARGETED AT OLDER PERSONS**

Countries	Social security		Employment		New business creation		Other forms of economic aid (special bonds, cash subsidies, family allowance, other)
	Special protection for poor people or those unable to pay contributions	Coverage or adjustment of pensions under the contributory system	Legislation prohibiting age discrimination in employment	Promotion of employment for older workers	Promotion of loan opportunities for productive activities	Promotion of productive initiatives by older persons	
Dutch Antilles		X					
Argentina	X	X					
Aruba ^a	X						
Belize	X					X	
Bolivia	X						
Brazil	X		X		X		
Chile	X	X		X		X	X
Colombia	X						
Costa Rica			X		X	X	
Cuba				X	X		X
El Salvador			X	X	X	X	
Guatemala	X			X			
Honduras	X	X		X	X	X	X
Mexico ^b	X		X	X		X	
Nicaragua		X					
Panama			X	X		X	X
Paraguay			X	X			X
Peru			X	X	X	X	
Dominican Republic	X	X					X
Puerto Rico				X			X
Uruguay	X	X	X	X		X	

Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, on the basis of Latin American and Caribbean countries' answers to a survey on programmes targeted at older persons.

^a Aruba has a non-contributory pension programme with universal coverage.

^b The Federal District of Mexico has a non-contributory pension programme targeted at all residents over the age of 70.

1. Social security

Universal social security coverage is still a pending issue in the region and, faced with demographic change, the challenge is how to increase pension coverage and quality and how to reduce inequalities of access to the pension system for people of working age, extending the non-contributory subsystem of social security. In the past five years, Latin American and Caribbean countries have made gradual efforts to increase pension coverage and quality, focusing their efforts on improving the quality of pensions and on protecting older adults with no income or no ability to pay contributions. However, there are persistent inequities and inequalities that call for more far-reaching public policy decisions to expand protection to the entire population. Countries that have made efforts to improve pension quality and have increased the value of benefits are: Aruba, the Dutch Antilles, Chile, Honduras, Nicaragua, the Dominican Republic and Uruguay.

Fewer special protection measures have been implemented for older persons who are unable to pay contributions. Only Argentina has introduced regulations allowing people to cease working at retirement age even though they have not paid enough years of contributions to entitle them to a pension. The law permits them to receive the pension by paying arrears under a payment facilities plan. This initiative will be of direct benefit to women and others with pension coverage gaps.

Bolivia is one of the countries to have devised special protection programmes for all older adults with no income. Its solidarity bonus programme, BONOSOL, pays a universal pension to all citizens over the age of 65, and by 2002 the programme had extended Bolivia's pension cover by 40% (ECLAC, 2006). In December 2006, Guatemala passed a law on an economic contribution programme for older adults without coverage, following a widespread effort to mobilize social organizations. In so doing, Bolivia and Guatemala, both of which have moderate ageing and widespread poverty, have followed in the footsteps of Brazil, Uruguay, Chile and Costa Rica, which, as mentioned earlier, have had more extensive experience of non-contributory pension programmes.

In other cases, actions have been targeted at specific segments of the older adult population. They include Brazil's rural pensions programme, Mexico's new rural pensions programme and Belize's programme of non-contributory pensions designed solely for women over the age of 65. Another selection criterion employed by a number of programmes is age. For instance, in 2003 Argentina extended entitlement to a non-contributory pension to all poor people over the age of 70 with no social security coverage. Another example is the Federal District of Mexico, where the Government grants a universal basic pension (*pensión ciudadana universal*) to all residents over the age of 70, irrespective of the beneficiary's income. Aruba also has a universal programme of non-contributory pensions which covered 13,692 pensioners in 2005, at a cost equivalent to US\$ 83.726 billion for the same year.

This older population segment has also been included in conditional transfer programmes. In Brazil, Colombia, Chile, Panama and Uruguay, poor families with an elderly member receive a grant. Uruguay introduced a novel programme in 2005 —the National Social Emergency Plan (PANES) run by the Ministry of Social Development. One of the Plan's lines of action is to grant a welfare benefit called '*ingreso ciudadano*' (universal basic income) to anyone in a situation of extreme poverty. Of the total beneficiary population, 7,000 are over the age of 65. After they cease receiving the universal basic income, the Social Security Bank (BPS) pays them a non-contributory old-age pension.

2. Employment

The older persons' employment trend analysed earlier in this report arises partly in response to this population's low levels of basic and core skills. The demand for new skills and knowledge places many older workers at a disadvantage, as their training earlier in life is likely to be obsolete (ILO, 2002b). To overcome such problems, countries have implemented a wide range of initiatives, including the provision of job training (Chile, El Salvador, Uruguay, Panama, Honduras, Puerto Rico and Colombia) and the development and maintenance of databases and information banks on jobs for older adults (El Salvador, Mexico and Puerto Rico).

Other advances have been made to abolish age discrimination in employment, in the form of positive action measures or a specific ban on segregating any worker on the grounds of age. In 2002, Brazil, El Salvador, Mexico, Paraguay, Peru and Uruguay adopted such measures, joining a number of countries that had already introduced them (Cuba, Colombia, Ecuador, Guatemala and the Dominican Republic). Panama has made the most recent progress in this respect. In June 2007, a plenary session of

the Panama's National Assembly approved a new bill repealing Law 61 of 20 August 1998 (known as the Faúndes Act) that had prevented civil servants over the age of 75 from continuing to work and draw salaries on the government payroll. Panama's new bill came in response to widespread petitions from older people's and civil servants' organizations, especially universities.

Mexico recently introduced a novel scheme for helping older people to find employment with state support. In March 2007, a decree was signed granting tax incentives to firms hiring older or disabled people. The decree establishes that a tax deduction of up to 25% of the actual wage shall be granted to improve the welfare of these two groups that are subject to job discrimination.

Uruguay has also implemented an innovative employment support programme to help older adults to increase their chances of finding work, supplemented by a number of reception and social support measures—the Social Security Bank's programme for the integrated care of older homeless persons. The Bank has carried out promotion activities at its day centre, which caters for the more basic needs of its target group, provides them with job training and promotes both retraining and the creation of productive microbusinesses. Peru is another country which has also expanded opportunities to enhance the employability of older persons in recent years, with some Ministry of Labour and Employment Promotion programmes also targeting the older adult population.

3. New business creation

This is a newer and less common area of government intervention than employment, although the two areas tend to be mutually reinforcing. In general, new business creation concentrates on two spheres of intervention: financial support by means of loans and donations, and technical support or microbusiness promotion.

Loans tend to be targeted at people receiving retirement or other pensions, as in Peru, where the state bank, Banco de la Nación, grants loans to retired civil servants, and in Costa Rica, where there is a loan programme for pensioners affiliated to the Teachers' Pension Board (*Junta de Pensionados del Magisterio Nacional*). In addition, governments have opened up credit opportunities to groups excluded from the financial market. In El Salvador, for example, a special line of credit was created for older adults in the Mutual Fund for Family Microenterprise (FOSOFAMILIA) and, in Honduras, there are bank microcredit programmes for members of the Central American Chamber of Commerce. In a similar vein, other countries have regulated credit operating conditions. For instance, in Cuba, older adults are given access to long-term loans with payment facilities and, in Brazil, the low-interest loans market has been expanded to include this social group.

There are also varying types of donation to support productive initiatives. Belize has a European Union-funded donations programme for the rural sector that includes older persons. In Chile, older people's organizations can apply for non-reimbursable project financing from a fund subsidized by the Inter-American Development Bank. Mexico runs the 'Tercera Llamada' programme, which funds viable productive initiatives by older adults by means of a joint fund run by a number of public institutions. Honduras runs the Honduran Social Investment Fund (FHIS) for the development of projects to help people to satisfy their own basic needs.

Another path to new business creation is to promote microenterprise. Peru's Ministry of Labour and Employment Promotion runs a programme that fosters the creation of microbusinesses by older adults. El Salvador's Ministry of Labour and Social Security supports older persons' cooperatives by

means of the 'Older Entrepreneurs' programme (*Adulto Mayor Emprendedor*). Costa Rica's Ministry of Labour and Social Security has implemented the National Support Programme for Micro- and Small Enterprises (PRONAMYPE) and the programme 'Entrepreneurs in their Golden Years' (*Emprendedores en la Edad de Oro*), the latter jointly with the University of Costa Rica.

The measures described in this section reveal that older people's economic status is beginning to be posted on Latin American and Caribbean public policy agendas. However, this is still at a very early stage. The current momentum stems in part from a favourable international context since the Second World Assembly on Ageing, together with a growing awareness of the need to gradually gear public policies to the population's changing age structure.

As with any new public policy issue, before this issue can be included on the agenda, it is first necessary to define the way in which society believes public problems should be addressed. According to the results presented in this section, most countries have opted for an approach centred on employment-promotion and hence centred on new business creation and on addressing poverty among older persons as ways for resolving the problems of economic insecurity in old age.

There has been little experience of rights-based policies in Latin American and the Caribbean. If the State fails to play an active role to ensure that employment really does evolve into systems for distributing income and social recognition (Offe, 1992) and unless the focus on the poorest people is accompanied by a suitable time dimension to gradually extend the benefits to other sectors of the population (OHCHR, 2004), in the future this will infringe two basic principles of rights-based social protection: solidarity and universality.

Other aspects of note in a number of countries are: (i) limited coverage of existing programmes; (ii) poor coordination with other sectoral policies and (iii) non-inclusion of programmes in national budgets. The latter gives cause for concern as, apart from being one of the most important instruments for government management, national budgets are essential to ensure that governments meet their human rights obligations. Progress in this area is crucial to ensure that the programmes currently being implemented really do become government policies and are not conditional upon the priorities of public administrations or international cooperation agencies.

In conclusion, in the past five years the region has come a long way in including economic status as an item on government agendas. Nonetheless, the challenges arising from this policy area are diverse and wide-ranging. In order to meet them it is first necessary to guarantee the sustainability, efficacy and coverage of interventions, focusing on the human rights principles of universality and solidarity. As Latin American and Caribbean countries are well aware of these challenges, they have pinpointed income security as a primary area of concern over the next five-year period and one of the core policies to be addressed without delay. To this end, it is essential not only to improve the economic conditions of today's older population but also to focus attention on the rest of the working-age population because, as mentioned in the introduction to this chapter, social security is still the public policy instrument par excellence that provides the greatest safeguards against the risk of loss of income in old age.

Chapter IV

HEALTH PROTECTION AND AGEING IN LATIN AMERICA AND THE CARIBBEAN

There is an interrelationship between the epidemiological transition and the demographic transition (Frenk and others, 1991; Galyin and Kates, 1997) that has implications in terms of the demand for health protection. Such demand is understood to mean the right to access to and use a whole range of facilities, goods, services and conditions required to achieve the highest attainable standard of health (United Nations, 2000), in other words, access to health care for people of all ages without discrimination.

The two transitions interact as population ageing is accompanied by an epidemiological shift from the predominance of infectious diseases and high maternal and child mortality to that of non-communicable diseases, especially chronic ones (United Nations, 2007b). This has specific consequences for the health systems of the region's countries in terms of the types of disease to be treated and the population groups affected.

The reduction in infectious causes of death mainly benefits children, young people and women, and is largely thanks to, *inter alia*, mass vaccination programmes, low-cost hygiene and preventive measures and the availability of antibiotics and medicines. Non-communicable illnesses in the form of chronic, degenerative and incapacitating diseases are becoming increasingly common causes of morbidity and mortality. They are progressive, lengthy, and difficult to control, and therefore more costly to treat.

As infectious diseases become a less significant cause of death, the lifespan of those who have survived childhood illnesses continues to expand over time. Eventually, there will be a higher number of older adults in the population who are more susceptible to chronic diseases than younger people. With the increase in the number of older persons, the prevalence of non-communicable diseases will likely increase as well (United Nations, 2007b). Added to this is the higher incidence of injuries and falls, which have major implications in terms of maintaining functionality during old age.

Increasing life expectancy at birth is undoubtedly a sign of social and economic development. However, the quality of the years gained is even more important. If medical treatments postpone deaths from chronic conditions but do not delay the onset of the conditions themselves or their disabling consequences, the result could be an expansion of morbidity and disability over the life course of individuals (United Nations, 2007b).

In developed countries, the pace of this transition was much slower than it is now in Latin America and the Caribbean, and the ageing process took place once societies had achieved higher standards of living, less social and economic inequality, and more equal access to health services. In this region, on the other hand, the process is taking place amidst precarious socio-economic conditions, high poverty levels, rising social and economic inequalities and unresolved problems of inequitable access to health services (CELADE, 2003). This essentially means that much of the reduction in mortality is due to the action of exogenous variables (medical discoveries and technology) rather than to higher standards of living (Palloni, DeVos and Peláez, 2002). This goes some way towards explaining why morbidity levels have not fallen and why people remain at risk of spending more of their lives in poor health.

There is an interrelationship between health in childhood and health during old age. Evidence in recent years has suggested that health in old age (and the prevalence of some chronic diseases) depends on being exposed to and suffering from harmful diseases or conditions during childhood (Barber, 1998; Palloni and others, 2007). For instance, the study by Palloni and others (2007) in Puerto Rico showed that obesity and diabetes (on the rise in many of the region's countries) are associated with malnutrition during childhood, while heart disease was also correlated with childhood illness.

The epidemiological changes under way throughout the region are far from uniform and vary according to the heterogeneity of conditions within each country. Thus, the stage reached by demographic and epidemiological processes becomes more advanced as the quality of socio-economic conditions and access to basic services rises. In the most disadvantaged areas, communicable diseases therefore remain the principal causes of morbidity and death in all age groups, including among older adults (Ham Chande, 2003).

This constitutes a twofold challenge for health protection known as the “epidemiological backlog”, whereby the incidence of chronic and degenerative diseases rises while certain communicable (and maternal) diseases—including respiratory disease—also remain a persistent problem. The complex nature of this dynamic calls for increased investment and resources for treating chronic and degenerative diseases (in terms of both human resources and curative and preventive technologies and instruments), as well as actions to prevent and treat communicable diseases.

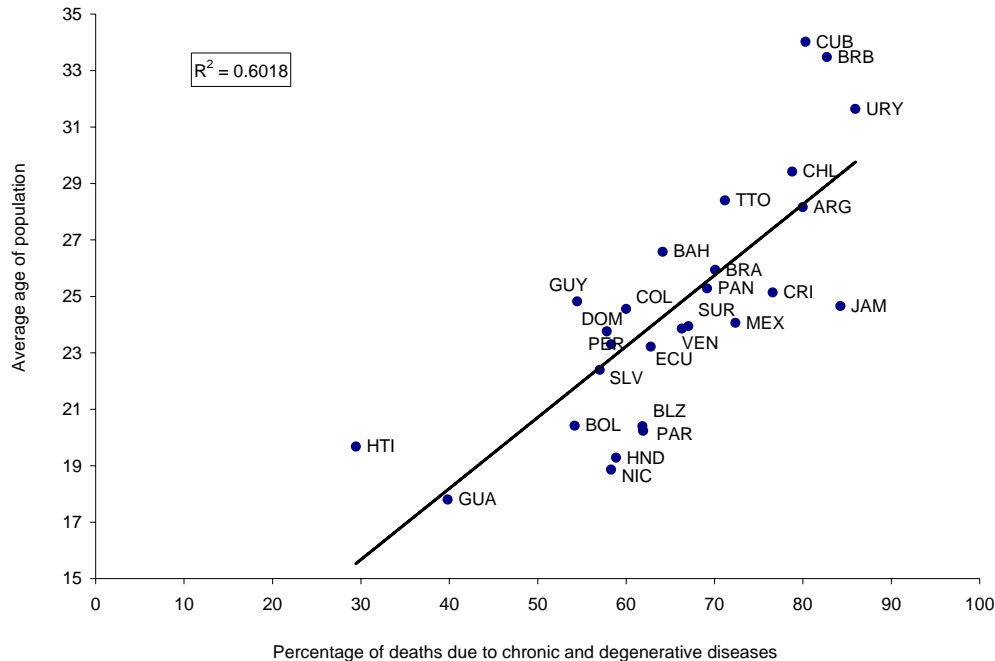
In summary, Latin American and Caribbean countries are facing both old and new challenges in the field of health policy. The latter relate to changes in demand that require new services and treatments, while the former have to do with the region's shortcomings in terms of equal access to timely and quality health services, lack of human and financial resources, and problems of articulation between the various levels of the health-care system and the public and private sectors (ECLAC, 2006).

This chapter aims to review and analyse the information available on health and ageing by studying the interactions between the demographic and epidemiological transitions and their consequences for public health, as well as the health requirements arising from epidemiological change in ageing populations and the outlook for health protection in those contexts. The chapter also summarizes the progress that the region's countries have made in terms of the second priority of the Regional Strategy, which relates to health and well-being into old age.

A. EPIDEMIOLOGICAL TRANSITION, AGEING AND HEALTH CONDITIONS OF THE POPULATION

According to the latest available data, there is a strong link between the level of ageing and the progress of the epidemiological transition. According to figure IV.1, which shows the proportion of causes of death due to chronic and degenerative diseases according to the average age of population (2002), on the one hand there are those countries in an advanced stage of demographic transition (Cuba, Uruguay, Chile, Argentina and Barbados) with over 80% of deaths due to such causes, while on the other hand there are countries about to enter a full demographic transition with a fairly recent ageing process.

Figure IV.1
LATIN AMERICA AND THE CARIBBEAN: PERCENTAGE OF DEATHS DUE TO CHRONIC AND DEGENERATIVE CAUSES AND AVERAGE AGE OF POPULATION^a



Source: World Health Organization (WHO), “Causes of death”[online] <http://www.who.int/research/en/>, 2004; and Economic Commission for Latin America and the Caribbean (ECLAC), *Social Panorama of Latin America, 2004* (LC/G.2259-P), Santiago, Chile, 2004.

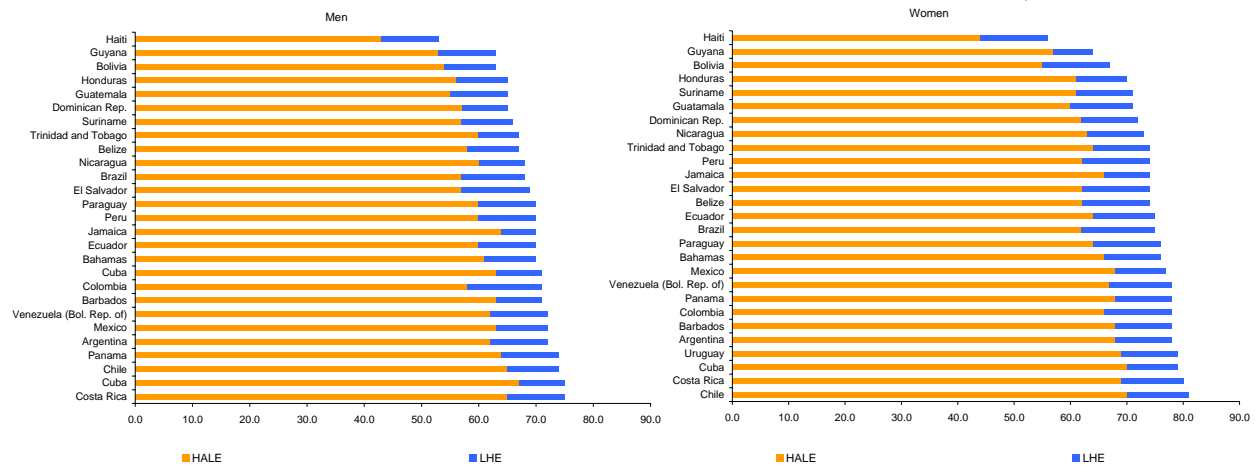
^a Average age refers to 2000 and proportion of deaths to 2002.

In the latter groups of countries, the median age of the population is below 20 and the proportion of deaths due to chronic and degenerative causes is less than 50%, as in Haiti and Guatemala. Despite having relatively young populations, some countries in this group (Bolivia, Honduras and Nicaragua) have a proportion of deaths due to non-communicable causes that is similar to countries with moderate levels of ageing.

On average, the Latin American and Caribbean population has a lower life expectancy than in developed countries, and people also spend much of their lives in poor health conditions. This may be illustrated by comparing life expectancy at birth and health-adjusted life expectancy (HALE) at birth. As shown in figure IV.2, despite the fact that most countries display a considerable increase in life expectancy at birth, each person spends an average of 10 years in poor health (lost health expectancy (LHE)).

Figure IV.2 also shows the heterogeneity of situations. In half of countries, for instance, men have above-average lost health expectancy (9 years), and in Colombia and El Salvador, LHE is 13 years and 12 years, respectively. As for women, 16 countries are above average (10.5 years). The country with the worst indicator is Brazil (13 years), followed by Colombia, Paraguay, Belize, El Salvador, Peru, Bolivia and Haiti (12 years).

Figure IV.2
LATIN AMERICA AND THE CARIBBEAN: LIFE EXPECTANCY AT BIRTH, BY SEX ^a



Source: World Health Organization (WHO), *World Health Statistics*, 2007.

^a Expressed in health-adjusted life expectancy (HALE) at birth and lost health expectancy (LHE). Lost health expectancy is the difference between life expectancy and healthy life expectancy at birth and is expressed as a number of years. In this case, health-adjusted life expectancy (HALE) at birth corresponds to 2002 and life expectancy to 2005.

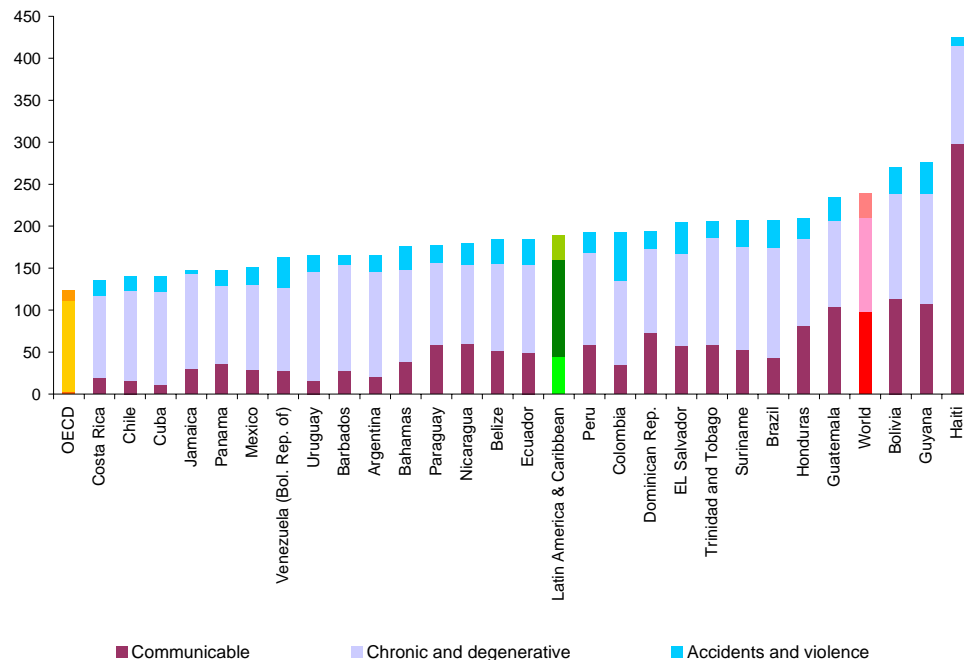
According to several studies (Romero, da Costa Leite and Landmann, 2005; United Nations, 2007b), despite the fact that women have higher life expectancy than men at birth, they tend to spend more years living in poor health. In Brazil, for instance, the National Household Survey (PNAD, 2003) found that women report a higher proportion of chronic illness and motor limitations (Guedes, 2006). In other words, women's physical and social vulnerability is related to both their increased morbidity and the cumulative effect of inequities throughout their lives (PAHO, 1994).

B. EPIDEMIOLOGICAL PROFILE, HEALTH NEEDS AND AGEING

The implementation of health policies and actions requires familiarity with the health needs of the population. One way of summarizing the population's needs is through the number of healthy life years lost (Disability-Adjusted Life Years (DALY)) for every 1,000 people. This is an indicator of the burden of disease that classifies a country's main health problems and is expressed as the number of life years lost due to premature death or disability. It should be borne in mind that chronic and degenerative diseases have higher associated levels of disability (in the case of neuropsychiatric conditions, for instance) than communicable diseases.

Figure IV.3 shows a breakdown of the healthy life years lost (Disability-Adjusted Life Years (DALYs)) due to three groups of causes of death: communicable diseases, chronic and degenerative diseases, and accidental and violent causes. The figure provides data on each Latin American and Caribbean country, which are then compared with the world average and the average for OECD countries with the highest incomes. Although the overall level of DALYs in the region is substantially below the world average, it is almost 50% above the figure for high-income countries of the Organisation for Economic Co-operation and Development (OECD). The largest differences with the latter group are in terms of healthy life years lost due to communicable diseases.

Figure IV.3
LATIN AMERICA AND THE CARIBBEAN: BURDEN OF DISEASE INDICATOR, 2002 ^a



Source: World Health Organization (WHO), 2004. Data relate to divisions by major areas, Economic Commission for Latin America and the Caribbean (ECLAC), *Shaping the Future of Social Protection: Access, Financing and Solidarity* (LC/G.2294(SES.31/3)), Santiago, Chile, 2006.

^a In Death and Disability Adjusted Life Years (DALYs) for every 1,000 people.

Grouping the region's countries by level of income (high, middle and low) shows that, overall, low-income countries have a higher burden of disease (almost equal to the world average). A breakdown by cause of DALYs shows that the poorest countries have a higher incidence of communicable diseases than middle- and high-income countries (ECLAC, 2006). An examination of figures at the country level mirrors the overall results, and shows that Haiti is strongly disadvantaged.

Differential analysis of DALYs by age and sex shows where the burden of disease is concentrated. As indicated in table IV.1, the burden of disease tends to be concentrated in old age. However, the breakdown of three large groups of diseases shows that the burden of disease due to communicable causes is concentrated in the 0 to 14 age group, while non-communicable causes are concentrated in older adults. These ratios apply to men and women. At the same time, accidental and violent causes are concentrated in male adults (aged 15-59 years).

Table IV.1 also shows that, in the low-income group, practically all age groups display more DALYs due to communicable diseases than the high-income group, whereas non-communicable diseases display similar trends in all income groups. This suggests that the low-income population group is at a triple disadvantage due to being poor, as well as having high levels of mortality and morbidity due to communicable and non-communicable causes alike. Such is the case of Panama, where the rate of communicable diseases is higher in disadvantaged areas (including suburbs) and indigenous zones than in the rest of the country (Ministry of Social Development, 2004).

Table IV.1
**LATIN AMERICA AND THE CARIBBEAN: BURDEN OF DISEASE INDICATORS BY
 AGE GROUP, GENDER, CAUSE AND INCOME BRACKET, 2002^a**

		High income				Middle income				Low income			
		Groups of causes			All causes	Groups of causes			All causes	Groups of causes			All causes
		G1 ^b	G2 ^c	G3 ^d		G1	G2	G3		G1	G2	G3	
Total		34.8	120.0	26.6	181.4	39.3	102.8	38.5	180.5	101.3	108.0	25.8	235.1
Men	0-14	79.6	66.0	20.6	166.2	69.4	57.9	24.3	151.6	170.7	65.9	22.4	259.1
	15-59	15.9	127.0	59.3	202.2	28.1	105.4	90.5	224.0	54.3	115.4	55.2	225.0
	60+	21.9	323.9	14.3	360.1	25.1	275.9	18.7	319.7	46.0	312.2	19.5	377.7
	Total	35.8	123.7	44.0	203.5	41.2	102.5	64.0	207.7	99.2	107.5	40.4	247.1
Women	0-14	67.8	66.3	10.8	144.9	59.8	59.3	13.3	132.4	161.6	67.6	11.8	241.0
	15-59	20.5	113.7	10.1	144.3	28.5	103.3	13.7	145.5	71.9	113.2	11.4	196.5
	60+	18.3	282.8	5.1	306.2	19.0	262.1	6.9	288.0	42.5	295.4	6.0	343.9
	Total	33.7	116.3	9.8	159.9	37.4	103.0	13.0	153.4	103.5	108.5	11.2	223.1

Source: Economic Commission for Latin America and the Caribbean (ECLAC), *Shaping the Future of Social Protection: Access, Financing and Solidarity* (LC/G.2294(SES.31/3)), Santiago, Chile, 2006.

^a Disability-Adjusted Life Years (DALYs) for every 1,000 people, by age, sex, cause and income group.

^b Communicable causes.

^c Non-communicable causes.

^d Accidental and violent causes.

One aspect to consider in the light of the above is that the consequences of disability resulting from chronic illness in old age are more severe in society's economically disadvantaged groups, mainly due to their lack of access to health services (Ham Chande, 2003). Moreover, the projected ageing of the population means that the burden of non-communicable diseases is bound to rise over time, so the demand for more costly health-care services is sure to increase (ECLAC, 2006). This will go hand in hand with the need to address the epidemiological backlog that affects the most vulnerable in society, regardless of age.

Box IV.1

LATIN AMERICA AND THE CARIBBEAN: SELF-PERCEPTION OF HEALTH IN OLD AGE

The public opinion survey "Latinobarómetro" (2006) makes it possible to analyse the determining factors of subjective health as it includes a question on health over the past 12 months. Within the logistic model, the dependent variable is the health rating ((i) good, very good (positive event), and (ii) fair, poor, very poor (negative event)). This provides the determining factors of subjective health (age, gender, declared socio-economic status, access to health services, level of education and place of residence).

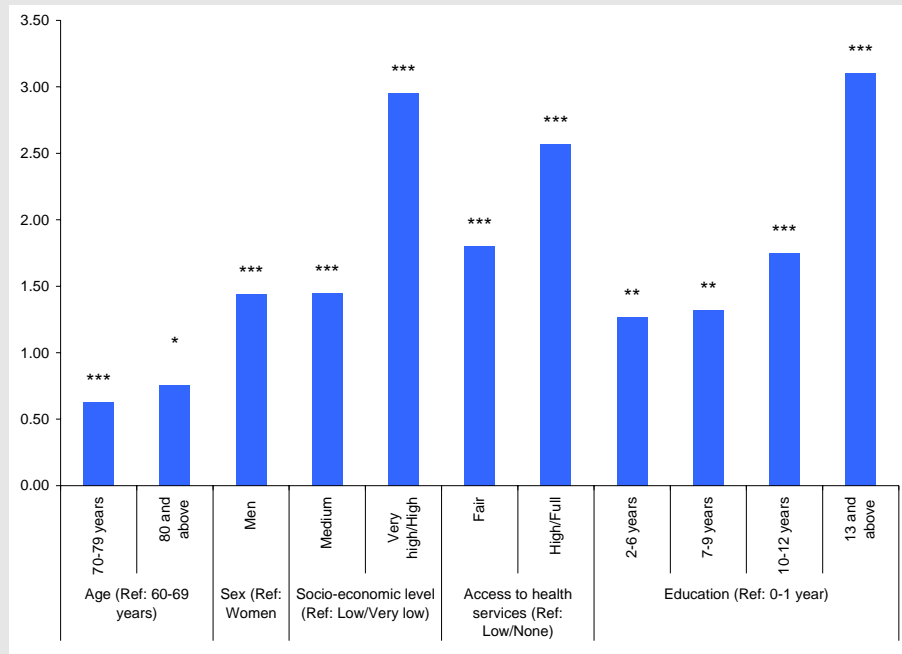
The model applied to those aged 60 and over helps to define more clearly the health risk factors for older adults, which is a key issue. The first finding is the strong effect of the socio-economic component, which persists even after controlling for major variables such as access to health services, age and education. This is the first sign of discriminatory factors in "access" to good health (even if only in terms of self-perception).

The probability of having good or very good health falls with age. However, there is a U-shaped relationship between age and self-perception of health after the age of 60, as those aged 70-79 are less likely to report good health than those aged 60-69. One probability is slightly higher in the latter group: older men are more likely to report good health than women of the same age. There have been many explanations put forward for these differences (Spizzichino and Egidi, 2007). First, non-fatal chronic diseases are more common among women (Molarius and Janson, 2002; Hoeymans et al., 1999; Idler, Russell and Davis, 2000). Second, women are more attentive to and familiar with their health, and are therefore more likely to report their health problems (Idler, 2003). Another characteristic that affects self-perceived health is level of education: higher schooling increases the probability of reporting good health. The major leap occurs in people with 13 years' schooling or more, who are 200% more likely than illiterate people to report self-perceived good or very good health (the probability is only 75% higher among those with 10-12 years' education).

Box IV.1 (concluded)

Access to health services is clearly a key factors for older adults who can enjoy good health. Those with such access are 195% more likely to report good health than those with limited access.

LOGISTICAL MODEL FOR SELF-PERCEPTION OF GOOD HEALTH (EXP β) IN POPULATION AGED 60 AND ABOVE



Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, on the basis of the Latinobarómetro survey.

Note: *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$. Also included in the model were place of residence and civil status (non significant).

The model clearly shows that there are considerable differences in the health of older adults according to socio-economic status (echoing the findings of the National Household Survey (PNAD, 2003) in Brazil) and also according to their access to health services (even after controlling for other determining factors). This underscores the importance of one of the key goals related to well-being and health into old age: the ability to access comprehensive health services and the adaptation of services to people's needs and economic conditions.

Source: Latin American and Caribbean Demographic Centre (CELADE)-Population Division of ECLAC, on the basis of the 2006 Latinobarómetro survey.

C. BURDEN OF DISEASE: THE IMPACT OF MORTALITY AND DISABILITY ON OLD AGE

The burden of disease provides information on the effects of mortality and disability. Death is the event that has the highest social cost in public health, and disability represents a huge social and individual cost that, in most cases, compromises the quality of life of the individuals and families concerned.

1. Mortality

Mortality rates are not only measures of the frequency of death in the population, but are also indicators of the absolute risk of dying of a given cause. Table IV.2 shows estimated mortality rates in men and women aged over 65 by the main causes of death in four of the region's countries that are at various stages of the ageing process (Uruguay (advanced), Argentina (moderate to advanced), Colombia (moderate), Ecuador (incipient)) in the mid-1990s (1995) and the most recent year of observation available.

Table IV.2
ARGENTINA, COLOMBIA, ECUADOR AND URUGUAY: ESTIMATED MORTALITY RATES IN MEN AND WOMEN AGED 65 AND ABOVE, 1995 AND 2005
(Groups of causes of death) (Per 100,000 population)

Causes of death/sex	Uruguay ^a		Argentina		Colombia		Ecuador	
	1995	2001	1995	2005	1995	2005	1995	2005
Men								
Communicable diseases	323.7	357.5	483.6	695.1	347.0	365.8	660.5	443.1
Circulatory system	2 901.2	2 400.8	3 058.4	2 272.9	2 680.8	2 450.5	1 655.0	1 458.9
Ischaemic heart disease	953.0	754.7	642.2	544.2	1 133.2	1 248.2	264.8	331.6
Malignant neoplasm	1 796.8	1 818.6	1 278.4	1 333.2	1 011.7	1 097.3	845.3	779.6
Diabetes mellitus	140.0	182.0	200.9	215.3	161.9	245.7	220.9	222.3
External causes	233.3	185.3	168.5	162.7	277.4	237.1	255.1	203.9
Women								
Communicable diseases	267.1	302.9	345.6	571.9	289.1	303.7	544.2	331.9
Circulatory system	2 328.5	2 017.8	2 399.4	1 799.2	2 374.4	2 051.3	1 455.1	1 338.8
Ischaemic heart disease	582.1	482.2	379.2	313.7	857.8	897.4	181.8	209.0
Malignant neoplasm	907.3	879.5	736.5	764.0	779.0	780.4	805.5	616.9
Diabetes mellitus	142.7	127.8	159.2	163.9	232.2	288.9	307.3	303.9
External causes	107.9	93.2	77.2	85.6	110.3	74.8	99.6	78.0

Source: Pan American Health Organization (PAHO), special processing, 2007.

^a Estimated mortality rates for communicable diseases and diabetes mellitus refer to 2004.

In the four countries selected, older adults die mainly due to causes relating to the circulatory system or malignant neoplasm (in Colombia, the rates are similar for ischaemic heart disease and malignant neoplasm). Predictably, the rates for chronic and degenerative diseases are lower in the youngest country (Ecuador) and higher in countries with more advanced population ageing (such as Uruguay).

Argentina and Uruguay have been able to manage chronic and degenerative illnesses in such a way as to avoid them resulting in death, whereas Colombia (with moderate population ageing) has not effectively tackled these often fatal illnesses, despite the existence of prevention programmes and technologies capable of palliating their final effect. This may indicate some difficulty in developing and implementing risk-factor monitoring programmes for primary and secondary prevention to curb the incidence of non-communicable diseases. If this trend continues, it could create long-term complications that, if left unchecked, will result in reduced functionality among older adults.

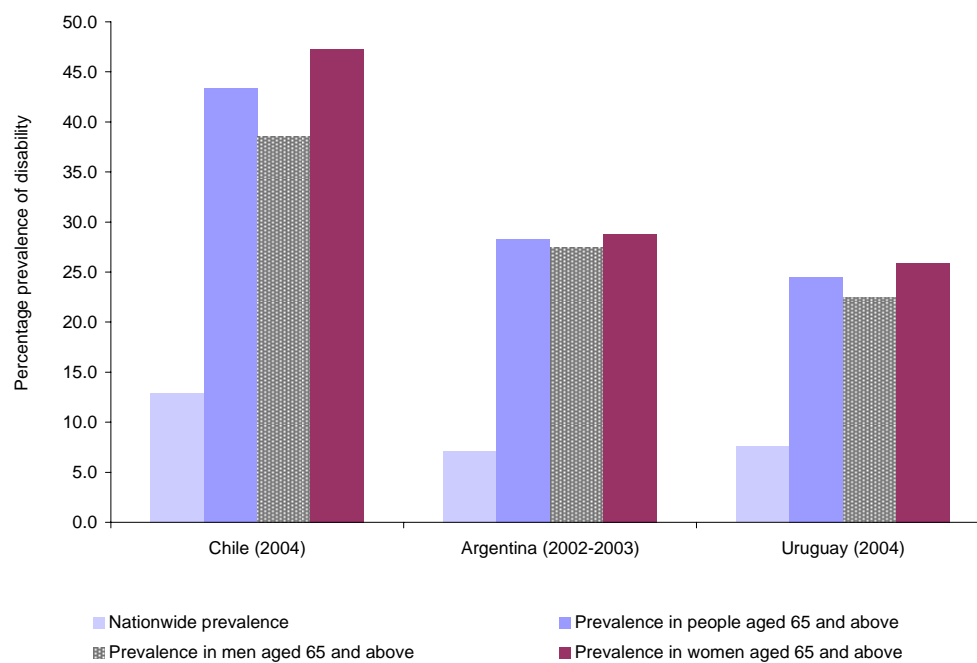
Another noteworthy element is that, except in Uruguay, diabetes is having an increasing effect on the health conditions of the older population, particularly women. The rise in the incidence of diabetes is the result of a series of factors that develop over an individual's lifetime (health during childhood, eating habits, etc.). Diabetes is a disease that responds effectively to preventive programmes and that, if not treated in time, has serious implications for physical autonomy in old age.

In terms of the incidence of communicable diseases, the main cause of death is acute respiratory diseases, which are responsible for the death of around 400 in 100,000 older people each year. Deaths from this kind of cause are typical in low- and middle-income countries, and an increase in the incidence of such diseases is associated with, inter alia, gaps in access to timely health care (PAHO, 2002). In the countries studied, the incidence rates of this type of illness are fairly constant over the different periods. However, the rate is rising among men and women in Argentina, which could be associated with the timeliness of the flu vaccination during the period concerned.

2. Disability

According to the most recent data obtained from special surveys carried out in Argentina, Chile and Uruguay, disability is more prevalent among those aged 65 and above than in the population as a whole (see figure IV.4).

Figure IV.4
**CHILE, ARGENTINA AND URUGUAY: NATIONWIDE PREVALENCE OF DISABILITY,
POPULATION AGED 65 AND ABOVE, BY SEX**
(Percentages)



Source: National disability survey, Chile 2004; national disability survey, Argentina 2002-2003; and national disability survey, Uruguay 2004.

Data by type of impairment for Argentina and Chile show that older people with disabilities tend to have motor limitations (32.0% and 35.5%, respectively), followed by those related to sensory organs. In many cases, the disability profiles of older adults often involve more than one limitation (36.6% in Argentina and 15.5% in Chile).

The prevalence of disability increases in proportion with a rise in age. In Nicaragua, for instance, 10.3% of the nationwide population has a disability, compared with 29.5% of those aged 60 to 64 years and 85.3% of those aged over 80 (National Institute of Statistics and Censuses (INEC), 2003). Changing the measurement criterion to limitations in carrying out activities of daily living (ADL), and restricting the sample to older adults gives a higher disability prevalence rate of 70.9% among those aged 65 and above (66.5% in men and 73.4% in women) (INEC, 2007).

Disability is also closely related to living in poverty. In Brazil, national research showed that the older adults with the lowest incomes have the highest levels of disability and have access to fewer medications, prostheses and orthoses (Lima-Costa et al., 2003). Similarly, inequalities in access to formal schooling during childhood increases the risk of dependency in old age. A longitudinal study carried out in Spain shows that people with no primary education (both sexes) were twice as likely to become dependent in old age (Otero et al., 2004).¹

To tackle this public health issue, the region's countries need to visualize the situations that will arise as a result of population ageing over the next few years and assess which type of interventions could ensure that functional autonomy lasts a lifetime. According to the Convention on the Rights of Persons with Disabilities: "States shall: [...] Provide those health services needed by persons with disabilities of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons" (United Nations, 2007a).

Box IV.2

INSTITUTIONALIZATION, LONG-TERM CARE AND HUMAN RIGHTS

The findings of various regional and international human rights bodies and specialized agencies of the United Nations show that older adults tend to be in a particularly vulnerable condition, whether that happens to be in institutions, community homes, long-term care services, psychiatric institutions, health centres or penitentiaries. In long-term care institutions or other services that provide housing or treatment for older people, the latter are often subjected to deplorable conditions or overcrowding, or indeed treated in a way that may harm their physical or mental health or infringe upon other basic human rights and fundamental freedoms with frequently irrevocable consequences (Vásquez, 2004).

The rights of residents are fundamental to the functioning of long-term care institutions and all members of staff must play an active role in respecting, protecting and promoting those rights. All residents of institutions have rights and liberties protected in international covenants and national laws, regardless of whether they suffer physical or mental disabilities.

There is little evidence on long-term care institutions in the region and the protection they offer their residents. However, there is an increasing number of media reports on the terrible living conditions of older people in this type of institution. Recent research carried out by the Inter-American Development Bank (IDB) and the Pan American Health Organization (PAHO) on the social exclusion of institutionalized older adults with physical and mental disabilities in three Southern Cone countries (Argentina, Chile and Uruguay) shows a heterogeneous situation in terms of these services.

Care requirements are the main reason for people entering such institutions (49% in Argentina, 52% in Uruguay and 63% in Chile). Argentina has the highest proportion of admittances that were not the decision of the older adults themselves (12%), while Chile has the highest percentage of older people admitted through not having anywhere to live (12%). Institutionalized older adults in Uruguay have a lower level of functional and mental capacities (45%), while in Argentina 65% of residents display no cognitive or physiological degeneration.

¹ Dependency is understood to mean a lack or loss of personal autonomy for various reasons (ageing but also illness, accidents, congenital malformation, etc.) resulting in the individual needing another person's help to carry out the basic activities of daily living (Sempere and Cavas, 2007).

Box IV.2 (concluded)

The social integration aspects of institution residents analysed in this study were: privacy, visits, outings and mistreatment. Argentina has the highest proportion of older people who share a room (almost 90%), followed Uruguay (nearly 80%), with that figure dropping to 55% in Chile. Most of those who share a room do so with one other person. Between 80% and 90% of care home residents receive visits, mainly from family members. As for outings, another critical aspect in such institutions, just under 70% of residents are involved in that type of activity, with poor health being the main cause for not going out. The proportion of older people who reported being mistreated or witnessing the mistreatment of a fellow resident was 2.4% in Uruguay, around 8% in Argentina and 14% in Chile. These figures are a cause for concern, as the study included a direct question on this issue.

The results of the research pointed to the need to:

- Formulate and apply statutory standards on the establishment and functioning of residential centres and on monitoring living conditions, human rights and the fundamental freedoms of older persons.
- Strengthen enforcement mechanisms for rules governing the functioning of establishments in order to protect the rights and freedoms of institutionalized older adults.
- Educate service providers and users on optimum care quality, human rights, freedoms and living conditions for well-being and set up effective complaint mechanisms.
- With special attention to mental health, create services and establishments that offer security and treatment while promoting personal dignity to meet the needs of older adults with mental disorders. Similarly, provide mental health services to older adults living in long-term care establishments.

Few countries have introduced legislation to regulate such institutions (Puerto Rico, Peru, Bolivarian Republic of Venezuela, Costa Rica and Uruguay). In practice, government bodies responsible for overseeing such services usually report problems in assessing compliance with care standards in private institutions; in some cases only institutions that receive State funding are monitored. It is therefore vital to set up effective mechanisms to enable the State to fulfil its obligation to protect the rights to, inter alia, health, freedom, personal integrity, legal protection and informed consent.

Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, on the basis of Javier Vázquez, “Discriminación y violencia en la vejez: mecanismos legales e instrumentos internacionales para la protección de los derechos en la edad avanzada”, document prepared for the Meeting of Experts on Ageing – Second Central American and Caribbean Forum on Policies for Older Persons, San Salvador, 10-12 November 2004; and L. Tellechea, “Derechos humanos en los cuidados a largo plazo”, presentation at the Meeting/International Workshop, Havana, 10-12 May 2007.

D. HEALTH SPENDING, AGEING AND THE EFFECT OF NON-DEMOGRAPHIC FACTORS

All issues of health in old age and among the population at large are linked to the coverage and quality of health care in each country. Throughout the region, the health sector has a wide range of institutions and mechanisms for funding, insuring, regulating and providing services (ECLAC, 2006). However, unequal access to health services is a common problem, with tangible consequences for public health. Population ageing poses an additional challenge in this sense, as it brings more pressure to bear on available health resources, at a time when countries are still having to contend with many basic health problems affecting other population groups.

Over the last 25 years, health spending has increased dramatically. Nonetheless, health spending in the poorest countries has grown slowly, with large inequalities remaining in world health spending (WHO, 2003). Comparing average health spending as a proportion of GDP in countries at various stages of population ageing (see table IV.3) shows that, despite the region being above the world average, there were no major variations in health spending between the two reference years (2002 and 2004) and no large differences in health spending according to the country's stage of population ageing.

Table IV.3
**LATIN AMERICA AND THE CARIBBEAN: DISTRIBUTION AND LEVEL OF HEALTH SPENDING,
 2002 AND 2004**

(According to different stages of population ageing)

Level of ageing	Country	Total spending as a percentage of GDP		Distribution of total health spending (as percentage of total)				Family spending as a percentage of private spending	
				Public spending (percentage)		Private spending (percentage)			
		2002	2004	2002	2004	2002	2004	2002	2004
Incipient ageing	Belize	4.6	5.1	47.4	53.8	52.6	46.2	100	100
	Bolivia	6.5	6.8	62.8	60.7	37.2	39.3	78.9	82.5
	Guatemala	5.2	5.7	36.9	41.0	63.1	59.0	90.5	90.5
	Haiti	7.5	7.6	39.4	38.5	60.6	61.5	69.6	69.6
	Honduras	6.8	7.2	55.3	54.9	44.7	45.1	85.5	84.3
	Nicaragua	7.9	8.2	49.2	47.1	50.8	52.9	95.1	95.9
	Paraguay	8.3	7.7	33.3	33.7	66.7	66.3	80.2	72.2
Moderate ageing	Bahamas	6.5	6.8	48.6	50.1	51.4	49.9	40.3	40.3
	Brazil	8.3	8.8	49.0	54.1	51.0	45.9	64.2	64.2
	Colombia	7.6	7.8	82.2	86.0	17.8	14.0	55.9	49.0
	Costa Rica	7.3	6.6	78.1	77.0	21.9	23.0	89.0	88.7
	Ecuador	5.1	5.5	37.7	40.7	62.3	59.3	85.7	85.4
	El Salvador	8.0	7.9	44.7	44.4	55.3	55.6	93.7	94.2
	Guyana	5.6	5.3	83.1	83.5	16.9	16.5	100	100
	Jamaica	5.6	5.2	57.4	54.3	42.6	45.7	61.8	63.6
	Mexico	6.2	6.5	43.9	46.4	56.1	53.6	94.8	94.4
	Panama	8.0	7.7	69.0	66.9	31.0	33.1	81.6	82.5
	Peru	4.6	4.1	51.3	46.9	48.7	53.1	78.8	79.2
	Dominican Republic	6.3	6.0	32.3	31.6	67.7	68.4	70.6	73.1
	Saint Lucia	5.0	5.0	69.1	65.0	30.9	35.0	100	100
	Suriname	8.1	7.8	46.3	46.0	53.7	54.0	45.4	60.2
	Venezuela (Bol. Rep. of)	5.0	4.7	46.1	42.0	53.9	58.0	87.3	88.3
Moderate-to-advanced ageing	Argentina	8.6	9.6	52.1	45.3	47.9	54.7	60.3	48.7
	Chile	6.2	6.1	48.1	47.0	51.9	53.0	47.3	45.9
	Trinidad and Tobago	3.8	3.5	37.6	38.9	62.4	61.1	86.7	88.5
Advanced ageing	Barbados	7.3	7.1	68.4	63.5	31.6	36.5	77.2	78.6
	Cuba	6.2	6.3	86.5	87.8	13.5	12.2	75.2	74.5
	Uruguay	10.3	8.2	31.3	43.5	68.7	56.5	25	31.1
Average for Latin America and the Caribbean		6.7	6.6	53.1	53.2	46.9	46.8	75.7	75.9

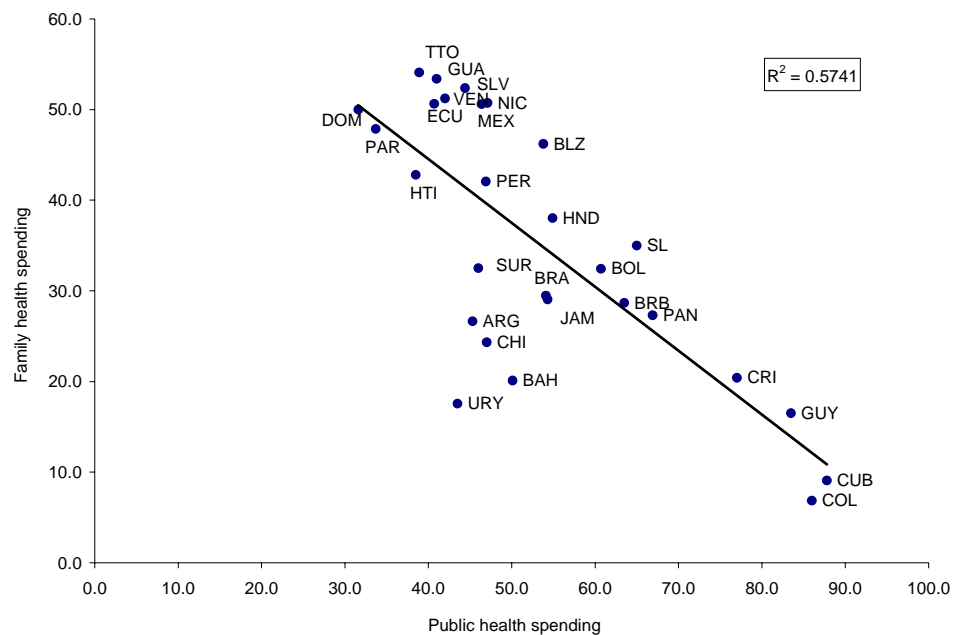
Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, on the basis of World Health Organization (WHO), *World Health Statistics*, 2007.

In Chile, research by the Superintendency of Health (2006) showed that estimated health spending on older people was 1% of GDP in the reference year (2002), rising to 2.1% in 2020, considering an average annual growth rate of 4% for the older population. The increase was less due to demographic factors and more to do with changes in people's health behaviours, inefficient health services, new medical technology and higher prices for medications and health insurance policies.

Although there were not any particular patterns in the private-public distribution of health spending based on the stage countries were at in the ageing process (see table IV.3), there was a strong link between that distribution and the country's level of health protection. Countries with higher levels of health protection had lower levels of private and out-of-pocket spending. Health spending as a proportion of GDP is likely to continue to increase in the future, and it would be problematic if this rise were to be directly absorbed by families funding their access to health services through out-of-pocket spending.

In 16 of the 28 countries analysed there has been an increase in private health spending, with an average of about 75% out-of-pocket spending. As shown in figure IV.5, countries with lower public health spending have higher levels of out-of-pocket spending. This not only means that public spending is limited, but also that families are responsible for the highest percentage of private spending, which results in greater vulnerability to the risks of illness.

Figure IV.5
LATIN AMERICA AND THE CARIBBEAN: HEALTH SPENDING AS A PERCENTAGE OF PUBLIC EXPENDITURE AND FAMILY EXPENDITURE, 2004
(Percentage of health spending)



Source: World Health Organization (WHO), *World Health Statistics*, 2007.

The situation of countries in the incipient or moderate stage of population ageing is particularly striking in this context. Ecuador, Haiti, Nicaragua and Paraguay, for instance, have public health spending below 50%, high out-of-pocket spending and a very low proportion of older adults. Given that the pace of population ageing in these countries will be extremely rapid, and that they must also face the epidemiological backlog amidst widespread poverty, the lack of health protection will definitely worsen unless measures are introduced to strengthen the public system.

E. HEALTH INSURANCE COVERAGE IN OLD AGE AND INEQUALITIES IN ACCESS TO HEALTH CARE

Where health is concerned, solidarity can be said to exist when access to services is independent of people's contributions to the system or their actual ability to make out-of-pocket payments (ECLAC, 2006). Inequity, on the other hand, stems from having to make out-of-pocket payments to access health services or buy medications (Titelman, 2000). During old age, this is reflected in levels of health insurance coverage and access to health care.

A study on health coverage for older adults in countries of the Southern Cone found that the level of income of older persons was more likely to be a factor of exclusion than their age, although this also depends on the type of health system in place within each country.

In Argentina, 76.5% of older people are covered by a charity or mutual or private health plan. Coverage rates increase in proportion with age (88.1% for those aged over 80 and 63.1% for those aged 60 to 64). In Brazil, 70% of older persons are covered by the public system. In Paraguay, over 83% of older people are estimated to have no form of medical insurance and, in the event of illness, either have to foot the bill or go without treatment (OISS, 2007).

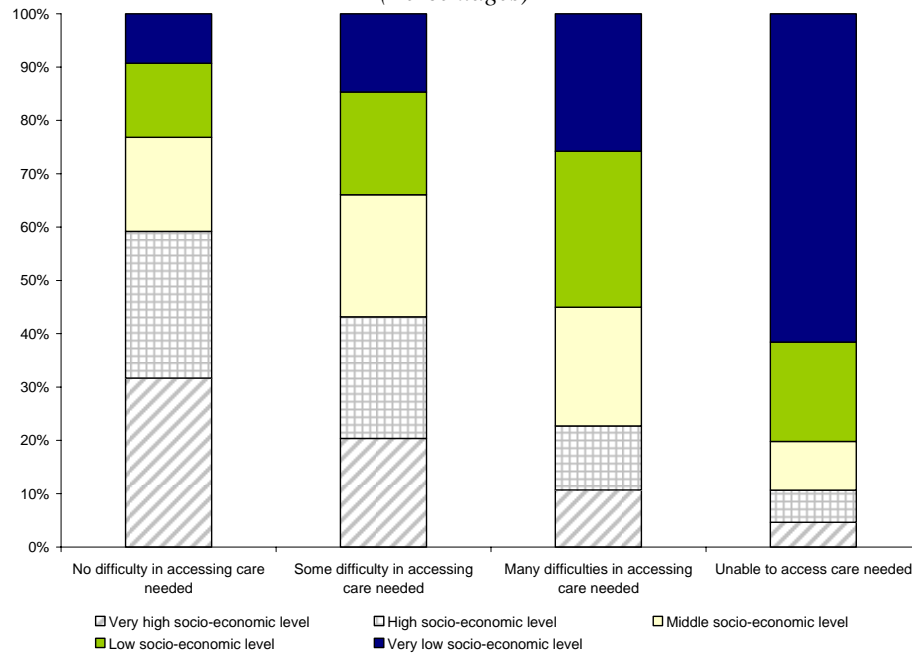
The coverage rates of Argentina and Brazil cannot be extended to the other countries in the region, although even formal coverage levels are no guarantee that insured older adults make consistent and effective use of health services. According to the latest household surveys available in Bolivia, Chile and El Salvador, 7 out of every 100 older adults with health problems have not visited a health service due to access problems. The proportion of older people who were not treated for financial reasons ranges from 11% in Chile and 17% in El Salvador, to 48% in Bolivia, which has a clear effect on morbidity and disability profiles during old age. Similar results were obtained in the INTRA III study in Peru. In Ecuador, the Demographic and Maternal and Child Health Survey (ENDEMAIN, 2004) found that 68% of those aged 60 to 74 had such difficulties and as did 82% of those aged over 75 years.

The region-wide panorama confirms this pattern. According to recent data from Latinobarómetro (see figure IV.6), problems in accessing health care are more acute for older people with lower socio-economic status. Those of extremely low socio-economic status clearly have no access to health care.

Although this situation is more common in some countries than in others, it is enough of a pattern to cause concern. Depending on a country's level of development and how the health protection system functions, older people may be faced with two types of situation: (i) widespread poverty whereby most people find it difficult to access health care and only the most privileged are able to solve their problems, and (ii) persistent inequalities in access, where middle- and high-income groups benefit and those lower down the socio-economic scale find access more difficult, leading to almost permanent exclusion in extreme cases (WHO, cited in Escobar, 2006).

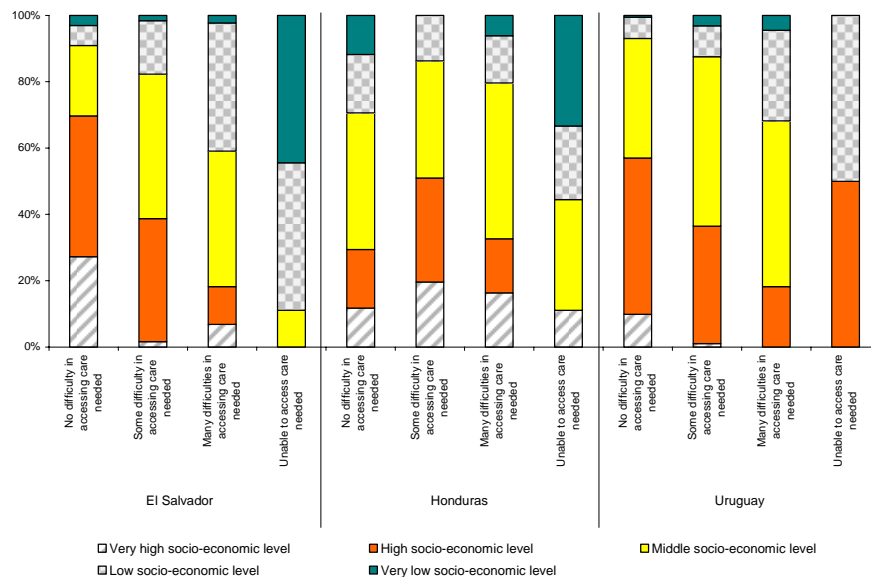
As shown in figure IV.7, in Uruguay older adults of high socio-economic status report no problems in accessing health care. There are no considerable gaps between this group and the poorest people who, despite their problems, also report accessing the system when they need to. The situation in Uruguay is less inequitable, although the same cannot be said of the other two countries in question.

Figure IV.6
LATIN AMERICA AND THE CARIBBEAN: ACCESS TO HEALTH CARE BY OLDER ADULTS, BY SOCIO-ECONOMIC STATUS, 2006
(Percentages)



Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, on the basis of the 2006 Latinobarómetro survey.

Figure IV.7
SELECTED COUNTRIES: ACCESS TO HEALTH CARE AMONG OLDER ADULTS, BY SOCIO-ECONOMIC STATUS, 2006
(Percentages)



Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, on the basis of the 2006 Latinobarómetro survey.

In El Salvador there are major gaps between older people of high socio-economic status and the poorest, with many of the latter definitely unable to access health care. In Honduras, on the other hand, all groups report difficulty in accessing health care, with even the lowest socio-economic group following a similar pattern to the rest, with even slightly higher levels of easy access (probably thanks to targeted initiatives to combat exclusion). Both countries need to work at extending levels of health protection to the entire population. The strategies recommended by WHO (2003) in this regard aim to combine different forms of targeting (direct, based on characteristics and self-targeting).

Box IV.3

ORIGINAL INTEGRATED SYSTEMS: HEALTH IN THE CARIBBEAN

For historical reasons such as the colonial heritage in English-speaking countries or scale factors, the public sector in the Caribbean subregion tends to be vertically integrated, while the private sector insures or provides services to a relatively small proportion of the population (Cuba may be considered an exception, as services are completely public).

In all Caribbean countries, except for the Dominican Republic, the public sector tends to have most of the responsibility for providing services, regulating and funding the health sector, with no explicit separation of the functions of procurement, insurance and provision of services. The financing of the public system is basically non-contributive and is based on budget allocation and, in some cases, specific taxes. The private sector generally supports service delivery and fundraising. In some countries, the private sector is at the early stages of development, while it has expanded considerably elsewhere (Cercone, 2005).

The increasing role played by private insurance and service providers, the high (and rising) level of out-of-pocket health spending and the effects of higher public system costs are pushing the Caribbean region (with the exception of Cuba) towards a model in which the wealthiest seek treatment abroad, middle-income groups use private insurance and services, and the poorest people are left with the public system (Caribbean Commission on Health and Development (CCHD), 2006). Reversing this trend and implementing the mechanisms needed to contain the growing system costs are the main challenges facing Caribbean countries in terms of equity and access to health services.

Given that Caribbean countries are expected to see costs rise significantly in the future, mainly due to the growing incidence of cardiovascular disease, obesity and HIV/AIDS (PAHO, 2005b), various reform proposals have been put forward with a view to integrating the system by setting up national health insurance systems as a way of identifying alternative sources of financing and increasing administrative efficiency. Bahamas, Belize, Jamaica, Trinidad and Tobago, Saint Lucia and Saint Vincent and the Grenadines, among others, are either in the early stages of the debate or are introducing various forms of national health insurance (CCHD, 2006).

The subregion's countries are well placed to implement such reforms, as their historical situation means that they have relatively strong public systems and no financial segmentation between the latter and social security. Such insurance could be funded through general income or the introduction of specific contributions from employers, employees or both, taking care to avoid the establishment of a social insurance system independent of the public sector and the segmentation of the system that this would entail.

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

F. EXPLICIT GUARANTEES AND OPTIONS FOR CLOSING HEALTH EQUITY GAPS IN OLD AGE

Improving the health of the older population requires the following: continued investment in curing certain communicable diseases (especially respiratory ones), the development of prevention and treatment plans for non-communicable diseases and consideration of how the latter impacts levels of functionality among older adults.

To achieve this, countries must make effective progress in developing ways of improving coverage for communicable diseases and pathologies that are the most expensive (in terms of treatment, recovery, morbidity, mortality rates and disability) and the most complex, such as chronic and degenerative diseases. All this must be part of the overall aim to eliminate inequity and solve the problems of social exclusion that are affecting large sections of society.

International human rights instruments make reference to universal access to health care. The Committee on Economic, Social and Cultural Rights establishes the progressive realization of the right to health, which involves various States obligations including available, accessible, acceptable and quality health care, as well as moving as expeditiously and effectively as possible towards the full realization of that right (United Nations, 2000).

As a way of advancing in this direction, some of the region's countries have defined packages of explicit guarantees, or health prioritization mechanisms to organize the investment of resources (Drago, 2007). These packages are offered to the entire population, regardless of risk and income. Despite the fact that explicit guarantees do not always include specific packages for older persons, the mechanism remains an interesting proposition, one that only works if the population is extremely well informed and the procedure is simple and accessible to all, and that includes diseases to which older adults are much more vulnerable than the rest of the population (cardiovascular disease, muscular-skeletal disease, malignant neoplasm, etc.).

As shown in table IV.4, the explicit guarantees that exist in some of the region's countries do not fully include diseases typical of old age or those catastrophic diseases that mainly affect those aged 60 and over. This implies that, in the process of establishing which benefits are to be covered and guaranteed, the needs of older people have not always been fully incorporated. In some cases, this is because pathologies are prioritized on the basis of prevalence, mortality and morbidity. In other cases, the reason is that guarantees are designed to incorporate segments excluded from health care and to reduce the epidemiological backlog (Sojo, 2006).

Given this context and the recommendation made by ECLAC (2006), the region's basic packages of entitlements should be construed as a means of advancing towards integrated health care systems that provide timely, quality care to the entire population, regardless of risk and income. As countries become more developed, and their population ages, prioritized packages should be progressively extended in accordance with the health needs of the population.

As an alternative strategy, some countries with problematic access to health care or a complex epidemiological profile have defined special packages for older persons that tend to focus on prevention. In Bolivia, for instance, free old-age medical insurance guarantees access for those aged 60 and over to public health and social security services such as in-kind assistance for disease insurance, preventive medicine and non-work-related accidents. In Colombia, the Subsidized Compulsory Health Plan (POSS) for older persons enables all those aged 45 and over to undergo a complete medical examination and laboratory tests every five years to detect preventable diseases in good time. Although these packages are not the solution for the most serious diseases, they are undoubtedly experiences that can be replicated and extended to countries that still have a long way to go in upholding the universal right to health.

Table IV.4
**LATIN AMERICA AND THE CARIBBEAN: PACKAGES OF EXPLICIT UNIVERSAL GUARANTEES
 AND DISEASES INCLUDED WITH A HIGHER INCIDENCE AMONG OLDER ADULTS**

Country	Basic package of benefits	Coverage for catastrophic illness	Coverage for diseases with a higher incidence among older adults
Chile	System of Universal Access with Explicit Guarantees (AUGE)	Yes	Visual, cardiovascular, cancer, osteoarticular, mental health, respiratory, surgical treatment of benign prostate hyperplasia, oral health, polytrauma, neurology, hearing
Brazil	Basic Care Plan (PAB)	Yes	Parkinson's disease, osteoporosis, Alzheimer's disease, special protocols for oncological diseases, heart disease and external causes (such as falls)
Colombia	Compulsory Health Plan (POS) Subsidized Compulsory Health Plan (POSS)	Yes	Hospitalization for observation, low-complexity surgical interventions, physical rehabilitation, cancer, prostheses, for hands, prostheses and orthoses authorized by Law, removal of prostate, uterus, calculus, cataracts (following 100 weeks or one year of contributions), transplant of kidneys, bone marrow, heart and cornea, dialysis and haemodialysis, joint replacements (such as hip), neurosurgery, chemotherapy and radiotherapy for cancer, major trauma treatment, cardiovascular surgery
Mexico	Industrial health insurance	Partial	Screening for diabetes mellitus, high blood pressure, cervical-uterine cancer and breast cancer, prostatism; diagnosis and pharmacological treatment of type II diabetes mellitus, high blood pressure, degenerative articular disease, closed fracture of long bones Stabilization of patients (high blood pressure, diabetes, angina)
Peru	Comprehensive health insurance	Partial	Screening for mental health problems, early screening for neoplasm, diagnosis and treatment of distortions, dislocations and fractures of extremities. Diagnosis and treatment of medical and surgical emergencies (max. 30 days), acute (non-cancerous) conditions of the digestive system. Rehabilitation following fractures

Source: Latin American and Caribbean Demographic Centre (CELADE)-Population Division of ECLAC, on the basis of information from the Ministry of Health of Chile; the Department of Health in Brazil, the Ministry of Social Protection in Colombia, the Health Department in Mexico and the Ministry of Health in Peru.

G. PROGRESS OF THE REGIONAL STRATEGY FOR THE IMPLEMENTATION IN LATIN AMERICA AND THE CARIBBEAN OF THE MADRID INTERNATIONAL PLAN OF ACTION ON AGEING: HEALTH SERVICES, PROFESSIONAL TRAINING AND LONG-TERM CARE

The health reforms undertaken in the region in the last few decades have not always resulted in the development of health systems that promote collective and equitable improvements to health. The goal of universal access to quality health care faces many stumbling blocks, in particular the lack of financial resources and qualified staff, as well as inequalities in access and quality. According to WHO (2003), it is therefore vital to reinforce health systems and establish priorities for developing health systems if such gaps are to be addressed.

Most of the region's countries have set up health programmes for older persons within the relevant ministries or departments. Such institutional arrangements are beginning to appear vital for including matters related to population ageing on the public health agenda. In some cases, these programmes have a steering role in terms of ageing such that, in addition to promotion and prevention activities (particularly those to develop personal care and vaccination programmes), they also provide social and health care services. However, there are considerable regional differences in the authority, management capability and resources of these government programmes. There are also broad differences among subregions, with striking particularities in the English-speaking Caribbean specifically. In some cases, the institutions concerned are well established while others are still in the process of being set up.

This section aims to analyse those actions that the region's countries have implemented in the sphere of old age, in the light of the recommendations of the Regional Strategy for the Implementation in Latin America and the Caribbean of the Madrid International Plan of Action on Ageing. The information herein comes from countries' replies to the survey on programmes for older persons in Latin America and the Caribbean sent out by the Latin American and Caribbean Demographic Centre (CELADE) – Population Division of ECLAC between June and August 2007. The Pan American Health Organization (PAHO), through its national offices, collaborated by collecting data from their national counterparts in the Ministries of Health. The information collected is organized under three headings: (a) health services; (b) professional training, and (c) long-term care (see table IV.5).

1. Health services

Countries are endeavouring to improve health services for the older population. Strategies include the strengthening of primary health care and the inclusion of specific health care services for older adults; specialized assistance for out-patients, and hospital patients and within the home; and pharmaceutical services.

(a) Primary health care

Primary health care became the central policy of WHO in 1978, with the adoption of the Declaration of Alma-Ata. The basic principles of primary health care are the following: universal access to care and coverage based on needs, health equity, community participation in the formulation and implementation of health agendas and an intersectoral approach to health. Primary health care is usually the first contact older adults have with health services. It is the area in which short-term health problems are resolved and most chronic health problems are managed (PAHO, 2007).

The study “Integrated response of health care systems to rapid population ageing (INTRA)” showed that much remains to be done before primary health care lives up to its guiding principles and the needs of older adults. The difficulties include shortcomings in medical recommendations, the high turnover of doctors, long waiting times and inadequate infrastructure. More structural problems included the fragmentation of primary health care, the lack of specific programmes for older persons and their poor treatment on the part of operators (PAHO, 2007).

These are common problems in the countries of the region, with only a handful reporting actions to support primary health care and ageing. Thanks to the family health programme in Brazil, primary care includes specific services for older adults. In Cuba, the family doctor and nurse programme includes a regular health check, which is the basis for sending individuals to a specialized primary structure known as the Multidisciplinary Geriatric Care Team, which assesses, treats and refers patients to secondary institutions where necessary. In Honduras, specific primary care services are included in the basic health package for disadvantaged communities, while Uruguay applies a care and diagnosis protocol for older adults at the primary care level.

Table IV.5
**MAIN AREAS OF INTERVENTION OF HEALTH PROGRAMMES TARGETING OLDER ADULTS
 IN LATIN AMERICA AND THE CARIBBEAN**

	Health services			Staff training		Long-term care		Health promotion and prevention strategies
	Inclusion of ageing in primary health care	Pharmaceutical services	Specialized care (outpatient, hospital, home based, emergency)	University-level specialization in geriatrics or gerontology	Geriatrics and gerontology training for health teams	Development of community-care options	Measures to regulate the opening and operation of long-term care institutions	
Netherlands Antilles			X		X		X	X
Argentina		X	X		X			
Aruba			X				X	X
Belize		X	X		X			X
Bolivia								X
Brazil	X	X						X
Chile	X		X	X	X	X	X	X
Costa Rica			X	X		X	X	
Cuba	X		X	X	X	X	X	X
El Salvador					X			X
Guatemala							X	
Honduras	X				X		X	
Mexico		X		X				X
Nicaragua			X					X
Panama	X		X			X		X
Paraguay		X				X		X
Peru			X		X			
Puerto Rico		X	X		X	X	X	X
Dominican Republic		X		X				X
Uruguay	X				X	X	X	X
Venezuela (Bol. Rep. of)		X	X	X			X	

Source: Latin American and Caribbean Demographic Centre (CELADE) – Population Division of ECLAC, on the basis of replies to the survey on programmes for older persons in Latin America and the Caribbean.

(b) Specialized care

Specialized care for older adults is in the early stages in the region's countries and is being developed in different areas of public health care: within the home, for outpatients and in hospitals.

Home care is a social and health service targeting older adults with some level of dependency and includes a series of actions carried out in the older people's residences to enable them to remain living at home in their usual environment. One of the main advantages of these services is that they reduce institutionalization and hospitalization costs while slowing down the deterioration of functions associated with old age.

This service is provided in Aruba, Argentina, Belize, Chile, Cuba, Netherlands Antilles, Peru and Puerto Rico. English-speaking Caribbean countries seem to have more experience in providing social and health services for older adults. One such example is found in Belize City where civil society has coordinated an integral care programme for older persons that, besides providing health care, organizes meals and visits from professionals within the home. Aruba has also made progress: in 2007, the Ministry of Health and the Ministry of Social Affairs adopted a strategic plan on continuous care designed to integrate the various levels of health and social assistance. There are currently two pilot projects aimed at identifying patients at risk of suffering cardiovascular accidents and psychiatric patients with drug addiction problems. In South America, Peru and Chile are exploring such services, with the longest experience and that with the widest coverage being the national home care programme of the Ministry of Social Development in Argentina, the strength of which lies in combining the needs of the older population, local development and the promotion of employment.

Another type of specialized care can be seen in the outpatient and hospital domains: Costa Rica has the outpatient care service programme (day hospital and medium-term stay); Cuba has geriatric hospital care programmes; Nicaragua has a breast cancer and cervical-uterine cancer care programme that recently extended its coverage to older women receiving widows' or old age pensions; and in the Bolivarian Republic of Venezuela, the National Institute of Social Services is implementing a multidisciplinary dental treatment and rehabilitation for older adults. Chile has introduced an emergency treatment system for acute respiratory diseases in clinics, while the Centre for Older Adults in Peru is developing geriatric care programmes for those with insurance.

(c) Pharmaceutical services

According to General Comment No. 14 of the Committee on Economic, Social and Cultural Rights, the basic obligations of States in terms of the right to health include facilitating the provision of essential drugs. Many international agencies have expressed their concern over the difficulties of accessible and available medications for the poorest in society.

Only a few countries have specific measures to facilitate access to medications in old age. One striking experience benefiting older adults and other groups has been under way in Argentina since 2002: the National Medication Policy that promotes the prescription of generic drugs. This gave rise to the "Remedy" programme, which provides free outpatient medication through primary health care centres, while the Ministry of Health monitors prices to detect any unjustified increases (Escobar, 2007).

Other initiatives to encourage access to medications involve subsidizing pharmaceutical products, as is the case in Belize and the Dominican Republic. Some medications are supplied free of charge in the Bolivarian Republic of Venezuela and in Paraguay, with the latter supplying free drugs to vulnerable

individuals aged over 70 through the Institute for Welfare of the Ministry of Health. In June 2007, 300 people were benefiting from the programme, which aims to reach 1,000 people by the end of the year. One of the pathologies covered by this programme is high blood pressure, and multivitamins and anti-inflammatories are also provided in the light of the types of condition suffered by older adults.

2. Staff training

One of thorniest problems that health care systems can face is a shortage of staff with which to function. There are two main areas of concern in this regard: a shortage of health workers trained to meet the needs of the older population, and the emigration of health workers (particularly from the English-speaking Caribbean and some Central American countries).

The shortage of health workers has an impact not only on the care provided to older adults but also other social groups. Although the economic and political landscape is very different to the situation 25 years ago and health requirements have shifted due to demographic and epidemiological changes, medical workers and other health professionals (nurses, technical staff, social workers, psychologists, etc.) still require training in terms of geriatric care.

The emigration of health workers, both to other countries and within the same country (internal movement towards urban areas), is another emerging issue and one that is also affected by demographic factors. According to WHO (2003), the most controversial form of emigration among health professionals is that of professionals from poor countries emigrating to rich countries. The same WHO report points out that *“nurses are in high demand in developed countries, partly because of population ageing”*. This is because baby boomers are now reaching retirement age; this calls for personal and social services geared towards care and health, which in turn has an effect on migration (Giorguli, Gaspar and Leite, 2006).

Medical specialization in geriatrics is at an early stage in the region, and there tends to be a shortage of medical professionals trained in this area. According to the most recent information available (2007), Puerto Rico has 14 geriatricians; Panama has 20 and Peru 86, while Cuba has 273 doctors specialized in gerontology and geriatrics. Countries that report having geriatrics as a university-level specialization are the Bolivarian Republic of Venezuela, Chile, Costa Rica, Dominican Republic and Mexico.

One fairly common and beneficial measure is to train other health professionals in geriatrics and gerontology, thereby extending the level of coverage. Cuba has 342 doctors who are not geriatricians but who care for older adults following completion of a diploma in gerontology and geriatrics. Chile has trained 347 primary care teams, 350 kinesiologists and 250 other professionals in the capacity-building and rehabilitation of non-sighted and partially sighted individuals. El Salvador and Honduras train primary medical workers, nurses and other health workers. Belize has trained nurses and other people to provide long-term care to older adults. The Netherlands Antilles has provided training in psychogeriatrics for health workers. In May 2007, Argentina introduced a gerontology specialization run by the Ministry of Social Development, with 300 enrolled students.

These and other initiatives in the region will broaden the range of professional training opportunities for health teams in the future and will improve countries' capacity to tackle the health needs of their growing populations. As pointed out by WHO (2003), however, progress must be made in developing incentives to better attract and retain medical workers, especially in the most disadvantaged areas (rural communities and poor urban neighbourhoods) and in countries with high levels of health-worker emigration.

3. Long-term care

Although countries have made some inroads into the policy area of long-term care, the next few years will involve many challenges. The two main focuses tend to be: developing community-care options and regulating long-term care institutions. With regard to the former, Chile set up the first integral community rehabilitation centres that treat certain pathologies associated with old age. In Cuba, community care initiatives are geared towards preserving and recovering the health of older adults through the Grandparents' Circle, Orientation Groups and the 120 Years Club. In Paraguay, rehabilitation workshops on health care for older persons are organized in the community, while Panama recently established a community support system for long-term care. Puerto Rico has various community services to promote the integration of older adults, with the Governor's Office of Elderly Affairs providing funding to over 120 day centres. One of the most important services on offer is meals, both for those who attend the centres and for the housebound. Uruguay and Costa Rica are also promoting day centres as community-based care options.

In terms of regulating long-term care institutions, the countries that have undertaken actions are the Aruba, Chile, Costa Rica, Honduras, the Netherlands Antilles and Uruguay. Aruba has restructured its long-term care arrangements and has adapted rest homes to the daily needs of residents. In the Netherlands Antilles, the needs of care institutions are assessed and their operations monitored.

Honduras is implementing actions to improve the capacity of institutions to provide the care needed by its target population. Guatemala and Puerto Rico have mechanisms to monitor the operation of long-stay institutions. In Guatemala, this is carried out through the Ombudsman for Older Adults, and in Puerto Rico, the Governor's Office of Elderly Affairs has a Long-Term Care Ombudsman Programme.

It is apparent that countries have been stepping up their efforts to improve services and benefits for the older population, although much still remains to be done. The main challenges over the next five years include: strengthening health programmes for older adults; ensuring that financial resources from international cooperation do not replace national resources (especially in basic public health matters such as vaccinations); and tackling head on the inequalities in the older population's access to health care due to the considerable difference between health benefits for retirees and pensioners in the context of social security institutions, on the one hand, and benefits for the rest of the older population in the framework of Ministries or Departments of Health, on the other.

Combined with the particularities of the demographic and epidemiological transitions in the region, this suggests that national health protection should move towards strengthening solidarity mechanisms designed to provide equitable access to health services for the whole population (ECLAC, 2006). Such measures are essential for older persons and other vulnerable groups in society, such as children and adolescents, the disabled and those living in poverty.

Health is a fundamental human right that should be enjoyed throughout a lifetime, irrespective of people's income and illness risk. The information in this chapter highlights the deep-seated inequalities based on socio-economic status, as well as gaps in access to health care for those living in rural areas or poor urban suburbs. Against this backdrop, in the short term it will be difficult to manage the region's double burden of morbidity, achieve the Millennium Development Goals or improve autonomy in old age unless health systems are strengthened.

Chapter V

ENABLING ENVIRONMENTS AND AGEING IN LATIN AMERICA AND THE CARIBBEAN**A. LIVING ARRANGEMENTS AND AGEING**

The demographic picture in Latin America and the Caribbean countries has altered profoundly in recent decades because of rapidly declining fertility and rising life expectancy at birth and at advanced ages. These changes have been a critical factor in shaping new living arrangements, with the result that families extending over three or even four generations have become common. Although there are also older people who live alone, this is less likely to be the case in Latin America and the Caribbean than in other regions of the world.

The composition and structure of households are associated with demographic, economic and cultural factors that are the driving forces in their formation, alteration and dissolution. Concerning the consequences of population ageing for living arrangements, one of the predominant views is that inadequate resources and progressively declining health prevent a large proportion of older people from living independently. Although this is true, it has also been found that in many instances older people live with their children because of the latter's difficulties in achieving financial independence (ECLAC, 2000).

From the cost-benefit standpoint, co-residence with others can benefit both older people themselves and other household members by providing them with companionship and physical and financial support, although it can also contribute to the loss of privacy, a reduced social status for the older person, and excessive physical and emotional demands on the families of older people with physical or mental impairments (Martin, 1990 in Saad, 2004).

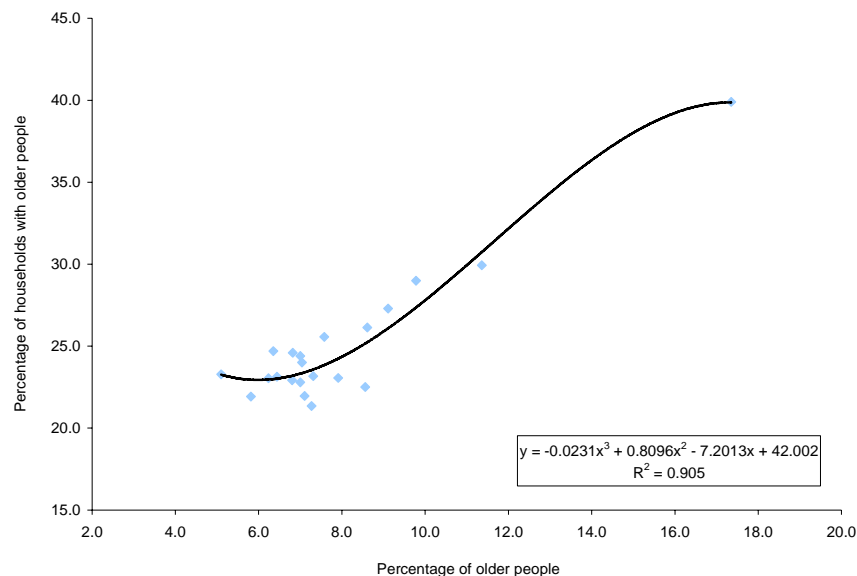
Whether or not older people live independently is very largely a matter of physical and financial viability. Older people who are in good health or can pay for support services, and who can defray the costs of running a home, are more likely to live independently. Once these prerequisites are in place, however, there are a number of other factors that may be evaluated. These include the location of the dwelling (close to services, low-cost transport facilities, opportunities for keeping up networks of friendships, etc.) and its design (number of rooms, temperature and noise control, indoor safety, etc.). To assess the living arrangements of older people, two types of households were distinguished: multigenerational households and single-person households. In addition, a typology was constructed to measure the relative importance of the resources contributed by older people to multigenerational households with a view to assessing their degree of financial independence from other household members.

1. Households containing older people: multigenerational arrangements and independent living in old age

Despite the changes on the horizon, the proportion of older people is still below 10% in most of the region's countries. An analysis of the proportion of households containing one or more older people shows, however, that at least two in every ten households in the region include an older person.

A more detailed analysis of this indicator reveals a significant relationship between the percentage of households containing older people and the relative size of the older adult population (see figure V.1). Thus, multigenerational households represent about 20% of total households in incipient ageing countries (Nicaragua, Paraguay) and almost 30% in moderate to advanced ageing countries (Chile, Argentina). Some exceptions are Ecuador and Brazil, where ageing is moderate but multigenerational households make up 27.3% and 19.8%, respectively, of the total.

Figure V.1
LATIN AMERICA (SELECTED COUNTRIES): RELATIONSHIP BETWEEN THE PERCENTAGE OF OLDER PEOPLE AND THE PERCENTAGE OF HOUSEHOLDS CONTAINING OLDER PEOPLE, 1990 AND 2000 CENSUSES



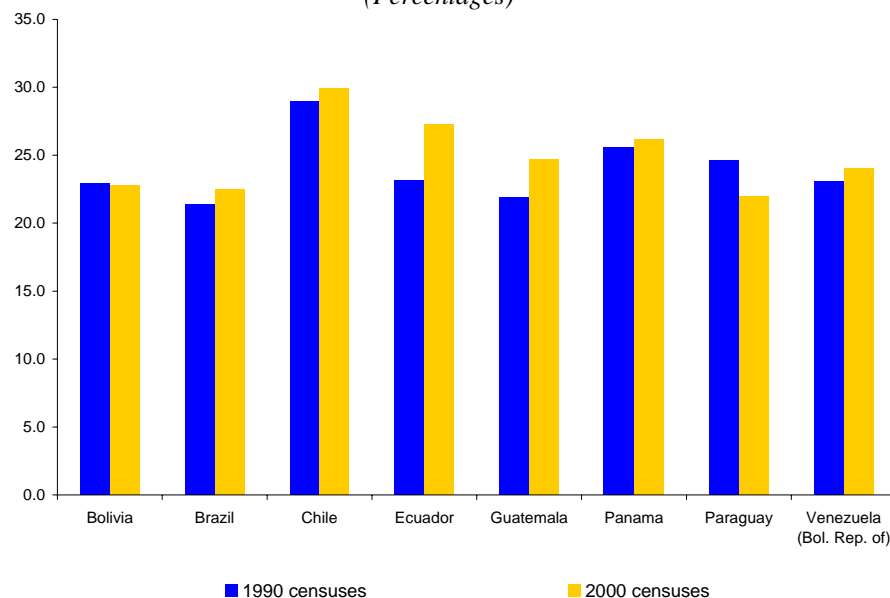
Source: National population censuses and microdata processed by the Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC.

Around 1990, one out of four households in the region had an elderly person among its members (see figure V.2). By the early 2000s, this figure had increased in most of the countries, the exception being Paraguay. The largest changes between periods were in Ecuador and Guatemala.

Few old people in Latin America live independently, although the data for five Latin American countries in three time periods (around 1980, 1990 and 2000) show some variations between countries. Thus, whereas the proportion of older people living alone increased by 5.7 percentage points in Chile over that 20-year period, in Paraguay it remained virtually unchanged (see figure V.3).

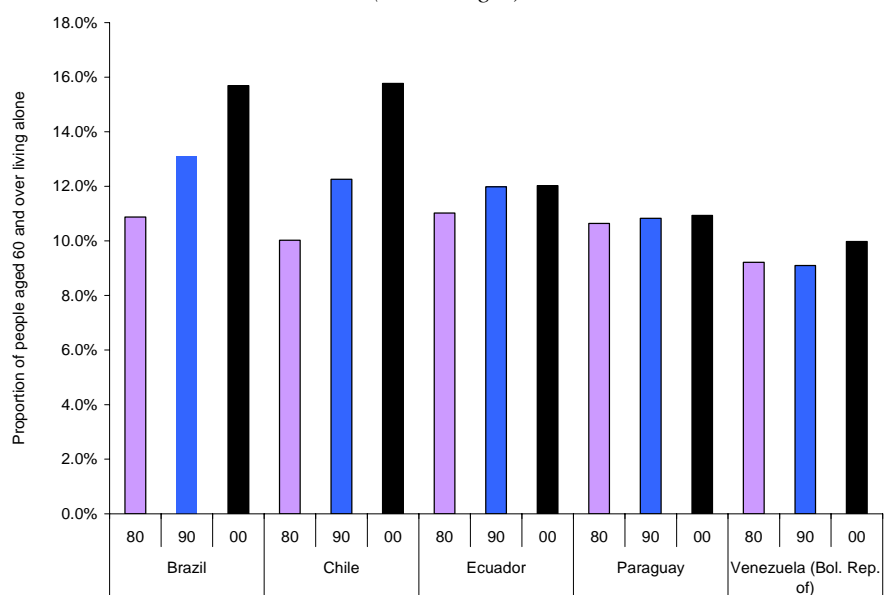
Except in the case of Brazil, older people are more likely to live alone in rural than in urban areas (see figure V.4). One study indicates that rural-urban migration is the main factor behind the breakdown of ties of co-residence and proximity, although it does not necessarily entail the absence of emotional ties or monetary transfers. However, the distance separating older people in rural areas from offspring living in towns rules out the kind of instrumental support that the former might require to carry out activities of daily life (Iwakami, Camarano and Leitão e Mello, 2004).

Figure V.2
LATIN AMERICA AND THE CARIBBEAN: HOUSEHOLDS CONTAINING OLDER PEOPLE,
1990 AND 2000
(Percentages)



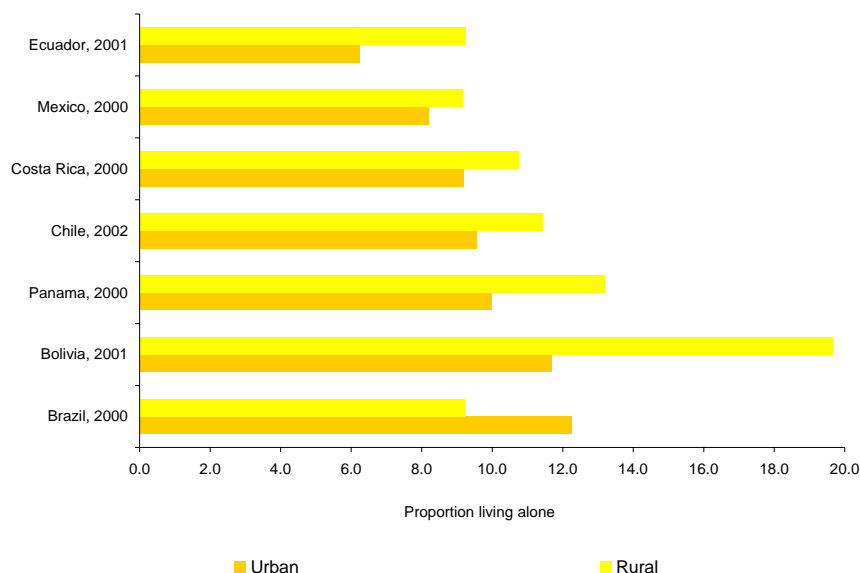
Source: National population censuses and microdata processed by the Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC.

Figure V.3
LATIN AMERICA (SELECTED COUNTRIES): PEOPLE AGED 60 AND OVER LIVING ALONE,
1980, 1990 AND 2000
(Percentages)



Source: National population censuses and microdata processed by the Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC.

Figure V.4
LATIN AMERICA (SELECTED COUNTRIES): PEOPLE AGED 60 AND OVER LIVING ALONE, URBAN AND RURAL AREAS, 2000
(Percentages)



Source: National population censuses and microdata processed by the Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC.

There are subregional differences in the percentages of older people living alone. Independent living is more prevalent in the Caribbean than in South and Central America, where the figures are considerably lower (United Nations, 2006b). In any event, in the region as a whole, there are fewer older people living alone than in other parts of the world. According to data from the United Nations Population Division (United Nations, 2006b), this type of household represents 9% of all households containing older people, a percentage very close to that seen in Africa (8%) and Asia (7%), whereas the figure in Europe and North America is 26%.

Looking beyond the figures, the main difference between older people living alone in the region and in the developed countries is that in the latter they are more likely to live alone as a matter of choice and conditions are favourable to this type of arrangement. In Latin America and the Caribbean, on the other hand, living alone may represent a risk for older people lacking a better choice (Saad, 2004).

2. Co-residence and opportunities for mutual support between generations

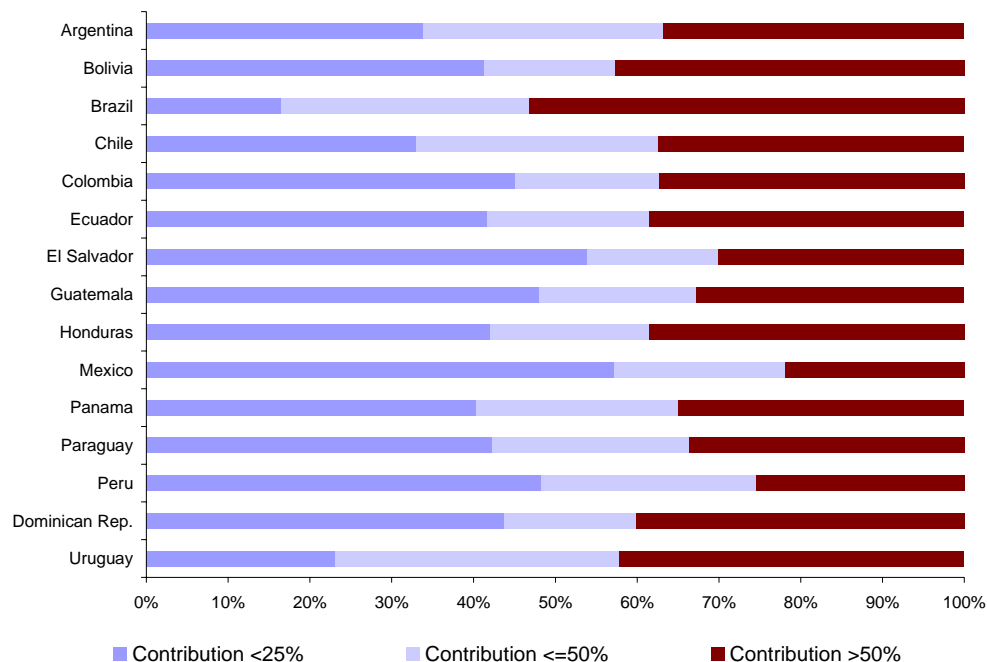
Multigenerational households remain a good option for older people and their families in the region as they facilitate support for older people with a high level of vulnerability (Saad, 2004) and can benefit from older people's income contributions to family resources (ECLAC, 2000).

There is a clear relationship between the contribution made to the family budget by older people in multigenerational households and the incidence of poverty. In poor households where the older person's contribution is small (less than 25%), co-residence is often associated with financial dependency or care needs of the older members. In poor households where the financial contribution of older people is

substantial (over 50%), on the other hand, it seems that the opposite relationship holds, i.e., members of younger generations are the ones who benefit the most from co-residence (ECLAC, 2000).

According to the latest information available, in 15 countries of the region older people provide more than 50% of family income in about four out of every 10 multigenerational households, while in a very similar proportion (3.5), older people contribute less than 25% of family income.¹ The data presented in figure V.5 show that the countries where older people contribute most to household income are Argentina, Bolivia, Brazil, Chile and Uruguay. In these countries, social security coverage (whether contributory or non-contributory) seems to have a direct impact on the ability of older people to make significant contributions to household income and, accordingly, on the likelihood of the families of younger generations attaching themselves to the households formed by older people.

Figure V.5
LATIN AMERICA (15 COUNTRIES): MULTIGENERATIONAL HOUSEHOLDS AND THE CONTRIBUTION OF OLDER PEOPLE TO HOUSEHOLD INCOME, AROUND 2005
(Percentages)



Source: Household surveys in the countries concerned.

To sum up, family arrangements involving the presence of older persons have a number of similar features among the countries of the region. From the perspective of the implications for well-being, the most significant is the effect of social protection benefits received by older members, which often spread to the whole family (see chapter 3). When older people have financial and other resources, they invariably share them with their children and younger family members, thus strengthening the family resource base and contributing to the well-being of different generations (United Nations, 2005a).

¹ If Brazil is excluded, the proportion of households where older people contribute over 50% falls to three in 10 and the proportion where older people contribute less than 25% rises to about four in 10.

B. AGEING AND CARE SYSTEMS

The increase in the older population and the gradual rise in life expectancy have aroused interest in the workings of care systems. The emphasis on this issue is due primarily to three factors. First, ageing increases the demand for assistance services because older people often experience some deterioration in their health (physical or mental, or both) and a weakening of social networks owing to the loss of partners, friends or relatives. Second, care has traditionally devolved upon women who, owing to economic or social pressures or as a matter of personal choice, have gradually been turning away from this kind of work. At the same time, the participation of women in the labour market outside the home is not always matched by a greater role for men in care responsibilities, whether because of gender socialization or because those requiring care set a lower value on men's capabilities in this area. Third, social services to support the social reproduction of the older population have not gained full public support, so that the family (and to a lesser extent the market) is acting as the main absorption mechanism for risks associated with the loss of functionality in old age.

The region's countries are particularly sensitive in this regard, since the ageing process has been faster than in the developed countries, demand for care at preschool ages is still high and socio-economic conditions have not always made it possible to introduce public measures sufficient to cover assistance needs; at best, other spheres of social protection have been given precedence.

1. The effect of ageing on care systems

The rise in the older population ought not to be a problem for care systems; the problem arises from the fact that societies have not created the proper mechanisms for coping with this development and its implications. Care is the social activity carried out to ensure the social and physical survival of dependent persons, i.e., those who lack personal autonomy and need help from others to carry out essential activities of daily living.

The need for care at more advanced ages is nothing new. In all societies there have always been people who have needed others' help to carry out day-to-day activities. Since the mid-twentieth century, however, the response to care needs has changed substantially (Casado and López, 2001). Thus, because of the peculiarities of the present situation, care has been turning into a problem of modern times.

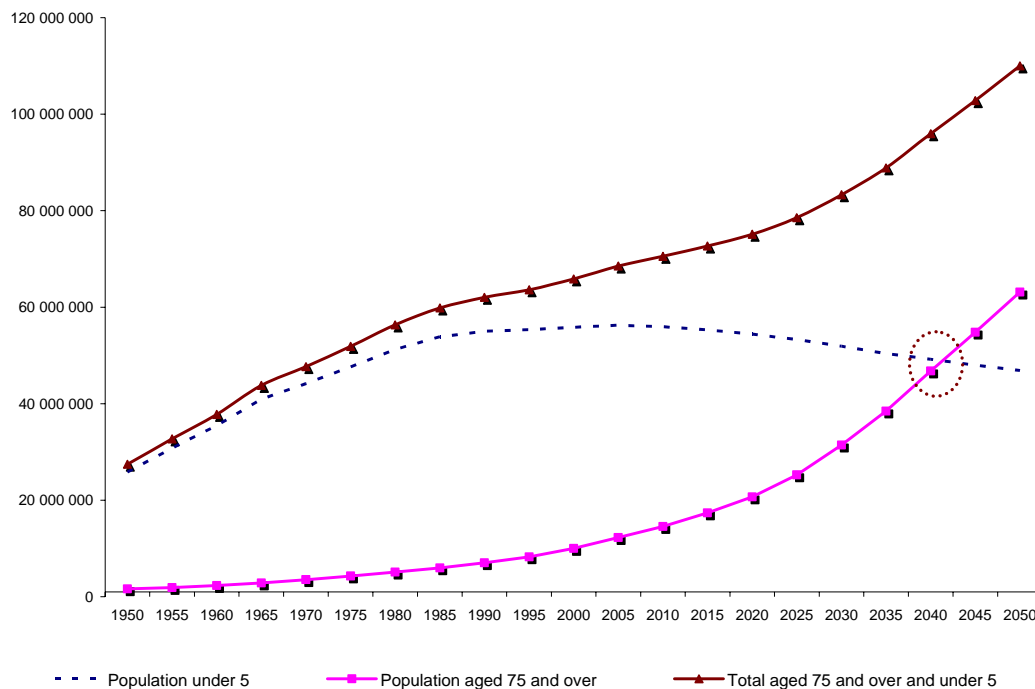
On the one hand, there are people who cannot look after themselves, as there always have been; and on the other, traditional methods of meeting their needs are in jeopardy, just at a time when increasing numbers of people are requiring help due to population ageing, the use of artificial methods to increase lifespans, higher accident survival rates, etc. (Sempere and Cavas, 2007). This is why numerous studies have identified the need for care as a new social risk, one that is characteristic of transition or post-transition societies and that demands a whole range of specific public protection services.

The main difference between the region's countries and the developed countries is that in the latter, the need for care began to be considered a social risk in the 1970s. At that time, a report by OECD (1973) stated that "growth is not an end in itself, but a means to raise the overall wellbeing of societies", and the opportunity to enjoy lifelong good health was placed at the top of a list of social concerns. In the countries of the region, on the other hand, this process has been taking place only recently, partly because traditional care systems continued to operate in a fairly stable way well into the 1980s.

As figure V.1 shows, the population requiring care is expected to increase greatly over the coming years. Even as the population under 5 remains a major source of demand for protection and care, the population aged over 75 will gradually increase. Although people often enjoy good health and a high degree of independence at this age, the fact remains that they are far more likely to become frail or disabled as they grow older.

The effect of these changes will be felt more strongly over the coming years as the trend becomes socially and demographically entrenched, requiring changes to the social and health-care provision currently available to the older adult population, children and the disabled.

Figure V.6
LATIN AMERICA: NUMBER OF PEOPLE AGED OVER 75 AND CHILDREN UNDER 5, 1950-2050



Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, on the basis of specially processed census microdata.

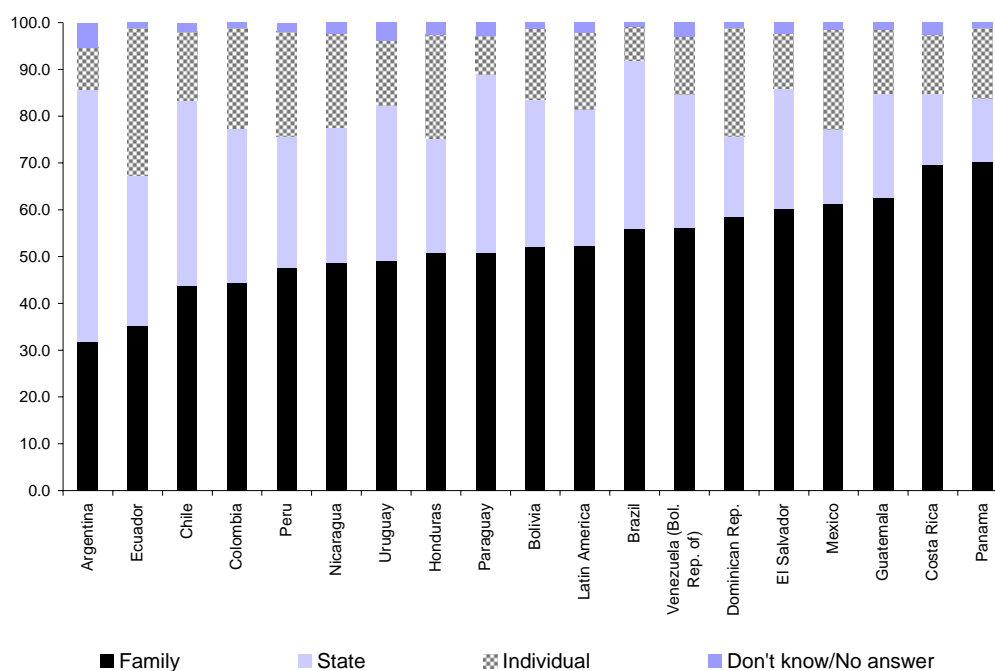
2. The role of the family and women as carers

In the sociology of old age, care systems are treated for academic purposes as part of the wider field of social support. In the economics of ageing, however, care is part of the field of economic security: if older people had to pay for the assistance services they received from relatives, the likelihood of their being poor would certainly be much greater.

There are three sources of care in old age: the family, the State and the market. None of these institutions has exclusive competence in the provision of care, and as a result there is not always a clear

dividing line between the assistance supplied by each of these three agents, although there are differences as regards the main responsibility attributed to each one. Data from the 2006 Latinobarómetro opinion survey show that, in most of the countries, the people interviewed thought the responsibility for ensuring that older people enjoyed decent living conditions fell upon the family, then to a lesser extent upon the State and, to a much lesser degree upon, the individual concerned (see figure V.7).

Figure V.7
**LATIN AMERICA AND THE CARIBBEAN: INSTITUTIONS CONCERNED WITH
 OLDER PEOPLE'S WELFARE**
(Percentages)



Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, on the basis of specially processed data from the 2006 Latinobarómetro opinion survey.

Although this view is a constant in most of the countries, opinions vary in some of them according to the sex of the respondent. Thus, while a larger proportion of women than men on average think that the family has prime responsibility, a larger proportion of men than women think that the main responsibility is the State's. The only country where more than 50% of men and a similar proportion of women think that the State has the main responsibility for the welfare of older people is Argentina. In Costa Rica and Panama, on the other hand, more than 65% of the men interviewed thought the family had the main responsibility.

It is interesting to note that when the State plays only a weak role as a unifying factor in political life and as a provider of social protection, hopes are placed on the family as a likely force for social cohesion, and it is subjected to excessive expectations as the institution with ultimate responsibility for filling the gaps in protection. This is part of the reason why, in countries with low levels of social protection, Latinobarómetro respondents tend to see the family as bearing the main responsibility for the well-being of older people.

In fact, the family is still one of the most important sources of care in old age. For example, data from the SABE survey show that around 2000 a large proportion of older people in seven cities of Latin America and the Caribbean received support from their families to carry out functional and instrumental activities of daily living (see table V.1).

Table V.1
**PROPORTION OF OLDER PEOPLE HAVING DIFFICULTY AND RECEIVING HELP WITH
ACTIVITIES OF DAILY LIVING^a**

Characteristics	Functional activities (FADL)		Instrumental activities (IADL)	
	Having difficulty	Receiving help ^b	Having difficulty	Receiving help ^b
Age				
60-64	13	26	15	75
65-74	15	33	21	79
75+	31	51	47	88
Sex				
Men	15	43	20	83
Women	23	42	35	84
Marital status				
Unmarried	23	43	35	85
Married	16	40	21	82

Source: Paulo Saad, “Transferencias informales de apoyo de los adultos mayores en América Latina y el Caribe: estudio comparativo de encuestas SABE”, *Notas de población*, No. 77 (LC/G.2213-P), Santiago, Chile, Economic Commission for Latin America and the Caribbean (ECLAC), 2003.

^a In seven selected cities, and by demographic characteristics.

^b As a proportion of those having difficulty.

In the Chilean sample, for example, the proportion receiving help with functional activities of daily living (about 52%) is twice as high as in Uruguay (about 26%). In general, the proportion receiving help with instrumental activities of daily living is significantly higher than the proportion receiving help with functional activities of daily living, ranging from just under 70% in Argentina to almost 92% in Brazil. Another aspect documented by this survey is that the greatest support comes from family members living in the same household, followed by children living outside it (Saad, 2003).

These data reveal the scale of the family contribution to the social reproduction of the elderly population. This is partly a consequence of the relatively young population structure and the slow and inadequate development of social security systems which, in most of the region’s countries, have yet to establish solid systems of institutional protection specifically designed for dependent older people. The result is that families have instead had to solve the problem by means of intergenerational solidarity strategies that often involve extending and reconfiguring households. Thus, financial assistance and the care of older people has become a responsibility for families themselves, the State having assumed only a secondary role (ECLAC, 2000).

Accordingly, as different authors have pointed out, some further distinctions have to be drawn, since in speaking of the family it is necessary to identify the role of women as carers (Sánchez, 1996).²

² Caring is usually associated only with children, so that other types of care are overlooked. In addition, it is generally assumed that most caring is done in youth, when women are responsible for their children. The evidence shows, however, that they can also be carers at other stages of life and that they end up providing care

The fact is that tradition, socialization and economic relationships make women the key carers for older people (and indeed for other social groups), irrespective in most cases of whether the woman works in paid employment or in the home.

The conclusion from all this is that unless there are explicit interventions to provide this type of service, the ability to provide care to older people can vary from family to family depending on the type of living arrangement. Setting out from the fact that women are the main carers for older people when they live with them in the same household, a major difference can be identified between families where the woman has a job outside the home and families where she is employed on domestic work.

In the first case, opportunities for providing assistance to an older person are more limited (although it is becoming increasingly common for women carrying out productive work outside the home to combine this with care tasks), and use is likely to be made of external services where affordable. In short, the likelihood of older people receiving help from their offspring with functional and instrumental activities of daily living is conditioned by the demographic and social circumstances of earlier decades, which have been changing substantially.

The main changes include:

- The large drop in fertility, which will reduce the potential size of the family support network available to older people in future. The generations that are currently providing help to older members of their families are not as likely to receive such support from their own children or grandchildren (Guzmán, 2002a).
- Full incorporation of women into non-domestic work is reducing their availability for care functions, with which they have traditionally been overburdened because of their gender status. This change is resulting in a reduction in the capacity to provide a range of assistance services to household members with some degree of dependency, making it necessary to use external services to replace female relatives in this task (Maldonado and Hernán, 1998).
- Rising life expectancy means that old age is being prolonged. Families are having to look after their older members for longer and women are ageing even as they care for the younger and older generations. A woman who has children at 25 can be a mother for 45 or 55 years. Despite the traditional notion that women's time is dedicated to their children only for the first 10 years, experience shows that providing help is a lifelong responsibility. Longer female lifespans will prolong this role, which will coexist with the role of daughter as parents too live longer (Calasanti, 1996 in Sánchez, 1996).

Protecting people who are in need of care in old age will be an unavoidable responsibility for public policies over the coming decades. The challenge is to meet the needs of people who are in a situation of particular vulnerability and thus require support to carry out essential activities of daily living, attain greater personal autonomy and be able to exercise their rights as citizens to the fullest extent (Sempere and Cavas, 2007).

more than once over their life cycle, first for their children, then for their parents, and finally for their infirm spouse. These three episodes generally occur at three distinct times in women's lives: youth, adulthood, and maturity (Kahan and others, 1994 in Robles, 2003).

Box V.1

PERCEPTIONS OF ILL-TREATMENT AND VIOLENCE AGAINST OLD PEOPLE IN LATIN AMERICA AND THE CARIBBEAN

Ill-treatment of older people was recognized as a social problem in the 1980s, since when there has been an ongoing debate about its definition and typology and the best ways of preventing it. It is now defined as any single or repeated act or omission that causes harm or suffering and occurs in any relationship where there is an expectation of trust. Physical, psychological, sexual and financial ill-treatment and the abuse of property are among the types recognized (CELADE, 2003).

No reliable, representative statistics are available in the region to give a full picture of the true scale of this problem. Often isolated cases are brought to light in the press or reported by family members or people close to the older individuals concerned, or monographs are published on the causes and consequences of the problem.

To ascertain how older people were treated, a question on the subject was included in the Latinobarómetro survey applied in 18 countries of Latin America and the Caribbean, and over half of all those interviewed replied that older people were treated badly or very badly. This regional perception differs by country. In six of them the proportion giving this answer was higher than the regional average, Guatemala being the country where the largest percentage of people (70%) answered that older people were treated badly or very badly. At the other extreme are three countries (Mexico, Dominican Republic and Bolivarian Republic of Venezuela) where over 60% of respondents thought older people were treated well or very well (figure 1).

While there are virtually no differences at the regional level between men and women in their perception of how older people are treated, in five countries (Chile, Mexico, Paraguay and Uruguay) women took a worse view of this treatment than men (gap of five points); only in El Salvador and the Bolivarian Republic of Venezuela did men have a worse perception than women. Perceptions do not differ much by the age of respondents: 52% of those aged between 15 and 29 thought that older people were treated badly or very badly, a figure that rises to 55% among those aged 30 to 59 and over 60 (figure 2).

Figure 1

Latin America and the Caribbean: people believing that older adults are treated badly or very badly, 2006
(Percentages)

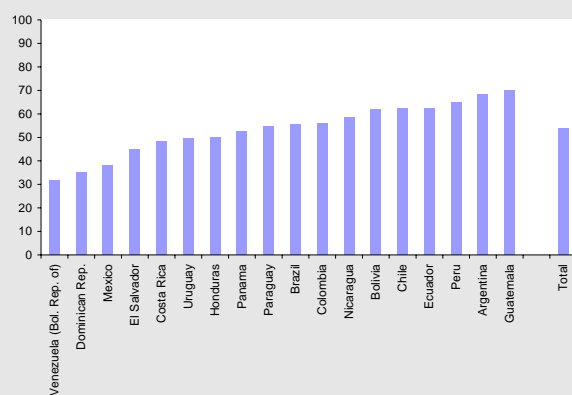
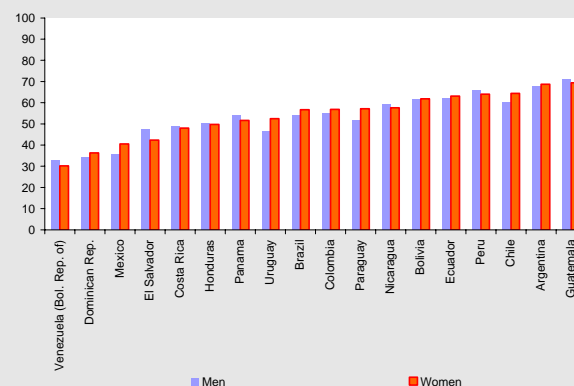


Figure 2

Latin America and the Caribbean: people believing that older adults are treated badly or very badly, by sex, 2006
(Percentages)



Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, on the basis of processed data from the 2006 Latinobarómetro opinion survey.

Box V.1 (concluded)

The same survey asked respondents whether they themselves knew of any cases of domestic violence against older people, and in the region as a whole 22% said they did. The highest proportions answering affirmatively were in Nicaragua and El Salvador, with 33% and 31%, respectively, while Brazil recorded the lowest level of awareness of cases of this type (figure 3). While in the region as a whole there is no clear divide between men and women as regards their awareness of domestic violence against older people, in seven countries (Brazil, Ecuador, Colombia, Peru, Dominican Republic, Costa Rica and Paraguay) women claimed to know of more such cases than men (figure 4).

Figure 3
Latin America and the Caribbean: people claiming to know of a case of domestic violence against older adults, 2006
(Percentages)

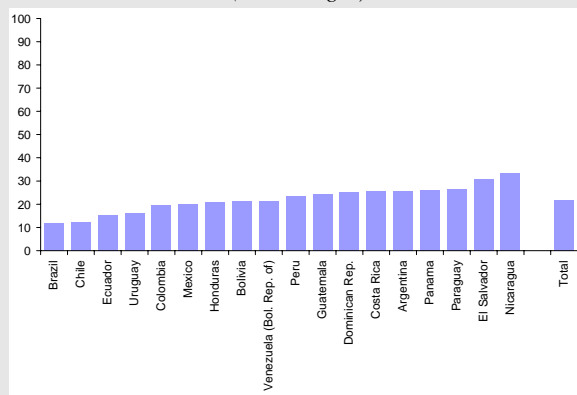
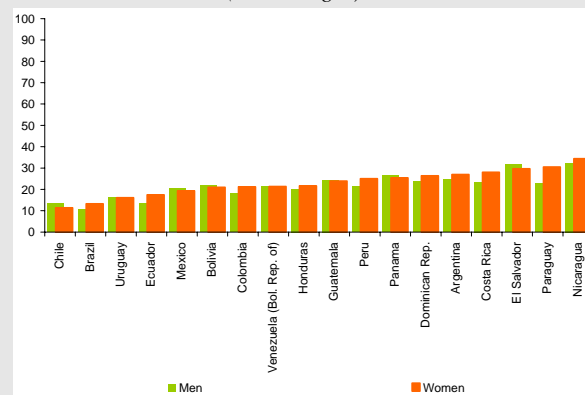


Figure 4
Latin America and the Caribbean: people claiming to know of a case of domestic violence against older adults, by sex, 2006
(Percentages)



Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, on the basis of processed data from the 2006 Latinobarómetro opinion survey.

There is now general acceptance that it is not enough merely to identify cases of ill-treatment involving older people. In addition to this, all the countries ought to develop systems of service provision (health, social, legal protection, police, etc.) to respond effectively to the problem and, if possible, prevent it (WHO, 2002). Given that the causes leading to ill-treatment are numerous and complex and that there are certain conditions that favour it (including stress among carers, lack of resources to meet victims' needs, the provision of care by unqualified individuals and situations of economic crisis and unemployment), prevention work is essential if this problem is not to spread further.

C. HOUSING, LOCAL ENVIRONMENTS AND AGEING

The major changes that have been occurring in the demographic profile of Latin America and the Caribbean over recent decades have had consequences for the planning and management of social services. Housing has been no exception, with the main issues deriving in this case from acute social inequity and a large backlog of unmet accommodation needs (Arriagada, 2003b). Thus, the ageing process is taking place in a context of housing shortages and problems with basic services access and social harmony in cities.

Access to housing is a human right which must be satisfied, and this entails changes in land use and environmental conditions. Decent housing is essential to survival and to a secure, independent and autonomous way of life. Precisely because it is so important to people's lives, consuming a large part of

their income and strongly influencing their own and their families' self-esteem and the welfare of the community in which they live, there is a consensus that access to housing should be treated as an enforceable right vis-à-vis the public authorities and the rest of society. In fact, the right to adequate housing is a composite one; when it is infringed, so are other essential rights and interests (Pisarello and De Cabo, 2003).

The right to housing can also be seen as extending to the environment and urban design in general. In this case, housing issues encompass of at least three levels of analysis: (i) the individual dwelling, (ii) its immediate environment and (iii) the urban or rural setting as an existential framework and way of life. Consequently, the question of whether housing is decent and appropriate should be answered with reference not just to the individual dwelling but also to its immediate environment and, most particularly, the urban or rural setting in which it is located (Bassols Coma, 1983).

Housing and its environment strongly influence older people's quality of life, both in the objective sphere of living conditions and assets and in the sphere of subjective or perceived well-being. Ensuring that housing is appropriate means recognizing the diversity of older people's needs and preferences, from the option of "growing old at home" to situations of frailty requiring care and special types of living arrangements (CELADE, 2003).

Housing should both satisfy the need for autonomy and independence and provide security across a broad spectrum of living situations, while creating the potential for well-being among older people and the other generations living with them. Viewed in this light, housing can be understood as an instrument for safeguarding older people's health and quality of life, with dwellings varying in the degree to which they match the needs of a heterogeneous older adult population. As for local environments, these should facilitate the integration of all citizens affected by some vulnerability, irrespective of its origin, and neutralize the risks of discrimination.

In short, housing and local environment policies should be designed on the basis of a renewed vision of social inclusion for all, and housing and urban programmes can play a significant part in helping older people to develop a fuller range of activities and social contacts, and thus to enjoy a healthy old age while participating in their residential environment on decent terms.

1. Security of housing tenure in old age

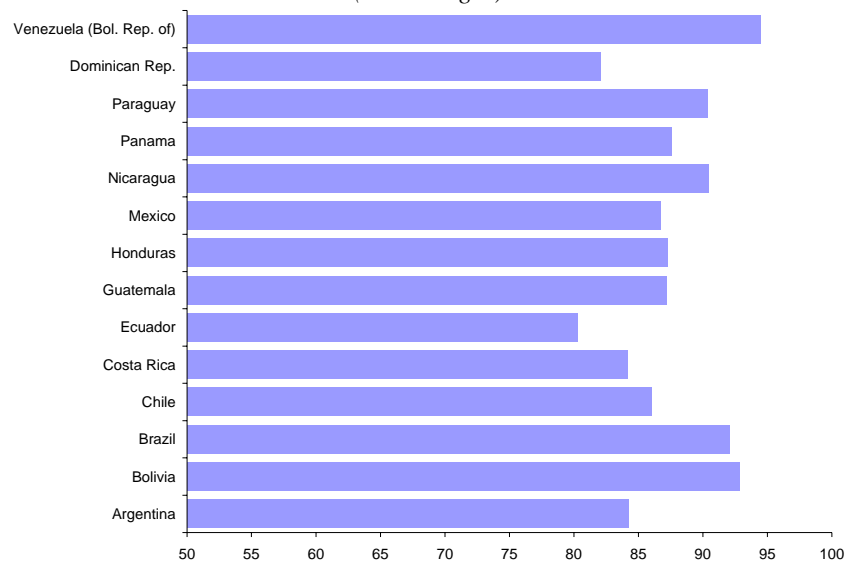
Among the attributes that adequate housing must possess, stability of occupation is very important as it provides security of access over time and allows people to connect with their social and geographical environment.

Assessing this means considering both the period of residence and the legal situation with tenure or occupation, and determining the occupant's degree of security in relation to the time horizon over which he or she wishes to inhabit the home. Thus, ownership can be taken as a reflection of stability in an older person's housing situation, as it is a measure of residential security and indicates greater protection against eviction.

In the countries with information available on this subject for the year 2000, over 80% of older people state that they are living in a home of their own (see figure V.8). There is no common pattern as regards differences between urban and rural areas. In some cases the percentages living in their own homes are higher in rural areas (Bolivia, Costa Rica, Ecuador, Guatemala, Nicaragua, Mexico, Panama,

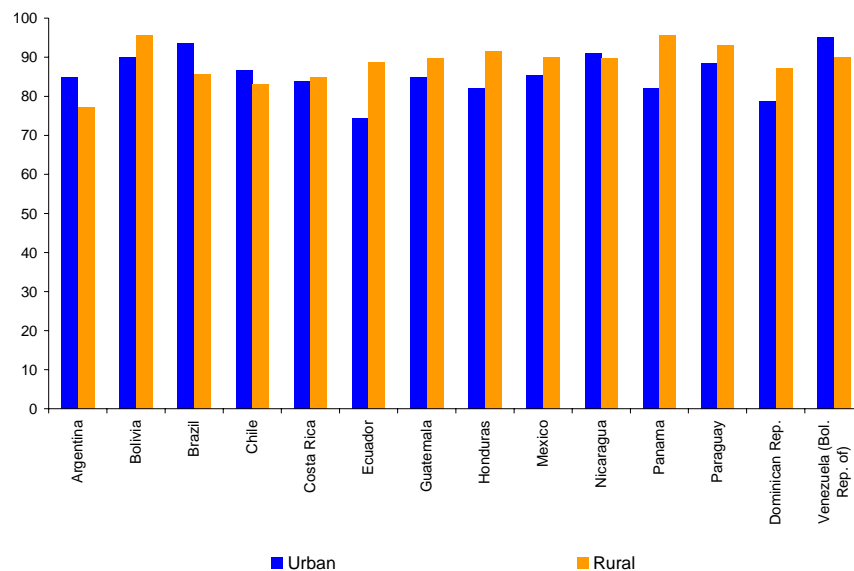
Paraguay and Dominican Republic), whereas in Argentina, Brazil, Chile and the Bolivarian Republic of Venezuela this rate is higher among older people in urban areas (see figure V.9).

Figure V.8
**LATIN AMERICA AND THE CARIBBEAN (SELECTED COUNTRIES): OLDER PEOPLE LIVING
 IN THEIR OWN HOMES, 2000 CENSUSES**
(Percentages)



Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, on the basis of specially processed census microdata.

Figure V.9
**LATIN AMERICA AND THE CARIBBEAN (SELECTED COUNTRIES): OLDER PEOPLE LIVING
 IN THEIR OWN HOMES, URBAN AND RURAL AREAS, 2000 CENSUSES**
(Percentages)



Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, on the basis of specially processed census microdata.

Homes containing older people are more likely to be owner-occupied than others and the rate of owner-occupation is higher in countries that are further advanced in the demographic transition. One reason for the higher percentage of older people declaring that they own their homes is the progress made in awarding title to land.³ It should be noted, though, that there are methodological biases in the perception of ownership (members of a household will often claim they own their home even though they do not own the site or land it stands on).

A home of their own can be an asset for older people and their families, as it represents property that can be bequeathed to future generations. To perform its function properly, however, a home needs to have a number of characteristics and facilities (in respect of health, mobility, equipment, fittings, etc.) that younger segments of the population might consider non-essential (Bosch, 2006).

Given all this, housing policy is an essential component of measures aimed at older people, since other social interventions can lose all their effectiveness if this right is not guaranteed. Other things being equal, furthermore, the best option is for people to grow old in their own homes, both from the point of view of their own dignity, wishes and independence and also financially, if the public expenditure associated with institutionalization is taken into account (Bosch, 2006).

2. The housing situation: deficiencies, housing quality and ageing

Changes in the age structure of the population have generated new housing needs owing to faster growth in the number of families containing older people, which are consumers of housing.

There are new housing requirements and major backlogs in all the region's countries. If each country's stage in the ageing process is compared with the quality of its housing stock, it transpires that countries which are less advanced in the ageing process have far-reaching problems with their housing stock and a large proportion of substandard housing lacking in basic amenities. In countries that are further advanced in the ageing process, on the other hand, the proportion of inadequate housing is smaller but more households and families are affected by quantitative deficiencies or the need for new housing (Arriagada, 2003b and González, 2006).

To obtain an overview of the region's housing situation, 12 countries at different stages in the ageing process were selected and the housing deficiency index was calculated for households containing older people. To calculate this indicator, use was made of a simple average that combines the percentage of households in which members are not living in homes of their own with a material conditions index (average percentage lacking floors and walls), the percentage without water inside the home and the percentage living in overcrowded dwellings. The figures in table V.2 reveal the following housing situation in some of the region's countries:

³ There has been a need in the region to consolidate procedures for awarding land title and improve the workings of land markets (FAO, 2002). Systematic land registration has reduced costs considerably and facilitated people's access to the land title process (Jaramillo, 1998). In the case of informal settlements in Latin America, government programmes have been limited to the creation of policies to provide credit or regularize land holdings and protect them with legal title (Marques, 2006).

Table V.2
SELECTED COUNTRIES OF LATIN AMERICA AND THE CARIBBEAN: HOUSING DEFICIENCY INDEX FOR HOUSEHOLDS CONTAINING OLDER PEOPLE

Ageing	Housing deficiency index		
	Low (index below 15)	Medium (15 to 30)	High (over 30)
Incipient			Paraguay - Bolivia Guatemala - Nicaragua
Moderate	Costa Rica Venezuela (Bol. Rep. of)	Mexico - Ecuador Brazil ^a - Panama	
Moderate-advanced	Chile		
Advanced	Uruguay		

Source: Camilo Arriagada, "El déficit habitacional en Brasil y México y sus dos megaciudades globales: estudio con los censos de 1990 y 2000", *Población y desarrollo* series, No. 62 (LC/L.2433-P), Santiago, Chile, Economic Commission for Latin America and the Caribbean (ECLAC), 2005. United Nations publication, Sales No. S.05.II.G.179.

^a The floor information was not available for Brazil.

- Incipient ageing countries. Households containing older persons score worst for housing deficiencies (Paraguay, Bolivia, Guatemala and Nicaragua). The housing situation is quite critical because a substantial proportion of households containing older people are lacking in floors or walls, have no access to drinking water or suffer from overcrowding, which would justify a substantial number of initiatives to meet the needs of this social group.
- Moderate ageing countries. Mexico, Ecuador, Brazil and Panama have intermediate housing deficiency scores. In the first two, this is mainly because of inadequate access to drinking water. In Costa Rica and the Bolivarian Republic of Venezuela, conversely, there is a low index of housing deficiencies in households containing older people.
- Moderate to advanced ageing countries. Housing indicators in Chile are positive, providing an opportunity to consolidate the housing situation of older people. This means focusing housing programmes on the country's housing backlog.
- Advanced ageing countries. In Uruguay, the housing deficiency index is low, meaning there is an opportunity to consolidate the housing situation of older people by means of targeted measures to deal with a housing backlog of moderate proportions.

3. Access to basic services in old age and inequalities by area of residence

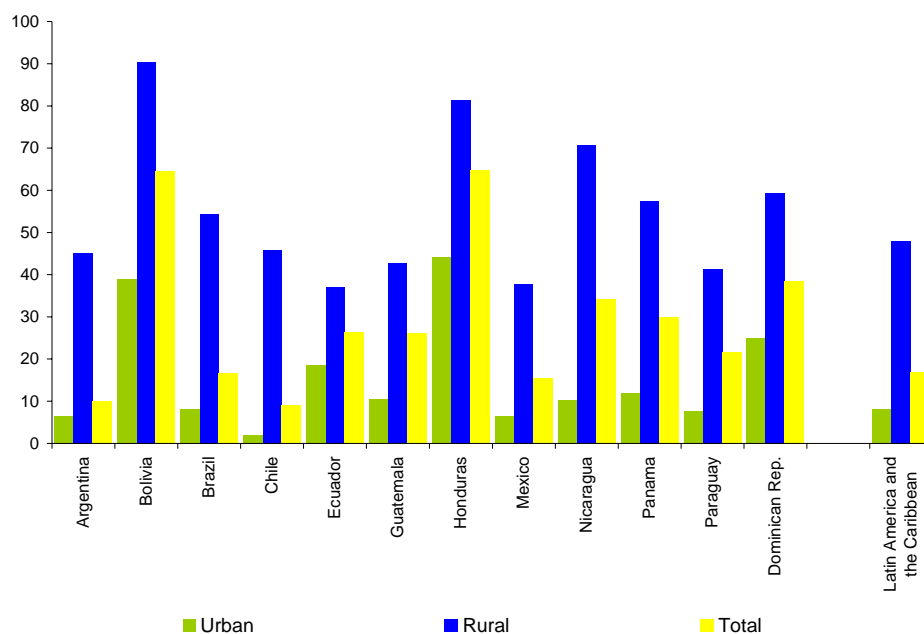
All persons have the right to sufficient supplies of drinking water to meet their essential needs and to have access to acceptable sanitation facilities that take account of the requirements of hygiene, human dignity, public health and environmental protection (United Nations, 2005b). Accordingly, the States drawing up the Millennium Development Goals included target 10, which is a commitment to "halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation".

The situation in the region as regards access to these services for older people is mixed and not well understood. Countries' situations differ by their development level, and access also varies within

countries by area of residence. In the 14 countries considered, 5.8 million older people, or 17% of the older adult population covered by the analysis, lack access to drinking water in the home.

There is a wide urban-rural divide: whereas 8% of older people (2.2 million) lack access to drinking water in urban areas, 3.6 million older people lack this service in rural areas. Thus, virtually half (48%) of all older people in rural areas suffer from this deficiency (see figure V.10). This is because drinking water and sanitation coverage in the region's countries is substantially higher in urban areas than in rural ones.

Figure V.10
LATIN AMERICA AND THE CARIBBEAN (SELECTED COUNTRIES): OLDER PEOPLE LIVING IN HOUSEHOLDS WITH NO DRINKING WATER SUPPLY INSIDE THE HOME, 2000 CENSUSES
(Percentages)

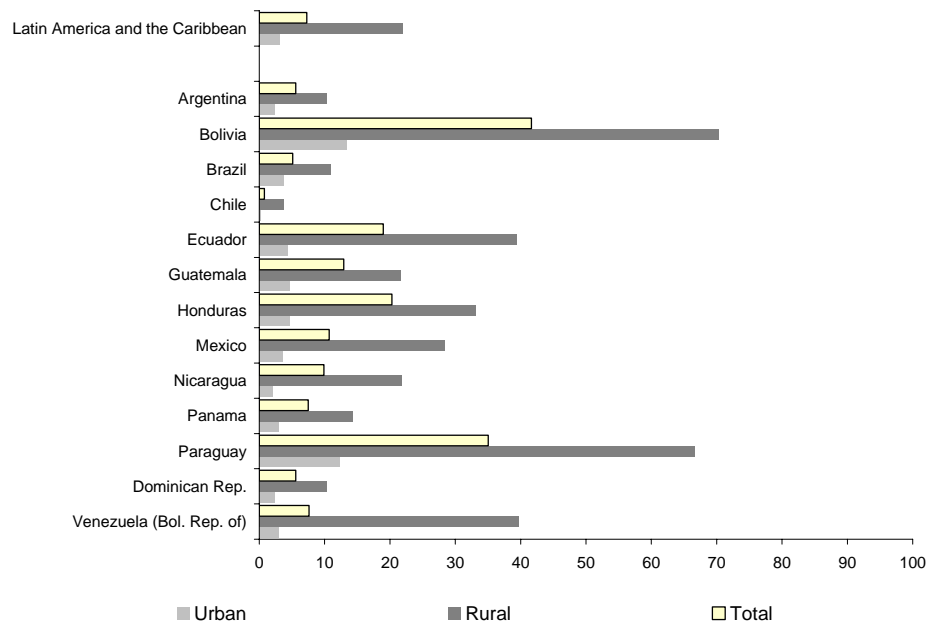


Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, on the basis of specially processed census microdata.

As a result of this situation, many of the solutions (such as tanker trucks) to which older people have to resort are similar to those used by poor people in the majority of areas lacking these basic services. They are extremely expensive, so that these people end up spending more on water (as a proportion of their income) than the better-off. In addition, these solutions pose great risks to health, since the quality of the water obtained cannot be assured (Jouravlev, 2004).

The number of older people living in households without sanitation is 2.5 million (7.3%), and the situation is worst in rural areas. There are 1.6 million older people lacking acceptable sanitary facilities in the countryside (22%), while in urban areas just 3.1% of the population over 60 live in homes without sanitation (see figure V.11). Frequently, too, the technological solutions adopted in rural areas (septic tanks and latrines) do not have a level of quality or functionality comparable to that found in cities, especially when it comes to home connections (Jouravlev, 2004).

Figure V.11
**LATIN AMERICA AND THE CARIBBEAN (SELECTED COUNTRIES): OLDER PEOPLE LIVING
 IN HOUSEHOLDS WITH NO SANITATION, 2000 CENSUSES**
(Percentages)



Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, on the basis of specially processed census microdata.

In the English-speaking Caribbean, the coverage of basic services is over 95% in a number of countries (Bahamas, Barbados, Saint Kitts and Nevis and Saint Lucia). Because of their size, the English-speaking Caribbean countries ought to find it easier to match growing demand to the resources available given the greater scope for communicating options and costs so that communities are predisposed to pay for services. Furthermore, local governments are closer to direct consumers, which means that programmes can be better targeted, more responsive and cheaper (Jouravlev, 2004).

Older people lacking basic services are extremely vulnerable to a variety of related risks, since the lack of appropriate sanitation facilities and an adequate, safe and physically accessible supply of water restricts their access to a range of other rights, such as the right to a healthy environment, health and adequate nutrition, that are directly or indirectly linked to water and sanitation (Hopenhayn and Espindola, 2007). Lack of access to high-quality basic services and a good environment that safeguards people's health and is conducive to full development of their capabilities does not only affect the elderly, but puts the entire family at a social disadvantage. If there are children in the household, for example, there are also increased risks of premature mortality and a higher incidence of communicable or diarrhoeic diseases.

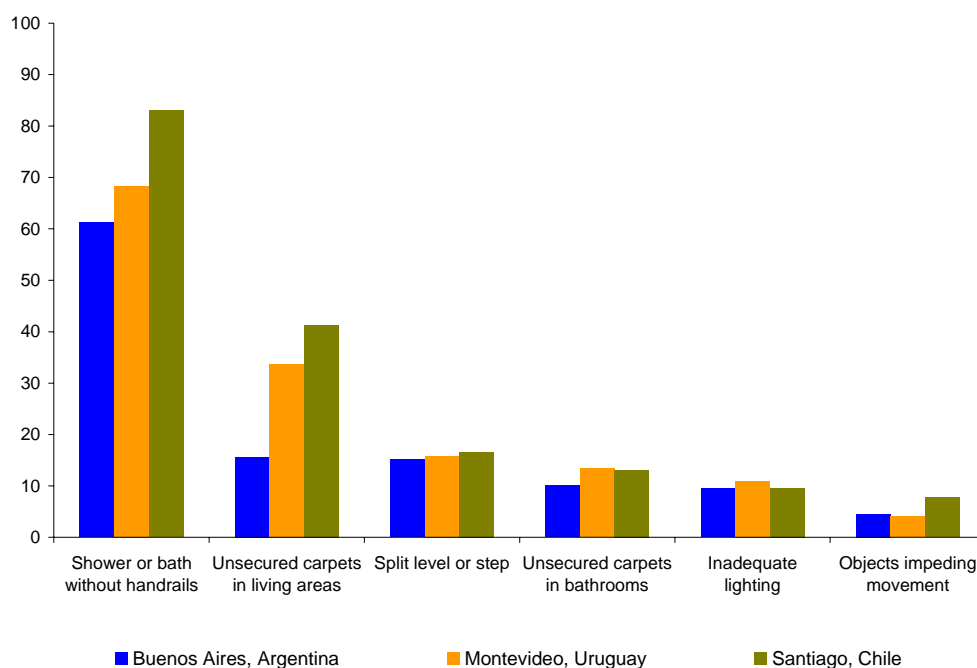
4. Equipping housing and local environments for social inclusion at all ages

When older people live with other family members, it is important for the home to be designed so that different generations can coexist harmoniously. This is not easy to achieve, but it does facilitate the integration of older people into their families (United Nations, 2006a).

The problems of housing for older people take a variety of forms, such as difficulties of access and mobility, inappropriate housing design and isolation. These different aspects of the problem tend to arise in combination, so that two or three of these difficulties are usually present at the same time.

In the Health, Well-Being, and Aging Survey (SABE), older people identified the main risks they were exposed to in the home. The leading risk comes from the lack of special fixtures in bathrooms, such as supports on sanitary installations and handles or rails to provide greater security when these are used. In second place they cite the risk that unsecured carpets create by causing older people to stumble or slip, with the danger of falls and injuries that this entails. Other risks identified by older people include split levels or steps, inadequate lighting and objects that impede movement (see figure V.12).

Figure V.12
LATIN AMERICA AND THE CARIBBEAN (SELECTED COUNTRIES): HAZARDS AFFECTING OLDER PEOPLE IN THE HOME



Source: Pan-American Health Organization (PAHO), Health, Well-Being, and Aging Survey (SABE), 2000.

It should be noted that these are some of the risks facing older people who live in the capital cities of the countries where the survey was conducted. In smaller towns and cities and scattered rural areas, risks in the home are probably greater because housing infrastructure tends to be less well adapted to the needs of an ageing population.

The idea of having housing that is suitable for all the generations living in it is to allow all household members to carry out their activities independently. The environment in which the housing is located is also vital for the prospects of maintaining good health and creating or strengthening formal and informal relationships between individuals and social groups and enhancing social cohesion (PAHO, 1996).

Although old age might constrain people's ability to remain integrated in the community, experience shows that the risk of increasing frailty is greater even than the individual difficulties involved in community participation. If conditions were as good as possible and appropriate to the needs of older people (and indeed of other social groups), there would surely be less potential for generational segregation. As the United Nations (2006a) has pointed out, "if older persons cannot be mobile, they will never feel truly independent... Addressing the needs of older persons requires the creation of enabling and supportive environments to give older persons the option of ageing in place if they do not need and do not wish to leave their homes."

Local neighbourhoods and cities need to have a plan to ensure social and physical accessibility for all, so that older people can play an active role in everyday life. This means adapting the urban environment of cities (handrails, ramps, anti-slip pavement surfaces, removal of obstacles to movement), but also designing them so that shapes, textures, colours, sounds and light allow people to visualize their journeys clearly, easily recognizing the environment and its components. This would be useful not only for older people but also for the disabled, children and pregnant women and indeed for everyone moving about the city, creating environments that were hospitable to all.

If it is accepted that people are entitled to housing and a safe, appropriate and stimulating environment so that they can have a decent life and a better old age, the policies implemented to this end will mean a fuller life for the whole of society.

Box V.2

THE QUALITY OF LOCAL ENVIRONMENTS IN OLD AGE: PERCEPTIONS OF LOCAL INFRASTRUCTURE AND EQUIPMENT IN CHILE

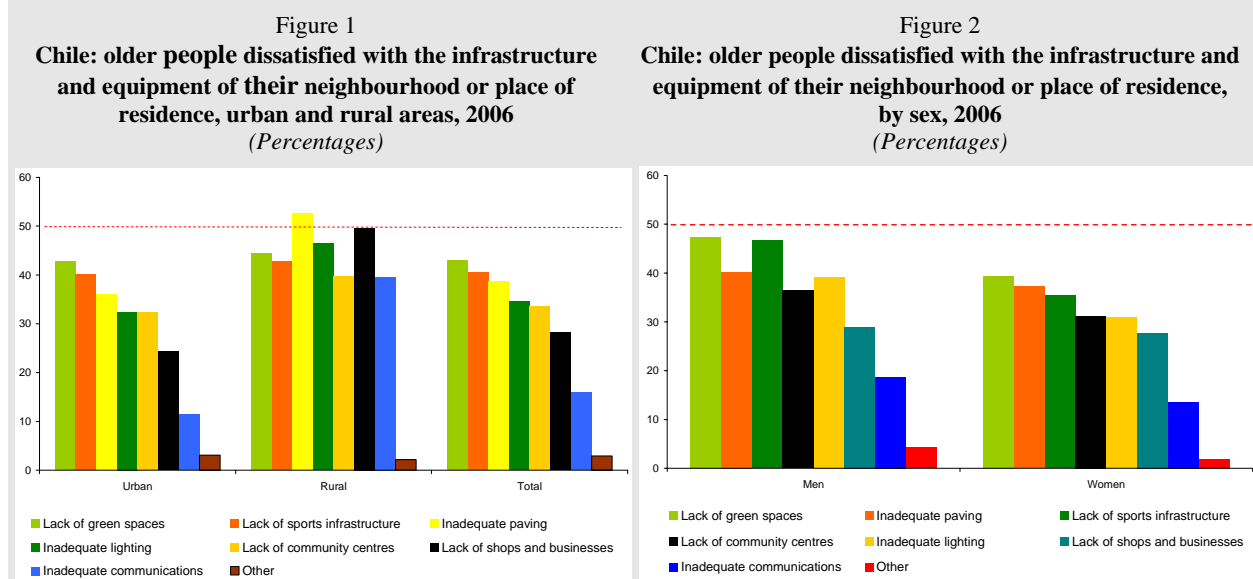
The second quality of life and health survey conducted in Chile in 2006 includes aspects relating to people's satisfaction in different areas of life, one example being their perception of their local environment. The information collected in that section brings to light some of the infrastructure and equipment problems affecting older people in their local areas.

At the national level, the greatest problem perceived by older people in relation to infrastructure and equipment is the lack of parks and green areas (43%), followed by the lack of sports infrastructure (40.5%), inadequate surfacing of streets and pavements (38.6%) and inadequate lighting of these (35%). The lack of community centres and of shops and businesses represents a problem for 33.5% and 28.3% of older people, respectively (figure 1).

Satisfaction levels are higher in urban areas than in rural ones. Taking all eight variables together, 43% of older people in urban areas say they are dissatisfied with local infrastructure and equipment, while in rural areas just over half (53%) of the older adult population expresses dissatisfaction with local infrastructure and equipment. Older people in the countryside express higher levels of dissatisfaction over the lack of paved roads (52.5%), the lack of shops and businesses (50%) and inadequate road lighting (46.4%). Another difference between urban and rural areas concerns perceptions of access to communications media: while 40% of older people in rural areas express dissatisfaction about this, just 12% of older people in urban areas do (figure 1).

There are also differences in satisfaction levels between older men and older women, with men expressing lower levels of satisfaction and differing over some of the main problems they identify. While there is general agreement that the lack of green areas locally is the main problem, this is a source of dissatisfaction to 47% of men but only 39% of women.

Box V.2 (concluded)



Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, on the basis of processed data from the second quality of life and health survey carried out by the Ministry of Health, Santiago, Chile, 2006.

The second most important problem for men is the lack of sports infrastructure (46.7%), while for women it is inadequate paving of streets (37.2%). Women place the lack of community centres and inadequate street lighting virtually on a par, whereas men regard inadequate lighting as a more important problem than the lack of community centres. The differences in satisfaction levels between older men and women and the different weight they give to infrastructure and equipment problems show that older people have different needs and priorities depending on sex, age and whether they live in an urban or rural area.

This information on older people's levels of satisfaction with local infrastructure and equipment provides an insight into this population group's perception of well-being in relation to its living conditions. It also offers information that it is very important to consider when developing and implementing interventions to improve the quality of local environments.

Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, on the basis of data from the second quality of life and health survey, Ministry of Health, Santiago, Chile, 2006.

D. PROGRESS IN IMPLEMENTING THE REGIONAL STRATEGY ON AGEING IN LATIN AMERICA AND THE CARIBBEAN: ENABLING SOCIAL AND PHYSICAL ENVIRONMENTS

The environment in which people age is changing rapidly. As has already been discussed, people are having fewer children, women are increasingly entering the labour market, and roles are being prolonged and renewed with advancing age. Again, young people are still finding it difficult to strike out on their own once they have started families, there are no institutional arrangements to help dependent older people grow old in their own homes, and there are persistent backlogs in the provision of basic services for the whole population.

The section on ensuring enabling and supportive environments in the Regional Strategy on Ageing lays it down as a goal that “*older persons shall be afforded physical, social and cultural environments conducive to their social development and to the exercise of rights and duties in old age*”. The Strategy recommendations include issues relating to housing, transport and public spaces in the physical environments category, while social environment issues include social support networks, image and ill-treatment. While issues relating to participation and education form part of the Regional Strategy’s first priority area, which deals with the elderly and development, they are included in the present section for the purposes of this analysis because of their close connection with the other matters dealt with in this subject area.

The progress made by the region’s countries will now be described, taking into consideration the recommendations of the Regional Strategy for the issues referred to in the previous paragraph. The information given in this section was supplied by the countries in their responses to the survey on programmes for older persons in Latin America and the Caribbean conducted by CELADE - Population Division of ECLAC between June and August 2007 (see table V.3).

1. Social environments: social support, ill-treatment, participation and education

One area of work that is beginning to come to prominence in interventions aimed at older people is the strengthening of social support networks; that is, the creation, promotion or consolidation of informal protection mechanisms developed by families and communities so that people can grow old in their homes and feel integrated into the community.

In some countries this issue is being addressed by encouraging volunteers to provide specific help to older people (Argentina, Costa Rica, Puerto Rico and Uruguay), while in some cases it is elderly people themselves who provide support to other people of their own generation. Another working method involves the provision of meal services. In Guatemala, for example, 12 community canteens have been set up for older people in rural and urban areas, while in Belize assistance, meals and health care are being provided to the poorest sections of the elderly population with the support of a non-governmental organization.

Measures have also been taken to strengthen the social fabric that provides older people with another type of support. In Costa Rica, for example, the Assistance Programme for Institutionalized Older People supplies financial resources to non-profit social welfare institutions providing care to the older adult population. In Nicaragua, support is being given to local organizations run by older people themselves in rural areas. And in Cuba, government agencies are working under the leadership of local governments to coordinate and strengthen the family and community support given to the older adult population. The effectiveness of this action is demonstrated by the fact that, in a country where ageing is very advanced, only 0.6% of older people are living in old people’s homes.

In Argentina, the Netherlands Antilles, Aruba, Panama and Puerto Rico, different community-based care options are being implemented. In the Dominican Republic, the Solidarity Programme is providing financial support to families that maintain an older person. In Chile, the Ministry of Planning’s Comprehensive Programme for Older Adults is designed to improve the quality of life of older people living in conditions of poverty and social isolation by bringing them into contact with the institutional resources available and helping them to integrate into the community; and in Brazil, the Social Assistance Reference Centres (CRAS) programme is being implemented to assist low-income families. The actions being undertaken include some designed to improve intergenerational relations in the family and the community.

Table V.3

**MAIN AREAS OF INTERVENTION OF PHYSICAL AND SOCIAL ENVIRONMENT PROGRAMMES DESIGNED FOR
OLDER PEOPLE IN LATIN AMERICA AND THE CARIBBEAN**

	Physical environments			Social environments			
	Housing	Transport	Accessibility	Social networks and family support	Social participation	Ill-treatment	Education
Aruba	X	X	X	X			
Netherlands Antilles				X			X
Argentina		X	X	X	X	X	
Belize	X			X	X	X	X
Bolivia						X	
Brazil		X		X	X	X	
Chile	X	X		X	X	X	
Colombia			X			X	
Costa Rica	X	X		X	X	X	X
Cuba	X	X		X	X	X	
El Salvador	X					X	
Guatemala		X		X			
Honduras			X			X	
Mexico	X		X			X	
Nicaragua			X	X		X	
Panama	X			X		X	
Paraguay			X		X		
Peru	X					X	
Puerto Rico	X	X	X	X		X	
Dominican Republic	X		X	X		X	X
Uruguay	X			X	X	X	
Venezuela (Bol. Rep. of)		X				X	

Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, on the basis of the countries' responses to the survey on programmes for older people in Latin America and the Caribbean.

Ill-treatment of older people is a violation of human rights and a major cause of injuries, sickness, lost productivity, isolation and despair (WHO, 2002), and it is a subject to which international agencies have paid special attention. Concern about it is expressed in all the countries, although intervention methods differ considerably in terms of scope and resources. This is partly because of the lack of statistical information on the extent of the problem and partly because violence against older people generally takes place in private, with neither the victim nor the aggressor being willing to acknowledge the situation. To deal with this issue, governments have launched campaigns for good treatment and taken specific preventive measures. In some cases public prosecutors have become directly involved, while in others the issue has now begun to be seen as a public policy matter for which the State has particular responsibility.

Thus, most of the countries report that campaigns have been held to raise awareness of the issue (Belize, Chile, Colombia, El Salvador, Mexico, Nicaragua, Panama, Puerto Rico and the Bolivarian Republic of Venezuela). Some countries describe more consolidated national working programmes, among them Brazil, which has its plan of action to deal with violence against older people (2007-2010), encompassing prevention, reporting, treatment and rehabilitation measures, supplemented by specialist social assistance referral centres, whose main focus is on helping the victims of violence.

Argentina has also been developing a programme to prevent discrimination, abuse and ill-treatment of older persons, while Costa Rica is implementing a programme called “Creating ties of solidarity” to finance care, rehabilitation and treatment projects for people who are indigent or have been ill-treated or abandoned. Puerto Rico is another country that has built up considerable experience of the issue through its Governor's Office of Older Persons Affairs, while in Peru the National Programme to Combat Family and Sexual Violence operated by the Ministry of Women and Social Development has included older adults in its target population.

Another area of work is socio-legal guidance for victims of violence. In Peru, local government social services are taking measures to prevent ill-treatment of older people and safeguard their rights. In the Dominican Republic, a special agency has been created within the public prosecutor's service to act on complaints in coordination with the National Council for the Elderly. In the Bolivarian Republic of Venezuela, the free legal support and assistance service of the National Institute of Social Services (INASS) assists the victims of ill-treatment, while in Honduras the remit of the public prosecution service for consumers and the elderly includes the rights of older people.

In Bolivia, the domestic violence law treats assaults on older persons as an aggravating circumstance, while in Belize the subject was recently included in the relevant legislation (March 2007). In Uruguay, an Inter-institutional Commission for Ill-Treatment of the Elderly was created in 2005, and the Police-Older Adult Programme is tasked with detecting cases of violence and providing victims with guidance and advice. In El Salvador, situations of ill-treatment are monitored; in Chile, the National Service for Older Adults has a telephone assistance hotline for older people who have been subjected to violence; and in Cuba, as a preventive strategy, the subject has been introduced in carers' training institutions for those dealing with physically or mentally dependent patients to foster a positive relationship between them.

Lastly, support for social participation by the elderly and access to continuing education are also areas that are beginning to be addressed by the countries. Argentina, Brazil, Cuba, Guatemala, Paraguay, Costa Rica, Chile, Honduras, Puerto Rico and Uruguay reported on specific activities to promote social networking, either by supporting older people's organizations or through training. A smaller number of countries are taking measures in the sphere of education, examples being the Dominican Republic, Costa Rica, the Netherlands Antilles and Belize. Here it is important to highlight the efforts of Argentina and

Brazil to provide the elderly with opportunities for participation so that their opinions can be listened to and taken into account when policies and programmes affecting them are designed. In both countries, older people's organizations have been seen as a first point of contact for participation in policy dialogue.

The issue of social environments is commonly dealt with by the main institutions responsible for ageing-related matters in the region's countries. This gives it a high profile nationally, unlike health or social security, which are usually construed as individual rather than collective matters. However, the brief synopsis provided in this section shows that, other than in a few countries, the measures taken do not always have public policy status and that, according to the information available, in several countries the work being done is in the nature of pilot projects that need to be consolidated and provided with guaranteed financing so that they can become sustainable.

2. Physical environments: housing, transport and accessibility

On the whole, physical environments are an area of intervention that has been left largely untouched by the region's countries, although there are some notable exceptions. Most housing-related initiatives are aimed at those living in poverty, or at those with the financial capacity to apply for credits. In the field of transport, only a few countries provide free travel while the rest offer fare reductions, which may be unenforced or involve bureaucratic procedures that older people are not always willing to undertake. As regards the accessibility of public spaces, the most promising interventions involve urban inclusion strategies, but they are largely confined to just a few countries. Other countries have taken steps to remove architectural barriers to access, focusing mainly on the mobility of the disabled but benefiting older people in the process.

The countries reporting on initiatives in the housing sector include Aruba, Belize, Chile, Costa Rica, Cuba, El Salvador, Mexico, Panama, Peru and Uruguay. In Aruba, the Ministry of Education, Social Affairs and Infrastructure reserves a number of housing units for people with special needs, including older people. Chile is implementing a similar scheme whereby the Ministry of Housing and Urban Affairs operates a special housing programme for older people.

In Peru, the Ministry of Housing, Construction and Sanitation is implementing the "Techo propio" (home ownership) and "Techo propio deuda cero" (debt-free home ownership) programmes, which promote access to housing and better living conditions for people on low incomes; while the programme is not exclusive to older adults, they have been included among its beneficiaries. Similar schemes exist in Panama and El Salvador, providing assistance and material support to improve the quality of housing for the poorest older people. Puerto Rico is implementing a programme of rental subsidies and home improvements for elderly people.

Cuba also has a house building and repair plan to help with refurbishment of homes occupied by elderly people, while Belize is implementing an initiative with the same objective, providing small-scale assistance to repair the homes of the poorest older people with financial support from a charity.

In Costa Rica, the Banco Hipotecario has a housing programme for older people living alone. In Mexico, the Security and Social Service Institute for State Workers has a lending programme to enable retired people to buy a new or used home or improve an existing one. In Uruguay, the "Programme for Other Housing Solutions" of the Social Security Bank includes a rental subsidy for insurance holders.

Interventions relating to transport are even fewer. Although a number of countries have legislated for fare reductions for older people, these are not always implemented. The most advisable option, according to the reports from the countries, would seem to be the provision of subsidies to transport firms so that older people can simply take up the benefit without charge. This avoids the need for bureaucratic procedures that actually make access to transport harder for older people, even when reduced fares are on offer. The countries with free transport are Aruba, Argentina, Brazil, Guatemala, Puerto Rico and the Bolivarian Republic of Venezuela, while the countries reporting specific discounts on transport fares are Belize and Chile.

In Aruba, older people have been exempt from paying fares on public transport since before 2001, and to this end the State provides a subsidy to transport firms, worth US\$ 611,000 in the 2007 fiscal year. In Argentina, the railway operating company in the suburban area of the city of Buenos Aires is given a subsidy so that retired people can use the service for free. In Brazil, older people can use public and semi-urban transport for free. In Puerto Rico, the “Golden Programme” of the Metropolitan Transport Authority allows free travel on metropolitan transport for people aged over 75, in addition to the SENDA programme designed to make it easier for older people and the disabled to reach different destinations (health services, supermarkets, banks and government offices). In Guatemala, an agreement was recently struck with private firms to allow older people to travel for free on public transport.

In the Bolivarian Republic of Venezuela, the elderly travel for free on ground transport in urban areas and receive discounts on air tickets and intercity services, and special seats are set aside for them. In Belize, some cities have reduced fares on public transport for older people, while Chile is implementing a preferential fare on the underground transport system in the capital.

The countries that have reported on interventions in the public space are Aruba, Peru, Colombia, Paraguay, Argentina, Honduras, Mexico and Nicaragua. The experience of Brazil is worth highlighting here: since 1990, the country has been pursuing an innovative public policy to democratize cities. This is the City Statute, whose aim is greater social and geographical inclusiveness in urban areas. Among other things, this instrument is designed to promote the full exercise of citizenship and the visible participation, action or organization of the city’s inhabitants, particularly the most vulnerable, who include older people, the disabled and children.

Argentina is also making progress in this direction. The national accessibility plan, which covers the whole population but is particularly aimed at people with reduced mobility and communication difficulties, is designed to amend provincial and municipal zoning, planning and building laws to reduce barriers to inclusion for all and to facilitate community living. A similar initiative is planned in Aruba, where a 2006 evaluation of the accessibility of public buildings and services for people with sensory and motor difficulties led to the formulation of a plan that was recently submitted to the Ministry of Education, Social Affairs and Infrastructure for implementation in the near future.

In Peru, the “Mi Barrio” (My Neighbourhood) programme is meant to improve the living environment and conditions of people in deprived urban neighbourhoods, while in Paraguay courses on accessibility in the physical environment are being held for engineers and architects. Nicaragua has developed a strategy to publicize the country’s compulsory technical standards for user access. Mexico and Honduras are also making progress with accessibility in public buildings, while Colombia is implementing programmes to facilitate access to physical spaces under its national plan for the disabled.

In summary, physical environments are an area in which more determined efforts will be required in the near future. Population ageing is placing new demands on housing, transport and public spaces. It is striking that no country reported on measures to extend the coverage of basic services or develop initiatives for the creation of specific housing solutions to facilitate intergenerational living, among a variety of other aspects.

As already mentioned, all these issues have vital implications for autonomy and independence in old age, and the fact that older people are benefiting from measures taken under disabled access plans shows that interventions in physical environments which benefit one vulnerable group are bound to have a positive effect on other social sectors with specific needs, and indeed on the population as a whole.

Chapter VI

CHALLENGES TO BE MET IN IMPLEMENTING THE REGIONAL STRATEGY

The age structure of the Latin American and Caribbean population has been changing at varying rates depending on the stage that the demographic transition has reached in each country. These changes in the size of generations relative to each other have come about as life expectancy has increased and fewer children are born, giving rise to a new scenario that has profound implications for family organization, levels of well-being and social cohesion, and the economic, political and cultural spheres (Guzmán, 2002b). Population ageing poses some major challenges for the countries of the region, since the older adult population is growing faster than it is in developed countries. This places Latin America and the Caribbean at a significant disadvantage.

A. THE MAIN CHALLENGES

The majority of older persons lack access to old-age pensions that would protect them against the risks of income loss when they reach an advanced age. Moreover, the social security coverage provided through employment is highly uneven, making it more likely that future generations will be financially vulnerable.

One of the ways to avert such vulnerability in old age is to generate income through participation in the labour market. This solution tends to be financially disadvantageous, however, and offers little security. As a result, the family acts as one of the main mechanisms of economic risk absorption in old age. This takes the form not only of informal money transfers, but also of service provision, since the market cost of those services is unaffordable for most older persons in the region.

Health-care systems are adapting slowly to the changes in demand arising from demographic, epidemiological and technical dynamics. This translates into higher costs and expenditures on health care and makes it more difficult to ensure timely access to good quality services for all the population. Health-care coverage is unequal and, even when older people have health insurance, it often falls short of covering attendance at a health centre whenever necessary. When it comes to matters of health, the current generation of older persons is concerned about whether they will be able to obtain medications at accessible prices and receive effective health services that are appropriate to their needs, as well as properly regulated long-term care that respects their fundamental rights and freedoms as they become more dependent.

Environments, too, are slow to adapt to empower older people to exercise their rights. There is still a culture in which older persons suffer age-based discrimination and in which violence against the most vulnerable members of society is thought best resolved at home. In addition, as well as lagging behind—more severely in some places than others—in terms of access to basic services and housing, the region is now showing a deficit in the quality of housing for older persons, which undermines their autonomy and the coexistence of the generations. In turn, there are large failings as regards access to public spaces, whose current state is far from conducive to the creation of community-based social capital in many of the region's countries.

In Latin America and the Caribbean, the demographic transition has wrought changes in the family structure and, as the population grows older, a higher percentage of households count older persons among their members. Until now, the family has provided emotional, economic, social and health-care support for its older members and has thus become established as the entity responsible for their care and social integration (Villa, 2003). But with families shrinking in size and—in recent decades—becoming structurally much more diversified, as well as facing an excessive task load as they are forced to meet new demands in the context of an ever weaker State, the fact is that excessive demands are now placed on them. As an institution, the family can hardly discharge all the functions assigned to it without the necessary support.

B. HOW STATES ARE RESPONDING

Faced with these challenges, the countries of the region have gradually formed responses to a demographic situation for which many of them were unprepared. One such response is to pass legislation to protect the rights of older persons exclusively and regulate basic aspects of human coexistence, such as the right to association, non-discrimination and personal safety, as well as providing social protection for rights such as education, work, social security, housing, the protection of the family, and so on.

This type of legislation is based on international human rights instruments, which necessarily constitute the normative framework for any rights-based action in support of older persons. In theory, these laws should lead to legally recognized rights being put into practice in the form of sectoral efforts on ageing and development. However, except for a few notable cases, legal standards do not always result in real rights coverage in old age and protection remains as flawed as ever.

The gap between *de jure* and *de facto* rights in old age is due, in part, to the lack of mechanisms to make them enforceable. Additionally, there are shortcomings in access to information. States have an obligation to produce and deliver relevant information on older persons' rights that are recognized in their national legislation. Although efforts have been made in this direction, in most of the countries older persons are unaware of their rights, thus making them ineffective.

Enforceability also depends on the public budget. Most of the existing legislation makes no reference to sources of funding to protect recognized rights. And in cases where the body of legislation does cover financing, the provisions are often disregarded. This limits the ability of governing bodies and of the public institutional structure as a whole to take action that could broaden the protection of older persons' rights.

Another issue that is becoming more prominent in the public policies of the Latin American and Caribbean countries is income protection. Although this is still an emerging area, there have been some noteworthy experiences in this direction. A number of countries have solid social security systems, which include broad coverage and extensive services and benefits for the retired and pensioned population.

Other countries are making efforts to make older persons more employable and to offer different alternatives for helping them achieve better positions in the labour market. This is an area into which a number of countries are venturing and interventions of this type, although still weak, are attracting governments' attention, especially where social security systems are severely flawed.

Income protection through non-contributory pensions —where the capacity of the contributory system is insufficient— is still limited in the region. In States where such programmes are run, they have been found to have a significant impact on levels of poverty in old age and to represent an important investment in development which benefits families and communities, as well as the economy at large (United Nations, 2005b).

The countries have broadened their efforts to improve services and benefits for the older adult population regarding health protection, too. They have invested resources in improving certain benefits and in training staff and regulating long-term care. Progress has also been made on developing an institutional structure specifically for health care in old age. Practically all of the region's health ministries or departments have a specific unit or programme that is responsible for organizing and coordinating action in this regard.

A number of countries have undertaken work on preventive care and the promotion of healthy habits. Although the impact of such initiatives is not yet known, systematic resources and efforts have been invested in this area in the last five years.

There are, however, some complex issues regarding health protection that have yet to be comprehensively tackled. One of these is access to medication, which currently requires a large proportion of out-of-pocket spending. The system has also been slow to adapt to the new epidemiological profile and, worst of all, access to health care is extremely uneven and highly associated with income level and level of social security coverage.

The physical and social environment is also beginning, albeit only just, to be viewed as a matter for public concern. Generally speaking, the institutions governing such matters in the countries of the region have concentrated on the social environment and much of their efforts have focused on the prevention of mistreatment, the promotion of association and the creation of opportunities for lifelong learning. As for the physical environment, what progress there is largely concerns broader action to improve access for people with disabilities, which also benefits the elderly population and other social groups. This achievement has had little impact on the ubiquitous matters of housing and transport, however, which have been less extensively addressed and need to be dealt with more comprehensively in the near future.

C. AGEING AND A SOCIETY FOR ALL

Although older persons are at the heart of the areas of effort mentioned, it is nonetheless true that the problems affecting the older adult population and those affecting the rest of society are closely linked. Hence, in view of the scarcity of resources in most of the region's countries, the visibility of ageing issues and their budgetary and technical allocations also affect society as a whole.

From this perspective, the problems of older persons —and the solutions found in terms of social protection— must be set within the broader framework of the construction of a society for all. As well as progressing towards broader coverage, social interventions must pursue such basic objectives as solidarity and social cohesion as key factors in obtaining certain levels of well-being, as well as the exercise of rights for the entire population.

Consensus is lacking as to whether it is economically feasible to provide social protection for older persons. Indeed, the policy options considered tend to address questions of social cohesion rather than economic issues. Some contend that the growing emphasis on promoting individual and family responsibility for the well-being of older persons will lead to a general weakening of overall social cohesion (United Nations, 2005b). By contrast, an active State role in providing protection for the entire population, especially the most vulnerable, will benefit not only the recipients of those funds, but their families as well, and will create social capital and economic assets for future generations.

The idea of social integration is not limited in time or space. On the contrary, it means that present and future generations have the right to equality and social justice. The decisions that are taken today affect the structure of social integration now and in the future, as well as the opportunities it creates. The idea of intergenerational equity supposes that each generation will address its own needs in such a way as not to prejudice or disadvantage the next. As societies and their demographic composition change, there is a need to refocus on the different generations' responsibilities to each other and to adjust to the new realities (United Nations, 2005b).

Rapid population ageing brings multiple challenges and requires responses that ensure a fair distribution of resources, in order to provide adequately for the needs of all society's age groups. It also requires shifts in attitudes, policies and practices so as to enhance quality of life for older persons. Older persons cannot be excluded, therefore, from whatever route the Latin American and Caribbean countries find towards progress and justice. The key question here is how to help this age group to participate fully in the possibilities created by progress and the demands imposed by justice (CELADE, 1997).

The effective social integration of older persons depends on equity of access to different and economic services and on guaranteed rights.

In countries where basic pensions are lacking and poverty widespread, policies to improve income security in old age must include poverty reduction as part of their strategy. The possibilities of future generations breaking the intergenerational transmission of poverty are likely to increase where non-contributory pensions are included in the range of solutions to poverty and the other aspects involved are also addressed. Countries that already have such programmes must continue to work towards increasing the coverage of benefits, taking into account such principles as the universality of social security.

Countries that bear a double epidemiological burden need health policies to deal more explicitly with this situation. Some will still be addressing the problem of meeting the Millennium Development Goals to reduce child mortality and improve maternal health, even as they are adjusting their health-care systems to deal with the needs of a growing older population (United Nations, 2007b). In the more advanced countries, by contrast, the emphasis should be on promoting a healthy lifestyle at all stages of life in order to reduce chronic disease to a minimum. It is also extremely important to improve solidarity in health-care systems, by broadening access opportunities on a basis of equality for the entire population.

Countries that are still lagging in terms of housing availability and access to basic services need to progress towards meeting the target of increasing sustainable access to drinking water and basic sanitation as set out in the Millennium Development Goals at the same time as they devise new solutions for living arrangements to facilitate the coexistence of several generations. It is also essential to create the conditions to promote ageing at home and support families in the caregiving tasks carried out by household members.

A recent report compiled by the United Nations (2007b) noted that developing countries must avoid repeating the mistakes of some of the richer nations, which built numerous institutions for older persons. Often, community-based care can be a more effective and inclusive solution and, where there is no alternative to long-term care facilities, the process should be adapted to the local culture and not limited to following previously established patterns.

The opportunity to make progress in all these areas is closely associated with the ability to take advantage of the demographic bonus. In Latin America and the Caribbean, changes in the age structure are occurring in such a way that the working-age population will increase proportionally during the next few decades of the twenty-first century. In other words, dependency ratios will tend to decrease, at least for a time, so most of the region's countries will have the opportunity to heighten their productive potential and prepare for the final stage of the demographic transition, when the older population will increase proportionally.

Given this scenario, the main challenge for Latin America and the Caribbean lies in the region's ability to take advantage of the positive potential created by the demographic transition to prepare itself opportunely and adequately to face the new requirements emerging from these changes, in order to foster sustainable development with social equity for the region (Machinea, 2007).

In short, and as is emphasized in the recent report by the Secretary-General of the United Nations, Governments are making efforts to address the challenge of population ageing (United Nations, 2006a). The information available suggests that such measures are essential and need to be further complemented with new interventions. In this regard, and building on the earlier discussion, it is extremely important to enhance the capacities and resources of the institutional structure available in the countries of the region, to strengthen the technical capacity of national teams responsible for ageing issues and to plan ahead and properly graduate the measures to be taken, for which up-to-date and accessible information on the older adult population and its needs is essential.

In more advanced countries, it is essential to gauge the effectiveness of the legislation, policies and programmes in place. A careful analysis should be undertaken to establish which public policy measures are most important and investment prioritized accordingly. Increasingly, participatory processes are acknowledged to be particularly important in improving public administration. A participatory normative and programmatic process makes interventions more effective and helps to include older persons in the decisions that affect them.

In order to move in this direction, each society must be aware of the value and significance of the intergenerational contract. It is important to appreciate what this pact contributes to society in terms of social cohesion and to value the willingness of societies to fulfill their social commitments (United Nations, 2005a). Governments need to reformulate policies in order to underpin and maintain a society that includes everyone, instead of treating action on older people as a matter separate from the future of society as a whole.

As noted in the Commission's proposal at its last Session, the region must, as a matter of urgency, move ahead by broadening social protection to include the entire population, on the one hand and, on the other, by strengthening solidarity mechanisms—in this case, between generations—as well as reducing the inequalities undermining social cohesion (ECLAC, 2006).

ANNEX

Table A.1
LATIN AMERICA AND THE CARIBBEAN: TOTAL, PROPORTION AND GROWTH RATE OF THE POPULATION AGED 60 AND OVER, 1950-2050

Country or territory	Population aged 60 and over					Percentage of the population aged 60 and over					Growth rate of the population aged 60 and over			
	1950	1975	2000	2025	2050	1950	1975	2000	2025	2050	1950-1975	1975-2000	2000-2025	2025-2050
Latin America and the Caribbean	9 305 994	20 986 036	42 920 967	100 452 132	183 688 194	5.6	6.5	9.0	14.8	24.3	3.3	2.9	3.4	2.4
Total	683 409	1 301 713	2 702 504	6 117 689	14 632 168	5.1	5.3	6.0	8.6	15.9	2.6	2.9	3.3	3.5
Belize	4 000	9 000	14 000	37 000	93 000	5.8	6.7	5.8	9.5	19.1	3.2	1.8	3.9	3.7
Bolivia	152 272	264 090	537 452	1 191 151	2 786 304	5.6	5.5	6.4	9.0	16.7	2.2	2.8	3.2	3.4
French Guiana	2 000	4 000	9 000	37 000	71 000	7.8	7.1	5.5	12.6	17.5	2.8	3.2	5.7	2.6
Guatemala	132 998	280 006	660 749	1 429 230	3 625 044	4.2	4.5	5.9	7.2	13.0	3.0	3.4	3.1	3.7
Haiti	179 625	321 103	527 062	1 039 305	2 542 712	5.5	6.5	6.3	8.3	15.7	2.3	2.0	2.7	3.6
Honduras	92 424	152 257	345 833	842 440	2 129 510	6.7	5.0	5.3	8.6	17.2	2.0	3.3	3.6	3.7
Nicaragua	53 612	114 638	263 681	672 506	1 569 275	4.5	4.4	5.3	9.8	19.6	3.0	3.3	3.7	3.4
Paraguay	66 478	156 619	344 727	869 057	1 815 323	4.5	5.9	6.3	10.8	18.0	3.4	3.2	3.7	2.9
Total	6 088 688	14 114 818	30 618 474	77 426 570	143 952 331	5.1	5.8	7.6	14.6	24.3	3.4	3.1	3.7	2.5
Bahamas	5 000	11 000	25 000	67 000	118 000	6.3	5.8	8.2	16.9	26.3	3.2	3.3	3.9	2.3
Brazil	2 627 168	6 541 030	14 031 549	35 076 146	63 117 213	4.9	6.0	8.0	15.2	24.6	3.6	3.1	3.7	2.3
Colombia	625 956	1 425 447	2 854 086	8 125 841	14 918 105	5.0	5.6	6.7	14.6	23.9	3.3	2.8	4.2	2.4
Costa Rica	73 731	141 318	297 281	878 067	1 654 843	7.6	6.9	7.6	15.8	26.6	2.6	3.0	4.3	2.5
Dominican Republic	105 758	233 602	638 708	1 509 370	2 729 130	4.5	4.6	7.7	12.5	19.5	3.2	4.0	3.4	2.4
Ecuador	275 680	422 401	902 716	2 255 926	4 423 165	8.1	6.1	7.3	13.2	21.9	1.7	3.0	3.7	2.7
El Salvador	93 072	194 906	451 705	953 718	2 249 054	4.8	4.7	7.2	10.4	20.1	3.0	3.4	3.0	3.4
Guyana	28 000	40 000	52 000	130 000	127 000	6.6	5.5	6.9	19.0	26.6	1.4	1.0	3.7	-0.1
Jamaica	83 000	173 000	258 000	420 000	620 000	5.9	8.6	10.0	14.4	22.4	2.9	1.6	1.9	1.6
Mexico	1 486 500	3 320 844	7 342 634	18 444 919	35 262 511	5.4	5.6	7.3	14.9	26.8	3.2	3.2	3.7	2.6
Panama	55 834	112 037	233 629	597 233	1 114 440	6.5	6.5	7.9	14.2	22.5	2.8	2.9	3.8	2.5
Peru	433 205	843 213	1 854 445	4 238 416	8 495 511	5.7	5.6	7.1	12.6	21.8	2.7	3.2	3.3	2.8
Saint Lucia	4 000	8 000	14 000	27 000	52 000	5.1	7.6	9.6	13.8	24.1	2.8	2.2	2.6	2.6
Suriname	18 000	21 000	37 000	77 000	122 000	8.4	5.8	8.7	16.0	28.6	0.6	2.3	2.9	1.8
Venezuela (Bol. Rep. of)	173 784	627 020	1 625 721	4 625 934	8 949 359	3.4	4.9	6.7	13.2	21.8	5.1	3.8	4.2	2.6
Total	1 686 950	3 905 182	6 702 127	12 020 128	18 813 891	7.0	10.3	12.4	18.0	25.8	3.4	2.2	2.3	1.8

Table A.1 (concluded)

Country or territory	Population aged 60 and over					Percentage of the population aged 60 and over					Growth rate of the population aged 60 and over			
	1950	1975	2000	2025	2050	1950	1975	2000	2025	2050	1950-1975	1975-2000	2000-2025	2025-2050
Argentina	1 207 209	2 971 006	4 941 660	7 749 566	12 476 798	7.0	11.4	13.4	16.9	24.7	3.6	2.0	1.8	1.9
Chile	416 741	814 176	1 568 467	3 846 562	5 698 093	6.9	7.8	10.2	20.1	28.2	2.7	2.6	3.6	1.6
Guadeloupe	14 000	29 000	55 000	119 000	154 000	6.7	8.8	12.8	24.7	32.9	2.9	2.6	3.1	1.0
Netherlands Antilles	10 000	14 000	23 000	53 000	74 000	9.0	8.4	10.7	25.6	39.8	1.3	2.0	3.3	1.3
Trinidad and Tobago	39 000	77 000	114 000	252 000	411 000	6.1	7.6	8.8	18.0	31.0	2.7	1.6	3.2	2.0
Total	846 947	1 664 323	2 897 862	4 887 745	6 289 804	7.9	10.7	15.3	24.7	33.6	2.7	2.2	2.1	1.0
Barbados	18 000	33 000	35 000	81 000	99 000	8.5	13.4	13.1	26.7	36.4	2.4	0.2	3.4	0.8
Cuba	411 955	928 847	1 635 230	2 918 713	3 733 718	7.0	10.0	14.7	26.1	37.5	3.3	2.3	2.3	1.0
Martinique	17 000	31 000	61 000	117 000	142 000	7.7	9.4	15.8	29.0	40.6	2.4	2.7	2.6	0.8
Puerto Rico	136 000	272 000	597 000	1 025 000	1 327 000	6.1	9.3	15.6	23.7	30.0	2.8	3.1	2.2	1.0
Uruguay	263 992	399 476	569 632	746 032	988 086	11.8	14.1	17.1	21.0	26.5	1.7	1.4	1.1	1.1

Source: Population projections and estimates by the Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC [online] http://www.eclac.cl/celade/proyecciones/basedatos_BD.htm.

Table A.2
**LATIN AMERICA AND THE CARIBBEAN: RANKING OF COUNTRIES AND TERRITORIES
 BY STAGES OF AGEING, 2000**

Stage	Country or territory	Ageing index	Global fertility rate
Incipient ageing	Belize	14.3	3.6
	Bolivia	16.1	4.1
	French Guiana	15.3	3.8
	Guatemala	13.4	4.8
	Haiti	15.2	4.3
	Honduras	13.1	4.0
	Nicaragua	12.6	3.3
	Paraguay	16.9	3.7
Moderate ageing	Bahamas	27.0	2.3
	Brazil	27.1	2.4
	Colombia	21.1	2.6
	Costa Rica	23.8	2.4
	Dominican Republic	21.1	3.0
	Ecuador	21.3	3.0
	El Salvador	20.2	3.0
	Guyana	22.7	2.5
	Jamaica	30.1	2.7
	Mexico	22.2	2.5
	Panama	24.9	2.7
	Peru	20.9	2.9
	Saint Lucia	31.9	2.3
	Suriname	25.7	2.7
	Venezuela (Bolivarian Rep. of)	19.8	2.8
Moderate-to-advanced ageing	Argentina	48.0	2.5
	Chile	36.6	2.1
	Guadeloupe	50.0	2.1
	Netherlands Antilles	51.1	2.1
	Trinidad and Tobago	32.8	1.7
Advanced ageing	Barbados	75.0	1.5
	Cuba	71.6	1.6
	Martinique	66.7	1.9
	Puerto Rico	65.7	1.9
	Uruguay	69.9	2.3

Source: Population projections and estimates by the Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC [online] http://www.eclac.cl/celade/proyecciones/basedatos_BD.htm.

Table A.3
**EUROPEAN COMMUNITY (SELECTED COUNTRIES): POPULATION AGED 65 AND OVER,
 NATIONAL TOTAL AND THREE MAJOR CITIES, 1999-2003**
(Percentages)

Country	National total	City		
United Kingdom	15.59	London	Birmingham	Liverpool
		12.44	14.53	15.28
France	16.12	Paris	Lyon	Lille
		15.4	14.67	12.78
Germany	16.64	Berlin	Hamburg	Munich
		15.02	17.08	16.05
Netherlands	13.6	Amsterdam	Rotterdam	Utrecht
		11.99	15	11.85
Spain	16.63	Madrid	Barcelona	Valencia
		19.54	22.03	17.61
Italy	18.25	Roma	Milan	Naples
		19.04	22.78	15.59

Source: Statistical Office of the European Communities (EUROSTAT) [online] <http://epp.eurostat.ec.europa.eu/>.

Table A.4
**LATIN AMERICA AND THE CARIBBEAN (SELECTED COUNTRIES): POPULATION AGED 60 AND OVER,
 NATIONAL TOTAL, MAJOR CITIES, OTHER URBAN AND RURAL, 2001 ROUND OF CENSUSES**
(Percentages)

Country and census year	Geographical entity	Population aged 60 and over	Women aged 60 and over	Population aged 60 and over and with fewer than four years of schooling
Argentina, 2001	National total	13.4	57.8	24.6
	Greater Buenos Aires	15.2	59.9	16.9
	Other urban	12.6	58.2	26.1
	Rural	11.8	47.1	48.3
Bolivia, 2001	National total	7.0	53.7	67.4
	La Paz	5.9	55.2	46.5
	Other urban	5.5	56.0	49.2
	Rural	9.2	51.7	86.8
Brazil, 2000	National total	8.6	55.1	49.3
	Río de Janeiro	11.0	59.7	25.1
	São Paulo	8.3	58.5	30.3
	Other urban	8.4	56.3	48.9
	Rural	8.4	47.1	72.1
Chile, 2002	National total	11.4	55.9	30.9
	Santiago	11.2	59.1	20.5
	Other urban	10.9	56.4	29.5
	Rural	13.4	46.9	58.7
Costa Rica, 2000	National total	7.9	52.3	49.7
	San José	8.8	57.1	33.3
	Other urban	8.2	54.5	43.3
	Rural	7.0	46.0	70.1
Ecuador, 2001	National total	9.1	51.9	47.7
	Quito	8.4	55.9	26.0
	Other urban	8.8	53.1	38.1
	Rural	9.8	49.5	64.3
Guatemala, 2002	National total	6.4	50.3	77.6
	Guatemala City	7.3	56.3	41.9
	Other urban	6.9	51.5	75.8
	Rural	5.8	47.1	93.6
Honduras, 2001	National total	5.8	51.1	50.3
	Tegucigalpa	5.3	59.3	28.5
	Other urban	5.9	54.5	42.5
	Rural	5.9	47.4	69.8
Mexico, 2000	National total	7.3	53.2	49.5
	Mexico City	7.0	57.1	29.2
	Other urban	7.0	54.4	44.3
	Rural	8.3	48.7	72.6
Panama, 2000	National total	8.6	50.6	41.3
	Panama City	8.0	55.9	21.0
	Other urban	9.0	53.5	31.1
	Rural	9.1	43.8	66.5
Paraguay, 2002	National total	7.1	53.2	39.2
	Asunción	7.5	58.3	24.6
	Other urban	6.7	54.9	37.6
	Rural	7.2	48.2	51.5

Source: Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, based on processing of census microdata using the System for the Retrieval of Census Data for Small Areas by Microcomputer (REDATAM), 2000 round of censuses.

Table A.5
**LATIN AMERICA AND THE CARIBBEAN: INDICES OF TOTAL DEPENDENCY AND DEPENDENCY
 IN OLD AGE, BY FIVE-YEAR PERIODS, 1950-2050**

Stages of ageing	Country or territory	Dependency index					Index of dependency in old age				
		1950	1975	2000	2025	2050	1950	1975	2000	2025	2050
Incipient ageing	Belize	81.6	116.1	84.8	57.7	62.2	10.5	14.5	10.6	14.2	31.1
	Bolivia	88.7	94.5	84.8	61.2	58.6	10.6	10.8	11.8	14.5	26.4
	French Guiana	66.7	80.6	70.1	65.9	63.7	13.3	9.7	9.3	20.5	28.6
	Guatemala	95.4	97.4	99.8	71.3	55.2	8.3	8.9	11.8	12.3	20.1
	Haiti	82.5	90.5	86.8	62.7	61.4	10.2	11.9	11.5	13.5	25.4
	Honduras	94.0	110.2	92.2	61.9	59.0	12.1	10.3	10.7	14.0	27.3
	Nicaragua	93.7	106.2	85.7	61.1	64.9	8.0	8.4	9.6	15.8	32.3
	Paraguay	106.3	98.8	80.7	61.7	62.9	9.3	11.1	11.6	17.4	29.4
Moderate ageing	Bahamas	83.7	89.0	59.8	61.1	76.7	11.6	11.0	12.7	27.5	45.8
	Brazil	86.7	86.4	60.4	59.8	73.6	9.1	11.3	12.9	24.3	42.8
	Colombia	90.9	96.8	64.9	58.5	71.3	9.5	11.1	11.3	23.1	40.9
	Costa Rica	85.5	93.3	64.9	57.9	76.7	14.2	13.3	12.5	24.9	47.0
	Dominican Republic	104.2	100.2	72.3	66.3	65.9	8.9	8.9	12.6	20.8	32.3
	Ecuador	91.0	99.7	71.9	60.5	67.9	15.5	12.2	12.6	21.2	36.8
	El Salvador	91.7	101.4	74.8	57.7	65.6	9.1	9.5	12.6	16.5	33.3
	Guyana	91.4	98.6	60.4	66.3	68.3	12.7	10.8	11.2	31.5	44.7
	Jamaica	71.8	115.8	75.2	65.4	70.6	9.9	18.2	17.4	24.0	38.3
	Mexico	91.6	106.9	68.1	57.2	77.0	10.3	11.3	12.4	23.4	47.4
	Panama	87.8	97.5	66.1	62.0	69.8	12.2	12.8	13.2	22.9	38.2
	Peru	89.5	95.3	71.7	59.1	67.5	10.8	10.9	12.4	20.0	36.5
	Saint Lucia	82.6	118.0	69.7	58.2	73.4	10.9	16.0	16.9	22.1	41.9
	Suriname	93.7	113.5	67.4	63.4	76.2	16.2	11.8	13.8	26.1	46.8
	Venezuela (Bol. Rep. of)	88.2	93.1	68.0	61.1	68.0	6.4	9.5	11.2	21.4	36.6
Moderate-to-advanced ageing	Argentina	60.2	68.4	70.8	63.8	73.8	11.3	19.2	22.9	27.8	42.8
	Chile	77.2	81.2	61.2	65.6	81.1	12.1	14.2	16.4	33.3	51.1
	Guadeloupe	85.8	102.5	60.7	77.1	96.2	12.4	17.3	20.2	44.3	64.4
	Netherlands Antilles	76.2	72.2	60.2	70.5	116.1	14.3	15.5	20.4	43.4	86.2
	Trinidad and Tobago	87.1	84.0	54.2	60.7	91.8	11.5	13.8	13.4	28.9	59.4
Advanced ageing	Barbados	71.5	83.6	50.5	70.2	103.8	14.6	25.4	18.9	45.5	74.4
	Cuba	76.4	89.8	54.4	67.5	100.2	12.3	18.7	22.7	43.8	75.1
	Martinique	81.1	98.8	63.6	80.7	112.1	13.1	19.3	25.4	52.0	85.5
	Puerto Rico	97.2	74.8	64.6	73.3	85.7	12.0	16.1	25.6	41.0	55.8
	Uruguay	65.8	71.9	71.8	68.8	77.0	19.5	24.3	29.5	35.4	46.9

Source: Population projections and estimates by the Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC [online] http://www.eclac.cl/celade/proyecciones/basedatos_BD.htm.

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