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Substantive inputs on the focus area "Right to health and health services"

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 in its resolution 65/182 with the purpose of strengthening the protection for the human rights of older persons, will hold its thirteenth session at the United Nations Headquarters from 3 to 6 April 2023. Under item 6 of the provisional agenda, the Working Group will discuss follow-up to General Assembly resolution 77/190: 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. The substantive discussions will focus on two areas: the right to health and access to health services; and social inclusion.

2. To that end, the Bureau called for substantive inputs from Member States, national human rights institutions, non-governmental organizations and United Nations system agencies and bodies, following questionnaires prepared by the Secretariat on the focus area. During the thirteenth session, the open-ended working group on ageing will consider and discuss the contributions received, based on the working documents prepared by the Secretariat.

3. The present document contains the analytical summary of contributions received on the focus area: right to health and access to health services.

II. Analysis of submissions received

A. International human rights framework

4. The right to health is recognized in most core international human rights treaties as well as other international and regional instruments and declarations.[1] In General Comment 14, the Committee on Economic, Social and Cultural Rights (CESCR) described the scope of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, noting specific issues for older persons.[2] While international human rights law recognizes that the right to the highest attainable standard of health is subject to progressive realization, States must still use their maximum available resources for its realization. The right to health also imposes some obligations of immediate effect, such as non-discrimination, and the requirement that States at least prepare and implement national health plans. Further, the right to health requires that there are indicators and benchmarks to monitor progressive realization and that individuals and communities have opportunities for active and informed participation in health decision making.

5. Many inputs including from the World Health Organization (WHO) and the International Labour Organization (ILO) made detailed comments about long-term care. The normative content of the rights to long-term care and palliative care were subject of a prior conference room paper.[3] In terms of health

[1] Article 25 of the Universal Declaration of Human Rights and article 12 of the International Covenant on Economic, Social and Cultural Rights, article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965; articles 11.1 (f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979; article 24 of the Convention on the Rights of the Child of 1989; the European Social Charter of 1961 as revised (art. 11); the African Charter on Human and Peoples' Rights of 1981 (art. 16); the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 (art. 10); and the Vienna Declaration and Programme of Action of 1993).

[2] Committee on Economic, Social and Cultural Rights. The right to the highest attainable standard of health: 11/08/2000. E/C.12/2000/4, CESCR General Comment 14. Twenty-second session Geneva, 25 April–12 May 2000 Agenda item 3. http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En, para 25.

[3] A/AC.278/2019/CRP.4. The paper noted, "The Open-Ended Working Group may wish to consider how best to reflect the interrelatedness of and differences between the right to long-term care and the right to palliative care, in particular the need for a specific statement of each right and the relationship of each to the right to health and other rights." (Para 29.)

standards, the ILO noted several instruments.[4] These include standards to provide social protection to cover health care interventions to maintain, restore or improve the health of protected persons and their ability to work and to attend to their personal needs,[5] and that the range of services covered should be comprehensive. The ILO observed that the scope of health care packages should be determined and defined through a national dialogue process, with due regard to the principles of availability, accessibility, acceptability and quality and packages should be regularly assessed to ensure that they remain sufficient to ensure a life with dignity.[6]

B. National legal and policy framework

6. The WHO noted the ongoing implementation of the UN Decade of Healthy Ageing (2021-2030), in collaboration with other UN agencies to realize the Decade's vision of longer and healthier lives for all. WHO supports countries on the development and the update of policies and strategies to foster healthy ageing across the Decade in four areas of action: addressing ageism as a public health concern; developing age-friendly cities; promoting integrated care; and supporting design and shaping of long-term care systems. The WHO also noted the Global Action Plan on the public health response to dementia[7] and the Global Report on health equity for persons with disabilities.[8]

7. The United Nations Economic Commission for Europe (UNECE) referred to the 2022 Rome Ministerial Declaration's goal of promoting active and healthy ageing throughout life.[9] UNECE noted its Member States acknowledge the need to further develop sustainable, accessible, and adequate social protection systems covering social security and universal health care. UNECE highlighted that health promotion and prevention efforts across the life course received prominent attention in health strategies, and older persons received specific focus in national health promotion programmes in several countries and awareness raising and training was conducted on detecting age-related non-communicable diseases. Most frequently, health promotion focused on healthy behaviours, physical exercise and a healthy diet. Inputs from Member States similarly noted the development of guidelines and initiatives to promote sports and physical activity among older persons.

8. The European Union noted that according to the Treaty of Functioning of the European Union, organisation of health systems and provision of health services is a Member State responsibility. The European Union and others referred to the Sustainable Development Goals' (SDGs') call to achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. Member States including Belarus and Bulgaria noted national policies (e.g. Active Longevity 2030) linked to SDG processes and timeframes. Contributions also noted the relevance of the European Convention on Human Rights, the (revised) European Social Charter[10] and the Charter of Fundamental Rights of the European Union.[11]

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[4] ILO Income Security Recommendation, 1944 (No. 67); ILO Medical Care Recommendation, 1944 (No. 69); ILO Social Security (Minimum Standards) Convention, 1952 (No. 102); ILO Medical Care and Sickness Benefits Convention (No. 130) and Recommendation, 1969 (No. 134); ILO Nursing Personnel Convention, 1977 (No. 149); ILO Nursing Personnel Recommendation, 1977 (No. 157); ILO Domestic Workers Convention, 2011 (No. 189); ILO Social Protection Floors Recommendation, 2012 (No. 202); ILC Resolution concerning employment and social protection in the new demographic context, 2013; ILO, Resolution concerning the second recurrent discussion on social protection (social security), 2021

[5] ILO Social Security (Minimum Standards) Convention, 1952 (No. 102).

[6] ILO Medical Care Recommendation, 1944 (No. 69).

[7] Global action plan on the public health response to dementia 2017–2025. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO.

[8] Global report on health equity for persons with disabilities. Geneva: World Health Organization; 2022. Licence: CC BY-NC-SA 3.0 IGO.

[9] https://unece.org/sites/default/files/2022-06/Rome__Ministerial_Declaration.pdf

[10] Article 11.

[11] Article 35.

9. Submissions referred to comprehensive articles in regional instruments, including the Inter-American Convention on the Protection of the Human Rights of Older Persons[12] and the Charter of Fundamental Rights as well as the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Older Persons in Africa.[13]

10. A constitutional right to health was mentioned by Member States such as Spain, Dominican Republic, Argentina, Colombia, Costa Rica and Mexico and NHRIs from the Netherlands, Ethiopia, Burundi, Croatia, Peru, El Salvador, Rwanda, Guatemala and Portugal. Spain described implementation through a range of national laws on health, public health and personal autonomy. Similarly, the Commission on Human Rights of the Philippines and the Provedor de Justiça Portugal noted constitutional protections, which incorporated specific priorities for older persons. The Commission on Human Rights of the Philippines mentioned that the elements of the protections included: protecting and promoting the right to health, health promotion, and an integrated and comprehensive approach to health development ensuring available and affordable health services. Colombia described constitutional precepts that consider health as a fundamental right and, simultaneously, a mandatory essential public service.

11. Implied constitutional protections were mentioned by NHRIs, including from Finland, Nigeria and India. By example, The National Human Rights Committee of Qatar stated the Qatari constitution stipulates the protection of ageing by the law, and health legislation generally guarantees the right to health for older persons, especially since health insurance is mandatory and treatment is free in the public medical sector. Ageing Nepal mentioned general and explicit constitutional guarantees. Implied constitutional guarantees were noted by Agewell India and Gramin Vikas Vigyan Samiti India who cited the Indian Supreme Court's interpretation on life and personal liberty as including access to health care.

12. Inputs from Member States including Bulgaria and Slovenia noted the existence of national health laws. Bulgaria described the protection of citizens' health in a state of complete physical, mental and social well-being as a national priority. This is reflected in the right to affordable medical care under the national Health Act and Health Insurance Act. The Ethiopian Human Rights Commission noted specific guarantees for older persons around allocation of resources, within available means, to provide rehabilitation and assistance to groups including older persons. Inputs from Germany, and Community Legal Centres Australia noted instances where there are no national constitutional or legislative guarantees, but such right is by implication. Common law protections were also noted by the Commission Nationale des Droits de l'Homme of Mali.

13. Member States described a wide range of national arrangements, incorporating laws, policies, decrees, directives, regulations and principles. For example, Tanzania and Slovenia noted national laws and policies regulating older persons' access to health and health services, whereas Türkiye described policies that prioritize older persons' access to health care in particular polyclinic services. A Rwandan NGO NSINDAGIZA reported the creation of a national older persons' policy in Rwanda in May 2021, with a specific objective on health promotion. The Finnish National Human Rights Institution mentioned national laws on supporting functional capacity, social and health services for older persons, and the status and rights of patients. The National Human Rights Committee of Qatar noted specific national laws on dementia and palliative care.

14. Several NHRIs (the Netherlands, Ethiopia, Burundi and Georgia) drew attention to national plans and frameworks that needed updating, while others such as Singapore, and the National Commission for Human Rights of Rwanda observed newly updated or adopted policies. NHRIs from Peru and El Salvador described national arrangements that implemented both national constitutional and regional guarantees, including the El Salvadorean 2022 Special Law for the Protection of the Rights of the Elderly Person.

[12] Article 19 on the Right to Health but also referring to articles 6 (Life) and 12 (Long-term Care).
[13] Article 11 on Residential Care, Article 13 on Protection of Older Persons with Disabilities and article 15 Access to Health Services.

15. The Republic of Croatia Ombudsman noted under the Mandatory Health Insurance Act, all Croatian citizens and residents have the right to health and the Croatian Health Insurance Fund provides universal health insurance coverage to most citizens. In common with many inputs, the Ombudsman noted that some health services are subject to co-payments, but that the poorest pensioners had the costs of additional health insurance paid by the State. The Commission on Human Rights of the Philippines reported that national laws to provide a comprehensive health care and rehabilitation system for older persons with disabilities to foster their capacity to attain a more meaningful and productive aging and to establish community-based health and rehabilitation programs for older persons in every political unit of society. This is operationalized by free services, discounted goods and services, dedicated public health facility wards, integrated health services for older persons, and community-based health workers. The Commission on Human Rights of the Philippines also noted that mental health services are guaranteed under law to older persons by virtue of non-discrimination provisions. The National Human Rights Commission of Korea noted wide-ranging, rights-based national laws in the areas of dementia, hospice and palliative care and decisions on life-sustaining treatment for patients at the end of life.

16. Inputs from Member States including Germany, Slovenia, Azerbaijan and NHRIs from the Philippines, the Republic of Korea, Mali and Croatia highlighted that a combination of statutory and private schemes were in place to realize universal health coverage. Gaps noted in universal schemes included medication, medical aids, dental services, and types of surgical procedures or diagnostic processes. Some such as the Provedor de Justiça Portugal gave examples of limited free dental services. Many inputs noted the limitations of national schemes. HelpAge International submitted that availability of health services is often limited and unable to meet older persons' health and care needs. They observed that systems tend to be orientated towards addressing infectious diseases and younger populations and remain unprepared for population ageing and changing patterns of disease and disability, including a rise in non-communicable diseases, like cancer, heart disease, diabetes, lung disease and mental and cognitive health and care needs.

17. Age International noted that high out-of-pocket costs for health services are a major barrier to older persons accessing their right to health. They recommended that reforms taken towards improving universal health coverage, where all people can access quality health services without financial hardship, are effective measures to help eliminate ageism from the health system and decrease health inequalities for older persons. They further suggested this include regular social pensions and national health insurance schemes to help older persons access health services and contribute to their ongoing independence and empowerment. The Japan Support Centre for Activity and Research for Older Persons mentioned the double burden of mandatory medical insurance premiums plus out-of-pocket expenses has increased, resulting in more uninsured persons, reduced access to medical care, and reported cases of serious illness and death. It also reported that out-of-pocket medical expenses for older persons have continued to rise significantly in recent years, severely affecting their lives by leading to fewer doctor visits, growing poverty, and deprivation of decent living. Referring to a 2022 post-COVID-19 survey by the Japan Senior Citizen's Council, Japan Support Centre for Activity and Research for Older Persons noted the increase was badly timed, harshly affecting older persons to the extent that some even said it was a struggle to continue living.

18. The International Association for Hospice and Palliative Care reinforced the recognition of palliative care in ICESCR,[14] the Inter-American Convention[15] and referred to the previous work of the Open-ended Working Group.[16] They called for States to integrate palliative care into primary health care systems in line with World Health Assembly resolution 67/19 and the Declaration of Astana (2018). International Association for Hospice and Palliative Care and Pallium India noted the evidence shows that palliative care benefits health systems, since it prevents unnecessary hospitalizations, non-beneficial treatments, and polypharmacy. HelpAge Spain and other inputs noted that despite arrangements between national

[14] Article 12.
[15] Article 6.
[16] https://social.un.org/ageing-working-group/documents/ninth/OEWGA9_Substantive_Report_LTC_Palliative-Care_DESA.pdf; A/AC.278/2019/CRP.4.

governments and regions, the right to health is not guaranteed throughout the national territory. For example, HAS suggested that while the constitution guarantees the right to foreigners in Spain, this is not a reality in some autonomous communities.

C. Challenges regarding the realization of the right to health and access to health services

19. Many inputs (Bulgaria, International Federation on Ageing-IFA, the Rwandan NGO NSINDAGIZA, HelpAge International, and HelpAge Germany) highlighted the increased prevalence of noncommunicable diseases as the leading cause of death and disability, globally. HelpAge Germany noted the shift towards an ageing society entailing new disease patterns, requires new occupational profiles in medical care and long-term care, but also raises serious questions about the financing of preventive and curative medical care in the coming decades, which must be answered to finance the costs in an appropriate manner. They further contextualized the importance of the right by stating that according to the World Bank, even before COVID-19, about half of the world's population did not have had access to adequate health care, despite that universal access to health care, without discrimination, is a human right enshrined in international human rights law and in the SDGs.[17]

20. The International Association for Hospice and Palliative Care noted people are living longer but not necessarily better, and with ageing often comes the development of chronic conditions whose serious impacts affect older persons' enjoyment of the highest attainable standard of physical and mental health. It submitted that serious illness when unsupported by the public health system or social insurance involves catastrophic pocket expenses and mires households in the medical poverty trap. The International Association for Hospice and Palliative Care and Pallium India noted the rapidly growing cohort of older persons worldwide who face systemic barriers in accessing preventive, curative and palliative care services, along with medicines to relieve preventable health related suffering.

D. Data and research

21. WHO highlighted the ageing data portal, that brings together data, disaggregated by sex and age, on available global indicators relevant to monitoring the health and well-being of older persons. The information helps to strengthen the visibility of older persons and inform actions to improve health and well-being across countries, in line with global, regional, and national commitments. It also noted the developing Monitoring and Evaluation framework for the Decade of Healthy Ageing, which will be over 60 indicators organized by multiple domains. WHO called on Member States to advance health equity for persons with disabilities by integrating indicators for disability inclusion into the monitoring and evaluation frameworks of national health systems.

22. ILO commented that systematic data collection is urgently needed to understand the extent to which core elements of adequacy of healthcare benefits (benefit packages, costs covered, network of providers) are guaranteed by law. ILO noted that data for SDG indicator 3.8.1 provides some insights into effective coverage. Though more data is needed to analyze the situation across a wider range of services, the basic package guaranteed by ILO standards cannot yet be accessed by most of the world's population. ILO reported that laudable progress was made in service coverage over the last two decades, and the service coverage index increased as access to essential interventions on communicable diseases improved. ILO highlighted that analysis shows that remaining deficits in service coverage are unevenly distributed across geographical locations, income levels, population groups and types of health interventions.[18]

[17] Target 3.8.

[18] Lozano, Rafael et al., 2020. Measuring universal health coverage based on an index of effective coverage of health services in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019, The Lancet, Volume 396, Issue 10258, 1250 – 1284.

23. Several States and NHRIs noted the use of nationally collected/census data to produce specific reports on older persons' health and wellbeing, including on intersectional issues. The type and frequency of disaggregated data was inconsistent. The European Union noted the report 'Improving access to healthcare through more powerful measurement tools', published by the Commission in 2021 provides examples of indicators used in national and subnational context to capture accessibility hurdles specific for certain groups.[19] Inputs from NHRIs and NGOs also identified the absence of national data collection systems.

24. Variables of data collected was diverse and included location, physical health, behavioral risk, cognitive function, mental health, violence, social isolation, loneliness, employment, social activities and participation, housing and assets, transportation, travel, self-reported unmet medical needs, out-of-pocket expenditure, self-perceived health and memory, medical biomarkers, prescriptions, access to drugs, history of falls, dependency, sexuality, connection to community and family, technology management and use, use of leisure time, support and social networks, and life satisfaction. Important data gaps identified included on non-communicable diseases, cancer and dementia.

25. Inputs noted that gaps in coverage were highlighted by data. By example, Mexico noted a 2021, study highlighting that 20 per cent of older persons nationwide were not affiliated to any health service institution. Data also helps identify priority areas. Tanzania described using data to identify older persons for treatment. Sweden among many other inputs noted using data as a basis for long-term planning at local and national health service levels. Slovenia noted projects to determine health in more remote, alpine regions. Contrary examples included limitations to the extent to which data informed authorities about older persons' health status or the best methods of health service delivery for them.[20] The German National Association of Senior Citizens' Organizations (BAGSO) noted results from the German Ageing Survey that older persons in Germany are disadvantaged or feel disadvantaged in the health care system At a rate of 7.2 per cent of 70- to 85-year-old respondents.

E. Progressive realization and the use of maximum available resources

26. Inputs covered a diverse range of issues, including fiscal policies and measures, economic projections and budgetary commentary. WHO noted at the 74th World Health Assembly, Member States adopted the resolution on the highest attainable standard of health for persons with disabilities. The resolution aims to make the health sector more inclusive of persons with disabilities, through tackling barriers that persons with disabilities experience in access to health services and recommends targeted actions to progress the realization of the right to the highest attainable health for persons with disabilities including older persons. ILO noted that while international social security standards have long called for universality of coverage, significant social health protection coverage gaps persist. ILO observed that this absence of social protection combined with insufficient public health expenditure more generally results in catastrophic out-of-pocket spending on health from households, and which is rising globally. Age International also noted macro-economic policy impacts on older persons' access through prohibitive costs, lack of supply and under-investment in the health care they need, noting health and care workforces as examples.

27. HelpAge Germany reported that healthcare costs increase with age and around 80 per cent of all lifecycle costs for medicines and care are incurred in the last two years of life. They noted that health systems in the Global South are hopelessly overburdened, and on average, 90 per cent of public health care expenditure worldwide is compulsory (for health care and preventive health care including infrastructure) and cannot be reduced for other health care expenditure. Germany described that their contribution-based system is financed to a disproportionally larger degree by contributions from working-age population; the expenditure is disproportionally benefitting older insured which is typically at a higher risk of temporary

[19] European Commission, Directorate-General for Health and Food Safety, *Improving access to healthcare through more powerful measurement tools : an overview of current approaches and opportunities for improvement*, Publications Office, 2021, https://data.europa.eu/doi/10.2875/776973

[20] https://www.gravis.org.in/images/Books/Determining%20Older%20People's%20Health%20Needs.pdf;

and chronic sickness and disability. Hence, the system has a non-negligible, intergenerational distributional impact at the macro-economic level.

28. Estimates of health spending, including projected budgets were not capable of meaningful comparison in this paper. Inputs included Member States reporting overall increases in actual and projected spending on federal health budgets. For example, Mexico noted a 5.7 per cent increase in government spending in 2023 when compared to 2022: this being the biggest increase in the last decade. Other Member States such as Azerbaijan and Tanzania noted significant increases to health budgets to address universal health coverage. NHRIs from Finland, Burundi, Rwanda and NGOs such as BAGSO and Réseau FADOQ noted modelling was either being done or had been done that showed significant increases are needed to address coverage, quality and access gaps. Other issues requiring budgetary measures were quality and competence (Sweden), increased and improved geriatric and gerontological care (NHRIs from Guatemala, the Philippines, Mali), vaccination (Commission on Human Rights of the Philippines), pharmaceutical benefits for non-communicable diseases (Public Defenders Office of Georgia), and health services in hard-to-reach and remote areas (Slovenia, Bulgaria, National Commission for Human Rights of Rwanda, GRAVIS).

29. Spending on older persons' health could not be reconciled in any meaningful way from the inputs, however, some commentary provides context. Age Action Ireland noted long term care and services for older persons in Ireland was €2.4 billion of a 2023 health budget of €23.6 billion out of total expenditure of €89.9 billion therefore 2.67 per cent. The Defensoría del Pueblo Argentina noted that in 2022 the Government allocated 6.31 per cent of total public expenditure to the health sector. Seen as a proportion of GDP, the National Senior Citizens Center of Nigeria noted 3.03 per cent of Nigeria's GDP is allocated to the health sector, which they suggested is below the 10 per cent recommended by WHO. The National Human Rights Committee of Qatar noted public spending on health represents 2.9 per cent of the total GDP. However, most inputs contained little information on what proportion is allocated towards older persons' health.

30. German and Ethiopian NHRIs reported national strategic alignments with the SDGs and the 2030 Agenda for Sustainable Development, including targets and indicators within that sphere, but noting that very few align with older persons' right to health. Slovenia noted Active Ageing Strategy alignments with MIPAA. Alzheimer's Disease International contended that dedicated, funded national dementia plans, created by expert, multidisciplinary teams, including those living with dementia and their carers, is the best and most robust way to manage the multifaceted challenges of dementia to healthcare systems, to governments, society and affected individuals.

F. Training of legislators, policymakers, health and care personnel

31. Inputs noted existing and developing training, predominantly for health workers and administrators. The WHO described various training on healthy ageing, age-friendly environments, integrated care for older persons to diverse stakeholders, from policy makers to health and care workers and caregivers of older persons. This includes training for health and care workers on how to identify and manage diverse health and care needs of older persons and self-help training and support manual for carers of people with dementia. WHO noted that together with its partners had already supported the provision of training in the ICOPE approach in 17 countries in all 6 regions. WHO also noted regular training on age-friendly environments, including through the Age-friendly Environments Mentorship Programme, with more than 300 people trained in all WHO Regions in 2022 and the Healthy Ageing Leadership training to 1000 Government, non-government, academic and UN personnel working on ageing.

32. The ILO noted the right to health for older persons cannot be achieved without ensuring equitable access to quality health and care services. A fundamental prerequisite for equal access is the availability of sufficient numbers of adequately trained, supported and protected health and care workers. ILO reported that many countries face severe challenges in the recruitment, deployment and retention of well-trained and

motivated health and care workers where they are needed, also noting dissatisfaction with working conditions, including low salaries, insufficient resourcing, work overload, long hours, and weak career prospects, which are among the main causes of high turnover and attrition rates of health workers in many countries.

33. The Institute of Human Rights Ombudsmen of Bosnia and Herzegovina, and NGOs BAGSO, Age International and HelpAge International noted ageism, discriminatory attitudes and prejudice against older persons was a significant problem in the health sector. Age International observed that negative attitudes and preconceived ideas about older persons' capacity and their right to health prevents them from seeking help and diminishes the quality of the care they receive. They also submitted that health and care professionals may not take older persons' concerns seriously or may assume that older persons are not able to make decisions about their own health and engage with older persons in patronising and negative ways. HelpAge International similarly noted older persons report that a key barrier to quality health and care services is the absence of a well-paid, well trained and well-resourced workforce able to respond to their diverse needs. Ageing Nepal also reinforced that training needed to be more broadly applied to administrators and policy makers.

34. Azerbaijan, and NHRIs from Burundi, Ethiopia, Portugal and Finland noted developing and distributing information materials on older persons and their rights among policy makers, health and care personnel. Member States including Argentina, German, Spain and Türkiye reported that health workers and physicians received specific training including on age-friendly environments and gender dimensions. Inputs also noted increased training efforts in key areas, including dementia (Slovenia), geriatrics and gerontology (Belarus, RCE, ACAMAGE, and NHRIs from the Philippines, El Salvador, Portugal, Germany and Qatar), nutrition (ACAMAGE), elder abuse (NSCC), paramedicine (Belarus, ACAMAGE), support and care work (Jordan, Belarus) and home carers, including through online learning (Belarus). Inputs identified various professions as in demand for improving health services. These included nursing, physiotherapy, clinical psychology, occupational and speech therapy and social work. In some cases (Kyrgyzstan) access to training in gerontology and geriatrics was offered to medical specialists from other fields. The Resource Center for the Elderly (RCE) noted that to provide quality medical services to older persons, it is necessary to train interdisciplinary specialists, introduce special training programs for specialists in medical schools, offer retraining and advanced training of social workers, psychologists, and nurses.

35. BAGSO noted the parallel need for investment in health promotion and prevention to tackle the need for care and to avoid or slow down its progression. Creating health-promoting conditions and providing nationwide services that promote a healthy lifestyle are crucial. By example, Mexico noted its National Institute offers educational opportunities to the public on dignified aging, palliative care, nutrition, physical and mental health and awareness-raising through its social media. Dementia Alliance International noted the need for health and support workers to be educated in dementia and disability. For personal support workers, examples of best practice include the freely available Wicking Institute 9-week 'Understanding Dementia" Massive Open Online Course.

36. Association Camerounaise pour la prise en Charge des Personne Agées (ACAMAGE) noted the use of social mobilization campaigns in the field of nutrition that are specific to older persons and older persons associations. The National Human Rights Committee of Qatar described online resources on healthy ageing containing information on common medical problems among older persons and information about healthy lifestyles. The Finnish National Human Rights Institution noted the importance in ensuring that training has an explicit focus on the rights-based approach. Public Defenders Office of Georgia highlighted the need to for training to develop and improve the knowledge and skills of health personnel and not just inform. In this regard, the National Senior Citizens Center of Nigeria gave an example of their approach of developing the capacity of master trainers in care quality assurance, and certification, who will be deployed to roll out national training to build capacity for the establishment of seniors' centers.

G. Ageism, equality and non-discrimination

37. Inputs were comprehensive and covered a significant diversity of challenges faced by older persons in their enjoyment of the right to health. The ILO noted that while social security standards stipulate that the range of services should be comprehensive, in practice, specific services are often excluded, such as dental and optometry care. A recent review of social health protection in Asia and the Pacific revealed this to be the case. The ILO contended that such health care interventions are essential for enabling individuals to perform daily activities and demand for them tends to increase with age. They are also crucial for the maintenance of general health; research shows that poor dental health, for instance, can lead to malnutrition among older persons.[21]

38. Inputs noted constitutional and legislative rights to equality, and the existence of national age discrimination laws and policies but also noted the absence of laws prohibiting age discrimination in health and care settings. Inputs including Argentina, Germany and Tanzania raised the challenge of promoting a positive image of old age, free from violence and discrimination based on age and other grounds. Germany noted the framework of ensuring availability, accessibility, acceptability, and quality should be observed in respect of the right to health.[22] Inputs including Argentina and El Salvador Procuraduría para la Defensa de los Derechos Humanos- (ESPDDH) also noted the importance of taking into consideration the diversity of older persons. Office of the Commissioner for Human Rights of Poland (OCHRP) noted that there is no public debate on the human rights of older persons, including the right to health, as the focus of public debate remains on the demographic change. Germany and BAGSO warned that older persons' perceptions of the health system also needed attention.

39. The United Nations High Commissioner for Refugees (UNHCR) and United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) reported that refugees face multiple barriers towards the equal enjoyment of their right to health across fields of operation, involving context specific challenges, including different legislative and policy frameworks, challenges related to legal status and access to healthcare and other basic services, the impacts of prologued displacement and decades of social and economic marginalization in terms of economic impoverishment and poor living conditions. UNHCR, UNRWA, the EHRC and Age International highlighted that older refugees face disproportionate challenges to the enjoyment of the right to health, given their language barriers, cultural differences, heightened vulnerability to physical decline and social isolation, exacerbated by intersecting factors including gender, disability, and legal status, resulting in a higher need for health, medical, and relief care. By example, the Netherlands Institute for Human Rights noted its own research showing that older Moroccan women experience challenges in accessing health services, mainly due to communication difficulties.

40. Many inputs including NHRIs from Ethiopia and Burundi noted costs to older persons, including insurance, contributions and out-of-pocket expenses were a significant barrier. Many inputs also noted the budgetary costs of health and care services including infrastructure such as hospitals, health centers, transport, medical, diagnostic and surgical equipment, and technology with its increasing and rapid development. Jordan and NHRIs from the Netherlands, Finland and Peru mentioned the high cost of, but critical need for 24-hour care and home care services, including in-home palliation. Germany, the Institution of Human Rights Ombudsperson of Bosnia and Herzegovina, BAGSO and APRe! suggested a challenge that older patients face is they are less often offered long-term therapies or rehabilitative care. Moreover, that diagnostics and treatment were influenced by discrimination based on age if health conditions are

[21] Ástvaldsdóttir Á, Boström AM, Davidson T, Gabre P, Gahnberg L, Sandborgh Englund G, Skott P, Ståhlnacke K, Tranaeus S, Wilhelmsson H, Wårdh I, Östlund P, Nilsson M. Oral health and dental care of older persons-A systematic map of systematic reviews. Gerodontology. 2018 Dec;35(4):290-304. doi: 10.1111/ger.12368. Epub 2018 Aug 20. PMID: 30129220.
[22] Britta Baer, MSc, Anjana Bhushan, MA, Hala Abou Taleb, DrPH, Javier Vasquez, LLM, Rebekah Thomas, LLM, The Right to Health of Older People, *The Gerontologist*, Volume 56, Issue Suppl_2, April 2016, Pages S206–S217, https://doi.org/10.1093/geront/gnw039

ascribed to age-related morbidity and life expectancy. Germany and Jordan, and NHRIs from Rwanda, the Philippines, Portugal, Peru and Ethiopia, and NGOs Agewell India, GRAVIS, Réseau FADOQ, APRe!, International Association for Hospice and Palliative Care and Pallium India submitted that access to specialists in some fields such as geriatrics and geriatric nursing, oncology, and palliative care is a key challenge. Slovenia particularly noted the areas of geriatric mental health and suicide prevention.

41. Many contributions indicated challenges include the uneven and inequitable distribution of medical care, rehabilitation and pharmaceutical treatment within countries due to the differentiation of regions and settlements. Many noted that these factors became amplified during pandemic or disaster. Inputs noted that remoteness of location prevents prompt and necessary medical attention resulting in discrimination and marginalization. Challenges are posed by geographic remoteness (such as communities in mountains or on islands) and, as the Institution of Human Rights Ombudsperson of Bosnia and Herzegovina pointed out, for seasonal factors such as heavy winter or hot summer. Institution of Human Rights Ombudsperson of Bosnia and Herzegovina also noted that during waiting periods for treatment, secondary conditions can occur in older persons that could have been avoided by earlier intervention. Inputs such as the Global Ageing Network, Türkiye and the Finnish National Human Rights Institute identified staffing costs and limitations, including severe workforce shortages, lack of trained staff, inability to access supplies and lack of government support for the care systems. The Netherlands Institute for Human Rights noted provision of health to care homes was a critical challenge within health systems.

42. In terms of intersectionality, the Equality and Human Rights Commission of Great Britain noted the importance of considering how age intersects with other characteristics. For instance, older ethnic minorities in the United Kingdom report poorer health than their White British counterparts.[23] Some migrant groups face deteriorating health in older age, despite initially having a health advantage compared to White British groups.[24] Age Action Ireland also reported inequality of health outcomes by income is significant and that excess winter mortality is high in Ireland compared to other north European countries. NHRIs from Germany and the Philippines and Age International noted many older persons, especially older women, older persons with disabilities, older migrants, and older LGBTIQ+ persons encounter discrimination, the lack of specially trained health and care staff, and cultural, attitudinal and language barriers. The Finnish National Human Rights Institute and Age International noted health care organisations often fail to recognise the diversity of older persons and cannot meet the individual needs of older persons who belong to particular groups (e.g. Sami, Roma, immigrant communities, persons with disabilities, LGBTIQ+ persons). This means that older persons belonging to different groups or with particular attributes or characteristics are not able to use healthcare services the same way as others for different reasons, including lack of appropriate information about the services and the fear and reality of discrimination. This also affects the quality of care they receive. Age International also observed that the health inequalities experienced by older persons are compounded by intersecting forms of discrimination. Dementia Alliance International contended that people with dementia must be central to processes that inform decision-makers about their health and care needs.

43. Age Action Ireland referred to ongoing concerns about gender inequality in relation to women's healthcare including, e.g. upper age limits to cancer screening services. They submitted that women are disproportionally impacted by many barriers to accessing healthcare. Legacy issues including access to reproductive and maternal healthcare highlights the need to address impact of cumulative disadvantage on older women by adopting a life-course approach to policy making. Age International reported that older women often exhibit lower scores on indicators measuring mental health and subjective well-being, and suffer more from limitations in physical functioning, including the ability to undertake activities of daily living. Age International and others also raised that older persons with disabilities frequently experience greater health inequalities because of discrimination. This is often due to deep-rooted stigmas and social

[23] Inequalities emerge in middle age for Bangladeshi, Pakistani and Black Caribbean groups. IFS Deaton Review, "Race/ethnic inequalities in health: moving beyond confusion to focus on fundamental causes" (2022).
[24] Fernandez-Reino, "The health of migrants in the UK" (2020).

misperceptions about disability, which limit older person's access to services and their ability to participate in their communities. By example, Alt noted up to 85% of those living with dementia do not receive necessary post-diagnostic support.

44. NHRIs from Germany, Peru, Ethiopia and El Salvador, and Portugal, and NGOs IFA, BAGSO, Age Action Ireland, UPVAC and HelpAge International suggested that age discrimination incorporated poor physical accessibility; situations lacking age-friendliness, poor privacy and signage; de-prioritization (including age discrimination in connection with a triage situation caused by a pandemic) and exorbitant health costs. The RCO noted the right to health is one of the most complained about issues, including by older persons and this was exacerbated by the pandemic. During the pandemic, chronically ill older persons postponed their treatments due to fear of COVID-19 or because of the overburdened health system. Many inputs suggested the need for greater prevention and care in the face of a high incidence of non-communicable diseasess, which are of long duration and, generally, slow progression (heart disease, heart attacks, cancer, respiratory diseases and diabetes). NHRI's from Ethiopia and Croatia and UPVAC noted limited monitoring and information on older persons' needs and health status (including on self-reported unmet needs). They also submitted that recurring conflicts make it difficult for older persons, including those internally displaced to access quality health services.

45. The NHRIs from the Republic of Korea, Georgia and Burundi, and Japan Support Centre for Activity and Research for Older Persons were concerned that age proxies continued to cause age discrimination and that age limits disproportionately affected women who have experienced inadequate access to medical and insufficient physical, mental and social resources. The FNHRI and BAGSO reported that the digitalization of health services presents challenges for older persons who lack digital skills or access to technological devices or the internet, and particularly for those with an immigrant, indigenous or lower educational background. Many inputs including Réseau FADOQ and the Global Ageing Network reflected on widespread cases of neglect of older persons within institutional care settings. Dementia Alliance International noted the importance of monitoring processes under the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in this regard. The National Human Rights Committee of Qatar and others stated that natural disasters and emergency crises affect older persons to health services. BAGSO called for realignment of the system: readjustment of the goals of treatment; ensuring holistic treatment and care beyond an acute medical event; and taking the living conditions, needs, desires and rights of older persons (and their relatives) into account. They contended that where cure is not possible, the stabilisation of the disease process, relief of discomfort and the maintenance of autonomy must be the focus – with the goal of ensuring and promoting quality of life and participation.

46. Inputs described a wide range of measures but overall comprehensive laws on age discrimination and ageism in respect of health were not common. The WHO noted its Global Campaign to Combat Ageism that works to reduce and prevent ageism at all levels, including the personal, institutional, and societal. From its work, the WHO suggested three strategies to reduce ageism should be promoted: the development and implementation of policies and laws that address age-based discrimination and inequities, intergenerational interventions, and educational activities.

47. Inputs described regional standards (NHRI Guatemala), general constitutional protections (Türkiye) and national laws (Germany, Spain, Colombia). Luxembourg, Jordan and NSINDAGIZA noted developing laws and programmes that emphasize prioritization of older persons, quality of services and positive ageing. Azerbaijan and the National Human Rights Committee of Qatar noted the need to embed historical and moral norms around care for older persons in the health and care systems. Member States such as Argentina highlighted programmatic measures to reduce ageism and violence such as the "Program for the Promotion of Good Treatment and Comprehensive Protection against Violence towards the Older Persons". The establishment of specialist 'Age Ombudsmen' were also described by several inputs. By example, the newly established Finnish Ombudsman for the Elderly has a duty to promote and assess the realization of the human rights of the older persons in legislation and decision-making and works to eliminate ageism and discrimination based on age.

48. The IFA noted that societal challenges exist that limit the effectiveness and quality of care. Ageism, lack of autonomy, and paternalistic treatment from health service providers contribute to an individual's dislike of health services which may cause them to delay seeking care when needed.[25] Japan Support Centre for Activity and Research for Older Persons noted that while the right to health is guaranteed by the Japanese Constitution and embodied in health and systems, national and municipal governments, and even older persons, have poor awareness of human rights. Medical workers, including doctors, are versed in medical ethics but are ignorant of the right to health as an international standard. Similarly, BAGSO noted research that age has an influence on quality of treatment. This included older persons being offered cheaper treatments than younger persons in a comparable situation. BAGSO noted the example of the treatment of patients with a heart attack, wherein a study looking at over 400,000 patients concluded: "The older the person with a heart attack, the less costly the treatment". As a classic example of age rationing, studies also point to mastectomies in older women instead of costly breast reconstruction. Agewell India and GRAVIS noted the impacts of self-ageism manifesting in failures to disclose health issues for 'dependency anxiety'.

49. The CNDHM, Provedor de Justiça Portugal and Age International noted ageism is also a significant cause of elder abuse, and a contributing factor to elder abuse being given a lower priority as a health concern. They noted that elder abuse is neglected in the SDGs and has no indicator of its own. Despite COVID-19 resulting in increased attention on elder abuse, it has not resulted in significant policy change. The lack of specific legislation on elder abuse acts as a major barrier to older persons receiving attention. Several inputs (FNHRI, CLCA, Réseau FADOQ) noted the COVID-19 pandemic in fact identified situations of neglect that now ought to be addressed through law and system reforms.

H. Older persons' ability to exercise their legal capacity, including making an informed consent, decisions and choices about their treatment and care

50. Measures were diverse and depended on whether the laws were modelled on existing instruments such as CRPD or were derived from other sources. The WHO, Luxembourg and other inputs noted the important starting point of positive social constructions of older persons. Member States such as Argentina and the NHRI Guatemala noted the need for policies and training around informed consent including the rights in the Inter-American Convention, observing that pervasive stereotypes and ageism still posed threats to implementation. Many inputs including Costa Rica, Singapore, Germany, Azerbaijan and NHRIs (Argentina, Finland, Philippines, Qatar, Portugal) mentioned statutory protections around informed consent exist in national laws, civil codes, and court, health and care system processes. Inputs described arrangements for legal, supported and substituted decision-makers and the use of legal documents such as enduring and advance directives. Sweden observed that under law that self-determination and integrity of all patients must be respected, including the right to receive information, adapted to their needs, to consent to treatment.

51. The National Human Rights Committee of Qatar noted national laws guaranteed a number of rights: the to choose a particular treatment when more than one option is available; to refuse any experimental treatments; to choose or request to change their health service provider; to get more than one opinion on the treatment method; to have the treatment plan clarified before proceeding with the treatment procedures; and to obtain educational guidelines that commensurate with their age and level of understanding and awareness. Germany highlighted that informed choice and consent extended to aspects of long-term care and advice and that counselling supports and care bases were available. Spain and Dementia Alliance International noted the necessary change of care model through the deinstitutionalization of long-term care

[25] Sun JK, Smith J, Gillespie CW. Self-Perceptions of Aging and Perceived Barriers to Care: Reasons for Health Care Delay. 2017 [cited 2023 Jan 24]; Available from: http://www.base-berlin.mpg.

and directing healthcare towards a person-centered model, including reference to the Committee on the Rights of Persons with Disabilities' Guidelines on deinstitutionalization, including in emergencies.[26]

52. HelpAge International noted older persons often report that health and care professionals, family and friends exclude them from decision-making about their health and care and fail to support their engagement and empowerment. Dementia Alliance International further noted the critical importance of safeguards for persons with dementia, including access to independent supported decision making, and the making of advanced directives. Inputs noted that Laws continue to develop in this regard. By example, Age Action Ireland referred to Ireland's Assisted Decision Making (Capacity) Acts. They suggested new Decision Support Service will be an important step, which will involve assuming and supporting people's capacity to make decisions for themselves as a replacement for the Ward of Court system.

I. Accountability

53. A wide range of mechanisms were noted in inputs including constitutional, legislative and administrative processes. Regional instruments were noted including the right to access justice in the Inter-American Convention[27] and the African Protocol.[28] Very few if any specific arrangements had been made for older persons. The WHO reinforced the importance of disability-inclusive feedback mechanisms for quality of health services. Constitutional and legislative mechanisms were many and varied. Despite the availability of higher-level judicial interventions, such measures were rarely used according to inputs except where statutory remedies mandated this form of action. Inputs suggested that more complex and formal processes warranted legal assistance, which was often not available. Models included Luxembourg's creation of a national mediation and information service for older persons and Dementia Alliance International's suggested reparations scheme for people with dementia who experience violence, abuse and neglect in health settings.[29]

54. Quasi-judicial, non-judicial and administrative mechanisms reflected significant diversity. Mechanisms included: patient rights units within hospitals (Türkiye) or in the community (Philippines); external complaints bodies included ministries (Qatar); ethics committees and regulatory authorities (Ethiopia); national committees (Burundi); directorates (Bulgaria); health superintendents (Argentina); ADR processes (arbitration, conciliation and mediation); and many commission-based (including NHRI-based) (Repulic of Korea, India, Qatar, Rwanda, Mexico, the Netherlands) processes. Further models included: special prosecutors (Dominican Republic); medical associations (Germany); and Ombudsman (Kyrgyzstan, Portugal, Slovenia) at national and provincial levels (Luxembourg, Spain, Azerbaijan, Argentina, Croatia). Specialist health and patient Ombudsman (Finland, Costa Rica) were also described. The Provedor de Justiça Portugal observed the majority (76%) of telephone claims came from older persons, with health being one of the most targeted themes. Inputs such as the National Commission for Human Rights of Rwanda noted the importance of legal aid to assist older persons with complaints processes.

J. Participation of older persons in the planning, design, implementation and evaluation of health laws, policies, programmes and services

55. Inputs described a broad range of mechanisms. The ILO described participation in decision-making through national social dialogue is the most effective method of achieving equitable progress toward meeting SDGs. They noted the CEACR also emphasized the importance of broad, inclusive and effective social dialogue, as well as social participation involving all stakeholders, namely the State and the social partners, in addition to representative and relevant organizations of persons concerned. National

[26] CRPD/C/5.
[27] Inter-American Convention, art 31.
[28] Article 4.
[29] https://www.dementiajustice.org/.

participatory models were suggested by Luxembourg, Tanzania and Colombia. Their respective national councils play a broad role in consultation, policy and law development, rights information and intergenerational dialogue. Similar national, statutory councils were noted by NHRIs from the Netherlands, Mali and Finland, and Member States including Spain. Member States like Jordan described Ministerial councils and a national multi-sectoral committee, representing most national governmental institutions. Similar, recent multi-sectoral arrangements to observe implementation of ageing policy were described by the DPP.

56. Inputs from Argentina, Mexico, Slovenia, and from NHRIs from Burundi and the Philippines described multi-layered mechanisms for participation and consultation within health program and policy structures. This included councils at local, regional and national levels, ensuring access regardless of where they live. Germany described engagement with national advocacy groups, specialist bodies with expertise in older persons' issues and along with Nigeria, consultation with NHRIs. Azerbaijan noted the use of biennial surveys that inform relevant policy makers and Ministries to shape and reshape future policies and services. This included during the COVID-19 pandemic to ensure freedom of movement and access to services.

57. The EHRC noted the existence of vibrant associations is a guarantee for ensuring the right to participation. Similarly, Age International and other NGOs noted the importance of older persons associationss. NGOs noted the lack of awareness of health rights among older persons which was amplified be regionality and remoteness. Inputs from Qatar's and Nigeria's NHRIs noted national centers had roles in representing older persons and in expressing their interests in planning, designing, implementing and evaluating legislation, policies, programs and health services. The National Senior Citizens Center of Nigeria noted contributions in the drafting of laws, policies, programmes and services. They also used stakeholder's forums, comprising older persons and their organizations to inform their work. HelpAge Spain noted the importance of evaluation mechanisms in determining the success of engagement.

K. Promising practices

58. Inputs described a range of measures to ensure access to health care and services in older age without discrimination. This included enforcing regional instruments, constitutional guarantees, establishing and enforcing national laws, and policy, regulatory and system controls. The WHO described its support for Member States to provide continuum of health care and services (i.e., promotive, preventive, curative, rehabilitative, and palliative care) without financial burden and without discrimination related to age or disability. For example, by providing a repository of health and long-term care interventions linked to healthy ageing (i.e. Universal Health Coverage compendium) as well as developing indicators for monitoring effective coverage of health and social care services to ensure older persons are not left behind in the 2030 Agenda for Sustainable Development.

59. The United Nations Office on Drugs and Crime noted the importance of appropriately mainstreaming gender and age perspectives into policies and programmes.[30] UNECE observed that the pandemic had clarified that public health decisions affecting older persons must be guided by a commitment to dignity and equality and the right to health, noting Member States' continuing efforts to improve health systems. UNECE also noted recommendations addressing common access issues: reduction of out-of-pocket costs for healthcare; more equal distribution of services across territories; dealing with staff shortages; better organisation of services; and reduction of waiting times. The European Union and Germany both reinforced that values of universality, access to good quality care, equity, and solidarity are important but equal access needs to be guaranteed according to need, regardless of age. The European Union noted the commitment in the European Pillar of Social Rights Action Plan adopted in 2021, which included more vulnerable groups such as older persons.

[30] https://www.unodc.org/documents/commissions/CND/2019/Ministerial_Declaration.pdf

60. The use of telemedicine was highlighted by Argentina and the Netherlands Institute for Human Rights. Free health services, subsidies, or relief from fees, contributions or tax were commonly cited including by Singapore, Sweden, Tanzania, Azerbaijan, Türkiye and Argentina and NHRIs from Burundi and Portugal. Bulgaria and others referred to the use of financial incentives to encourage medical practitioners to serve in remote and hard-to-reach areas with older populations. Several inputs noted additional payments to providers of medical care, dental care and medical-diagnostic activities for working under unfavorable conditions. Inputs such as Dominican Republic noted the use of home visiting services. The Japan Support Centre for Activity and Research for Older Persons reported that in rural and underpopulated communities, the number of medical facilities has fallen since the 1980s due to consolidation and realignment, which worsened access to health care for older persons. HelpAge International and others emphasized accessibility; wherein older persons report that they face significant difficulties physically accessing services. Many older persons, even with good levels of mobility, report that the distance and cost of reaching services put them off seeking healthcare. HelpAge International further noted that older persons also report that even when they can reach health services, they are not accessible because of the lack of ramps, long queues, few suitable toilet facilities, or because services do not meet the needs of different groups, such as failing to provide information they can access.

61. Many inputs including Sweden, Dominican Republic and NHRIs from the Netherlands, the Philippines and Bosnia Herzegovina observed that close cooperation between levels of government was necessary for providing integrated and person-centred health care. National legal or policy approaches to specific or key issues were also common, including for dementia, mental health, rehabilitation, geriatric and gerontological, preventative health care, rural or remote health, treatment and medication for non-communicable diseases, health screening and oncology. Community health models were also commonly cited in contributions received, including an example from Ethiopian Human Rights Commission, who reported a government issued community-based health insurance proclamation, which is expected to ensure access to equitable, quality, and sustainable health services to accelerate the move toward universal health coverage. Ethiopian Human Rights Commission also noted that older persons in conflict and disaster-affected areas continue to experience challenges with accessibility and affordability. NGOs highlighted policy approach as including capacity development of medical, paramedical and family-based caregivers.

62. The issue of health debt attracted many comments, including the Finnish National Human Rights Institution who suggested the system for caps on health payments could be confusing and required individual monitoring. They also noted that debts among older persons were increasing. Out of pocket costs were the subject of many inputs, including HelpAge International who noted affordability as a significant barrier. They observed that limited access to health insurance and high out-of-pocket costs saw older persons report that they must forgo seeking health services or face impossible choices between health and other basic needs. NSINDAGIZA described various areas of discrimination existed around access to workplace schemes, health and life insurance providers and finance companies, and accordingly many older persons are unable to access quality health services.

63. Member States such as Luxembourg and Germany noted the importance of age discrimination laws at regional and national levels. Agewell USA noted the right to health obliges governments to enact laws and policies promoting available and affordable basic health services without discrimination. NGOs noted effective implementation of health policy was still a barrier and that protections against discrimination were not made explicit simply by virtue of a targeted policy. Access to dental services was also a critical human right issue raised by Argentina and was given by others as an example of a preventative health need often beyond the reach of older persons. The Netherlands Institute for Human Rights and Réseau FADOQ noted quality of health service issues in long-term care. They reported that health care in long-term care suffered many organizational deficiencies, had shortcomings in monitoring and quality assurance systems, insufficient staffing, and inadequate supervision of personnel.

III. Conclusion and Summary

64. Inputs from United Nations system agencies and bodies, Member States, NHRIs and NGOs distinguished between the right to health and the right to health services. Inputs were not constrained in the manner identified by the CESCR General Comment. Existing regional instruments provided normative descriptions describing the right to health,[31] and health services.[32] Inputs, including about regional instruments, noted the interconnectedness of the right[33] with a multiplicity of other rights including: safety and freedom from violence;[34] protection from abuse and harmful traditional practices;[35] free informed consent;[36] long-term care;[37] recreation, leisure and sport;[38] housing (that is healthy and can adapt to health services);[39] a healthy environment;[40] and access to justice (for enforcement of the right);[41]and non-discrimination. Existing regional instruments also provided examples of how health was embedded in critical definitions.[42]

65. Contributions noted that older persons and those with chronic conditions such as non-communicable diseases are at high risk of serious and life-threatening complications from communicable diseases if left without proper access to health services. This trend was shown extensively throughout the COVID-19 pandemic, which highlights the need for health and long-term care policies and consideration of older adults when planning and funding health services. Contributions also noted a need to refocus health services on patient-centered care and move away from individual diagnosis-based care. Holistic, patient centered care is increasingly important in older adults due to the high prevalence of multimorbidity in this demographic.[43]

66. Many inputs noted the right to health is insufficiently realised for older persons. That is, older persons' health and care needs, and the barriers they face in realising their right to health, are not adequately covered in international human rights law. The lack of specific provisions that clearly set out State obligations with regards 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. Regional instruments, national constitutions and laws are limited in geographical scope and do not offer the same level of protection across or within regions.

67. While steps had been taken to ensure access, many national constitutions and national laws did not provide guarantees of the right to older persons, nor did they definitively prohibit age discrimination and ageism in health and health services. The national examples were in essence inconsistent and lacked comprehensiveness and uniformity.

68. Similarly, despite leadership from the WHO and others, data collection about older persons' health appeared inconsistent and of limited priority. Use of the data appeared to be strategic at times, but greater use could be made through consistent data strategies and collecting disaggregated data, aligned with assessing the extent to which the right is guaranteed.

[31] Inter-American Convention, art 19.
[32] African protocol, art 15.
[33] Inter-American Convention, art 19; African Protocol, art 15.
[34] Inter-American Convention, art 9.
[35] African Protocol, article 8.
[36] Inter-American Convention, art 11.
[37] Inter-American Convention, art 12.
[38] Inter-American Convention, art 22.
[39] Inter-American Convention, art 24.
[40] Inter-American Convention, Article 25.
[41] Inter-American Convention, Article 31.
[42] The Inter-American Convention included health within definitions of "Active and healthy ageing", "Older person receiving long-term care services", "Integrated social and health care services".
[43] Referring to Picco L, Achilla E, Abdin E, Ann Chong S, Ajit Vaingankar J, McCrone P, et al. Economic burden of multimorbidity among older adults: impact on healthcare and societal costs. 2016; and Global report on health equity for persons with disabilities. Geneva: World Health Organization; 2022.

69. Steps had been taken to train more health and care professionals though the approach was fragmented, inconsistent and without any considered or noted strategic approach.

70. The alignment of macroeconomic policies could not be meaningfully reconciled but examples revealed possible inadequate spending by Governments of on older persons' health and health services.

71. Older persons face significant and diverse challenges in their enjoyment of the right to health, including the impact of intersectional discrimination and inequality based on age, gender, disability, and other grounds. Submissions lacked a comprehensive analysis on multiple and intersecting forms of discrimination relating to all areas of the right to health. There was limited evidence that laws adequately dealt with the issue of intersectionality and examples showed that intersections with gender, disability and other attributes were commonly experienced. Older persons' informed consent followed international, regional, and national models but inputs lacked sufficient information to assess their compliance with existing standards such as the Convention on the Rights of Persons with Disability, or the need to add adopt a more nuanced and complementary system for older persons, including those without disability.

72. Mechanisms for redress for denial of the right and participation were diverse and limited attention was noted about their effectiveness in enforcing the right or evaluation as to best practices.