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Ageism, Eldercare, and Healthcare: An Examination of Growing Old in Costa Rica

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AGEISM, ELDERCARE, AND HEALTHCARE: AN EXAMINATION OF GROWING OLD IN COSTA RICA

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ABSTRACT

AKSHAYA VIJAYASANKAR: Ageism, Eldercare, and Health: An Examination of Growing Old in Costa Rica
(Under the Direction of Dr. Sarah Moses)

The world's aging population and the Covid-19 pandemic have revealed the high level of ageism against older adults around the globe, which has resulted in an overall decreased quality of life for elders. Societies are now faced with the challenge of creating a suitable and equitable model of care to support their aging population. Despite the recent publication of the World Health Organization's Global Report on Ageism, there is still a large gap in the literature regarding ageism. This paper addresses the issues of institutional ageism in the eldercare and healthcare sector. I argue that Costa Rica serves as a model for other countries in reducing institutional ageism through the analysis of ethnographic interviews and supplementary data on the quality of aging in the country. This paper shows that Costa Rica combats institutional ageism through its laws and policies in its healthcare and long-term care systems.

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INTRODUCTION

It was a bright, sunny afternoon during mid-November of 2021 in Costa Rica as I climbed into my Uber ride with my backpack. I was heading to an Hogar de Adultos Mayores – nursing home – in Colonia Del Rio, a neighborhood twenty minutes away from my host family's house. "Estamos cerca," said my Uber driver, as we turned from the bustling main road into an empty street with small buildings laid side by side. I double-checked my mask, my recording equipment, and my permission forms as the car rolled to a stop in front of a bright blue building. Blue metal gates separated the building from the street, as was common in most houses in San Jose. Inside the gates were a small flight of stairs leading to another smaller gate, which finally opened to a wooden door. I was afraid I was in the wrong place for a second, but a small oval sign above the gates confirmed my location. The sun was beating down as I walked up to the gate and pressed an ominous doorbell with the sign "aqui" beside it. The wooden door cracked open to a small woman dressed in green scrubs. As soon as she saw me, she smiled and began opening the gates with a silver key around her neck. She identified herself as the caregiver I had talked to on the phone earlier and ushered me inside.

I was first led to a small office room, where I was asked to wash my hands and spray my clothes with a disinfectant. The caregiver then led me to the main hall with the residents and gave me permission to talk to any of the residents. As I glanced around the room, I noticed Sharon – dressed in yellow pants, a pink cardigan with a matching pink hat – and walked towards her. After some small talk over her evening coffee, I hit record on my phone and began my interview with her. At eighty-two years old, Sharon occasionally struggled to remember events or understand my questions. Each time she trailed off, a gentle reminder of what she was describing would get her back on track.

As I toured this and other nursing homes and interviewed their residents, I was reminded of the challenges elders faced on a daily basis, especially during the Covid-19 pandemic. I was first introduced to the topic of eldercare and ageism in the spring of 2021, during Dr. Sarah Moses' Special Topics class, but only began to understand its consequences as I researched the topic and conducted interviews with elders in Costa Rica. In my personal experience and research of ageism, I was faced with a striking realization: societies are faced with the important task of providing support and care for older people in a manner that promotes their health and dignity. This is especially relevant now, as population aging and the pandemic have revealed problems such as ageism, which exist at multiple levels and undermine the well-being of older people, and has caused some societies to re-evaluate their eldercare systems. One way countries can seek to reduce problems like ageism is through policies within the healthcare and eldercare system.

I will discuss ageism more fully in Part 1 of my thesis. It is a term first coined by Robert Butler, an American gerontologist and the first director of the National Institute of Aging in the United States, in 1964 to describe this form of age prejudice. Ageism refers to the process of "systematic stereotyping, prejudice and discrimination" directed towards others or oneself based on age (Butler 1975). It arises when age is used to categorize and divide people in ways that lead to harm, disadvantage and injustice.

This realization is especially urgent given the world's aging population. Essentially every country in the world is witnessing growth in the number and percentage of older persons in their population. People aged 65 and older are the fastest-growing sector of the population compared to all other age groups, and for the first time in 2018, outnumbered children under five years old (United Nations 2021). By 2050, 1 in 6 people will be over the age of 65, up from 1 in 11 in

2020. Population projections from UN DESA's Population Division also show that the number of people aged 80 years or older will triple in the next 30 years (United Nations 2019). This trend is defined as population aging – the demographic shift that occurs when the proportion of older persons in a population is increasing (Land 2008). It is a global issue and will have implications in nearly all sectors of society including housing, transportation, social protection, family structures, and labor and financial markets (United Nations 2021).

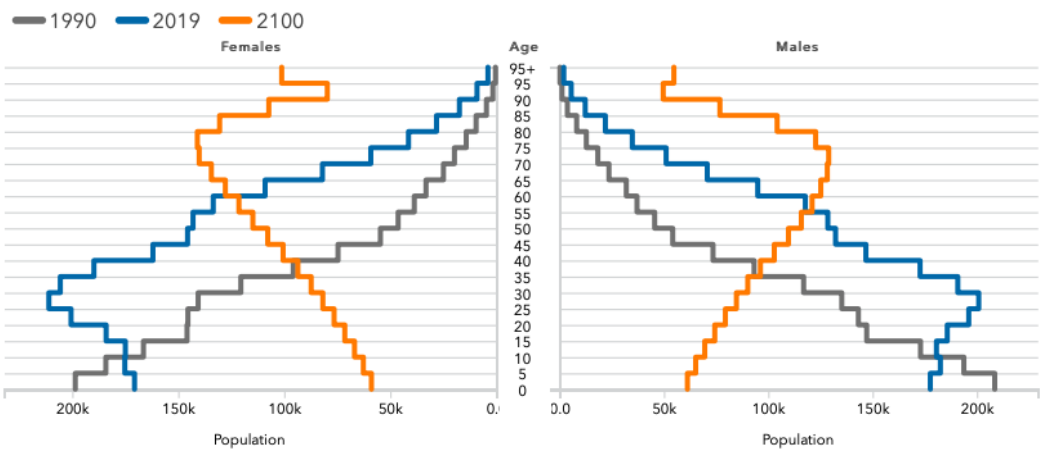
As people are living longer across the world, countries face the challenge of creating suitable and equitable long-term care systems that meet the needs of older people. Long-term care systems include services such as nursing homes and adult daycare centers that provide personal and medical care for elders for an extended period of time (NIA 2017). The Covid-19 pandemic revealed the already existing issues in facilities – low quality of care, abuse and neglect, constant staffing turnover, unmet resident needs, and a lack of integration with medical care – around the globe and has served as a wake-up call to the world to confront ageism and the inadequacies within healthcare and long-term care systems. Even developed, high-income countries like the United States witnessed chronic problems such as labor shortages, high mortality rates, and wage pressures in its long-term care facilities (Helmuth et al. 2021). The United States Congress is currently seeking to make improvements with bills such as the Nursing Home Reform Modernization Act (Library of Congress 2021) and is looking for other models of successful long-term care facilities. Along with several other countries, the United States is looking for innovative ways to respond to the future demographic reality. I argue that Costa Rica serves as a model country for addressing the international population shift while tackling problems such as age-based discrimination.

Why Costa Rica?

In my quest to find examples of countries with exemplary eldercare and healthcare – where the medical and societal needs of elders are met and ageism is low– I discovered Costa Rica. Though population aging is a worldwide challenge, it is particularly acute in Latin America, a region that is aging faster compared to other areas across the globe (Matus-López and Chaverri-Carvajal 2021). Older persons aged 65+ in Latin America will have multiplied 2.5 times and those aged 80+ by 3.5 times by 2050 (Perales-Puchalt et al. 2019). Though people are rapidly aging, it does not necessarily mean that they are living healthily. Older persons in this region face a high prevalence of health issues such as diabetes, dementia and obesity (Aranco et al. 2018; Salas et al. 2016). This, combined with an overall lower GDP and high inequity in the Latin America region, makes the creation of a successful eldercare system difficult (Busso and Messina 2020).

Age Structure

These same trends are present today in Costa Rica's age structure. Costa Rica has witnessed a sharp increase in life expectancy at birth and a sharp decrease in the birth rate. The average number of children born per woman has fallen from about 7 in the 1960s to 3.5 in the early 1980s to below replacement level today (CIA 2021). This has resulted in Costa Rica's age structure having a Stage 4 or Contracting population pyramid, which can be seen in the image below (Worldometer 2021). This means that as the number of older people is growing, there are fewer people in the younger age cohorts.



Source Age Structure: Institute for Health Metrics and Evaluation 2017

During my semester abroad in Costa Rica, I witnessed the country's changing age structure. Elders were present throughout society – sitting outside, grocery shopping, traveling, etc. I could see that, proportionally, older adults comprised a large part of the population in the country. One can especially notice the country's aging population with a visit to the Nicoya peninsula, which is located in the northern Guanacaste province and the southern Puntarenas province. It is one of six Blue Zones – areas with life expectancies higher than the average – around the globe where residents enjoy long, healthy lives. There are currently over 44 centenarians in the area, further proving that Costa Rica is doing something right (Villegas 2020).

Social Structure

In addition to demographic shifts, Costa Rica is also experiencing changes in its social infrastructure. Typically, families serve as the primary social infrastructure for elders as several generations live in the same household. According to AARP's Aging Readiness Report (2018), 85% of adults aged 65 or more in the country lived in households with at least two people in 2017. However, this structure is changing, and more and more older adults are living

independently. Older adults living alone increased by 46% from 2013-to 2017, and this number is expected to rise exponentially within the next few years (AARP 2018). In the last few years, single-person households for elders have grown from 14% to 19% and nuclear households without children – where elders live with only their spouse – rose from 15% to 21% (Universidad de Costa Rica 2020). This trend is due to older adults living longer and healthier lives with higher levels of income, which has allowed for them to live independently of their kids (AARP 2018). Cultural and economic changes in the country, such as a slow shift away from multigenerational families and higher living wages, has also resulted in adult children living separately from their families.

Isa, a staff member in one of San Jose's nursing homes, described the effect of this. "In my two years [at the nursing home], I have witnessed the number of residents almost triple." She said that as younger people moved away from home, the adults usually ended up living alone or in long-term care facilities. Though multigenerational families are still the norm in Costa Rica, there has been a shift in children living separately from their families. This is partly due to urbanization and mobility in the younger generations, which has led children to leave their home and move to urban cities (Trovato 1987). My host family also discussed the cultural change occurring in the country, where adult children nowadays prefer to live separate but near their parents.

Despite challenges such as a changing age and social structure, Costa Rica has become one of the first to create a national healthcare and long-term care system in a middle-income country that prioritizes the needs of its older citizens. It has defied the trend of life expectancy being closely related to national income: even with a relatively low per-capita income and healthcare costs globally, its life expectancy of 81 years is higher than several high-income

countries (Gawande 2021). Though Costa Rica shares several characteristics with other countries in the Latin American region, it is important to note that it has its own particularities. Its per capita income of $11,460 is higher than the regional average of $7,716 (Statista 2021). It is one of 5 Latin American countries ranking high in the United Nations' human development index. Its healthcare data are some of the best in the region despite having a regionally low healthcare expenditure of 7.56, which is lower than the regional average (World Bank 2021). Despite these differences, scholars claim that Costa Rica's long-term care facilities can be feasibly implemented in other middle-income countries (Matus-López and Chaverri-Carvajal 2021). Other countries, including the United States, are looking at Costa Rica's model as an example. For example, Costa Rica was included as one of the four case studies in the 1985 Rockefeller Founding report on "Good Health at Low Cost" (Halstead 1985).

As I began researching Costa Rica, it became apparent that the country was doing something right: it has a high longevity rate, universal healthcare, and an inclusive long-term care system. It was attracting attention from authors like Atul Gawande and countries like the United States, and receiving millions of North American and European elderly expats each year. This realization led me to ask the question: How does Costa Rica's approach to long-term care and medical care of seniors help combat institutional ageism, and what lessons might other countries take from this approach?

This thesis is divided into three main parts. In Part 1, I provide an overview of ageism, its history, and its relevance. I define ageism and discuss the different classifications, determinants, and impacts of ageism on elders. I also include proposed solutions from the WHO's Global Report on ageism, and utilize this to determine if Costa Rica utilizes these recommendations to reduce institutional ageism. In Part 2, I discuss Costa Rica's healthcare and eldercare system in

detail. Regarding healthcare, I include the country's current system, its history, and how it functions. I provide a "lived experience" section utilizing two stories from my interviews to show differing perspectives of citizens in the country. Concerning eldercare, I explore the current institutional care options for elders, the rights that older adults currently have in the country, and the newly declared national long-term care system. In Part 3, I analyze my interviews with six elders in long-term care facilities. I determine what works in Costa Rica in its healthcare and eldercare arena that successfully reduce institutional ageism and provide recommendations for other countries.

My interviews and research in Costa Rica have shown me how government intervention through policies within the healthcare and eldercare sectors is a way in which countries can reduce institutional ageism. The interviews with Costa Rican elders yielded two key findings: that they view aging as freeing, and that they feel valued as elders in the country. I show that these sentiments are largely due to the country's efforts in reducing ageism. I argue that the country uses its policies and programs in the healthcare sector to reduce institutional ageism: it ensures that elders have access to cost-free healthcare, prioritizes disability-free aging, invests in geriatric care and healthcare professionals, and includes elders in its medical education program. In the eldercare arena, I argue that Costa Rica is combating institutional ageism by protecting its elders' rights through national and international decrees, investing in geriatric care and facilities, and creating a national long-term care system. This thesis shows that Costa Rica provides an important model for other countries in the world in creating a health and eldercare system that protects the health and well-being of elders.

RESEARCH METHODOLOGY

The focus of this study is to determine if and how Costa Rica tackles institutional ageism through its policies in the arena of healthcare and eldercare for older persons. In order to pursue this research question, my thesis is interdisciplinary, drawing on sources from gerontology, psychology, sociology and social science research in population health statistics. The overall approach is a mixed-method study, combining statistical data with ethnographic interviews and direct observations.

Data Collection

I utilized methods of direct observation and ethnographic interviews while studying abroad in Costa Rica. The first portion of my research included observing different long-term care facilities and medical centers and taking detailed notes on the interactions with and treatment of elders. Through these observations, I viewed how elders were treated in Costa Rican society and how accessible healthcare was to them. While staying with a host family, I also researched and observed home and community-based modes of care, as my host family was multigenerational and had elders residing with the family.

In the nursing homes I visited, I conducted in-depth interviews with six Costa Ricans, aged 65 years or more, to collect data on the attitudes of ageism, and to determine what it is like to age in Costa Rica. I was able to visit and observe two nursing homes, so I interviewed three individuals from each. The interviews were conducted in Spanish and approved by the University of Mississippi IRB. Subjects were selected randomly and were verbally invited for an interview if they met the age requirements and agreed to participate.

Prior to the interview, I provided the subjects with the informed consent sheet and asked them for permission to audio record their responses. I also made sure to explain that they were

not obligated to participate or answer any questions if it made them uncomfortable, and that they could stop at any time. Once the subjects agreed, I began recording on the Voice Memo app on my iPhone. To protect the identity of the elders, all data has been de-identified and pseudonyms have been assigned instead of the subjects' real names throughout this thesis. During the interview, I prompted each subject with the same initial ten questions, but let the topics evolve based on their individual responses. I asked them questions such as What does aging mean to you? and What, if any, discrimination did you face due to your age?

Throughout my study abroad, I also had the opportunity to converse with members of my host family, my health professor, two staff members from the nursing homes, and my Costa Rican peers to glean information and insight about the prevalence of ageism in the country. I took detailed notes during these conversations and have utilized these to add to the analysis of Costa Rican elder and healthcare.

In addition to interviews, I consulted data on Costa Rica's medical care and long-term care towards elders. Examples include longevity, elderly dependence due to diseases, and COVID rates in long-term care facilities from sources such as the Costa Rican Longevity and Healthy Aging Study (CRELES), CEPAL's economic commission for Latin America, The 2018 Aging Readiness & Competitiveness Report for Costa Rica, and other publications from the Costa Rican government and the University of Costa Rica. I also utilized databases/libraries from La Universidad Veritas, where I studied.

Data Analysis

To analyze the data I collected while abroad, I compiled all my interviews and notes. I listened to the audio recordings of the interviews and took detailed notes on their contents. I conducted a comparative analysis of the themes discussed during the interviews and noted any

overlaps in the responses of the participants. First, I consolidated background information such as age, gender, and nursing home location to categorize the interviewees. Then I identified and compared their discussion of their experiences growing old, discrimination they faced, and perspectives on the country's healthcare. Finally, I took note of what, if any, types of ageism and discrimination the interview subjects witnessed and if there were any similarities or differences between the two nursing homes. I used this information to narrow down the main themes discussed and determine if the interviewees were in agreement with each other or not.

I used the aforementioned statistical data on Costa Rica's health and eldercare to determine if Costa Rica follows the strategies provided by the United Nations to combat institutional ageism: Policy and Law, Educational Interventions, and Intergenerational contact interventions. I argue that Costa Rica uses these strategies and policies in its healthcare and eldercare systems to reduce institutional ageism. The results from this data and the interviews were then used to help me make recommendations to other countries on what strategies seem to be most effective.

Limitations

Although studying abroad in Costa Rica provided me with a unique perspective and opportunity to interview elders, the reality is that my observations and data offer only a small glimpse into eldercare and ageism in the country. One of the major limiting factors was conducting research during a pandemic, as I was denied access to several facilities due to protective measures. I was also limited in reaching various nursing homes due to my lack of access to transportation and my limited time in the country. Out of 23 nursing homes in San Jose, where I was located, I was only permitted to observe and conduct interviews in two.

I also acknowledge the limitations of my relatively small sample size. However, I believe that they are diverse enough in age and gender to portray some of the beliefs held by the larger population of elders in nursing homes across the country. For these reasons, I have attempted not to use my interviews and observations as substantial evidence but simply as additive information along with my statistical research. If I were to expand this research in future directions, I would want to conduct interviews with a greater population of Costa Rican elders rather than limiting it to elders in nursing homes. I would also like to research further into different types of ageism, such as inter-personal and self-directed ageism and its prevalence in the country.

PART 1: AGEISM

Introduction

Aging is the process of becoming older. It is a natural phenomenon that occurs across species, kingdoms and domains. It is associated with changes in dynamic biological, physiological, environmental, psychological, behavioral, and social processes (NIA 2021). Though it is a universal phenomenon, it is often not uniform in its experience. How you age depends on your culture, your relationships, your environment, and your personal characteristics. Age is one of the first characteristics people notice about someone, so the differences in how people experience aging can lead to age prejudice. This type of prejudice is widely accepted and institutionalized across the world; in fact, it is so common that most people do not recognize it when they experience it and often perpetuate it themselves (Levy 2009).

Ageism affects both younger and older people. This often manifests as stereotypes (both positive and negative) and leads to prejudice and discrimination (Fiske 1998). For example, younger people are often described as healthy and physically active, but also lazy and unmotivated. Older people are stereotyped as warm and committed but also senile and frail (Hummert et al. 1994). These stereotypes, or how we think, influence how we feel (prejudice) and even how we act (discrimination) in relation to ourselves and others based on age (WHO 2021, 3).

My focus is on ageism against older persons, as it is a particular social concern at this time due to the recent consequences of the Covid-19 pandemic and global population aging. The Covid-19 pandemic has brought attention to the devastating impacts that elders in long-term care facilities faced, which resulted in an exorbitant amount of mortality rates, social isolation, and mental and physical health problems (Tyrrell and Williams 2020). In just the United States, over

200,000 residents in long-term care facilities have died, accounting for over 23% of all Covid-19 deaths in the country (Chidambaram 2022). In addition, 43% of residents in the United States reported feeling isolated and lonely, which has been associated with an 50% increased risk of dementia, 32% increased risk of stroke, and a fourfold increased rate of death among patients with heart issues (Paulin 2020). During the pandemic, ageist phrases such as "Boomer remover," "Stay home, save grandma," and "The old ones spoil the statistics" have circulated the public and have contributed to the description of older persons as a vulnerable and burdensome group (Kornadt et al. 2021). Several studies have shown an increase of ageism against elders during Covid-19, including outright and subtle forms of ageism. Examples of outright ageism include the decisions to withhold life-saving treatments from patients due to their age or prioritizing giving care to younger patients (Cesari and Proietti 2020). Subtle forms of ageism include patronizing forms of help, such as requiring older persons to self-isolate despite their health status or wishes (Kessler and Bowen 2020). Dr. Louise Aronson, a geriatrician at USCF, described the blatant ageism in the United States during the pandemic – people seemed indifferent when Covid-19 was thought to primarily kill old people, but grew more concerned as it began to affect young people. She explained how society deprioritizes the well-being of elders and warns that accepting "the second-class citizenship of an entire category of human being" leads to a "precedent for treating others with the same disregard" (Aronson 2020).

Though ageism has existed for centuries, it has often gone unrecognized and unchallenged. In fact, it is just being widely acknowledged – on March 18, 2021, the World Health Organization, in collaboration with the United Nations, released its *Global Report on Ageism*. It highlights the global reality of ageism and is the first "all-inclusive" text on ageism that closes the gap in research, data, and analysis needed to provide a forward-thinking approach

to address the problem. It is a call to action and challenges people to change how they think, feel and act regarding age and aging. In its 200 pages, the report defines ageism, its manifestations, and its impacts. It also lists effective strategies proven to reduce ageism and ends with three recommendations for action that everyone can follow to create a more equal world. This report could not have been timelier, as the ageism witnessed during the pandemic combined with the world's population aging have posed problems that require immediate action. The first chapter of this thesis relies extensively on the WHO's Global Report to analyze ageism as a global reality.

Dimensions

There are three main dimensions of ageism: institutional, interpersonal, and self-directed (WHO 2021, 8-21). Institutional ageism, also known as organizational ageism, consists of the laws, rules, social norms, policies and practices of institutions that lead to systematic disadvantages or unfair restriction of opportunities for individuals based on their age (Lloyd-Sherlock et al. 2016). This can be manifested in several forms, including workplace and recruitment processes, stereotyping in marketing and advertising, and access to certain services. It occurs in healthcare, social care, the workplace, media, the legal system, housing, technology, education and other institutions (WHO 2021, 22-29). Institutional ageism is often hard to recognize because these norms and practices are normalized and long-standing. For example, targeting a certain age group for work recruitment is often seen as normal despite being ageist (Dennis and Thomas 2007, 84-89). Another example of institutional ageism can be seen during the Covid-19 pandemic, where long-term care facilities prohibited access to non-essential staff, including family members, adult protective services and advocates. Though these measures were to protect the elders, it resulted in isolation and no mental and physical support for the residents (Swift and Chasteen 2021).

Interpersonal ageism occurs within interactions between two or more people. In this situation, the perpetrator is distinguished from the target of ageism and the interaction is perceived as discriminatory (WHO 2021, 31). Interpersonal ageism arises when age is used to devalue one's work ("that is good for their age"), or to patronize or disrespect someone ("you're having a senior moment") (NCALL 2021). This type of ageism also arises when someone modifies their speech, tone or vocabulary when interacting with a certain age group – it is known as elderspeak when interacting with older persons. This form of discrimination infantilizes elders and paints them as incompetent (Williams et al. 2008). Interpersonal ageism is common across the globe, but is concentrated in countries that have high or moderate levels of ageist attitudes (WHO 2021, 32-33).

The final dimension of ageism is self-directed ageism. It refers to ageist attitudes against oneself. Self-directed ageism occurs when people internalize age-based biases from repeated exposure and direct it against themselves. This type of ageism often begins at a young age, where children internalize the predominantly negative societal views of older people (Ayalon and Tesch-Römer 2017). This in turn shapes their beliefs about themselves as they age. Examples include people believing they are too old to start a new career or too young to apply for a job. Self-directed ageism is a critical dimension of ageism, as aging self-stereotypes have cognitive and physical effects (Levy 2003).

In this thesis, I will focus exclusively on institutional ageism as countries have the direct power to address this aspect of discrimation through laws and policies. However, I consider it important to understand that ageism functions on multiple levels and that these three dimensions of ageism are not mutually exclusive; they are interconnected. They interact and reinforce each

other, and addressing one dimension – such as institutional ageism – may help shape and combat against the other dimensions.

Impact

Ageism is found at all levels of society. Nerenberg's (2019) ecological model shows that ageism can disrupt society at every level. This disruption occurs at the individual level (eg. threats to autonomy and privacy), community-level (ex: lack of volunteer opportunities or jobs for elders), and social level (eg. lack of accessible and affordable housing for elders) (Leedahl et al. 2020). This disruption causes drastic impacts on elders' health and the economy.

Health

Ageism against older persons results is one factor in causing negative health outcomes. The impact of ageism on health is equal to, if not greater than, that of racism and sexism (Chang et al. 2020). These manifest in three different dimensions: physical health, mental health, and social well-being (WHO 2021, 48-54). Ageism affects physical health by lowering longevity, resulting in physical illness, leading to risky health behaviors, increasing sexually transmitted diseases, and increasing inappropriate medication use (WHO 2021, 49). Studies conducted in several countries show that older persons subject to ageism had higher rates – up to 20% – of mortality rates in comparison to those who had positive self-perceptions (Zhao et al. 2017). Physical illnesses such as functional impairment, chronic conditions, and the number of acute medical events and hospitalizations were also higher in adults impacted by ageism; over fifty different studies have found that ageism is directly linked to poorer physical health and leads to higher rates of disability and dependency, and lower recovery rates (Chang et al. 2020). Older people have an increasing rate of sexually transmitted diseases due to a lack of sexual health

services and awareness that stem from ageism, such as fewer opportunities to discuss their sexual health with their healthcare providers (Minichiello et al. 2012). In just the United States, STIs among adults aged 65 years or more have more than doubled in the past decade (CDC 2018). Polypharmacy and inappropriate prescribing due to ageism – which occur when elders with multiple ailments are "loaded" with medications rather than receiving proper geriatric care – have resulted in nonadherence to medication regimens and increased diseases and hospital visits (Vermeire et al. 2002).

Mental health impacts of ageism include mental disorders and cognitive impairment. Research has shown that ageism increases worrying, depression and anxiety over time (Ettman, Abdalla, Cohen 2020). There have been reports of post-traumatic stress disorders, depression and anxiety among elders during the Covid-19 pandemic, especially among those in confinement and those with pre-existing mental conditions (Hwang et al. 2020). Negative stereotypes and discrimination against older people have been shown to decrease their cognitive and memory ability (Lamont, Swift, Abrams 2015).

Ageism also impacts the social well-being of elders. Studies conducted in various countries found that ageism resulted in a lowered quality of life, including high levels of social isolation and loneliness, which negatively impact health (Chang et al. 2020). Violence against older persons has also been linked to ageism. Almost 20% of elders are victims of abuse, whether psychological, financial, neglect, sexual, or physical abuse (Yon et al. 2017). An extreme example of this can be seen in elderly women in sub-Saharan Africa, who are frequently accused of witchcraft. This leads to them being ostracized and banished from their community, neglected, or results in them being burned, stoned, chained or even killed (WHO 2021, 36).

Healthcare systems are also affected by ageism. Ageism causes societies to undervalue their geriatric systems, which in turn results in more adverse health outcomes in elders. This can be seen in the shortage of providers for older persons in the United States – there are only around 3,600 full-time geriatricians for over 14 million elders, when at least 20,000 geriatricians would be needed (Denis 2020). Aronson discusses this shortage in her book *Elderhood* (2019) and states that a majority of older adults are treated by non-geriatric doctors who prioritize treating diseases over a better quality of life. This leads to elders being over-treated and over-medicated, which further exacerbates their health problems. According to Aronson, healthcare systems in the United States also prioritize improving and funding departments that focus on children, cancer, neurology, and research instead of providing the same attention to geriatrics. This means that older patients end up in old, outdated facilities that don't meet their needs. It leads to a "one-size-fits-all approach" to geriatric care that "doesn't acknowledge that the needs, preferences, and realities of a 75- or 95-year-old with a medical condition might differ from those of a 35- or 55-year-old with the same thing" (Aronson 2018).

There is also a connection between ageism and ableism. Ableism refers to the discrimination and prejudice against people with disabilities, and often increases in prevalence as a person grows older, which in turn exacerbates ageism. According to the WHO, ageism and ableism are intertwined and often result in mutual reinforcement; this can be seen in the United States, where younger individuals with disabilities receive substantially higher government expenditures (WHO 2021, 10). This is a form of structural ageism, and it exists in several regions around the world. A recent Harvard Gazette story also revealed that most physicians are biased towards persons with disabilities, with over 59.3% of surveyed physicians stating that they were not confident in their ability to provide the same quality of care and service to a

disabled patient as their other patients (Slomski 2021). This has huge implications for elderly persons with disabilities, as they face not only ageism but also ableism. The substandard care provided by physicians who make assumptions about the quality and value of the lives of disabled people can be exacerbated with ageist views. In the next two chapters, I show how Costa Rica tackles this form of institutional ageism by creating a single long-term care system that unifies the fields of disability studies and gerontology to address overlapping issues.

Economy

Ageism affects the economy in two main ways — by worsening health conditions among older persons and by costing societies billions of dollars in lost productivity each year (WHO 2021, 55). As the section above discussed, ageism increases risky health behaviors, negatively impacts physical and mental health, increases recovery time due to disability, and accelerates cognitive decline. These impacts of ageism also cost the economy, as shown by a study conducted in 2020 in the United States. According to the study, healthcare costs of ageism in one year amounted to $63 billion, which is one dollar for every seven spent on the eight most common health conditions in older persons (Levy et al. 2018). It also found that 17.04 million cases of health conditions in the United States were caused by ageism.

Age discrimination also plays a factor in the loss of productivity in the workforce and leads to economic loss. A study conducted in the United States found that, on average, age discrimination against the elderly cost the economy over $850 billion in GDP and the loss is estimated to climb to $3.9 trillion by 2050 (Terrell 2020). People aged 50+ contributed to 40% of the GDP despite comprising just 35% of the population in the United States in 2018 (Accius and Suh 2020). However, this impact is projected to decrease due to ageism: there have been rising incidences of involuntary retirement, involuntary part-time labor, and involuntary unemployment

due to age-based discrimination (Accius and Suh 2020). Older persons who are willing and capable to work are being denied the opportunity to, which is drastically reducing the productivity of workplaces and affecting the economy. Discrimination against elders also leads to lost productivity due to disengagement of workers, which resulted in unexcused days of absence, lost salary payments, expensive health conditions, and unemployment, which all contributed to the negative effects on the economy (WHO 2021, 55-56).

WHO's Recommendations

Ageism exists in several aspects of life, meaning that in order to tackle it, proposed solutions need to target each characteristic. This means addressing and preventing ageism in policy, law, education, health, and intergenerational contact. The WHO's *Global Report on Ageism* provides three main recommendations to fight ageism (WHO 2021, 153-159):

1: Invest in Evidence-based strategies to prevent and respond to ageism

In the first recommendation, the WHO suggests that countries implement policies and laws that prevent age discrimination and foster equal rights of people of all ages. This also involves creating enforcement mechanisms/bodies to ensure effective implementations of the laws. It urges national governments and others to create and implement formal and non-formal educational activities to tackle ageism. These can include strategies such as campaigns (i.e. Take a Stand Against Ageism – HelpAge's International campaign) or educational activities such as perspective-taking through virtual reality, simulation, or role-playing to address ageism. Investments in intergenerational contact interventions are another evidence-based strategy that nations can use to foster contact between people of different generations, which reduces prejudice and threat against different age groups (154-156).

2: Improve data and research to gain a better understanding of ageism and how to reduce it

Successfully addressing and tackling ageism will require an understanding of all aspects of it. Currently, there are not adequate quantitative and qualitative data on the forms, prevalence, and effects of ageism. Reliable and valid data is necessary and needs to be collected. Governments, global organizations, and civil society organizations can all contribute to the creation, collection, and evaluation of data on ageism. For example, governments can allocate resources to ageism-based research and include modules on ageism in national surveys and data collection exercises, international development organizations can fund research on ageism and support the collection of age-disaggregated information, and academic and research institutions can conduct research and address gaps in data (157-159).

3: Build a movement to change the narrative around age and aging

WHO's final recommendation urges countries, international organizations, non-governmental agencies, national organizations, communities and individuals to change the narrative around age and aging. A global coalition against aging and cooperation among all entities is required to combat ageism. Actions by governments can include contributing to the global coalition aiming to change the narrative around age and aging, international development organizations can develop a global coalition to combat ageism and develop guidance to help stakeholders change the narrative, and civil society organizations can raise awareness and build understanding in communities about ageism (159-161).

Ageism is an immense problem in societies today and needs to be addressed immediately. It exists in several aspects of society and negatively impacts the physical, mental and social well-being of elders, the healthcare systems of countries, and the economy. Now more than ever, as older people live longer across the world, countries face the responsibility to adequately support this aging population while ensuring a discrimination-free aging. The main way they can

control ageism is by reducing institutional ageism through the use of laws, policies, and programs. In the next section, I demonstrate how Costa Rica is confronting ageism through policies in its healthcare and eldercare sectors.

PART 2: THE COSTA RICAN SYSTEM

Costa Rica and Healthcare

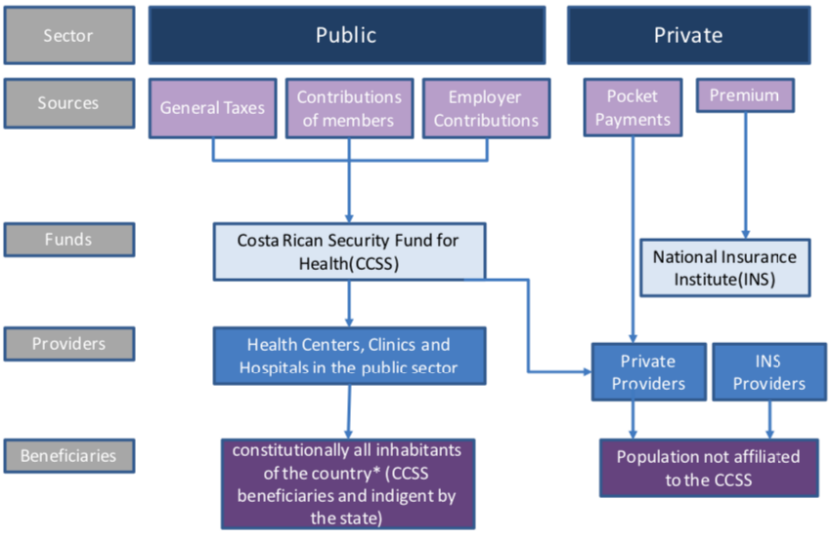
Costa Rica is a small, tropical country located in Central America. In the early 1900s, Costa Rica was labeled as one of the "poorest and most underdeveloped" countries in the Central American region and witnessed a constant threat from diseases (Ortiz 2010). During this time, as throughout the region, there were high rates of infectious diseases, low life expectancy, and high infant and maternal mortality rates. (Gawande 2021; Ortiz 2010). My host dad's abuela, Maria, recalls the lack of public health during this time. "It was very bad. There were supposed to be eleven of us [kids] in total, but three of my siblings died before they turned one." Maria says getting sick was expensive. There were no clinics near her house, so only serious illnesses would result in a doctor's visit. Things got better when she was in middle school, she thinks. "After the Caja was established, we all took a big sigh of relief."

Costa Rica is notable in that it completely transformed itself in the matter of just a few decades. Now, it is known for being the oldest democracy in Latin America, with a government that prioritizes and invests substantially in social redistributive programs (Rosero-Bixby and Dow 2016). One such program is the healthcare system, which is unique in structure and function. The country's health system consists of five main entities: Ministerio de Salud (MH), Caja Costarricense de Seguro Social (CCSS), Instituto Nacional de Seguros (INS), Instituto Costarricense de Acueductos y Alcantarillados (AyA), and la Universidad de Costa Rica.

The Ministry of Health comprises a Minister, Vice-Minister, General Director, and six central directors (Ministerio De Salud 2021). It deals with epidemiological surveillance, health research, technological development, health promotion and controls the role and regulation of health and the health market (Herrera 2005). The Caja controls the public healthcare sector. It is

a social security insurance system that was established in 1941 and consists of an Executive President, Board of Directors and six Managements (PHCPI 2015). The INS consists of an Executive President and a General Management committee with several sub-committees (Groupo INS 2021). It manages commercial insurance and insurance for traffic accidents and occupational risks (Herrera 2005). The AyA is in charge of providing potable water and sanitary sewage services throughout the country (PAHO 2002). Finally, the University of Costa Rica is responsible for teaching and training health professionals and at times providing primary health services on behalf of the Caja (Herrera 2005).

The Caja is the main entity that provides public healthcare in Costa Rica. Since its creation, the Caja has undergone several rounds of reform. In 1943, it was only in charge of the second and third level care for the insured population but grew to encompass primary care after 1995 (Baker and Gallicchio 2020). To provide health services, the Caja system relies on its own network of hospitals, clinics, health areas and the Equipos Basicos de Atencion Integral de Salud (EBAIS). Currently, the Caja has five central management offices, seven health regions, and 103 health areas (Herrera 2005). Pedro, my health professor in Costa Rica, explained, “There are three levels to the Caja like a pyramid – each gets smaller as you go up… [the system] is very organized.”



Health System Outline Source: Fernando Montenegro Torres 2013 (World Bank)

At the base of the pyramid, the Caja is organized into hundreds of health areas. These areas consist of several EBAIS, which are Costa Rica's basic comprehensive healthcare system. Each EBAIS contains specialized medical personnel, including doctors, nurses, technical assistants, pharmacists, and medical clerks (PHCPI 2019). Each EBAIS serves around 4,000 inhabitants and provides public health, including preventive services. EBAIS teams often conduct house visits to increase health coverage and collect data from communities to assess population health and performance targets (PHCPI 2019). Around 80-90% of the population's health needs are addressed in the first level of care. The other 10-20% that require complex interventions are addressed by the second and third level of care (Torres 2013).

The middle section of the pyramid or the second level of the Caja consists of a network of major clinics, and peripheral and regional hospitals that provide emergency services, specialized outpatient care, simple surgeries, and diagnostic support (Sáenz et al. 2011). The top of the pyramid and the third level of care is made up of three large general hospitals and six specialized national hospitals (Torres 2013) . These hospitals provide high-level inpatient

services and medical and surgical services that are complex in nature (Herrera 2005; Sáenz et al. 2011)

Workers pay anywhere from 4-12% of their income to support the Caja. The percentages are based on their income level compared to the minimum salary (MS). As my host dad, Miguel, explained, "The Caja is like a big team… everyone pays some money from each paycheck to support it." Employers cover employees and their families under the Caja. Independent workers have a different coverage, known as "Asegurado Voluntario" (PHCPI 2019). Minors and pregnant women not protected by the family plan, identified indigenous people, and pensioners are insured at the expense of the State (Sáenz et al. 2011).

CCSS Fees				
Category	Income Level	Contribution		
		Health Insurance		
		Member	Estate	Total
1	< 0.5777% MS	4.00%	8.00	12.00
2	0.5777% > 2MS	6.00%	6.00	12.00
3	2 MS > 4 MS	7.00%	5.00	12.00
4	4 MS > 6MS	9.00%	3.00	12.00
5	6 MS>	12.00%	0.00	12.00

CCSS Fees Source: Rafael Valverde 2019

Via this taxation system, the Caja provides healthcare and insurance to all citizens and residents of Costa Rica. After retirement (60 years for women and 62 years for men), the Caja continues to pay for healthcare and pensions for senior citizens (Torres 2013). Therefore, a majority of the elderly population receives free healthcare and access to geriatric care.

The EBAIS system is primarily credited for the excellent health of elders in Costa Rica due to its role in health promotion and disease prevention. EBAIS members conduct visits to households in their designated health areas, relieving the responsibility of elders (Torres 2013). Houses are grouped into three categories based on their priority levels. Physician and author Atul

Gawande (2021) explains in his article: “Priority 1 homes have an elderly person living alone or an individual with a severe disability, an uncontrolled chronic disease, or a high-risk condition; they average three preventive visits a year. Priority 2 homes have occupants with more moderate risk and get two visits a year. The rest are Priority 3 homes and get one visit a year.”

My host mom, Paola, says that the EBAIS systems give people peace of mind. Her great-aunt, who she thinks is around 80, lives alone. “She likes to be independent… but [during the pandemic] we were worried about her.” Due to the lockdowns and restrictions, Paola and her family were not able to visit her great-aunt often. “But we knew the EBAIS would check [up] on her…to make sure she was safe.” While abroad, I had the opportunity to visit an EBAIS clinic with my health class. The building looked like a big house from the front. Though the red paint was faded and peeling in areas, the clinic was teeming with life. Patients of all ages were seated and some even lined up outside, waiting to see a physician. Pedro, my professor, mentioned that despite the success of these clinics, there were still some drawbacks, such as long wait times and slow rates of lab results. Other criticisms of the Caja system include its long queues for clinic visits, long waiting periods for non-urgent procedures, lack of patient choice of hospitals or doctors, and limited access to certain medications.[1]

The country has also made progress in the field of geriatrics and gerontology in the other two levels of care. The Caja system is working towards a future where all hospitals and health services have at least one geriatrician with formal training. As of now, the country has invested

[1] In regards to these complaints, it is worth noting that private care is another option for residents in the country. Costa Rica has a private healthcare sector where coverage is mostly out-of-pocket or from private insurance (Sánez et al. 2011). There are separate clinics and healthcare workers who make up this system. Residents can utilize this system if they want to escape the long wait times for certain procedures or treatments in the Caja system. For example, patients can perform their laboratory tests at a private clinic for a small fee, and then submit these results to their doctors in the Caja system to expedite the overall process.

in the National Hospital of Geriatrics and Gerontology Raúl Blanco Cervantes, which exclusively serves older adults (AARP 2018).

While the Caja system covers almost all the population, there are still elders who fall through the cracks. This is where the Red Cuido, established by the National Council for Older Adults (CONAPAM), comes into play (AARP 2018). This system is the safety net for elders in exceptionally vulnerable circumstances and provides community health and wellness programs, recreational activities, and even housing to those in extreme poverty. It has served over 15,000 elders since its creation in 2014 (AARP 2018). [2]

Health and Outcomes

It is no secret that Costa Rican elders have some of the highest life expectancies and disability-free living across the globe. The Costa Rica Estudio de Longevidad y Envejecimiento Saludable (CRELES) is a set of nationally representative longitudinal surveys of health and life-course experiences of Costa Rican elders that consists of two different age cohorts (Pre-1945 and 1945-1955 Retirement Cohort). Interviews and data sampling were conducted in these cohorts in different waves (2005, 2007, 2009 for the Pre-1945 cohort and 2010 and 2012 for the

[2] It is important to discuss Costa Rica's large expat and retirement population. Costa Rica is a popular destination for expat retirees as a tropical country with beaches, mountains, and rainforests with access to universal healthcare, a lower cost of living, and a pura vida lifestyle. Costa Rica was also the first Central American country to create a "pensionado" visa to attract retirees. This visa grants temporary residency to foreigners with proof of a lifetime pension and includes full coverage for things such as hospitalizations and prescriptions (IITR 2021). Prior to the Covid-19 pandemic, around 120,000 American citizens – most of them retirees – resided in Costa Rica (US Department of State 2021).

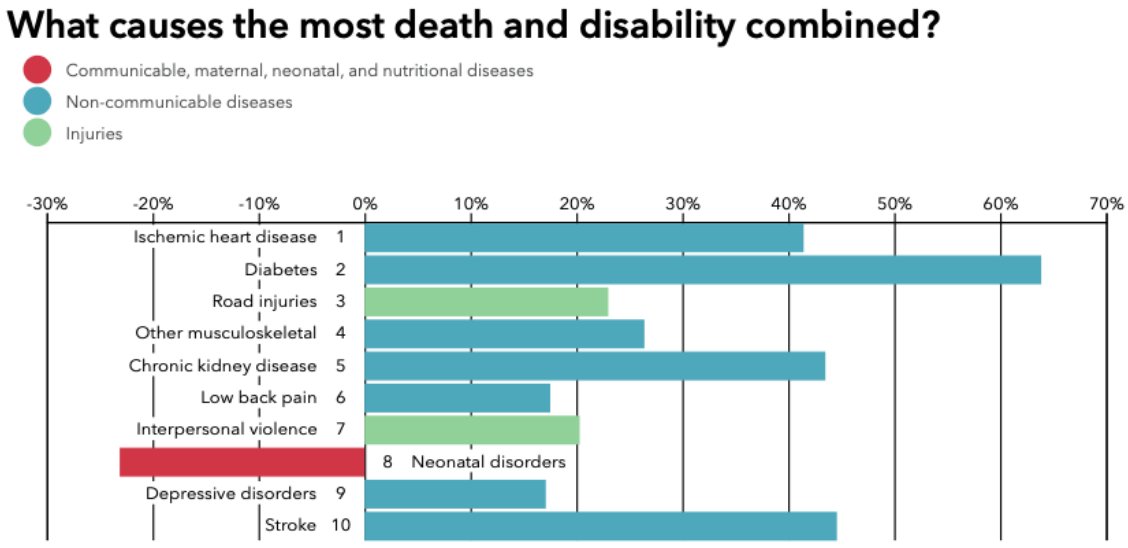
In July 2021, Costa Rica's president Carlos Alvarado passed Law 9996 (project 22.156) to attract foreign retirees and residents to the country by including incentives such as tax-free importations of vehicles and tax exemptions for importing household goods (Zúñiga 2021). Expat retirees are projected to contribute millions of dollars to the Costa Rican economy. Several new and progressive retirement homes have been built catered towards expat retirees, including Verdeza, a $10 million structure located in Escazú, San Jose (Isenberg 2013).

The future implications of the growing expat population on the country's healthcare is not clear. However, current long-term expats are required to enroll in the Caja system as a resident, and therefore pay a part of their pension for monthly premiums.

1945-1955 RC cohort). Key findings from this study show Costa Rican elders have a life expectancy as high as elders in industrialized countries. They have an advantage in cardiovascular health compared to other countries and high levels of markers of healthy aging, including longer telomere length and higher DHEAS levels (Rosero-Bixby et al. 2019).

I asked Fernando, 65, during my interview at the nursing home why he thinks Costa Rican elders are healthier. “Pura Vida,” he replied, referring to the popular phrase I kept hearing around the country. It is a phrase that means “pure life” or “simple life.” Ticos (Costa Ricans) use this phrase in almost every sentence; it is used as a greeting and goodbye, but is also an emotion, attitude, and way of life in Costa Rica. “We do not worry as much,” Fernando continued. He explained that Ticos try to be happy and live a healthy life. “It is not always easy… [but with] good family and [a] good support system…you will have less stress.”

I argue that less stress, healthy lifestyles, and a national health insurance system could be the reasons why older adults in Costa Rica are living longer and healthier. In 2011, 96% of Costa Rican elders were insured by the Caja (Rosero-Bixby and Dow 2016). The few uninsured elders can either utilize the country’s private healthcare system or, if they have no means of paying, use the Caja or the Red Cuidado, which provide subsidized or free healthcare services, among others. This, coupled with a robust primary care and geriatrics system, has drastically reduced health ailments in Costa Rica. The major causes of mortality in the country mirror that of wealthier countries and consist of noncommunicable diseases such as cancer (20%), cardiovascular disease (16%) and stroke (7%) (CDC 2022). However, older adults in Costa Rica have lower mortality rates from these diseases compared to countries like the United States (Rosero-Bixby and Dow 2016). They also have lower dependency rates due to disability or disease in old age compared to other wealthy, developed countries (Payne 2015).



Source Death and Disability: Institute for Health Metrics and Evaluation 2017

Lived Experience

I wanted to see how the healthcare and eldercare system worked for elders living in the country and decided to expand on the experiences of Sharon and Pamela, two women from the same nursing home who had very different opinions, after conducting my interviews. I was able to draw these conclusions from them: though the Costa Rican system contains problems, it was still integral in providing care and support to older adults. Improvements in the efficacy of the system were necessary, but overall, both women cited the institutional support greatly reduced their stress.

Sharon

Sharon, 82, grew up in a Catholic family in Alajuela, a province just north of San Jose. She was the eighth kid out of a family of eleven. Growing up, she recalls her family being in extreme poverty. “We were in a small house with three rooms and one bathroom… our [extended] family always had to help us.” Her family struggled to find enough money to eat, let

alone pay for healthcare. After the Caja was established, health issues became less stressful. She mentions that her local EBAIS was only fifteen minutes from her house. “It was a gift from God,” she said. When she was in her late 20s, her mother became very ill. She says the EBAIS workers would visit their house every few months to check on her mother and provide medications. However, not everything was perfect. As Sharon got older, her body became weaker. “My family has a history of health problems… when I turned 50, I got high blood pressure, high cholesterol, diabetes and a long list of other diseases.” The EBIAS lines kept getting longer, she complained. Each treatment took longer than the last. Her clinic was so overwhelmed sometimes that she would have to pay money out-of-pocket to go to a private clinic. “I was angry,” she told me. After paying a big portion of her paycheck towards the Caja every month, it was frustrating to spend more money on private care. The worst experience was when she went to the EBAIS with pain in her abdomen. The doctor told her it was most likely due to her weight and age. Despite waiting several days, she was not able to get any test results at the clinic. She eventually was admitted to a private hospital, where she was diagnosed with kidney stones. “But not everything was bad,” she continued. There have been several times when the EBAIS saved the lives of her and her family. She was very thankful for the care they provided and the house checks they conducted.

I asked Sharon about her experience growing old in Costa Rica. I questioned if she witnessed any discrimination or stereotypes due to her age and mentioned the term “edadismo” – the word for ageism in Spanish. She made a confused face and questioned, “What do you mean?” I tried to probe her more and explained what ageism was and the forms it could take, giving her examples of ageism that occurred in the US. It is different in Costa Rica, she told me. As long as you respect others, they respect you regardless of your age. “It is good to grow old

here," she continued. She mentioned that she had never heard of any negative stereotypes about aging, nor did she witness any discrimination. In fact, people like growing older here as they have more time to relax and enjoy the Pura Vida lifestyle as a Ciudadano de Oro, she said. She was the third of my interviewees to tell me that, but I was still not convinced. I asked her a few more questions regarding ageism but was met with the same answer.

I changed the topic and asked her about the nursing home -- "How did you end up here? Do you like it?" I asked. Once she turned 70, Sharon said it became hard for her children to take care of her. They were busy with their own families and work. She had to take several medications every day, each at a different time and in different amounts. She also needed extensive help moving around and bathing. These were too difficult for her family; it was easier and safer for her to stay at a nursing home. "I am very happy here," Sharon told me. She enjoys spending time with the staff, who she considers her second child. They keep her and the other residents entertained with daily activities and lots of exercises, especially during the pandemic. Usually, they get to go to the city every day, but they had been confined inside for the last seven months due to the pandemic. Though lonely at times, Sharon said it was bearable because she could see her family every morning during breakfast.

Pamela

Pamela, 77, grew up in San Jose. She was the first out of three children in an upper-middle-income family. Growing up, she was very fond of Costa Rica's health care system. "I never had any problems [with it]," Pamela said to me. She and her family would visit her local EBIAS once a year for a checkup or more often if someone was sick. She never had the need to visit a private clinic in her life.

As the interview progressed, I asked Pamela about her experience growing old in Costa Rica. “It was normal,” she said, not elaborating. “Do you know about edadismo?” I continued, describing some examples. She did not recognize the term, but she began nodding at some of my examples. She told me about a clinic a few kilometers from this one, which was shut down a few years ago due to elder abuse. She could not recall the name or describe exactly what happened, just that it was a big deal. “It happens here [in Costa Rica], but not many people know about it,” she told me. I asked her why and she mentioned that usually elders are too afraid or do not think it is a big problem.

When asked if she had any personal experiences with discrimination due to her age, she replied no. However, as we began to talk about her journey to the nursing home, I realized that she too was a victim of ageism without realizing it. Pamela had two children: a daughter and a son. She became estranged from her son when he turned 20 due to religious differences. She lived with her daughter until her late 60s, when she got into several disagreements with her daughter’s family. Pamela’s son-in-law would often infantilize her and make decisions for her. She described how he would financially control her as he was in charge of her pensions, but would never listen to her desires due to her age. As she got older, it got worse. She eventually was placed in the nursing home by her daughter.

The nursing home is where she met Sharon, her now best friend. She confided that life would be very lonely without Sharon. “My family does not talk to me anymore,” she said. She enjoys the staff, especially her favorite caretaker, Laura, who is like a daughter to Pamela.

Costa Rica and Eldercare

As noted by Sharon and Pamela above, Costa Rica's eldercare system is an essential factor in older adults in the country feeling valued and protected. The country is able to tackle institutional ageism by eradicating systematic disadvantages and ensuring that elders are an active sector in society. It does so in three ways: by creating the Ciudadanos de Oro program for elders, protecting the rights of elders, and constructing a national long-term care system.

Ciudadanos de Oro

In Costa Rica, people receive the title "Ciudadano de Oro" or "gold citizen" once they turn 65 years old. The Golden Citizen Program was established by the Caja system in 1997 to improve the quality of life for elders and it provides preferential treatment to seniors (Next Generation Trust Company 2021). With the card issued under this program, elders who are citizens or residents enjoy benefits such as skipping long lines, free bus rides, and commercial discounts in over 2000 establishments around the country (Gobierno del Bicentenario 2017; Henfling 2019). Executive Policy 26991 also mandates all public institutions in the country to give special treatment to the elderly (WHO 2003). While interviewing elders at a long-term care facility in Guadalupe, CR, I asked Diego, 69, about his experience as a ciudadano de oro. "It is fantastic," he exclaimed. "I feel like a king…I pay less for food, medicine from pharmacies, even clothes." The Caja has even created virtual courses on subjects such as physical activity, psychology, technology, etc to educate and offer the elderly population support and services they can subscribe to from home and has had significant outreach (TCRN 2021). Another interviewee, Guillermo, 73, says he and his friends would receive free workout and nutrition classes back in his community center in Limon. "My daughter would always force me to go," he laughed, "but it was good. I learned a lot… it kept me active."

Elders' Rights

Costa Rica has been a pioneer in protecting the rights of its elders. It has incorporated a series of over 100 national and international laws and decrees to guarantee that older people in the country have an "equality of opportunities" and a "dignified life" (Universidad de Costa Rica 2020). These commitments protect four different dimensions of rights for elders: Economic, social and cultural rights, Social security rights, Health and medical care rights, Adequate housing rights, and Rights to justice, peace, solidarity and digital citizenship. Some examples include la Declaración de Tres Ríos, la Carta de San José, las Reglas de Brasilia, and Law 9.857 (Penalization of Abandonment of Older Adults). These documents have been integral in the development of public policies, programs and projects that seek to protect the rights and livelihood of adults aged 65 and older in Costa Rica. The country has been a pioneer in adopting laws, programs, and policies towards elders with a human rights approach in Latin America and began creating legislation regarding this topic in the early 1970s. It is considered one of the best countries in this region for upholding these rights.

The country also has a government body – El Consejo Nacional de la Persona Adulta Mayor (CONAPAM) – dedicated to the matters of aging and old age. It was established in Article 34 of Law No. 7935 (Ley Integral para la Persona Adulta Mayor) on October 25, 1999, and is in charge of formulating national plans and policies aimed at older adults, promoting and executing the development of these programs (along with projects and services implemented by public and private entities aimed at the elderly population), and guaranteeing the improvement of the quality of life for elders in Costa Rica with a rights-based, intergenerational approach (CONAPAM n.d.).

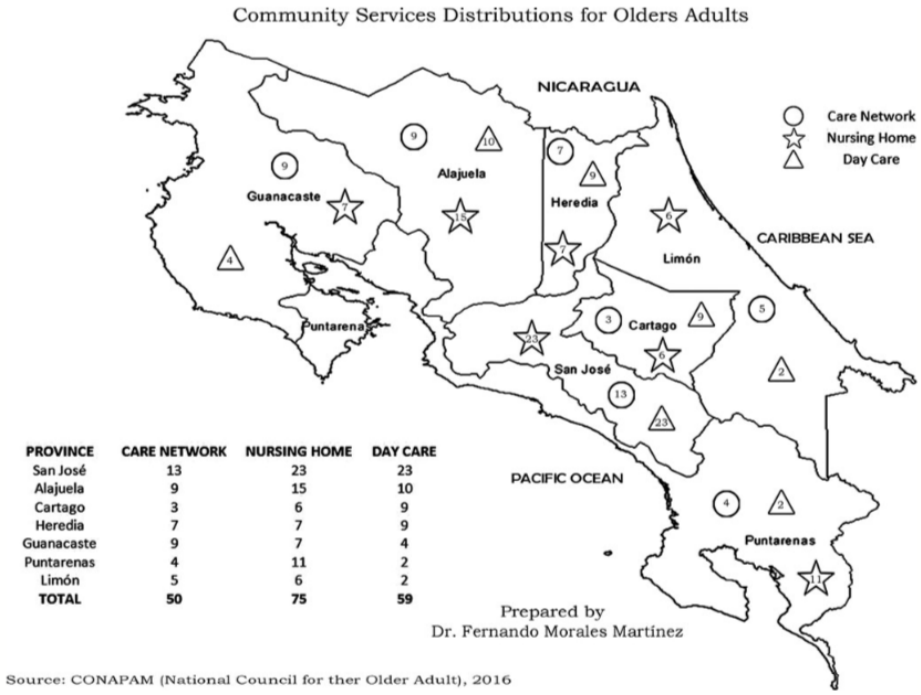
Along with rights, Costa Rica also provides elders with several public institutions that receive complaints and attend to specific situations of abuse, mistreatment, or violence. These services are divided into judicial and non-judicial services. Judicial services include the Prosecutor's Offices of the Judicial Branch, the Judicial Investigation Office [OIJ], and the Criminal and Family Courts and Tribunals (Universidad de Costa Rica 2020). These services are part of the formal judicial process that can result in the trial of the offending person, with consequences of a criminal or civil nature. The non-judicial services include institutions such as CONAPAM, the University of Costa Rica's Houses of Justice and Legal Clinics, the Ombudsman's Office, the National Women's Institute [INAMU], the Operational Center for Attention to Domestic Violence [COAVIF], the Operational Center for Attention to Domestic Violence [COAVIF], the Social and Legal Guidance Services of the Costa Rican Gerontological Association [AGECO], the 911 Emergency System, the local police, the Social Work departments of the EBAIS of the Costa Rican Social Security Fund, and the Committee for the Integral Study of the Assaulted and Abandoned Elderly [CEINAA] (Universidad de Costa Rica 2020). These services offer advisory and support services for older adults when they are victims of abuse or mistreatment.

Long Term Care

Before 2021

Though Costa Rica’s universal healthcare system is a global leader, its long-term care system is still in its infancy. However, demand for this system is rising as the country is expected to have the highest percentage of people older than 65 in the region (>30%) by 2065 (Matus-López and Chaverri-Carvajal 2021). In 2014, there were a total of 75 nursing homes, 59 day care centers, and 50 care networks for older adults in Costa Rica (CONAPAM 2014). These

institutions are usually public and supported by the Junta de Protección Social and private donors (Morales-Martínez 2017). However, some new facilities are private and funded by donors.



PROVINCE	CARE NETWORK	NURSING HOME	DAY CARE
San José	13	23	23
Alajuela	9	15	10
Cartago	3	6	9
Heredia	7	7	9
Guanacaste	9	7	4
Puntarenas	4	11	2
Limón	5	6	2
TOTAL	**50**	**75**	**59**

Source: Fernando Morales-Martínez 2017

The organization of these structures was usually divided into two programs: elderly in poverty and disability in poverty (Chaverri-Carvajal and Matus-López 2021). The first program was directed by the Consejo Nacional de la Persona Adulta Mayor and offered elders in poverty access to long-term care. However, only a small percentage of elders in poverty had access to these services, including 3,204 elders in facilities, 1,549 elders in day care centers, 799 elders in abandonment-institutional care, and 535 elders in home care (Chaverri-Carvajal and Matus-López 2021). The disability in poverty program was run by the National Council for Persons with Disabilities (CONAPDIS) and served people of all ages. However, elders 65 years

and older only comprised 4% of CONAPDIS beneficiaries (Chaverri-Carvajal and Matus-López 2021).

After 2021

On March 3, 2021, Costa Rica's president Carlos Alvarado signed decree 42878-MP-MDHIS. This decree established the National Care Policy 2021-2031, which is the country's plan to progressively implement a system of long-term care for dependent people in Costa Rica (Gobierno del Bicentenario 2021). This system is an initiative to provide welfare to the elderly, disabled persons, and chronically ill persons who require continued support and care to carry out daily activities as well as to increase coverage and add new care modalities that combine technology and the family environment. President Alvarado stated that the creation of this national public system is a step to "vindicate historically invisible populations" and carry out the country's responsibility in responding to the "cultural and demographic needs" of Costa Rica (Gobierno del Bicentenario 2021).

The National Care System (NCS) will collaborate with and join over ten other institutions to provide care for dependent persons. The National Care Secretariat, elected from the Ministry of Human Development and Social Inclusion, will manage the NCS (Chaverri-Carvajal and Matus-López 2021). This is so that the NCS and the health system will share information of dependency needs and health within the same system, creating a "complete" profile for each individual. Below is a summary of the characteristics of the NCS according to the public decree.

Coverage: The NCS will cover people over 18 years of age who lack autonomy and require assistance with daily life. It is currently estimated that there are 280,000 people in a situation of dependency, of which more than half are over the age of 65 years (Gobierno del Bicentenario 2021).

Provision of Care: The NCS will be responsible for the provision of care and will be in charge of training and/or providing financial transfers to agencies or families who will act as care workers and provide services. These workers will register with the Caja system.

Services: Telecare, home care, day care centers, long-term care centers, and a cash-for-care scheme include some of the services that will be utilized for care. Home-based care, however, will be the principal service and consists of formally trained care workers who can support beneficiaries for up to a maximum of 80 hours per month (Chaverri-Carvajal and Matus-López 2021). The cash-for-care service will only apply under specific conditions: the recipient must be entitled to home care service, their relative caregiver can't access the job market, and they live in extreme poverty (Matus-López and Chaverri-Carvajal 2021). The NCS wants to avoid institutionalization of the dependent population and emphasizes home-based services and care.

Finances: All people and services within the system will be financed through taxes and co-pays, with government revenues being the major source of funding. Income-based and co-payments will be implemented within 2022 and are estimated to cost 0.21% of the country's GDP (0.16% for elders 65+) (Chaverri-Carvajal and Matus-López 2021).

The creation of the NCS aims to create a unified, national long-term care system for elders and other disabled persons in Costa Rica. The centralized model of care will be able to cover a larger extent of the population, and with the focus on home-based care, it will allow for elders to stay longer in their family environment. The construction of this system is yet another way that Costa Rica is utilizing its legislative power to target institutional ageism. It is closing the gap in care, insurance, and services between elderly disabled persons and younger disabled persons. Though this system has not been fully implemented yet and its benefits are currently

only aspirational, the country has taken important steps in achieving its goal of complete execution of the NCS within the next 10 years.

PART 3: PRIMARY SOURCE ANALYSIS

Through my research and interviews, I discovered that institutional ageism is perceived to be very low or even non-existent among older adults I spoke with in Costa Rica. This could be because the country has invested in and created a strong foundation for its elderly citizens in the health and eldercare arena. It is important to note that the term edadismo– Spanish for ageism – is not a common concept or term in the country. This could result in elders not perceiving discrimination as ageism, which could skew the results. However, during my interviews, I utilized more common terms such as discrimination and prejudice and provided examples to prevent this from occuring.

In my analysis of the interviews I conducted with long-term care residents in Costa Rica, several of the interviewees brought up two main themes regarding age, aging, and ageism in the country. The first common theme was that elders view aging as freeing in the country. The second common theme was that the elders in the nursing home felt like their country valued them.

Aging as Freeing

The older adults I interviewed and the elders I talked to in my host family all mentioned that they viewed aging as freeing in Costa Rica. “My job is done,” said Irene, 67, when I asked her why she felt getting old felt like freedom. “There is nothing else for me to do…. I feel happier now than before,” she continued. Another interviewee, Guillermo, seconded this sentiment. “I feel free… I have worked hard my whole life and now I get to relax and watch my family grow,” he stated. All six interviewees mentioned the happiness they felt as the stress of their roles associated with raising their family or working was relinquished. I asked them if they were worried about the discrimination that comes with growing old but received blank stares. I

explained that in the United States and other countries worldwide, elders were looked down upon and often labeled as “feeble” – people were afraid of getting old. They replied that in Costa Rica, elders are viewed with respect. “No, no, there is nothing bad about growing old… other than joint pain,” joked Diego. He stated that he has not heard of any stereotypes or discrimination with aging in Costa Rica. Diego explained that growing old is seen as a normal process in the country as most people live with elders. I witnessed this phenomenon while studying abroad. Elders were represented in several aspects of society in the country; there were pictures of elders on billboards, advertisements, restaurants and even murals. In fact, my friends and I would frequent a restaurant jokingly known as “Abuelo’s restaurante” because of the giant poster of an elderly man with a quesadilla near the entrance. Guillermo discussed the various protections elders have against discrimination. “You can’t exclude older people anymore… even at jobs, or you will get in trouble.” He told me a story of his friend, who was discriminated against while looking for work due to his age. However, after complaining to CONAPAM, his employer was fired.

Source: ICDS n.d; an older Tica woman in traditional clothing as a nod to the heritage and burden of the older generation

A discrimination-free aging process was integral for the elders' view of aging as freeing. Five out of six (83%) of my interviewees stated that they had not witnessed any forms of discrimination or negative stereotypes of aging and added that the lack of this led to a worry-free aging process. This sentiment is reflected in the country's National Survey on Disability (La Encuesta Nacional de Discapacidad - ENADIS) and other surveys conducted by CONAPAM and AGECO, which measure the perception and frequency of abuse, mistreatment, and discrimination against older adults. Data from these surveys found that 10% of elders have perceived being discriminated against, with two of three elders of this percentage stating the discrimination arose due to their age (Universidad de Costa Rica 2020). However, it is essential to take these national survey results with a grain of salt as the results can stem from one of two situations: either there is actually a low level of discrimination against elders in Costa Rica, or older adults don't perceive situations as discriminatory, which can lead to underestimation. The latter was the case with Pamela (discussed in Part 2), who believed she was not discriminated against even though her story said otherwise.

From these interviews, it is evident that the perception of aging in Costa Rica is overall positive. Elders feel at peace with this process and even mention feeling freer and happier than before. A large part of this positive experience is the (perceived) lack of ageism against older adults. From my research and personal observations, this stems from two main sources: the prevalence of multigenerational families and the country's efforts to reduce institutional ageism. The prevalence of multigenerational families leads to lots of contact between different generations and leads to fewer stereotypes of older adults as it reduces the view of elders as "others." This intergenerational contact fosters interaction between people of different generations and leads to cross-generational bonding, especially within multigenerational

families. I noticed that older adults and the process of growing old were seen as normal because children grew up with their grandparents. For example, my two-year-old host brother, Tomas, spends several hours a day with his grandparents and therefore will grow up with positive impressions of the aging process in comparison to someone who does not live in a multigenerational household and has very little to no contact with older adults.

The country's lack of institutional ageism plays a prominent role in stress-free aging. Costa Rica prevents discrimination against elders in sectors such as education, transportation, and the workplace, among others and has institutions such as CONAPAM that ensure an environment free of prejudice and bias. It has ensured that its older population will continue to be integrated into society by including them in everyday life, such as in advertisements and on billboards (and not just those for health issues). These organizational efforts are mighty and have contributed to the current Pura Vida lifestyle of elders in Costa Rica, who are able to grow old without stresses about discrimination.

Valued as Elders

All six of the residents felt like they were valued members of society in Costa Rica. "The country does a good job of making us [elders] feel important," explained Fernando. He explained that Costa Rica assures that older adults can stay involved in society by having programs such as dancing, art, and exercise. "I liked the online classes I took," he continued, "they teach you about things like technology and law… I took a class on psychology." Six out of six (100%) of the residents participated in an activity dedicated to older adults in their communities at least once, and four out of six (67%) residents mentioned having attended at least ten workshops or activities. All of the residents participated in the activities provided by the nursing home and stated that this made them feel seen and valued. These activities include cooking classes or going

on trips downtown. “Two times a week we go to the green fair,” stated Sharon. “It is my favorite because we can buy things… I always buy lots of fruits and chocolate.” She mentioned that these activities help her feel “normal” and keep her connected to the community even while living in a nursing home.

I asked the elders how the Covid-19 pandemic has affected their views on aging in Costa Rica, and provided examples of the isolation adults in nursing homes faced in other countries. “It was really hard… we could not go out a lot for seven months,” said Pamela. Though difficult, the transition was bearable as the residents were not in complete isolation. The residents from both nursing homes were still allowed to have one visitor every day, as long as they were vaccinated and tested negative beforehand. The activities inside the nursing homes, though, continued. “We had regular exercise classes [and] painting classes,” Pamela said. The staff members I talked to, Isa and Laura, mentioned that they received special training and funding from CONAPAM’s smaller private organizations to keep the residents active and involved. These institutional efforts such as mandatory activities and additional funding were significant in keeping elders feeling connected to society during the pandemic and combating isolation and loneliness.

Source: Escazú News 2017; Senior day dance

Source: Mora 2016; Yoga class for older adults

My interviews showed how Costa Rica's healthcare system was another important institution in which the elders felt valued. Irene discussed how elders were the first to receive Covid vaccinations and how the local EBAIS teams delivered them. "They were very nice and

understanding… they gave us a presentation on what [the pandemic] was and explained how the vaccinations will protect us." Other interviewees seconded this statement and said they felt prioritized and cared for by the country. "Everyone knows health is wealth," Sharon said. She mentioned that elders were so healthy and happy in Costa Rica because the country helps them be healthy and active. Older adults do not need to worry about paying for expensive treatments or procedures, drastically reducing their stress. Healthcare teams also come to them, which makes them feel valued. Irene joked that if there is anything she could count on in life, it would be the EBIAS team that used to visit her house. "They always come," she laughed. While discussing the downsides of the healthcare system, such as long wait times and the gap between urban and rural health, all the elders mentioned that despite these problems, the overall situation of healthcare for elders was exceptional in the country.

While discussing the value of elders in Costa Rica, I brought up the topic of elder abuse. According to recent data from national surveys in the country, 43% of elders aged 65 and above report having been victims of violence, with the majority being verbal (38%) and physical (15%) (Universidad de Costa Rica 2020). However, over 50% of my interviewees could not think of an example of elder abuse that occurred to them or someone else. Three of the residents mentioned hearing about instances in the family setting, and only one of the three could name an incidence of elder abuse that occurred in a nursing home. Laura and Isa discussed an incident of abuse in a nursing home in San Jose where the residents were being financially abused. "It was a big deal… the police were involved, and the [nursing home] was shut down," Laura said. Fernando stated that though cases of elder abuse occurred throughout the country, the government has made efforts to halt them. He discussed how there were lots of marches against elder abuse in the past that older persons could participate in to raise awareness.

These interviews have shown that Costa Rica treats elders as valued members of society through the healthcare and eldercare systems. All six residents highlighted the importance of active participation in society to feel appreciated. Even when problems arise, such as elder abuse and discrimination, the country has been very efficient in creating laws and policies to minimize their occurrences. Costa Rica's institutional interventions – free classes for elders, EBAIS teams, geriatric healthcare, CONAPAM, protests against elder abuse – have helped combat ageism in the country.

Source: Universidad de Costa Rica 2011; March against elder abuse

PART 4: SYSTEM ANALYSIS

Lessons from Costa Rica

Healthcare

Costa Rica has been a model for health since the creation of its national healthcare system in the late 1900s. In the last few decades, the country has transformed a system that was once decentralized and controlled by banana plantations into one that protects and advocates for all of its citizens and residents. The Costa Rican universal healthcare model has ensured access to an affordable, high-quality, comprehensive primary care system that prioritizes elderly care. The people I talked to while studying abroad reiterated its effectiveness. They feel like their country truly cares about and prioritizes their well-being.

The country utilizes policies and programs in the healthcare sector to reduce institutional ageism. It has created a strong foundation of care that focuses on the quality of life for older adults and recognizes the disparities in the medical care of elders. By ensuring that older adults in the country have access to a universal healthcare system that invests in geriatric care and professionals, prioritizes disability-free aging, and includes elders in its medical education program, Costa Rica is actively combating ageism on an institutional level. Based on my research, I consider the Costa Rican healthcare system to be an exemplary model, and I believe the United States and other countries can learn from it. There are three main lessons that we can learn from the healthcare system, and that several organizations such as the Commonwealth Fund (2021) and Ariadne Labs (2021) recommend.

1: Bureaucratic Integration of Public Health

At a glance, it is easy to see that Costa Rica prioritizes public health. The country has integrated its primary health responsibilities, previously under the Ministry of Health, into the

national Caja system. This has allowed all primary, secondary, and tertiary levels of care to be organized under a single national system that focuses on one goal. I saw some of the results of this integration first hand – any healthcare problem, no matter how small or big, would be handled by a single institution, making healthcare more accessible and more efficient for Costa Ricans and foreign visitors. This large-scale integration of public health is integral to reducing institutional ageism, as it can help reduce some of the social determinants of disease and disability. For example, the Costa Rican system routinely tracks the demographic, socioeconomic and health-related characteristics of the elders they serve and includes them in national surveys. This allows for important data that policymakers can then use to improve current problems in the aging population. Integrating public health and geriatric care under one system also allows the country to prioritize the overall person rather than just their symptoms, which reduces ageist attitudes.

Other countries could follow this example. In the United States, this would mean consolidating different institutions such as the Department of Health and Human Services, Centers for Medicare and Medicaid, the National Institution of Health, and the Department of Veterans Affairs into one large agency that would have national oversight over healthcare to all Americans. This would reduce the complex bureaucratic processes regarding healthcare and create a system that is easy to navigate, especially for older adults. Additionally, it would narrow the gaps in healthcare systems in areas such as research where elders are currently not included.

2: Multidisciplinary Health Teams

Perhaps my favorite aspect of the Costa Rican healthcare system is the creation of small, multidisciplinary health teams that treat a specific population. As I discussed in detail in Part 2, these EBAIS teams prioritize health by focusing on holistic and preventative-based care models.

On top of having a clinic that can handle primary health concerns, they also conduct annual home visits. This ensures that all members of a population, especially vulnerable ones such as younger and older adults, still have access to care. Members of my host family and elders I interviewed emphasized the importance of these teams in their care. Without the EBAIS teams and their visits, many say they would have missed several appointments, vaccinations, and overall checkups. These teams are also responsible for the in-depth collection of health data, which allows the country to monitor diseases and the overall trends of population health. EBAIS teams are an essential aspect of reducing institutional ageism, as they ensure that elders have the same access to services that others have, thereby reducing disparities in healthcare.

I argue that every country can benefit from implementing teams like these, as they focus not only on treating ailments but also on preventing future problems. The emphasis on public health and data collection will also ensure a healthy population. This would be useful in the United States, especially in rural areas.[3]

3: Empanelment

Empanelment is "a continuous, iterative set of processes that identify and assign populations to facilities, care teams, or providers who have a responsibility to know their assigned population and to proactively deliver coordinated primary health care towards achieving universal health coverage" (JLN 2019). As mentioned in Part 2, it is what Costa Rica does to provide healthcare to its citizens by dividing the country into over 104 health areas, each

[3] Johns Hopkins' CAPABLE is a program in the United States that is similar to the EBAIS teams in Costa Rica. It is a model that provides five months of in-home support to elders and provides them with an occupational therapist, registered nurse and handy worker. These interdisciplinary teams help older adults with daily challenges such as bathing and dressing and help improve function without relocation to a nursing home. The program is affordable: for $3,000 in program costs, elders save around $22,000 in medical fees. Though it is not as extensive or integrated as the EBIAS teams, it is an important step towards reducing the disparities in care that elders in the United States currently witness. (Johns Hopkins Healthcare Solution 2021).

with its own healthcare team. The creation of healthcare teams that focus on only a certain section of the population allows for enhanced care and management of health. Empanelment allows elders access to nearby healthcare systems and creates a long-term relationship between the patient and the healthcare provider. This relationship can combat ageism in the healthcare system, and help elders receive an "all-around" mode of care that takes into account their life experiences.

Introducing the idea of geographic empanelment could be a game-changer for several countries. The clinic I work at in the United States often serves elderly populations from several different states. When I asked patients what led them to drive several hours for a check-up, they would mention that nearby clinics were either at capacity or too expensive. Currently, the system in the United States is more provider-centered care rather than patient-centered. This leads to problems such as significant portions of the population not having access to a usual source of care, certain population areas having higher rates of mortality or morbidity, patients not receiving satisfactory care, or patients over-utilizing secondary and tertiary levels of care due to not having access to primary care. Using geographic empanelment to "assign" specific clinics to a population could address these problems in the United States and other countries.

Eldercare

Costa Rica has made important strides toward providing eldercare for its senior citizens. As with several Central and South American countries, elders in Costa Rica hold a sacred place in society and are highly prioritized. Several elements from Costa Rica's current system that successfully reduce institutional ageism in eldercare can be applied to other countries. There are three main components to the country's system that I believe are central to eldercare:

<u>1: Support system for elders</u>

The Ciudadanos de Oro program, CONAPAM, and elders' rights, in my opinion, set Costa Rica apart from other countries in the space of eldercare. Elders I interviewed mentioned that these programs allow them to feel seen and well-respected within the country, which is unfortunately uncommon in other countries such as the United States. Costa Rica is actively creating a sense of belonging for its aging population. By providing shorter wait times, free bus passes, and discounts for department stores through the Ciudadanos de Oro program, growing old can be something people can look forward to instead of loathing. The country also tackles institutional ageism through CONAPAM, a national institution that is dedicated solely to the aging population and that is involved in creating and subscribing to national and international decrees that protect the rights of elders. This institution not only offers geriatric and social services for elders, it also offers legal protection (through the complaint system) for elders against abuse and discrimination. It is vital in providing older adults with a voice and reducing ageism. Costa Rica's commitment to elders' rights is another way the country targets institutional ageism, and it enhances the lives of elders and ensures they are equally protected.

This support system could be utilized in other countries to combat the negative perceptions of aging and to reduce stereotypes and prejudices against elders. There are currently small-scale versions of the Ciudadanos de Oro program in the United States, where elders often receive discounted items such as food from restaurants and movie theater tickets. However, it is not as abundantly used or available as in Costa Rica. Countries can follow Costa Rica's example and create a system similar to CONAPAM to reduce institutional ageism. This can aid in providing elders a space in society and help them feel heard and valued. The commitment to protecting and ensuring elders' rights is another vital aspect of reducing institutional ageism – it

guarantees that older populations are treated as equal to other populations, and protects them from abuse and mistreatment.

2: Geriatric health and wellness services

As of 2016, Costa Rica had over 50 care networks, 75 nursing homes, and 59 day care centers for older adults. Other developments include sheltered housing, club programs, and palliative care centers. The creation of these geriatric health and wellness services offers older adults options to stay engaged with the community while bettering their physical and mental health. The different care options also provide elders with a choice regarding the amount of help they need – anywhere from daycare centers to full-time nursing homes. My interviewees utilized these geriatric programs by living in a nursing home, and engaged with society through activities in local programs dedicated to elders.

This system is lacking in several countries, including the United States. These developments are crucial in helping prevent isolation, mental and physical health problems, and abuse in the elderly population. By creating systems like these, countries can tackle institutional ageism through providing adequate support and care for older populations.

3: National Long-Term Care System

Though this system has only been declared for a year, its objectives are vital to addressing institutional ageism. Creating a national long-term care system that is integrated with medical care results in a unified system with higher regulations and standards of care for elderly patients. Costa Rica's system reduces institutional ageism by emphasizing the importance of home-based care, as it prevents older adults from being displaced from their normal environment. This system maintains the independence of adults and prevents them from feeling infantilized. By linking disability in younger and older patients, the country strengthens the

movement by increasing intergenerational contact and thereby lessening ageism. It also alleviates the disparity in public support and care between younger and older persons with disability, which further reduces institutional ageism.

A national long-term care system would be beneficial to other countries, especially the United States, where the current long-term care system is fragmented and varies in the quality of care. Though the national long-term care system has not been implemented fully yet in Costa Rica, its policy framework is worth immulating. In the United States, this system would involve redesigning Medicare and Medicaid, and reimagining nursing homes. It would include enhancing training and pay for care workers. This would prevent institutional problems such as labor and funding shortages, and improve the care that elders receive.[4]

[4] The PACE (Programs of All-Inclusive Care for the Elderly) is a model of care and financing for vulnerable adults who are recipients of Medicare/Medicaid. PACE organizations provide all-around medical and supportive services and consist of primary care providers, nurses, social workers, and physical/occupational/recreational therapists (Bloom 2021). These services are provided in a PACE center, which combine geriatric and social wellness services, similar to the long-term model in Costa Rica. Though this model is on a smaller scale – with only 135 PACE organizations in 31 states – compared to Costa Rica, there have been efforts to expand the system. In fact, there has been a bipartisan bill introduced in the Senate by Senators Bob Casey and Tim Scott to expand the PACE model and include an additional $150 billion in Medicaid funding for home and community-based services (National Pace Association 2022).

CONCLUSION

The purpose of this investigation was to understand how Costa Rica's approach to healthcare and eldercare helped reduce institutional ageism. Pursuant to this question, I learned through my interviews and research that Costa Rica prioritizes the health and well-being of its older adults through the creation of policies and programs that help address disparities in the current aging population. This is done in two main sectors in the country: healthcare and eldercare. Not surprisingly, Costa Rica's model follows all of the World Health Organization's recommendations for combating ageism:

First, Costa Rica invests in evidence-based strategies to prevent and respond to ageism. The country has created over 100 laws that protect various rights of elders. These help create and foster equal rights for everyone in the country and prevent age discrimination in the healthcare and eldercare sector. The creation of institutions such as CONAPAM also serves as an enforcement body to ensure the implementation of these laws and provides older adults opportunities to make complaints if their rights are being violated.

Second, the country has dedicated itself to improving data and research to better understand ageism and ways to reduce it. This has been achieved through the creation of national surveys about discrimination and abuse that elders can participate in. Data is also collected in health settings to bridge the gap between medical treatments for elders versus populations of other ages.

Third, Costa Rica is building a movement to change the narrative around age and aging. It has established programs such as the Cuidado de Oro that create a positive outlook on growing older. The inclusion of elders in daily life, whether in murals or restaurants, also helps enforce the idea that aging is a normal part of life. The integration of medical care with long-term care,

especially for people with disabilities, is another method in which Costa Rica is creating a positive narrative of aging. The culture of multigenerational households in the country also fosters intergenerational contact and combat against ageism.

Future Directions

This thesis has greatly impacted my views on aging and has shaped my ideas about my future career in the healthcare field. As an aspiring doctor, I now feel a responsibility to advocate for older populations in the medical sector and provide competent care that takes the life experiences of elders into account while treating them. It has also taught me how the United States is lacking in healthcare and eldercare for its older population; the current system is largely fragmented and has resulted in large amounts of ageism and higher incidences of disease and disability. I hope to use this knowledge to be a proponent for institutional change in the United States.

This thesis helps provide a model for other countries in creating a system for elders that prioritizes their well-being while reducing stigmas against aging. Some of the necessary changes in the United States' long-term care that leaders like Howard Gleckman and Melissa Favreault are arguing for, such as integrating medical care and long-term services, redesigning Medicaid, and supporting adults with disabilities, could be targeted through institutional efforts such as the ones currently taking place in Costa Rica (Gleckman and Favreault 2021).

Current efforts such as the CAPABLE and PACE models in the United States contain elements of the health and eldercare system in Costa Rica, and are being explored to some degree. Though these programs are not as extensive, the successes of reducing institutional ageism in Costa Rica prove that these frameworks are necessary in societies as the age structure changes.

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ADDITIONAL CITATIONS

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