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Follow-up to resolution 78/177: measures to enhance the promotion and protection of the human rights and dignity of older persons: best practices, lessons learned, possible content for a multilateral legal instrument and identification of areas and issues where further protection and action are needed

Substantive inputs in the form of normative content for the development of a possible international standard on the focus areas "right to health and access to health services" and "social inclusion"

Working document submitted by the Office of the High Commissioner for Human Rights*

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I. Introduction

1. The Open-ended Working Group on Ageing, established by the General Assembly through its resolution 65/182 with the purpose of strengthening the protection for the human rights of older persons, will hold its fourteenth session at the United Nations Headquarters from 20 to 22 and 24 May 2024. Under item 6 of the provisional agenda, the Working Group will discuss normative inputs in follow-up of the focus areas of the thirteenth session, namely: the right to health and access to health services; and social inclusion. To that end, the Chair of the Open-ended Working Group called for inputs from Member States, national human rights institutions (NHRIs) with A-status, non-governmental organizations (NGOs) and United Nations system agencies and bodies, following questionnaires prepared by the Secretariat on the afore-mentioned two focus areas.

2. The present document contains an analytical summary of contributions received. The document also benefitted from the working documents submitted to the thirteenth session summarizing substantive inputs on the above-mentioned focus areas.

II. Right to health and access to health services

A. International framework and legal obligations

3. The right to the enjoyment of the highest attainable standard of physical and mental health is a fundamental human right, central to the enjoyment of all other human rights. It is necessary for living a life in dignity and its violation can amount to a violation of the right to life. It is anchored in various universal international and regional instruments, including the Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights. Several other human rights treaties also include provisions on the right to health, such as article 12 of the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), article 11 of the Convention on the Elimination of all forms of Racial Discrimination (CERD) and article 25 of the Convention on the Rights of Persons with Disabilities (CRPD).

4. The right to the enjoyment of the highest attainable standard of health applies to older persons as everybody else. The United Nations Principles on Older Persons (A/RES/46/91) under the section 'care' proclaim that older persons should have access to healthcare to maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness. The two recent regional treaties on the rights of older persons provide more specific references to the right to health in old age.[1]

5. Although traditionally ageing has been seen as a biomedical problem associated with physical and cognitive decline, older persons are a very heterogeneous group with diverse capacities and needs. Gender stereotypes combined with ageism may create additional barriers for women to equally enjoy the right to the highest attainable standard of health.[2] It is therefore important that the realization of the right to health

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[1] See in particular articles 11, 12, 19 and 25 of the Inter-American Convention on Protecting the Human Rights of Older Persons; articles 11 and 15 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Older Persons in Africa.

[2] For example, General Recommendation 27 of the Committee on the Elimination of Discrimination against Women recognizes in para. 14 that "[m]any older women face neglect as they are no longer considered useful in their productive and reproductive roles, and are seen as a burden on their families. Widowhood and divorce further exacerbate discrimination, while lack

does not stigmatize older persons as sick, frail or dependent and that it aims to facilitate older persons' full and effective participation to society.[3] This necessitates a fundamental change in how society perceives ageing and older persons, from a needs-based to a rights-based approach, as called for by the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.[4] Ageist stereotypes and prejudice are not only barriers to accessing healthcare, but they have also been shown to have an adverse impact on older persons' physical and mental health and their life expectancy.[5] Therefore, provisions to ensure equality and non-discrimination are central to the realization of the right to health in old age.

6. The right to health and to access to health services contains not merely to the right to equal and effective access to health services but also to the obligation of States to respect (i.e. to not interfere with the right), protect (i.e. to prevent others from interfering with the right) and fulfill (i.e. adopt appropriate measures for the full realization) the right to health and its underlying determinants. The International Covenant on Economic, Social and Cultural Rights and the General Comments No. 3 (on the nature of state parties' obligations) and No. 14 (on the right to the highest attainable standard of health) of the Committee on Economic, Social and Cultural Rights (CESCR) detail State obligations in general terms, imposing on states both obligations with immediate effect (including respect for autonomy and non-discrimination) and obligations subject to progressive realization.

7. CESCR General Comment No. 14 (para. 25) and General Comment No. 6 (paras. 34-35) explicitly refer to the right to health of older persons, calling for an integrated approach, which involves periodical check-ups; rehabilitative measures aimed at maintaining the functionality and autonomy of older persons; and attention and care for chronically and terminally ill persons, sparing them avoidable pain and enabling them to die with dignity. International instruments and their interpretation by General Comments therefore do not offer an adequate level of detail and clarity covering the wide breadth of the components of the right to the enjoyment of the highest attainable standard of health and access to health services as defined in the questionnaire for the fourteenth session of the Open-ended Working Group on Ageing. Furthermore, provisions on, inter alia, the elimination of ageism and the impact of intersectional inequalities across the lifespan, reasonable accommodations, positive action, health promotion, and measures to ensure availability, accessibility, acceptability, quality and respect for informed consent of older persons are lacking from the existing international framework. As mentioned earlier, the Independent Expert on the enjoyment of all human rights by older persons and the Special Rapporteur on the enjoyment of the highest attainable standard of health have included in their reports some normative examples that cover more widely the different aspects of the right to health.

8. Regional instruments include explicit provisions on access to health and health services[6] but they neither cover all geographic regions nor the full continuum of the

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of or limited access to health-care services for diseases and conditions, such as diabetes, cancer, hypertension, heart disease, cataract, osteoporosis and Alzheimer, prevent older women from enjoying their full human rights."

[3] Thematic study on the realization of the right to health of older persons by the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grove (2011), A/HRC/18/37, para. 13.

[4] Ibid., para. 71.

[5] World Health Organization, Global Report on Ageism, 2021.

[6] In particular, articles 11, 12, 19 and 25 of the Inter-American Convention on Protecting the Human Rights of Older Persons; articles 11 and 15 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Older Persons in Africa.

right, including health promotion, prevention, treatment, specialist care, rehabilitation, long-term care and support, palliative and end-of-life care, with access to related medicines, vaccines and assistive products.[7] The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Older Persons in Africa requires States to take measures to facilitate access to health services and medical insurance that meet older persons' needs and to include geriatrics in the training of healthcare personnel. In addition, States are required to adopt measures that support families that care for older people (art. 10) and that ensure access to residential long-term care and palliative care, thus limiting the scope of receiving long-term care and support in the community. Interpretation of Article 23 of the Revised European Social Charter on the right of elderly persons to social protection requires that healthcare programmes and services (in particular primary healthcare services including domiciliary nursing/healthcare services) specifically aimed older persons must exist, together with guidelines on healthcare for older persons. In addition, there should be mental health programmes for any mental health conditions in respect of older persons, and adequate palliative care services.[8] The Inter-American Convention on Protecting the Human Rights of Older Persons includes more detailed provisions on informed consent, long-term care, health and a healthy environment.

9. Submissions identified the need to strengthen equality and non-discrimination frameworks and review laws, policies and programmes to address systemic barriers to equal access to health facilities, goods and services, in particular those related to ageism. Inputs suggest that new standards are needed to address the systemic gaps of protection from discrimination in the context of health and health services. ESCAP called for codifying older persons' right to health in national laws based on international standards and including explicit provisions against age discrimination. The United Kingdom noted that the deprioritization of older persons in the health sector can reflect endemic ageism and a lack of practical geriatric training.

10. According to the respondents, States have an obligation to provide healthcare to older persons without discrimination. They must eliminate ageism in law, policy and practice, and prohibit all forms of discrimination, including on multiple grounds, in the provision of healthcare, access to services, treatment decisions (including triage), medical research and trials, health and life insurance, access to underlying determinants of health promotion programs and all other aspects of the right to health. A few inputs stressed that age limits or age-based rationing in the allocation of services and benefits (e.g. disability allowance, access to rehabilitation, cancer prevention or surgical treatment) must be explicitly prohibited. AGE Platform Europe, NHRI Philippines and HelpAge Deutschland argued that States must ensure that health programmes do not stigmatize older persons, old age or disability.

11. Inputs stressed that ageism has been linked to poorer physical and mental health and earlier death among older persons. This is why the impacts of ageism and measures to address and combat age discrimination must be considered in the development of normative content on older persons' right to health. Several inputs also referred to the need for a fundamental change in the care model, which should focus on autonomy and participation of older persons.

12. States have the obligation to not discriminate in the provision of health services, but also to adopt legislation or to take other measures to address existing inequalities and to ensure equal access to healthcare and health-related services provided by third parties. This includes measures to ensure that services are gender- and disability-

[7] Input by HelpAge International.

[8] Digest of the case law of the European Committee of Social Rights, 2021, Council of Europe, available at: https://rm.coe.int/digest-ecsr-prems-106522-web-en/1680a95dbd.

sensitive and to protect and support marginalized groups of older persons or those who do not have sufficient means or access to necessary resources.

13. Inputs further underlined the need for specific measures to support groups who face or have faced entrenched discrimination so they can have equal access to healthcare and appropriate services that meet their needs. Several inputs referred to gender imbalances in access to and in the provision of health and care services, in particular how gendered norms and practices adversely affect women's socioeconomic status and decision-making power putting them in more vulnerable situations and risks of violations.

14. Inputs suggested that the definition, scope, and application of the right to health must be embedded in clear binding legal frameworks. States must regularly review (existing and draft) national laws and policies to ensure compliance with the standards of the right to health and access to health services. Some inputs also suggested that states must include older persons as a priority group in national health policies and plans of action.

15. In order to achieve the highest attainable standard of health, States must ensure proper health infrastructure and human resources. States must enact legislation to address existing gaps in health provision, such as age limits in rehabilitation services, and to extend existing services, for example palliative care for all patients with serious health related suffering and not only to those with cancer. States must ensure that the provision of healthcare is not subject to long waiting lists, that older persons' needs are not deprioritized and that the number and distribution of healthcare professionals and equipment is adequate to meet the needs of the population. Inputs also refer to the State obligation to ensure universal health coverage with special measures of social assistance for vulnerable groups, such as uninsured or marginalized groups.

16. Submissions stressed the State obligation to develop geriatric care facilities and to integrate geriatric training into the education of medical practitioners, other health professionals and informal caregivers to meet appropriate standards of education, skills and ethical codes of conduct. Inputs paid particular attention to the need to include a gerontological/geriatric perspective, to create awareness and consciousness of ageism and its impact on medical practice and on individual health, and to provide training on the rights of older persons. States must also increase education on palliative care, improve information on patients' rights and train health professionals and carers on how to effectively communicate with patients. Submissions further emphasized the need for better integration between specialized and general healthcare services and also between health, long-term, rehabilitative and palliative care in order to ensure seamless provision of services.

17. Health literacy and promotion are also considered crucial. States are obliged to inform older persons about particular risks to their health and how to avoid them. States should also proactively promote and facilitate healthy choices in lifestyle in matters such as nutrition, alcohol intake, and exercise, which can dramatically affect the onset of illness and diseases later in life when they can be more difficult to treat. Public health campaigns should include appropriate education throughout the lifecycle.

18. To prevent the onset of diseases and health related risks, States must also address the underlying determinants of health, such as dangerous impacts on health arising from, for example, the environment, air pollution, water and sanitation hazards. In case older persons are particularly susceptible to, for example, environmental pollution, more targeted measures may be required.

19. Inputs also refer to the crucial element of participation in the design, implementation and monitoring of health policies, organization of the health sector

and the insurance system, and all decisions related to the right to health. States should also ensure that older persons are consulted in all decisions with regard to their right to health and that no diagnosis or treatment takes place without their free and informed consent. States are required to prohibit and take all necessary measures to prevent the forced institutionalization or deprivation of liberty of older persons for treatment or care purposes. States must also ensure that older persons have access to decision-making supports and services.

20. States must ensure that all older persons are treated with humanity and with respect for the inherent dignity of the human person and that all necessary measures are taken to prevent and address violence, abuse and neglect in health and care contexts. Inputs also suggested that states must take all necessary measures to ensure that health and care providers and care services respect, facilitate and develop older persons' capacities.

21. States must monitor health facilities, goods and services and ensure compliance with the principles of the fundamental right to health throughout the national territory and according to the health needs of the population. Inputs stressed that states must ensure access to accessible channels for older persons to report concerns, offer feedback, and seek redress regarding violations of their right to health.

22. Some inputs referred to the state obligation for international cooperation and exchange of expertise to support their ongoing efforts in the progressive realization of the right to health. Finally, inputs stressed the need for disaggregated health data to help identify and address the diverse health needs of this heterogeneous group.

B. Normative standards and national application

23 International definitions of the right to the enjoyment of the highest attainable standard of health apply entirely to older persons. However, although thematic treaties have provided specific safeguards for certain groups, including, women, children, persons with disabilities and migrant workers, this right has not been adequately defined in the context of old age. This is why it has been argued that there is a gap in the existing international system.[9] Regional instruments on the rights of older persons have provided more explicit guidance on State obligations, including aspects of informed consent, access to health facilities, goods and services, long-term and palliative care, healthy environments and support for families providing care among others. The right to the enjoyment of the highest attainable standard of health is not the right to be healthy, as good health depends on a number of factors beyond a state's control. Consequently, 'the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health'.[10] The enjoyment of the highest attainable standard of health in old age is dependent upon individuals' access to health throughout their lifetime, as health inequalities tend to accumulate and aggravate in later life.[11] The World Health Organization (WHO) defines healthy ageing as "the process of developing and maintaining the functional ability that enables wellbeing in older age. Functional ability is about having the capabilities that enable all people to be and do what they have reason to value".[12]

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[9] A/HRC/18/37, para. 20 and Substantive Inputs on the Focus Area "Right to Health and Health Services", A/AC.278/2023/CRP.3, para. 71.

[10] Committee on Economic, Social and Cultural Rights, General Comment No. 14 on the Right to the Highest Attainable Standard of Health (Article 12), contained in E/C.12/2000/4, para. 9.

[11] A/HRC/18/37, para. 14.

[12] https://www.who.int/news-room/questions-and-answers/item/healthy-ageing-and-functional-ability.

24. General comment No. 14 of the Committee on Economic, Social and Cultural Rights (CESCR) outlines key elements of the right to health of older persons including “preventive, curative and rehabilitative health treatment…maintaining the functionality and autonomy of older persons … [and] attention and care for chronically and terminally ill persons, sparing them avoidable pain and enabling them to die with dignity”. While not referring explicitly to the terms long-term care and palliative care, it is agreed that these constitute integral aspects of the right to health of older persons.[13] Health promotion is also tacitly included in this definition, as described in other parts of General Comment No. 14 and also reflected in the received contributions. General Comment No. 6 on the economic, social and cultural rights of older persons reaffirms the need for an integrated approach across the lifespan for the realization of the right to health in old age.[14]

25. The inputs received generally emphasized that the enjoyment of the right to health by older persons involves both aspects of physical and mental health[15] and that the range of services should be comprehensive. It is also understood that it covers both generalist and specialist treatment, including sexual and reproductive health services, dental, auditive and optometry care, and that it caters for the specific situation of older persons. For example, HelpAge International referred to ‘goods, facilities and services that meet their physical, mental, cognitive and psychosocial health and long-term care and support needs.’ Belarus underlined the need for health promotion, prevention and rehabilitation that allows older persons to maintain their levels of activity and health status. The NHRI of El Salvador noted that the Special Law for the Protection of the Rights of older persons of El Salvador defines it as the right to "receive comprehensive medical, geriatric, nutritional, and gerontological assistance in a timely and effective manner."

26. Access to medicines and assistive devices were also included in the contributions received as an integral part of the right to health. The International Association for Hospice and Palliative Care defined palliative care as the “active holistic care of individuals across all ages with serious health-related suffering due to severe illness, and especially of those near the end of life. It aims to improve the quality of life of patients, their families and their caregivers”.

27. While few inputs made specific references to the underlying determinants of health, it is generally accepted that environmental, economic and social aspects play an important role in the enjoyment of the right to health of older persons. Some respondents cited national provisions, which relate to wider issues and/or other interdependent rights, with a particular focus on social protection.

28. The United Nations Economic and Social Commission for Asia and the Pacific (ESCAP) stated that the right to health for older persons goes beyond mere access to healthcare services, touching on broader issues, such as social protection, access to adequate water and sanitation, housing and health education. Colombia mentioned that national policy adopts a social determinants approach aiming to overcome economic dependence, facilitate inclusion, protect from violence, promote healthy ageing and provide education, training and research. Malta referred to easy access to water and sanitation, institutional housing options for older persons in need of care and health education initiatives. The Mexican Constitution establishes the rights to live in an adequate environment for individual development and welfare; to a dignified and decent household; to nutritious, sufficient, quality food; to sufficient safe, acceptable and affordable water; and to non-contributory state pensions.

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[13] A/HRC/18/37.

[14] Contained in document E/1996/22. See in particular paras. 34 and 35.

[15] For example, see inputs by WHO, HelpAge International, NHRI Nigeria, AGE Platform Europe, ILC-Canada in collaboration with WPA-SOAP & IPA-APAC.

29. Respondents indicated that national standards and definitions were derived from a range of laws, policies, regulations, administrative decrees, and non-binding resolutions or principles. Some countries included a universal provision to the right to health and/or access to medical aid in their Constitutions.[16] Others include constitutional provisions with explicit reference to older persons as is the case in Colombia, Spain and Poland. For example, the Colombian Constitution recognizes that older persons are subjects of special protection by the State. Some inputs referred to the application of international or regional instruments in their domestic order as the main normative source for the realization of this right.[17]

30. Secondary law includes statutory health, social welfare and/or long-term care acts, provisions for social insurance and social assistance and/or for universal health or social care coverage regardless of employment/insurance. Several respondents also mentioned consumer protections. For example, in Mauritius, the Food Act ensures that consumers are protected from contaminated and unhealthy food.

31. Some countries have adopted comprehensive laws on older persons, which also include aspects of healthcare. For example, the Guatemalan Protection Law for the Older People includes provisions for social security, housing in healthy environments and the obligation for health plans based on geriatric and gerontological approach. Argentinian law integrates social and health services into a rights-based perspective, with focus on the rights to adequate medical care; prevention and health promotion; autonomy and decision-making; dignity and respect; protection against abuse, discrimination, and mistreatment and social and community participation.

32. A couple of respondents focused on disability- and/or dementia-related provisions.[18] Inputs revealed several policies and programmes targeting specifically older persons' preventive, curative and rehabilitative care. There is a wide range of policies and systems that aim to secure access to free, highly subsidized and/or affordable medical care to older persons. For example, in Australia the Commonwealth Seniors Health Card and the Pensioner Concession Card entitles holders to refunds and concessions for medical expenses.[19]

33. In a few cases, older persons are given priority/preferential treatment and/or special protection under statutory law. A couple of inputs referred to citizen participation as an integral part of the right to health. For example, Saudi Arabia has a committee of older persons, which is responsible for developing preventive plans aimed at meeting the requirements of older persons, proposing laws, policies and programmes, increasing awareness of older persons' conditions, enhancing their role in society and encouraging family to care for older persons. The NHRI from Egypt mentioned that national law includes the right to do sport and to participate in recreational activities as a way to protect older persons' health.

34. In many cases, relevant provisions and guidelines are dispersed across several general and targeted national instruments .The United States of America for instance mentions that there is not one standard definition on the right to health and cites distinct laws that support older persons to receive necessary medical treatment; make decisions about their healthcare; receive care without discrimination; protect their personal health information; and access complaints about healthcare services.

35. Some of the responses from NGOs and NHRIs explicitly referred to systemic failures or gaps in the protection of this right either generally or more specifically as

[16] For example, inputs by NGO Gravis India, NHRI Guatemala and the Governments of Belarus, Nigeria and Mexico.

[17] For example, Germany, Argentina and Malta.

[18] Input by Malta, Slovenia and the NHRI of the Republic of Korea.

[19] Input by the NHRI of Australia.

it applies to the specific context and challenges of older persons. For example, ILC Canada mentioned that this is not a legally enforceable right in the domestic order. Saint Elizabeth Health Care also added that the Canada Health Act excludes home care services. The NHRIs of Nigeria and the Democratic Republic of Congo identified the lack of a specific framework in domestic legislation. Amman Center for Human Rights Studies mentioned that in Jordan limited access to care, partial social protection deficits, weak or uneven water access, and limited geriatric services pose issues despite progress. The Australian NHRI noted that the right to health should further include appropriate measures to address and combat ageism and age discrimination. HelpAge International España mentioned that while related initiatives exist, health promotion is not a right under the national framework.

36. Overall, the inputs pointed to the need for a comprehensive understanding of the right to health of older persons. However, all the different dimensions of the right to the enjoyment of the highest attainable standard of physical and mental health and to access to health services are not consistently enshrined as rights and the scope of domestic provisions varies.

37. A common thread in the inputs is the lack of references to specific provisions that clearly set out comprehensive normative standards on the application of the right to health to older persons. Several contributions (ex. HelpAge International, WHO, ESCAP) referred to normative guidelines or aspirations instead of safeguards enshrined in existing national or regional law. Where there is mention of laws, policies or measures, these are either implicit, have narrow scope, are too general in nature or lack detail about the specific realities and barriers that older persons face. For example, many of the issues surfaced in the discussions at the thirteenth session of the Open-ended Working Group on Ageing, such as protections against age-based rationing, age limits to health services and other discriminatory practices are not adequately reflected in existing norms, despite general prohibitions of age discrimination in primary or secondary legislation.

1. Equality and non-discrimination

38. Inputs generally confirmed that non-discrimination is a key human rights principle and central obligation of the right to health. Everyone, including older persons should have equal access to healthcare and underlying determinants of health without discrimination based on any grounds, including race, colour, sex, language, religion, political or other opinion, national, social or economic status, physical and mental disability, health statues, sexual orientation, and civil and political status among others.[20] For example, HelpAge International referred to 'the right to enjoy the highest attainable standard of physical and mental health on an equal basis with others and without discrimination on the basis of age or any other status'. WHO viewed equality as an integral part of the human rights-based approach to health, which provides a set of clear principles for setting and evaluating health policy and service delivery, targeting discriminatory practices and unjust power relations that are at the heart of inequitable health outcomes.

39. Contributions referred to equality provisions which include general prohibitions of discrimination without explicit reference to age, safeguards that cover widely age discrimination in different areas of public life, but without detailed obligations in relation to discriminatory access to healthcare, healthcare provisions applied equally regardless of age and targeted legislation on older persons, which includes references to non-discriminatory access to various health services. Older persons are in a few cases included in constitutional or statutory provisions among vulnerable groups or are subject to special protection. Some national provisions include the prioritization

[20] CESCR, General Comment No. 14.

or preferential treatment of older persons in access to health facilities, goods and services, but this principle is not consistently found across different frameworks. In the United Kingdom the Public Sector Equality Duty ensures that all policy decisions have due regard to the need to eliminate discrimination, harassment, or victimization of individuals with protected characteristics, including older age.

40. In several countries age discrimination is covered under fragmented provisions. For example, in the United States of America the Age Discrimination Act prohibits discrimination in programs or activities receiving federal financial assistance, whereas the Patient Protection and Affordable Care Act, the Americans with Disabilities Act (ADA), the Age Discrimination in Employment Act (ADEA), the Fair Housing Act and the Rehabilitation Act protect older persons in the respected contexts. Other challenges include the limited scope of protections. In the European Union, there is a significant gap in that equality legislation does not cover age discrimination in access to health services and medical treatment.[21] Several contributions referred to the reality of age-based rationing, exclusion or deprioritization of older persons from healthcare during emergencies or resource constraints, as was the case during the Covid-19 pandemic, despite general non-discrimination provisions. The Finnish NHRI noted that people over the age of 65 do not have access to the system of medical rehabilitation organized by the Social Insurance Institution. HelpAge Deutschland mentioned that many older persons lack access to medical care and due to discriminatory laws, cannot return to statutory health insurance after opting for private health insurance. The obligation to provide reasonable accommodation is barely mentioned in national inputs, which implies that it is not adequately covered in existing safeguards.[22]

41. Overall, respondents emphasized that both negative (non-interference) and positive actions are necessary to realize the right to non-discrimination in health and health services. Several inputs recognized how intersecting forms of discrimination contribute to a diminished state of health and quality of life throughout a person's lifespan and call for holistic approaches that aim to address these interlocking inequalities and also cater for the diverse needs of the older population. Yet not all submissions paid adequate attention to how stereotypes based on other grounds combined with ageism are or should be addressed in domestic frameworks.[23]

42. Finally, several inputs mentioned that the implementation of the right to health needs to take a life course approach, which underlines the compounding impact of discrimination and other socioeconomic disadvantages in earlier life to health and well-being in older age.

43. Ensuring equality and non-discrimination also involves tailoring programmes to the specific needs of older persons (such as the increasing prevalence of non-communicable diseases, polypharmacy, mental health issues, and overcoming the digital divide). Stronger and comprehensive legal frameworks are crucial in this regard (see also following section on State obligations).

2. Provision of promotive, preventive, curative, rehabilitative, long-term and palliative care facilities, goods and services

[21] Input by AGE Platform Europe.

[22] The United Kingdom referred to the obligation for reasonable accommodation but only in relation to the disability and not old age.

[23] General Recommendation 27 on the rights of older women (CEDAW/C/GC/27) refers in para. 14 to the combination of age and gender stereotypes, which exacerbate discrimination, impact access to health services and prevent older women from enjoying their human rights.

44. Inputs addressed the full spectrum of promotive, preventive, curative, rehabilitative, palliative and long-term care and support[24] and called for integrated approaches that bring together seamlessly all these aspects of the right to health.

45. Yet not all responses provided evidence of the existence of domestic services covering all these aspects of the right to health. Some focused on long-term care, others gave detailed accounts of measures aimed at prevention and promotion of health, a few lacked any reference to palliative care, while some underlined particular issues or populations at risk, such as persons with dementia and older persons in conflicts or emergencies. Only a small number of inputs referred to access to medicines and assistive devices. Despite being included in definitions of the right to health, only a minority of contributions referred to specialist services, such as dental care, audiology, and sexual and reproductive healthcare. Some respondents listed national provisions covering the whole population, without explaining how these apply in the context of older persons. These responses point to the fragmentation of existing health systems and legal framework as they apply to older persons.

46. To ensure continuity of care, coordination of all levels of service providers including local, provincial and national governments and community organizations is considered necessary. Collaboration between different medical disciplines, as well as between public, private and voluntary sectors is deemed crucial. Access to both general and specialized services (e.g. geriatric care, mental health or services for sexual health) must be guaranteed. AGE Platform Europe stressed that the continuity of services should cover remote and in-presence treatment options, based on the individual's free and informed consent.

47. Several responses focused on long-term care, stressing systematic failures, but also efforts to address existing gaps and challenges, by expanding long-term care infrastructure, providing person-centered care in the community, extending funding, as well as offering training, support and better regulations and working conditions for caregivers. The International Association for Hospice and Palliative Care noted that palliative care is not consistently recognized as a right in national frameworks. Inputs also mentioned that access to health facilities, goods and services should not be inhibited due to costs. Several countries referred to the existence of laws and policies aiming to improve the accessibility and affordability of health services; yet this was one of the most commonly-cited remaining challenges, which is discussed in the following section. Some frameworks included provisions for access to free or affordable medication and medical or assistive devices.[25] The NHRI from Australia indicated that there are free prevention mechanisms, such as immunization and health screenings for older persons. Several respondents referred to the inadequacy of geriatric services.

48. The type and scope of health promotion measures vary greatly. Some are enshrined in law and others appear as ad hoc initiatives. Some focus on information (ex. leaflets, online resources), while others involve the implementation of programmes covering different aspects of healthy ageing, such as nutrition, physical activity etc. A few initiatives focus on subgroups of older persons, for example migrants or persons with dementia.

49. The majority of respondents focused on health facilities, goods and services provided by the public sector. A few inputs also addressed the role of private and non-profit providers of healthcare. Agewell foundation USA, mentioned that

[24] While reflecting on aspects of long-term care, palliative care and social protection, this report does not cover in detail these aspects, which were the subject of previous working papers submitted to the Open-ended Working Group on Ageing.

[25] For example: Belarus, Mexico, Poland, NHRI Mauritius, NHRI Philippines, HelpAge International España.

predominantly, healthcare facilities in the United States of America are owned and operated by private-sector entities.

50. Overall, the inputs illustrated that the existing frameworks lack consistency and comprehensiveness in adequately addressing the different facets of the right to health of older persons.

3. Availability, accessibility, acceptability and quality of health facilities, goods and services

51. Under the international standards on the right to health, health facilities, goods and services should be made available, accessible, affordable, acceptable and be of good quality for older persons.[26]

Availability

52. Public health-care facilities, goods and services, must be available in sufficient quantity, including the underlying determinants of health.[27] Inputs refer to the need to address gaps in the provision of long-term care services, in particular home and community care. HelpAge International España refers to the fragmentation of healthcare, which depends on each autonomous regions and involves inequalities in provision across the country. The NGO also underlines that long waiting lists to access the public system due to limited availability, often forces older persons to seek healthcare in the private sector. Gravis India states there is a need to increase public health infrastructure with a sufficient number of health centers, human resources and facilities. Amnesty International stresses that states and humanitarian agencies must ensure uninterrupted access to appropriate healthcare and medication for older persons in the context of armed conflict or other emergencies, including for the treatment of chronic conditions.

Accessibility

53. Stakeholders reported that age discrimination in employment is pervasive. Inputs by NGOs highlighted that ageism hinders professional (re)training and work opportunities for older persons. Some stakeholders acknowledged that changes in technology and the production processes have made it harder for older persons to adapt to new labour market needs. Outdated knowledge and skills were noted as challenges for older persons. Even middle-aged persons can be considered as old by employers, and therefore, they experience more frequent layoffs, difficulties in employment and other forms of discrimination in the field of work. Many stakeholders also referred to the gender gap in employment rate and pay that disadvantages older women. An NGO noted that mandatory retirement age limits older persons' right to work.

Physical accessibility

54. A number of inputs reveal gaps of access to health facilities, goods and services and underlying determinants of health, such as sanitation facilities, in particular for

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[26] According to CESCR General Comment No. 14, para. 12, States must ensure that health-care goods, services and facilities are available in adequate quantity (availability); are financially, geographically and physically accessible, including by securing access to accessible information and communication, without discrimination (accessibility); are in compliance with medical ethics, culturally appropriate and sensitive to gender, age, disability and other requirements (acceptability); and scientifically and medically appropriate and of good quality (quality). The right to health also demands participation in all health-related decision-making and access to redress.

[27] Ibid., para. 12(a).

older persons in remote or rural areas, for persons with disabilities and for specialized treatment and long-term care and support. Several national and local practices aim to improve physical access to medical services. The NHRI from Mauritius indicated that there are free visits at home for people aged 90 and above and bedridden individuals aged 75 and above. Older persons also have priority access to medical institutions and in collecting medicines from hospitals. Belarus offered remote medical services using technological means.

55. NHRI from the Republic of Korea emphasized that older persons must be guaranteed access to healthcare services as close as possible to the community in which they live. Ensuring the physical accessibility of buildings, equipment and services is crucial as well as providing adequate support for individuals who need it (e.g. adequate public transport, remote consultation, language support, reasonable accommodation, etc.).

Financial accessibility

56. Poverty, lack of social insurance and excessive healthcare costs can inhibit older persons' access to health services, facilities and products. Inputs stressed the need for universal health coverage and for expanding social insurance coverage and non-contributory schemes. Special measures may be necessary to ensure access for disadvantaged groups. In Cyprus, uninsured individuals have equal access to the general healthcare system and there is a right to choose between private and public health providers. In Kenya, according to the NHRI, older persons regularly receive cash transfers to help improve their living standards and meet their basic needs, including access to healthcare. A few contributions refer to the need to ensure access to medicines, assisted devices (such as wheelchairs, hearing aids, dentures and eyeglasses) free of charge or on preferential terms. Amnesty International referred to the plight of older persons in situations of conflict, who are faced with increases in the costs of medicine and outpatient medical services. It further suggested that States must provide access to affordable healthcare for older persons, including during crises when the price of medication can fluctuate significantly, for all healthcare including the treatment of long-term conditions.

Informational accessibility

57. Older persons should enjoy on an equal basis the right to seek, receive and impart information related to heath issues and outcomes. Lack of access to information can impede access to health. The Special Rapporteur on the right to health stressed that health-related information should be tailored to suit older persons' needs and communicated to them in an appropriate, comprehensible manner allowing them to make fully informed decisions about their health condition and treatment.[28]

58. Inputs suggested that information and signage must be accessible and available to everyone, including through non-digital means. Information should also be user-friendly and take into account linguistic and digital obstacles. Support, especially for persons in vulnerable situations must be available. In Finland, according to the NHRI, healthcare professionals must provide an explanation in a manner that the patient sufficiently understands. If the healthcare professional does not speak the language used by the patient or if the patient, due to sensory impairment or speech impediment, cannot be understood, interpretation should, if possible, be arranged. In the United Kingdom, organizations of the National Health System and publicly funded social care providers must comply with the Accessible Information Standard to meet the communication needs of patients and carers with a disability or sensory loss.

[28] A/HRC/18/38, para. 25.

Acceptability

59. All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.[29]

60. Several inputs referred to the need to ensure community-based facilities and services that respect individual's wishes and allow them to remain integrated in their communities. The need for tailored, person-centered services catering to the specific needs for the older population is also mentioned, including care that is age-, gender- and disability-sensitive. Inputs highlighted particular issues for older women, including the heightened risk of neglect and abuse, poverty linked with gender inequalities across their lifespan, gender stereotypes, their role as informal caregivers and women's longer life expectancy. Inputs however did not reflect other issues that might require gender sensitive measures, such as those found in General recommendation 27 on the rights of older women.[30] AgeWell foundation India suggested setting up dedicated healthcare facilities for older persons. ESCAP referred to New Zealand's culturally sensitive healthcare system, which provides specialized services for Maori and Pacific older persons. ILC Canada in collaboration with others noted that interventions aiming to improve cognitive and psychological functioning (e.g., sleep, nutrition, exercise, substance use, spiritual care) must take into account individual cultural beliefs.

Quality

61. Quality refers to the need for care to adhere to scientific and ethical principles. This involves regulation and monitoring for healthcare professionals, medication, facilities, equipment, safe and potable water and sanitation. Care services must be appropriate, prompt and responsive to individual needs. Legislation safeguarding dignity and preventing abuse and mistreatment is crucial. In addition, improving working conditions of formal and informal carers through monitoring, regulation, training, environmental adaptations and support can lower the risk of abuse and neglect in care settings. The Special Rapporteur on the right to health also notes that increasing the availability and coordination between specialties, including geriatrics can improve overall quality of healthcare.[31]

62. The Finnish Law on Supporting the Functional Capacity of the Older Population and Social and Health Services for Older Persons stipulates that welfare counties must provide older persons with high-quality social and health services that are timely, catering to their needs and supporting their well-being, independent living, and participation. The NHRI from the Philippines noted that quality also means ensuring age-appropriate interventions based on scientific and medical evidence, not ageist assumptions on older age.

63. Several contributions noted shortcomings that compromise the quality of essential health services. Amman Center for Human Rights Studies referred to overcrowding and inadequate equipment in Jordan. Reseau FADOQ underlined those conditions in residential care facilities in Quebec, Canada, where there was neglect of basic needs due to shortage of staff were akin to abuse.

[29] CESCR, General Comment No. 14, para 12.

[30] For example, post-menopausal, post-reproductive and other age-related and gender-specific physical and mental health conditions and diseases, lack of access to state funded or private insurance, etc.

[31] A/HRC/18/37, para. 26.

4. Legal capacity and informed consent

64. Free and informed consent is an integral part of the enjoyment of the right to health. The Inter-American Convention also includes a specific provision for this right under Article 11. Article 25 (d) of the CRPD enshrines the right to free and informed consent to medical treatment and experimentation, including the right to refuse treatment for persons with disabilities. The Committee on the Rights of Persons with Disabilities has stressed that this provision creates an obligation for States parties not to allow substitute decision-makers (e.g. guardians) to provide consent on behalf of persons with disabilities and called for supported decisions mechanisms that respect individuals' wills and preferences.

65. The Independent Expert on the enjoyment of all human rights by older persons has addressed aspects of informed consent, calling for safeguards to be adopted through legislation, policies and administrative procedures and a clear set of standards for care settings. The mandate has also paid particular attention to informed consent for the use and withdrawal of assistive and robotics technology, including data gathering and highlighted both risks and opportunities in using technology to understand and express individual wills and preferences.[32] The Special Rapporteur on the rights of persons with disabilities noted that older persons with disabilities are at a particularly high risk of receiving treatment or being placed in institutions without their informed consent.[33]

66. Inputs noted that there is a lack of adequate legal frameworks on free and informed consent. For example, HelpAge International commented that there are no explicit standards on autonomy and independence in older age in international human rights law and that Article 12 of the Convention on the Rights of Persons with Disabilities does not adequately protect older persons without disabilities. NHRI Guatemala stated that there is no national law covering informed consent, decision and choice about health and care treatment. Relationships Australia mentioned that the protections of older persons in respect of restrictive practices are inferior to those of persons with disabilities. The Finnish NHRI commented that there is no national legislation on supported decision-making and there are thus no legal safeguards to guarantee that a person has access to support in decisions regarding their care. Amnesty International highlighted that during the COVID-19 pandemic in the United Kingdom, blanket 'Do Not Attempt Resuscitation' decisions were taken without consultation with older care home residents or their families. AGE Platform Europe and Human Rights Center of the University of Galway emphasized that forced institutionalization and non-consensual care amount to violations of the right to health and to deprivation of liberty under international standards and must be prohibited.

67. Some of the inputs received showed evidence of ad hoc reforms in a small number of national frameworks to comply with the obligation of supported decision-making. In other responses however, the maintenance of substitute decision-making was noted. Only a handful of submissions included references to provisions on advance directives, care planning or lasting powers of attorney.

68. Restrictions of autonomy and legal capacity in practice despite the existence of some general guarantees, call for the revision of domestic frameworks and stronger legal protection mechanisms to avoid the normalization/legitimization of violations. Inputs suggested that monitoring, adequate and accessible information, support for decision-making as well as training and better conditions for caregivers are also necessary. NHRI from the Republic of Korea added that healthcare professionals need

[32] See for example: A/HRC/33/44, A/HRC/36/48, A/75/205, A/76/157, A/HRC/51/27 and A/78/226.

[33] Report of the Special Rapporteur on the rights of persons with disabilities, A/74/186, para. 30.

to respect an older person's right to change or withdraw decisions about their health, care, and medical treatment.

5. Access to remedies and redress

69. Inputs suggested that the absence of comprehensive and strong legal frameworks inhibits older persons' access to remedies and redress. Lack of direct enforceability of rights, limited awareness and absence of support to claim rights are also key issues that lead to underreporting and injustice. Relationships Australia regretted that Aged Care legislation offers no remedy to an individual whose human rights have been breached unless there is evidence of physical harm.

70. Domestic resources of redress vary a lot ranging from judicial, to non-judicial, quasi-judicial and different types of administrative or arbitration procedures. In addition to having the possibility of recourse to national courts, several inputs referred to the key role of NHRIs to receive complaints and act as watchdogs for human rights violations. Patients-oriented complaint systems exist in a small number of countries. In Malta there is a commissioner for older persons who investigates any alleged breaches of the rights of older persons and initiates measures which safeguard their rights. In Colombia the Public Prosecutor's office can bring cases of violations brought to its attention by the local health secretariats. According to the NHRI from Egypt, under the Egyptian law, the competent ministry is committed to providing a hotline to report any risks that threaten the security, safety, dignity, and lives of older persons.

71. Fragmentation of complaints mechanisms is not uncommon, based on territory or type of violation. For example, in the United States of America there are distinct systems of complaints for violations regarding hospital care, health insurance benefits, and standards for care. In Australia, in addition to separate bodies handling complaints in each State and Territory, there is also a distinct system for Aged Care.

72. Systems of support for victims include the United Kingdom's Equality Advisory and Support Service, which is a helpline that provides free advice to individuals to resolve their disputes informally and can refer cases to the Equality and Human Rights Commission and the Saudi Arabian free mobile notary service, for older persons who are unable to visit the notary's office.

73. The discrepancy between these national and local measures cannot guarantee the same standards of accountability and access to justice. ILC Canada suggested that the remedies brought forward by the CRPD can provide a good model that can be adapted in the context of older persons. AGE Platform Europe called for the independence of reporting and redress mechanisms as well as for the support of victims. HelpAge Deutschland suggested that a new legally binding international instrument would empower older persons to assert and claim their rights.

C. Special considerations

74. Inputs drew attention to specific health needs or risks affecting the older population, which include the simultaneous presence of multiple diseases (multimorbidity) and the use of multiple medications (polypharmacy). The State should ensure the holistic assessment of older individuals and the provision of coordinated healthcare to prevent some of the adverse effects related to these particular needs or risks.

75. Inputs highlighted the risk of abuse and neglect in health settings, including the risk of overmedicalization and chemical restraints and called for special measures to prevent abuse and maltreatment.

76. Inputs referred to the impact of the digital divide on the realization of the right to health and the need for the normative content of the right to health to consider the impact of artificial intelligence and emerging and future technologies on the rights of older persons. State obligations to provide digital literacy and access to digital information and support to deal with digital exclusion were also emphasized in the submissions.

77. Several inputs mention that the implementation of the right to health needs to take a life course approach, which underlines the compounding impact of discrimination and other socioeconomic disadvantages in earlier life to health and well-being in older age.

Third party obligations

78. Although not all submissions refer to the role of non-State parties, especially private actors, in the realization of the right to health, several inputs mentioned that non-State parties should be held to the same standards as public authorities and that states should adopt regulations and monitoring mechanisms to guarantee quality of services, prevent discrimination and ensure accountability.

79. Most inputs referred generally to State obligation to protect older persons from violations by third parties and some focus in particular on care services. In Spain such facilities have to comply with the "Agreement on Common Criteria for accreditation and quality of the centers and services of the System for Autonomy and Care for Dependency". Slovenia referred to State obligations to maintain high standards of care tailored to the needs of older patients, take proactive measures to prevent abuse and neglect, make healthcare services affordable and accessible to older persons, coordinate efforts with public health authorities for effective healthcare provision, invest in research and innovation for better health outcomes, operate transparently and address grievances promptly, engage in health promotion activities for older persons, provide staff training in geriatric care and advocate for policies supporting the right to health of older persons.

80. In some countries the private sector plays a prominent role in the provision of healthcare as is the case in the United States of America and Australia. Inputs also referred to the role of private insurers in ensuring equitable access to healthcare. Only a couple of submissions referred to States' role to regulate the market for medicines, assistive devices and health supplies.

81. In addition to health laws, consumer protection provisions can also be called upon to protect older persons who receive health services from non-state parties. Some inputs also referred to the role of NGOs both as providers of health services, in particular for vulnerable groups, but also to support them in making claims of refund for the cost of treatment and medications or the filing of complaints regarding irregularities concerning their treatment by third parties.

D. Implementation – challenges and promising practices

82. Noncompliance with existing human rights obligations and the absence of adequate legal frameworks were identified as key barriers in the enforcement of rights and in accessing appropriate redress and remedy for older persons.

83. Inputs emphasized the existing disparities in access to healthcare and the lack of coordination between services as one of the key challenges. Inconsistent healthcare coverage, high out-of-pocket expenses, and limited access to specialized services for older persons, particularly in rural and remote areas were widely mentioned. Inputs also noted significant gaps in accessing quality long term care in the community and

gender disparities. There is a large deficit in the availability of palliative care systems coupled with a shortage of health personnel trained to provide palliative care. The German NHRI mentioned that one of the main challenges is ensuring consistent access to health across the federal structure. Each federal state (Bundesland) has significant autonomy in health policy, which can lead to variations in the quality and accessibility of healthcare for older persons. The NHRI from Finland expressed concern with recent austerity measures, which led to a deterioration in the availability and accessibility of services.

84. ESCAP noted that enhancing the quality of care, including patient safety and dignity in health services for older persons, is critical. This involves training health professionals in geriatric care to ensure high standards of care, including palliative and rehabilitative services. WHO also noted that building the capacity of health and care workers including knowledge and skills on integrated care for older persons, as well as meaningful engagement of older persons would facilitate implementation of the human right to health of older persons.

85. A number of inputs focused on the challenges affecting older persons in times of conflict, including lack of access to basic health services and medication, lack of information regarding their treatment, displacement, malnutrition, and the violent take away of assistive devices, such as glasses, hearing aids, sleeping aids. Inputs mentioned that emergency responses, whether to armed conflict or other emergency situations, often overlook older persons' unique healthcare needs and fail to include older persons' representatives in decision-making.

86. A further challenge was identified that many older persons lack awareness of their right to health and available healthcare services, hindering their ability to access timely and appropriate care and claim their rights. The scarcity and fragmentation of data poses an additional challenge in developing evidence-based policy to support older persons' access to health.

87. To ensure that older persons and their families can access adequate, high-quality, long-term care services to meet their care needs, WHO has developed a framework for countries to achieve an integrated continuum of long-term care. WHO also serves as a secretariat of implementation of United Nations Decade of Healthy Ageing (2021-2030), which is based on the human rights approach and addresses the universality, inalienability, and indivisibility of all human rights.

88. Inputs also referred to a number of initiatives that promote person-centered care and aim to improve and expand community care services. Argentina has extensive training and certification programmes for formal and informal care workers. Chile has adopted quality standards for long-stay facilities for older persons and developed a citizens' guide to rights in long-stay facilities for older adults.

89. To improve the accessibility of healthcare services Bangladesh has deployed community health workers (also known as "Shasthya Kormis") to reach older persons in remote areas, providing essential healthcare services, health education, and referrals to healthcare facilities.

90. In Argentina informed consent is enshrined in patients' rights law, while the national civil and commercial code has been revised to integrate provisions for the right to make decisions and, if necessary, to receive assistance in exercising rights, including older persons' right to health.

91. To improve participation and accountability, in Colombia there are instances of citizen participation and oversight through which all Colombians can monitor compliance with the right to health.

92. Some inputs also referred to measures to support caregivers, such as the United States of America National Strategy to Support Family Caregivers. In addition, inputs mentioned various measures to ensure universal access, either through social protection, free healthcare provision or other means of support. In the Philippines the national health insurance programme was revised to extend coverage of the population. In Mexico the National Institute of Older Persons through its Integral Attention Center, provides specialized and general medical services to older persons without any charge.

93. To ensure compliance with non-discrimination obligations, the Public Sector Equality Duty in the United Kingdom ensures that in all policy decisions the public service has due regard to the need to eliminate discrimination, harassment, and/or victimization of individuals with protected characteristics, including older age.

E. Conclusions

94. The right to health and access to health services is normatively anchored in various international instruments and its realization has received widespread political support. However, it has not been well defined in the context of old age and the specific situation of older persons. Overall, while referring to a wide range of national arrangements and measures, the inputs do not bring evidence of consistent and comprehensive domestic frameworks encompassing adequate provisions of older persons' right to the enjoyment of the highest attainable standard of health and to access health services.

95. Several signs of progress can be noted in domestic provisions: anti-ageism awareness is widely accepted as a form to address structural inequalities but also to promote health, although socially embedded ageism in law, policy and practice still impedes the equal realization of the right to health. Inputs referred to several health promotion initiatives that seem to have moved away from a paradigm of dependency, needs and welfare, which traditionally characterized ageing policies and moved towards consciousness of the need to apply rights-based, integrated and comprehensive approaches to health. Still, there is a wide diversity among such practices, which range from simple information materials to fully fledged training and programmes targeting large numbers of older persons across different territories.

96. There is increased awareness of the importance of geriatric specialization focusing on older persons' needs and comorbidities in old age. However, there are still important gaps in training, availability of geriatrics professionals and integration with the rest of the healthcare system. Despite considerable efforts by many countries to improve accessibility, availability and quality of healthcare, many older persons still face challenges in accessing healthcare services, particularly in rural and remote areas where healthcare infrastructure is inadequate and there is a shortage of healthcare professionals. Socio-economic factors such as poverty and out-of-pocket healthcare expenses pose barriers to older persons seeking healthcare, exacerbating inequalities in health outcomes. Ageism and discrimination in healthcare practice contribute to older persons receiving substandard care or being denied access to necessary medical interventions, facilities, goods and services undermining their right to health.

97. While recognizing the existence of ad hoc initiatives for universal coverage and special measures to protect vulnerable parts of the older population, the inputs noted significant deficiencies and gaps, which some of the submissions link to the lack of clear, enforceable and concrete standards in international and national frameworks.

98. The lack of specific provisions that clearly set out State obligations with regard to the application of the right to health to older persons leads to systemic failures in

promoting, protecting, and fulfilling the right at all levels. Inputs suggested that there must be legal frameworks and structures in place that support the operationalization of this right, specifically recognizing the specific changes that need to take places so that older persons are capable to enjoy the highest attainable standard of physical and mental health.

99. Inputs noted specific barriers at the intersection of ageing with other grounds of discrimination and socioeconomic disadvantages, which are not adequately visible or addressed in public policy. Measures to address gender inequalities are not consistently found in existing frameworks. Domestic health provisions seem to at least partly rely on a model of informed consent that is in contradiction with the right to supported decision-making promulgated by the Convention on the Rights of Persons with Disabilities. Mechanisms for redress are fragmented and diverse and there is no evidence of their effectiveness.

100. Overall, in describing the normative content and associated State obligations of the right to health and access to health services inputs illustrate the deficiencies and conceptual limitations of the existing framework, which only partly, narrowly, inconsistently, implicitly and without sufficient details addresses the wide scope of this right and its interdependence with other human rights. In particular, the absence of clear frameworks that require states to take concrete action to eliminate ageism is an important obstacle in the realization of the right to health in old age. The submissions recognized the need for strengthened legal frameworks on the right to health and to access health services based on the principles of equality, autonomy and inclusion of older persons.

III. Social inclusion

A. International framework and legal obligations

101. Social inclusion is not explicitly recognized as a human right under existing normative standards. Various elements of the right to social inclusion can be found in a fragmented form under general human rights provisions, including references to civic and political participation (art. 21 of the Universal Declaration of Human Rights and art. 25 of the International Covenant on Civil and Political Rights) and to participation in cultural, artistic and scientific life (art. 27 of the Universal Declaration of Human Rights and art. 15 of the International Covenant on Economic, Social and Cultural Rights). Participation and inclusion are principles that permeate the Convention on the Rights of Persons with Disabilities (art. 3) and are protected under dedicated articles about public and cultural life (arts. 29-30) and about implementation and monitoring mechanisms (arts. 4 and 33-35). The Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) aims to ensure the maximum participation of women on equal terms with men in all fields and includes provisions on women's civic and political participation, access to education, and participation in recreational activities, sports and culture, development and community. General Recommendation No. 27 on older women adopted by the Committee on the Elimination of Discrimination against Women outlines State obligations and includes policy recommendations aimed at mainstreaming the responses to the concerns of older women into national strategies, development initiatives and positive action so that older women can fully participate in society without discrimination and on an equal basis with men.[34] Related provisions can also be found in other international treaties.

102. Inputs to the thirteenth session of the Open-ended Working Group on Ageing on the substantive elements of the right to social inclusion have noted the interdependence of the right to social inclusion with other rights, including access to employment, education, healthcare, independent living, economic security and civic and political participation.

103. The Independent Expert on the enjoyment of all human rights by older persons highlighted that ageism drives and also normalizes social exclusion of older persons and that domestic, regional and international laws and policies reflect and legitimize such ageist biases.[35] The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health stressed the need to reframe society's concept of ageing focusing on the continued participation of older persons, as well as their continuous contributions to society longer into their lives.[36]

104. Participation also features among the United Nations Principles for Older Persons, which recognize that older persons should participate actively in the formulation and implementation of policies that directly affect their well-being (principle 7) and that they should have access to the educational, cultural, spiritual and recreational resources of society (principle 16). The active participation of older persons in society and development is among the priority actions of the 2002 Madrid International Plan of Action on Ageing (MIPAA), which aims to promote the full and effective inclusion of older persons, fight exclusionary practices due to ageist stereotypes and pays particular attention to the risk of marginalization of subgroups of older persons, such as those living in rural communities, older refugees, older

[34] CEDAW/C/GC/27, para. 9.
[35] A/HRC/48/53, para. 73.
[36] See A/HRC/18/37.

women and older persons with disabilities. MIPAA also affirms that negative stereotypes of ageing and older persons reinforce exclusionary practices.

105. The existing international instruments do not include explicit State obligations on older persons' right to social inclusion. Regional standards include some specific provisions outlining State obligations on older persons' right to participation and community integration.

106. WHO indicated that the full and effective inclusion of older persons in society involves interventions at societal, community and individual level. Societal strategies will involve laws and policies to address discrimination and marginalization (including ageism), socio-economic inequality, digital divides, social cohesion, and intergenerational solidarity. At community level, strategies will address barriers to social inclusion such as transportation, digital inclusion, and the built environment, encourage intergenerational contact, volunteering and promote the development of "age-friendly communities." At individual level, strategies should address social skills training; psychoeducation (providing information and support to better understand and cope); peer-support and social activity groups; "befriending" services, social prescribing, which helps patients access local non-clinical sources of support and awareness and education to reduce self-directed ageism can help with isolation and increase older persons' social participation.

107. Inputs stressed that the general and specific obligations under international and regional treaties need to be guaranteed to older persons without discrimination and that the state should take positive action towards the full realization of these rights.

108. Submissions suggested that States adopt comprehensive anti-discrimination laws, which prohibit discrimination, ageism and harassment as well as multiple and intersectional discrimination. Equality duties also include the review and abolition of existing discriminatory laws, policies and practices and the need for training and education of public authorities and other relevant actors. A few respondents referred to mainstreaming older persons' rights into the preparation, design, implementation, monitoring and evaluation of policies, laws, and regulation to promote age equality and reduce age discrimination. Submissions also referred to the need for special measures to eliminate ageism in society, which impinges on older persons' inclusion and include awareness raising, training, intergenerational initiatives, research, visibility of the potential and contributions of older persons and promoting a culture of respect and inclusion. Inputs also referred to the need for measures of positive action and reasonable accommodation to address existing inequalities and marginalization in old age.

109. States must ensure the preconditions for older persons' participation, by adopting legal and policy frameworks which address existing inequalities and drivers of exclusion and ensure access to sufficient income and material resources, safe housing, access to information, access to transportation, support, accessibility of services, independent living in the community, access to training and education, digital inclusion, freedom of choice, health promotion, prevention of abuse and exploitation, and exercise of civil and political rights. Specific consideration should also be given to the diversity of older persons, including intersections with other forms of discrimination, gender disparities and socioeconomic disadvantage.

110. ESCAP noted that to foster social inclusion of older persons, states must develop and enforce legal frameworks that clearly define and safeguard their rights to social participation. Establishing mechanisms for the regular assessment of social inclusion policies and encouraging international cooperation can further enrich the sharing of good practices and innovations in promoting the social inclusion of older persons.

111. The NHRI from El Salvador referred to the need to expand the coverage of the Universal Basic Pension program and to implement effective policies to reduce inequalities, extreme poverty, vulnerability, and social exclusion of older persons. ECLAC put emphasis on reducing the gender gap by designing and implementing policies, programmes and actions with a gender perspective, taking into account the inequalities that accumulated during the life course. Relationships Australia mentioned that a national human rights act, identifying older persons' rights as a national priority, would provide a normative basis for upholding our rights as we age.

112. States must also ensure the implementation of measures that actively promote inclusion and prevent exclusion. The Independent expert has noted that lack of accessibility hinders older persons from living independently and reinforces their social exclusion.[37] Inputs confirm that state obligations involve improving the accessibility of housing, public buildings and spaces and transport. The NHRI from Poland noted that the right to social inclusion is directly related to ensuring spatial accessibility and availability of services, including healthcare services, in the local community where older persons live and includes the right to effective information. The NHRI from Germany referred to an obligation for human rights-based care and housing facilities for older persons. The United Kingdom referred to the need for accessible means of mobility including through technological advancements, the provision of new mobility services and automated and connected transport systems. These should all be designed and developed with accessibility considerations embedded, in collaboration with representative bodies of older persons.

113. Several inputs stressed the need for measures of social protection, which guarantee economic security. Submissions further referred to an obligation to adopt and promote programmes that enhance intergenerational solidarity, increase opportunities for older persons to participate in public life; in volunteering, recreation, tourism, leisure, culture and sports. Inputs also called for State measures to support digital literacy.

114. Other inputs refer to interventions at local and spatial level, suggesting that age-friendly communities are preconditions for older persons to remain integrated in society. This refers to the obligation to create and adapt spaces to facilitate social, civil and political participation taking into account older persons' needs.

115. A few inputs also referred to an obligation to provide older persons with preferential access in public and private establishments that provide services to the public. Support and training to build capacity and help older persons to flourish through life transitions and maintain connections to family, friends, neighbourhood and community are also considered important.

116. Submissions reiterated the obligation to collect appropriate information, including statistical and research data, to understand drivers of social exclusion and enable states to formulate and implement policies related to social inclusion of older persons. This includes providing State support to research activities that seek to understand the causes and manifestations of ageism and exclusion in societies. ECLAC mentioned that states must improve the information systems and administrative records for older persons who receive benefits under social programmes, to ensure they have up-to-date data.

117. Some respondents also referred to an obligation to protect older persons from abuse, to enact legislation on crimes and hate speech promulgated by ageism and to provide redress and support for victims. State programmes and laws must be in line with existing human rights obligations. A few inputs referred to the obligation to include explicit reference to older persons and their rights in relation to social

[37] A/77/239, para. 46.

inclusion in legislation and/or to adopt a new legally-binding international instrument on the human rights of older persons.

B. Normative elements and national application

118. Although none of the United Nations human rights treaties specifically defines the right of older persons to social inclusion, social inclusion has been interpreted as "the process of improving the terms of participation in society, particularly for people who are disadvantaged, through enhancing opportunities, access to resources, voice and respect for rights."[38]

119. The Independent Expert on the enjoyment of all human rights by older persons has referred to social exclusion as "a complex process that involves the lack or denial of resources, rights, goods and services as people age and the inability to participate in societal relationships and activities, available to the majority of people across the varied and multiple domains of society. It affects both the quality of life of older persons and the equity and cohesion of an ageing society as a whole. Unlike related concepts such as poverty and deprivation, social exclusion provides a means to understand the dynamic and multilevel construction of old age disadvantage."[39]

120. The working paper on social inclusion submitted to the thirteenth session of the Open-Ended Working Group on Ageing (A/AC.278/2023/CRP.4) noted several interrelated dimensions of social inclusion that span beyond the narrow scope of the existing normative standards on participation in public and cultural life described above. These include: elimination of ageism, opportunities for meaningful social connections to avoid isolation, age-friendly environments and services, digital inclusion, autonomy, eradicating poverty, and addressing the impact of intersectional discrimination.

121. Although most of the contributions received in response to the questionnaire do not include a definition of social inclusion, respondents seem to accept a broad understanding of the concept, which includes social, economic and environmental aspects. ILC Canada defined social inclusion as the ability to participate fully in the political, educational, economic and social aspects of one's communities. HelpAge Deutschland stated that inclusion means that individuals must no longer adapt to existing structures; rather, it is society which must create structures that enable every person to be a valuable part of society. Luxembourg suggested that older persons' right to social inclusion could be defined as encompassing: the right to live with dignity, make their own decisions, and fully participate in society; the right to access essential services without discrimination and in a manner tailored to their specific age-related needs; and the right to participate in public life, be consulted in decision-making processes, and have access to inclusive social and cultural spaces.

122. The inputs provided no evidence of the existence of a comprehensive normative definition of the right to social inclusion that can apply consistently in old age. According to the respondents, elements of this right are dispersed across various laws and policies, such as general (i.e. implicit) constitutional guarantees, legislation specifically targeting older persons, employment acts, legislation on social welfare/social services, social protection acts, adult education acts, regulatory standards, digital inclusion policies, accessibility legislation, national ageing strategies, general or sectorial national programmes and action plans covering the whole population, income security initiatives, recommendations and others.

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[38] United Nations, Monitoring the convention on the rights of persons with disabilities guidance for human rights monitors professional training series no. 17 (2010).

[39] A/HRC/39/50, para. 17.

123. Most of these legal and policy frameworks are of a general/universal scope, but some include explicit old age-specific provisions. For example, the Spanish Constitution in its article 50 establishes the promotion of older persons' welfare through, -among other public policies- social services which will provide them with health, housing, culture and leisure. The NHRI from Egypt referred to article 83 of the national Constitution, which refers to the State's obligation to guarantee health, economic, social, cultural and entertainment rights, provide older persons with appropriate pensions to ensure them a decent standard of living and empower them to participate in public life.

124. Where specific protections exist, the inputs demonstrated a tendency to describe broad principles and goals without detailed normative guidance. For example, the Law "On the Basic Principles of Social Protection of Labor Veterans and Other Elderly Citizens in Ukraine" guarantees older citizens the opportunity to enjoy all socio-economic and personal rights and freedoms enshrined in the Constitution of Ukraine and other legislative acts and prohibits discrimination against older citizens. The Guatemalan "Protection Law for the Older People" establishes that older persons have the right to keep participating in the development of the country. Inclusion and citizen participation counts among the strategic priorities of Colombia's National Public Policy on Ageing and Old Age.

125. Several NGOs and NHRIs suggested that the declaratory/non-binding nature of these provisions seems to fall short of providing sufficient normative standards in the realization of older persons' right to social inclusion. Germany commented that it is 'impossible to establish a uniform legal definition for the rights of older persons in the various legal texts'. The Polish NHRI regrets the fact that the 2015 Act on older persons in Poland does not contain any definitions of aspects of social inclusion.

126. Several contributions referred to national frameworks that only partly addressed social inclusion focusing on specific aspects or contexts, such as care, culture or digital inclusion. The Polish NHRI stressed that public policies refer mainly to the participation and activation of older persons, thus adopting a narrow notion of social inclusion. Some inputs focused on the social inclusion of groups at particular risk of exclusion, such as people with high support needs. In Germany for instance the long-term care insurance benefits aim to help persons with care needs live as independently as possible.

127. States bound by regional treaties also pursue the social inclusion of older persons based on the normative obligations of these instruments. The German NHRI referred to domestic efforts to promote independence and social participation in old age as part of the country's MIPAA Implementation.

128. Various civil society and NHRI responses stressed the need for a fundamental mind shift in how older persons are seen by societal and political institutions and the need to recognize their potential and rights.

129. International instruments do not explicitly guarantee older persons' right to social inclusion. Regional standards provide specific frameworks for the protection of human rights in old age. Participation, integration, and full and effective inclusion in society count among the principles of the Inter- American Convention on the Protection of the Human Rights of Older Persons. Article 8 of this Convention establishes the right to community participation and integration, which creates an obligation for States to adopt measures to enable older persons to participate actively and productively in the community, and develop their capacities and potentials. Such measures include action to eradicate prejudice and stereotypes that prevent older persons from fully enjoying this right; promoting intergenerational activities and ensuring that facilities and community services for the general population are available to older persons on an equal basis and that they take account of their needs.

The Protocol to the African Charter on Human and People's Rights on the Rights of Older Persons in Africa establishes in article 17 the obligation to develop policies that ensure the rights of older persons to enjoy all aspects of life, including active participation in socio-economic development, cultural programmes, leisure, and sports.

130. Article 23 of the European Social Charter requires State Parties to undertake appropriate measures to enable older persons to remain full members of society for as long as possible. This obligation is operationalized through allocation of adequate resources enabling them to lead a decent life and play an active part in public, social and cultural life; and provision of information about services and facilities available for older persons and their opportunities to make use of them. The Committee that monitors the implementation of the European Social Charter has expanded through its casework obligations under article 23, requiring states to adopt comprehensive legislation prohibiting discrimination on grounds of age and to take a wide range of measures to combat ageism in society.

131. Article 25 of the European Union Charter of Fundamental Rights states that the Union recognizes and respects the rights of the elderly to lead a life of dignity and independence and to participate in social and cultural life. Two NGOs referred also referred to the non-binding European Pillar of Social Rights, which includes principles and rights that are essential in guaranteeing the social inclusion of older persons.

132. Several NGOs and NHRIs commented the absence of domestic standards in this field and argued that the existing normative framework needs to be expanded to include elements of older persons' right to social inclusion, stressing the need for a new legally-binding international instrument specifically focusing on the human rights of older persons.

133. Several inputs described the interconnected dimensions of the right to social inclusion, such as participation in cultural activities, digital engagement, independent living, community involvement, access to age-friendly environments, participation in decision-making, prevention of social isolation, food security, housing, protection from abuse, and participation in movements and associations.

134. HelpAge International stated that older persons should enjoy on an equal basis with others the right to meaningful participation in public and political life, the right to take part in cultural life, the right to an accessible environment, transportation, information and communication, and public services and facilities, the right to live independently and be included in the community, the right to legal capacity, and the right to access digital devices, digital technology and information. The Australian NHRI called for standards, which include the obligation to adopt measures to eliminate ageism, that allow for positive action to foster greater inclusion of marginalized groups, that prevent and protect older persons from abuse and that provide access to remedy and redress in cases of violations of the right to social inclusion. The German and the Polish NHRIs referred to the Convention on the Rights of Persons with Disabilities as a useful model for establishing more detailed and comprehensive normative standards of how the right to social inclusion should apply in old age.

1. Equality and non-discrimination

135. Overall, respondents identified that ageism and age discrimination constitute significant barriers to social inclusion in old age. Several examples of structural, inter-personal and internalized ageism were used to exemplify the need for an overarching framework based on equality with safeguards against ageism to promote older persons' social inclusion. This finding is consistent with the conclusions of reports of

the Independent Expert on the enjoyment of all human rights by older persons and the Office of the High Commissioner for Human Rights, which noted that one of the key challenges to ensuring the social inclusion of older persons is the lack of understanding of their contributions and untapped potential, which is deeply rooted in ageist stereotypes and prejudices.[40] The Independent Expert further noted that older persons are at a greater risk of social exclusion once they leave the paid labour force and that ageism also contributes to the reduced integration of older persons in neighbourhood activities, driving them into further social isolation.[41]

136. Despite the acknowledgement of how ageism is a key driver of exclusion, most responses did not identify existing normative provisions that explicitly linked non-discrimination with social inclusion. Almost all contributions referred to general or sectorial (e.g. only covering employment) prohibitions of discrimination in domestic, regional or international law. At the same time, many inputs pointed to both formal and informal age-based restrictions and exclusionary practices.

137. AGE Platform Europe noted that article 23 of the European Social Charter only aims to enable older persons to remain full members of society ‘for as long as possible’ instead of ‘on an equal basis with others’. It also stressed that the European Union legislation only covers age discrimination in employment and allows for a wide range of practices that restrict the rights of older persons to enter and/or remain in the labour market. The NHRI from the Philippines referred to the institutionalization of age discrimination in national law and policy, for example through the acceptance of mandatory retirement. The Australian NHRI underlined the fragmentation of the domestic anti-discrimination framework, which involved different levels of coverage for different grounds, leading to complexity, inconsistency and protection gaps, especially in cases of intersectional discrimination. The inputs therefore suggested that the scope of the current framework goes a considerable distance from a concept of equality that is centered around enabling inclusion.

138. Several respondents called for expanding the notion of equality and non-discrimination on the basis of age through elaborating new normative standards, which would go beyond ensuring formal equality. The NHRI from Germany stressed the need for laws that include an obligation to dismantle discriminatory structures and that allow for positive action that actively promotes inclusion. Others referred to the need to recognize and accommodate older persons’ specific needs and contributions. The United Kingdom referred to the Public Sector Duty under their Equality Act, which requires public sector bodies to ensure that equality issues are proactively considered to remove or minimize disadvantage, meet the needs and encourage greater participation in public life by those with protected characteristics.

2. Participation in cultural life

139. Regarding the right of everyone to participate in, access and contribute to cultural life, individually or in association with others, the CESCR General Comment No. 21 (paras. 28 and 29) calls on states to pay particular attention to the important role that older persons play in most societies by reason of their creative, artistic and intellectual abilities, encourages the development of programmes that facilitate older persons’ involvement as teachers and transmitters of knowledge, culture and spiritual values, and that provide older persons with easier physical access to cultural institutions.

140. The Committee on Economic, Social and Cultural Rights understands culture as encompassing wide range of resources and products, such as language, literature,

[40] A/HRC/48/53, para. 25.
[41] A/HRC/48/53, paras. 66-67.

music, religion or belief, sports, technology, food, clothing, arts, traditions inter alia, ways of life, language, oral and written literature, music and others. Finland further extended this notion to include prevention, nutrition and physical activity that can enhance individual capacity and improve one's quality of life.

141. Despite this broad definition, inputs mainly referred to initiatives and measures that address older persons as passive receivers of culture. The role of older persons as contributors and transmitters of culture is not equally emphasized. Submissions referred to several policies or ad hoc initiatives aiming to facilitate older persons' participation in cultural life, such as free or discounted tickets for access to cultural activities and/or transport, opportunities for entertainment and recreation, policies and benefits to facilitate the participation in sports events, volunteering, intergenerational activities, promotion of senior tourism, access to adult training, literacy programmes and non-formal education and older persons' involvement in theatrical plays. A national act in the Republic of Korea provides for leisure and cultural activities in old age. Colombian Law 1171 of 2007 establishes preferential access in health, transportation, tourism and public events. Finnish law includes a statutory task for national educational institutions to organize studies to promote lifelong learning, wellbeing, active citizenship, democracy, and the activities of civil society.

142. Several responses referred to challenges related to availability and accessibility, such as inequalities affecting rural areas and marginalized groups, the digital divide, gender inequalities, poverty and lack of affordability. Aspects of acceptability, adaptability and appropriateness are barely addressed in the answers. Germany clarified that provisions on age discrimination apply to many areas relevant to cultural life (e.g. tickets to concerts and theatre, restaurant visits, museums and exhibitions), but not to voluntary work. AGE Platform Europe mentioned that the Revised European Charter of Social Rights allows restrictions on the right to access cultural life for older persons who live in residential care settings.

143. Overall, inputs revealed that existing provisions rely on a fairly limited notion of older persons' participation in cultural life and lack comprehensive normative guarantees.

3. Digital inclusion

144. Inputs referred to article 20(d) on the right to education under the Inter-American Convention on the Protection of the Human Rights of Older Persons, which requires State action that promotes education and training for older persons in the use of new information and communication technologies (ICTs) in order to bridge the digital, generational, and geographical divide and to increase social and community integration.

145. The Independent Expert on the enjoyment of all human rights by older persons has highlighted that digital technologies can contribute both to the inclusion and exclusion of older persons, especially in case they are not adequately trained and supported to use the technology.[42] MIPAA calls for digital training to allow older persons to equally benefit from and contribute to advancements in society and to avoid alienation.[43]

146. Several contributions refer to challenges for older persons who lack basic digital skills or have limited internet access and underline the importance of measures to address the extant digital divide. For example, digital literacy classes were among the priority actions for social inclusion surfacing through a survey with older persons

[42] A/HRC/48/53, para. 91.
[43] A/CONF.197/9, annex II, para. 38.

undertaken by AgeWell Foundation in India. The International Fund for Agricultural Development mentioned that older farmers should have equal access to training on innovative technologies and stresses the need to overcome ageist perceptions about their learning abilities. Economic Commission for Latin America and the Caribbean (ECLAC) considered digital training as an integral part of lifelong learning and also asks for research on the causes and effects of the digital divide. In several countries the need to close the digital divide and/or the promotion of training in this area is enshrined in domestic law. Many national policies, programmes and action plans include initiatives aiming to improve digital literacy and inclusion of the older population. ESCAP referred to several national programmes in the Asia-Pacific region aiming to improve digital skills, some of which are targeting older persons while others the general population. In others, there is no evidence of a specific regulation or policy framework in this field. Gravis India mentioned that older persons are excluded from the national digital literacy mission.

147. Inputs emphasized the interdependence of the right to digital inclusion with other rights, including the right to education, non-discrimination, adequate standard of living, self-determination, work and protection from violence and exploitation. In the United Kingdom, public funds can be used to support the digitally excluded working age out-of-work and in-work individuals. Age Action Ireland stressed that digital exclusion creates additional risks of abuse and mistreatment.

148. Submissions referred to the need to ensure physical and economic accessibility (affordability) of digital services, the importance of education and training and the need for technical support. Several respondents also referred to the need to provide non-digital alternatives as a means to ensure inclusion of older persons.

149. Overall, the inputs provided ample evidence of the recognition under the existing frameworks of the need to address older persons' digital exclusion. However, they lack reference to comprehensive provisions on digital inclusion for older persons, which include specific normative guarantees, such as a right to support and/or reasonable accommodation, or a legal obligation for special measures to address existing inequalities.

4. Independent living in the community

150. The working paper on long-term care and palliative care submitted to the tenth session of the Open-ended Working Group on Ageing referred to the lack of coherent international norms for realizing the right to live independently in the community in old age. At regional level this right has been further defined by dedicated provisions.[44]

151. The Independent Expert stressed that to guarantee independent living in the community, both provisions protecting personal autonomy and agency and guaranteeing equal access to public services and support are necessary.[45] Similarly, inputs suggested that retaining autonomy and control over decisions about where and with whom to live is central to fostering social inclusion in old age. When there are limited choices of housing, care options and other residential facilities, older persons' right to inclusion in the community is restricted. To realize the right to independent living, older persons should have access to adequate support in the community regardless of their care needs. Accessibility of the physical environment is also considered paramount to the realization of this right. Several respondents also referred to the need for preventive measures, such as health promotion.

[44] Substantive Inputs in the form of Normative Content for the Development of a Possible International Standard on the Focus Areas "Autonomy and Independence" and "Long-term and Palliative Care" (A/AC.278/2019/CRP.4).

[45] A/HRC/48/53, paras. 66 and 70.

152. Several contributions referred to existing legal provisions, policy measures, community services and programmes aiming to support older persons to live independently. In Germany, the Social Code provides for social participation assistance for persons with disabilities at all ages and for specific measures at local level for advice and support in old age. There is also a soft law charter on care (Pflege-Charta), which enshrines fundamental rights of older persons in care settings, including the right to interact with others and participate in social life. Colombian legislation defines criteria for comprehensive care services, regulates conditions of care, establishes mechanisms for the prevention of abuse and mistreatment in care settings. In Argentina care centres and day clubs seek to stimulate the creation of ties and social support networks, promoting integration of persons in their social and community environments, delaying and/or avoiding institutionalization. The Law of the Republic of Belarus "On Social Services" provides for an expansion of long-term care services, improved quality, monitoring and accessibility (e.g. through organizing transportation of service recipients). In the United States of America, the Older Americans Act funds a variety of services and programs that address social determinants of health, with the aim of maximizing the ability of older persons to live independently, and actively participate, in the community. In Greece, national law imposes a statutory obligation on municipalities to implement policies aimed at the support and social care of the older persons, including by establishing open care, day care and community centres. Slovenia adopted the Long-Term Care Act, which aims to provide a solid public network of community-based services that allows older persons to stay in their home environment for as long as possible. The United Kingdom's Care Act allows for direct payments, which individuals can use to cover their care needs. In Malta, community care services are provided either free or charge or at a heavily subsidized price.

153. Several NGOs and NHRIs referred to gaps and limitations of existing provisions. The Finnish NHRI pointed out that older persons who live at home do not have an equal right to personal assistance. Likewise, HelpAge Deutschland mentioned that the social participation benefits provided under the German Social Code apply only to persons with significant mental, psychological, physical or sensory restrictions. Age Action Ireland referred to cases of forced institutionalisation and barriers to living independently in the community due to lack of transport and inability to afford home repairs and adaptations. ILC Canada deplored the "More Beds, Better Care Act" of the province of Ontario which allows for the forced relocation of older persons from hospitals to long term care facilities as far as 150 kilometres away from their families and communities. The NHRI from Georgia noted that older persons who live outside care institutions do not have access to psychological support. The European Federation for Family Employment and Home Care observed the unequal access of rural groups to homecare services.

154. Overall, inputs suggested that independent living in the community depends on the realization of other rights, including equality and non-discrimination, legal capacity and informed consent, health, long-term care and support, accessibility, housing, and social protection, which are not explicitly protected in existing instruments in the context of old age. The joint submission by AGE Platform Europe and the Human Rights Center of the University of Galway argued that non-consensual care can amount to deprivation of liberty.

155. Several NHRIs referred to the Convention on the Rights of Persons with Disabilities and to the legislative measures taken to transpose the convention at domestic level as the most comprehensive framework that guarantees independent living in the community, although it only applies to older persons with disabilities.

156. When it comes to social inclusion of older persons living in institutions, several inputs referred to national acts and regulations that guarantee the quality and

monitoring of residential care facilities. In Spain the law on dependency aims to guarantee the social inclusion of older persons living in institutions. In Luxembourg the Law on the quality of services for the elderly aims to prevent social isolation through recreational and social services that bring residents into contact with the wider community, social and cultural events, freedom of worship, and structured meals. In Slovenia and Malta there are programmes that bring older residents in contact with school age children. The NHRIs of the Republic of Korea and Guatemala report that there is a lack of framework that regulates care institutions.

157. While many contributions demonstrated the prioritization of home care/community-based services over institutional care, it is unclear whether domestic provisions constitute a compelling framework for a fundamental change of direction in care services. There is no evidence of national legislation that prohibits institutionalization or conceives institutional care as a form of exclusion or deprivation of liberty. In fact, some of the inputs implied that extant frameworks permit the violation of rights, by referring to discrimination, lack of informed consent and deprivation of liberty in institutional settings. This overall permissiveness of institutional care stands in contrast with international disability rights standards. In addition, it is unclear whether the existing safeguards constitute a comprehensive and coherent framework for realizing the multidimensional right to independent living in the community, including an enforceable right to social inclusion for older persons who receive care in residential settings.

5. Inclusion in intergenerational policies and programmes

158. While there is general recognition of the importance of intergenerational actions to foster inclusion and eliminate ageism in society, there is vast diversity in the type and scope of provisions that enable this in practice: from responses mentioning that intergenerational exchange is enshrined in law to others where there is no mention at all; from contributions that refer to initiatives that aim to support generational contact in the public sphere to those focusing on the family; from state-led action, to programmes run by civil society; and from targeted efforts encouraging intergenerational learning to generic declarations of intent. The discrepancy of existing intergenerational provisions makes it difficult to extract generally accepted and comprehensive normative elements.

159. In Luxembourg, the Law on the quality of services for the elderly establishes a Higher Council for the Elderly, whose mission includes the promotion of intergenerational and intercultural exchange. ESCAP observed that intergenerational exchange programmes are vital for bridging the gap between young and old, promoting mutual understanding and respect. Other initiatives referred to intergenerational care and housing.

160. Overall, inputs suggested the need for special measures that promote intergenerational solidarity. Age Action Ireland referred to a poll demonstrating that in sectors where intergenerational contact happens organically (e.g. in healthcare or agriculture), below average levels of ageism are noted. This finding could imply the need for both mainstreaming and positive action to facilitate intergenerational relations.

6. Economic inclusion

161. Exclusion from material and financial resources in later life is one of the manifestations of social exclusion. Inputs confirm that ensuring an adequate standard of living is essential to preventing social exclusion. This right is generally understood to encompass access to adequate food and nutrition, housing, income, health and long-term care services, family and community support, employment and social security.

162. The Spanish constitution explicitly links social inclusion with economic security referring to the need for adequate pensions and social services. The NHRI of Argentina noted that to guarantee the right to social security, which is essential for the social inclusion of older persons, the right to retirement and to public pensions is granted by the National Constitution. Several contributions stressed the need to ensure access to formal employment for older persons who wish to continue working and to regulate informal/domestic work. Social protection must include unemployment and retirement benefits for formal and informal workers. Policies aiming to increase the employment of older workers and to fight ageism at work are also considered important. The Polish NHRI called for flexible employment conditions, availability of training or labour activation programmes for older persons, and equal access to the labour market without age discrimination. ESCAP and the Food and Agriculture Organization of the United Nations also referred to the need to improve digital skills of older workers to enhance employability.

7. Participation in decision-making

163. Participation is a core human rights principle that enables the realization of other human rights. Inputs provided several examples of initiatives that aim to create conditions for the social inclusion of older persons by promoting civic participation. In Luxembourg, the National Council for the Elderly can advise the government on issues affecting older persons and can provide information on relevant laws and policies. The National Strategy of the Republic of Belarus “Active Longevity - 2030” stipulates the establishment of senior citizen councils. Australia’s Council of Elders is crucial for ensuring that policies reflect the insights and experiences of older persons. Mexico promotes participation in the formulation and implementation of decisions that directly affect older persons’ welfare, neighborhood, street, delegation or municipality and in various bodies of citizen representation and consultation.

8. Remedies and redress

164. Inputs referred to existing provisions on access to justice at international level (e.g. article 2(3) of the International Covenant on Civil and Political Rights) and regional level (article 13 of the European Convention on Human Rights; article 31 of Inter-American Convention on the Protection of the Human Rights of Older Persons; and article 4 of the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Older Persons in Africa). They also described a range of judicial and non-judicial remedies, without however referring to specific provisions or mechanisms in case of denial of the right to social inclusion in old age. Some of the available options relate to specific aspects of the right, such as access to employment or care services.

165. Contributions also referred to legal assistance and support for victims. In Mauritius the Protection of Elderly Persons Act makes provision for the creation of the Elderly Person’s Protection Unit to, ensure, promote and sustain the physical, emotional, social, cultural and economic protection of elderly persons. It also receives complaints from older persons who are in need of protection or assistance and can apply to the Court for a protection order where it deems there is a real danger to, or threat on, the life of an older person. In the United States of America, the legal services network can provide important assistance for older persons in accessing long-term care options and other community-based services. In the Philippines the Offices for Senior Citizens Affairs are to be established in all cities and municipalities of the country, to provide assistance to senior citizens in filing complaints or charges against any individual, establishments, business entity, institution, or agency refusing to comply with laws and policies related to the rights and privileges of senior citizens. The NHRI of Argentina mentioned that the Supreme Court of Argentina has adhered

to the Brasilia Regulations on Access to Justice for Vulnerable Persons, which also target the older population. In Mexico, the Law on the Rights of the Older Persons, guarantees the rights of older persons to receive dignified and appropriate treatment in any judicial proceeding involving them; to receive the support of federal, state and municipal institutions in the exercise and respect of their rights; to receive free legal advice in administrative or judicial proceedings in which they are a party and to have a legal representative when they consider it necessary. In India the National Policy for Senior Citizens includes a provision for national commission for senior citizens to deal with cases pertaining to violations.

166. Some inputs identified the absence of an adequate legal framework as a barrier in accessing redress in case of violation of the right to social inclusion. AGE Platform Europe noted that the lack of a legal framework at the European Union level covering comprehensively age discrimination is an important barrier to effectively promoting social inclusion in old age and in accessing justice in case of denial of older persons' right to participate in society on an equal basis with others. ILC Canada suggested that the development and implementation of a legally binding international instrument could set the groundwork for proper legal remedies for instances where social inclusion is absent.

C. Special considerations

167. According to the inputs, special attention must be paid to the promotion of positive images of ageing and the recognition of older persons' contributions among all sectors of government and society to change stereotypes that affect older persons' full, effective and meaningful participation. This implies cross-sectoral efforts and collaboration to change the extant narrow conception of inclusion in old age. For example, the NHRI from the Republic of Korea mentioned that supports for social participation of older persons are limited to "Volunteering opportunities" or "work capacity" (article 23 of the "Welfare of Senior Citizen Act" of the Republic of Korea). Additionally, in Poland restrictions of legal capacity are still allowed under national law. Inputs consistently referred to systemic forms of ageism, which are embedded and often legitimized through national frameworks. The legal normalization and societal acceptance of ageism in society calls for a fundamental change, which cannot be achieved through limited, inconsistent efforts to promote inclusion.

168. Inputs further stressed the need for additional efforts to address intersectionality and marginalized groups. Current frameworks have not paid adequate attention to the multiple and interlocking factors of exclusion in old age. Several inputs referred specifically to the need to address the plight of older women and older persons with disabilities. The United States of America mentioned that addressing inequities experienced by older persons in underserved communities must be a priority. NHRI Philippines mentioned that exclusion experienced earlier in life may compound and result in more severe experiences of marginalization and exclusion in older age, in particular for older women. ECLAC considered it vital to integrate the intersectional perspective into the design of public policies, programmes and measures, as it increases the visibility of the diverse nature of old age and of ageing. Adopting this perspective enables consideration of the multidimensional nature of older persons' vulnerability to poverty, financial insecurity, lack of access to health services, education, and care and can thus guide public policies that guarantee older persons' rights and freedoms.

D. Implementation – challenges and promising practices

169. Inputs referred to a number of frameworks, institutional bodies and policy guidelines and initiatives that promote inclusion, such as the Interagency commission on issues affecting the elderly and the 2023-2040 Demographic Strategy of the of the Republic of Armenia, which promote opportunities to use their potential. The United States of America issued an Advisory entitled Our Epidemic of Loneliness and Isolation, which offers a definition of social connectedness and sets forth a proposed framework of a national strategy to fight loneliness and social isolation. In June 2023, the Ministry of Social Solidarity of Egypt launched a new initiative called "The Golden Age". The initiative aims to promote social inclusion of older persons, organize cultural, religious and recreational activities to highlight their talents and abilities and improve awareness of their rights. El Salvador trained public servants on the Special Law for the Protection of the Rights of Older Adults.

170. In terms of data collection, Mexico mentioned the National Survey on Discrimination (ENADIS) on the perception of discrimination, which identifies which elements must be reinforced to guarantee the full exercise of rights. An advocacy brief developed for the United Nations Decade of Healthy Ageing 2021-2030 by WHO, International Telecommunication Union and the United Nations Department of Economic and Social Affairs in 2021 summarized the evidence on the prevalence and impact of social isolation and loneliness among older persons and on strategies to reduce them.

171. Inputs referred also to initiatives that aim to promote positive images of older persons and combat ageism. In the Philippines the Elderly Filipino week is celebrated every year as a way to promote the contributions of older persons to society and to engage the public in addressing societal issues confronted by senior citizens. In Egypt, a television show produced in cooperation with the Ministry of Social Solidarity promotes positive messages of ageing and encourages social inclusion. Argentina has trained care professionals on the rights of older persons. The Australian Human Rights Commission supported the Centenarian Portrait Project by Teenagers, a seven-year nation-wide intergenerational initiative, which involved teenage artists painting people aged 100 years or older. The project demonstrated the positive impacts intergenerational programs can have in promoting social cohesion and inclusion across generations. In Chile, the age limit for National Training and Employment Service (SENCE) programmes was abolished, putting an end to a form of ageism that affected the right to lifelong and in-service education.

172. Several respondents provided examples of initiatives that tackle loneliness and digital exclusion. To raise the political urgency of loneliness, the United Kingdom launched the world's first government strategy on loneliness in October 2018. Germany has adopted a Federal Strategy to Counter Loneliness and provides funding to more than 180 projects that support older persons. WHO recently launched a Commission on Social Connection, reframing isolation as a global public health problem for all groups and advancing effective solutions. In Slovenia the ''Older for Older'' programme is implemented by an NGO, under which trained volunteers, who are usually representatives of the older generation, visit older persons in their area to identify the needs of older persons, especially those at risk of isolation.

173. Ukraine is implementing with financial support from Sweden, a digital platform on which grandchildren explain to their older relatives how to install messengers on their smartphones, use search engines, make an appointment with a doctor, top up their mobile accounts, and use digital education hubs. The United Kingdom Department for Work and Pensions has introduced a digital Midlife MOT which is a

review for workers in their 40s, 50s and 60s that helps them take stock of their finances, skills and health, and acts as a review process by enabling them to get access to the best possible financial, health and career guidance.

174. Several inputs referred to policies that aim to expand home care and community services. In Germany it is a legal requirement that all long-term care service providers act along professional standards and are subject to an external quality inspection which needs to be conducted once a year. Support with mobility and maintaining social contacts are some of the central aspects of these audits. In the German region of Lower Saxony the coalition agreement of 2022 stipulates that the building regulations will be amended so that housing construction will be designed to be inclusive in future, so that persons with disabilities and older persons can remain living in their familiar surroundings.

175. Other promising practices shared by respondents aimed to address poverty, ensure economic independence and promote decent work among older persons. In Kenya, the Upper Tana Nairobi Water Fund Project works with public and private sector partners providing subsidies for women, older persons and households headed by persons with disabilities. Greece is promoting an initiative focused on economically empowering older women and narrowing the gender pension gap. To promote access to culture Armenia gives free tickets for state supported events. To address informal work, Chile and Colombia have adopted tax incentives and subsidies as a strategy to help older persons enter and re-enter the labour market.

176. Inputs also referred to initiatives that build skills and capacity and expand opportunities for training and education in old age. In Ethiopia, the Pastoral Community Development Project (PCDP) has focused on improving access to community demand-driven social and economic services for pastoralists and agro-pastoralists. To allow older members of the pastor communities to participate, the project started evening classes by powering classrooms through solar energy.

177. Sixteen countries of the ECLAC region have implemented programmes of formal and non-formal education to improve older persons' literacy, to help them obtain primary and secondary education certificates, and to receive vocational training in different subjects. In the Caribbean, educational programmes have an emphasis on promoting health, well-being and development, as well as social skills.

178. Inputs referred to a number of practices which promote participation in decision-making, such as community planning in Malta and policy and service planning in Luxembourg. Intergenerational initiatives also promote participation in community activities, as documented by GRAVIS India.

179. In Germany, intergenerational activities involved both fostering the digital skills and countering loneliness among older persons, but also sharing older persons experience and knowledge with younger persons, helping young children with homework, teaching crafts, etc. Another way to promote intergeneration exchange is by encouraging the cohabitation of childcare centers and retirement homes, a policy implemented in Quebec Province of Canada, although at the moment it only applies to new buildings.

180. Finally, respondents shared practices that promote health literacy and promotion of healthy lifestyles. For example, the United States of America Substance Abuse and Mental Health Services Administration has established the Engage, Educate, Empower for Equity: E4 Center of Excellence for Behavioral Health Disparities in Aging, the mission of which is to engage, empower, and educate healthcare providers and community-based organizations for equity in behavioral health for older persons and their families and address the high risks of mental illness among older persons .

181. Respondents identified the lack of consistent and comprehensive legal frameworks as one the key challenges in facilitating inclusion in old age. Compliance with and enforcement of existing provisions is also considered problematic. ESCAP noted that the outcomes of the regional review of the Madrid International Plan of Action in Asia and the Pacific emphasized the need for comprehensive, integrated policy frameworks that incorporate ageing into national development strategies, ensuring a human rights-based and persons-centered approach.

182. Other challenges identified included the prevalence of ageism and discrimination, which affect all aspects of older persons' participation in society. Inputs reported the lack of accessibility and digital exclusion as creating significant inequalities in accessing opportunities for inclusion. Many older persons continue to face difficulties in accessing essential services such as quality healthcare, adequate housing, care and social inclusion programs, especially in rural and low-resource areas. Economic vulnerability and poverty also contribute to social exclusion in later life and is particularly prevalent in low-income countries. However, ensuring adequate income in old age also affects older persons in high income countries. Lack of transport and information and the absence of measures to reach marginalised communities contribute to isolation in all regions.

E. Conclusions

183. Participation and inclusion lie at the core of a human rights-based approach to ageing. Inputs demonstrate the need to move away from the welfare model has long characterized ageing policy and discourse, which focuses on deficits and needs and fails to recognize older persons' potential and ongoing contributions.

184. Inputs to the fourteenth session of the Open-ended Working Group emphasized the importance of the interplay between different human rights to secure social inclusion in old age, such the rights to an adequate standard of living, social protection, employment, health, care and support, housing, autonomy and self-determination, civic and political participation, accessibility, information, independent living, culture, education, protection from abuse and degrading treatment, protection from deprivation of liberty, access to public services, equality and non-discrimination.

185. The submissions revealed a large number of regional, national and local, legislative and policy initiatives and programmes, which aim to foster older persons' social inclusion. Yet, these provisions are often generic and/or implicit, rarely comprehensive and not consistently diffused with the transformational paradigm of the human rights-based approach to ageing. Inputs also identified normative deficiencies, such as the pursuit of social inclusion 'for as long as possible' as opposed to 'on an equal basis with others' and conceptual limitations of policies that view older people merely as receivers and not as transmitters of knowledge and culture.

186. Some provisions focus on activation as opposed to inclusion. Whereas some of the existing provisions recognize the need to address ageism and understand social inclusion as a gateway to accessing other human rights, others allow for restrictions or are not adequately equipped to challenge laws stemming from the old paradigm and to act as catalyst for the equal enjoyment of the right to social inclusion. This contradiction is exemplified in the context of care. Whereas most inputs referred to increased opportunities for social participation for persons living in the community, a small number of inputs referred to practices that provide more support for older persons in institutions than for older persons receiving care at home.

187. Inputs notes specific barriers related to lack of autonomy and independence, ageist societal norms, economic disadvantages, digital exclusion and inaccessible or

disabling environments which need to be dismantled for the equal realization of this right in old age. The absence of frameworks that enshrine a human right to social inclusion in old age, contribute to the systemic failure to guarantee older persons' participation in society on an equal basis with others.

188. Despite the multidimensional nature of social inclusion, domestic frameworks often appear to be limited to specific contexts, such as care or digital inclusion, leading to gaps and fragmentation. Inputs also suggested that the benchmarks of the existing framework are fragmented, complex and incomplete. Despite varied provisions that aim to promote social inclusion in old age, stereotypes of older persons as a burden to society or objects of care continue to persist. Existing guarantees have failed to eliminate all the legislative, institutional, attitudinal, and other barriers that impede older persons' full participation in society.

189. Although the inputs gave evidence of general equality frameworks, existing provisions do not explicitly link inclusion with equality. The inputs did not provide sufficient details on the scope and potential of these provisions and there was no mention of obligations beyond the pursuit of formal equality (i.e. refrain from discrimination and prohibit discrimination to protect from third party discrimination). Yet full and effective inclusion in society relies on a transformational process which would strive to eliminate ageism and also address structural inequalities (i.e. substantive equality). Notably, the inputs brought to the fore the absence of norms, which require states to take concrete measures to facilitate and guarantee older persons' inclusion. Submissions identified several normative gaps, inter alia, the lack of obligations for positive action and for special measures to promote intergenerational solidarity and address multiple and intersectional discrimination. These gaps point to the need to define inclusion as a principle, process and a right and to explicitly link it with a far-reaching normative concept of equality which accommodates for disadvantage and difference.

190. Access to redress is inconsistent and complex. Inputs referred to general guarantees without specific reference to the right to social inclusion, which implies that there are probably limited avenues for enforcing this right and accessing appropriate remedies and redress in case of infringement.

191. By prioritizing concepts of safety, care and needs over participation and empowerment and lacking specific obligations to prevent isolation and marginalization, existing provisions involve serious deficiencies and limitations. To move towards laws and policies that enable the full and effective social inclusion of older persons, including of those in vulnerable situations, such as older persons in care settings, there is a need for a specific provision, which imposes a duty to rethink inclusion in old age and to change the overall line of direction. A more empowering framework is needed to tie human rights responsibilities with opportunities for growth and contribution to society.