

**The admission of older people into residential care homes in Argentina:
Coercion and human rights abuse**

Abstract

[250 words]

Purpose of the study: There is very little information about the appropriateness of procedures for admitting older people into care homes in low and middle-income countries like Argentina. This study provides the first systematic study of practice and assesses the extent to which current practice respects fundamental human rights.

Design and methods: We apply different methods, including document review and national survey analysis. The study also includes a case study of a single city, La Plata, which draws on local key informant interviews, focus group discussions in different neighbourhoods, and a clandestine surrogate patient survey led by local pensioners. This innovative design provides a highly triangulated and contextualised data set.

Results: Many older people admitted to care homes did not have high levels of care dependency. Care homes did not usually require or even seek the informed consent of older people, regardless of their cognitive status. There were indications of coercive admission by family members, sometimes in order to obtain access to older people's homes and other property and finances.

Implications: The study indicates the widespread abuse of the fundamental human rights of tens of thousands of older people in Argentina. There is a need for researchers, policy-makers and civil society to acknowledge the scale of abuse and develop safeguards.

Keywords: Care homes, Argentina, admission, abuse.

Introduction

This paper examines practices of admissions into residential long-term care facilities in a Latin American city. We pay particular attention to the extent to which these practices are respectful of older people's human rights. There is a growing presence of old age care homes in Asia, Africa and Latin America, and evidence that the industry is weakly regulated (Sasat et al, 2013; Camarano et al, 2010; Cheung Wong and Leung, 2012). This raises concerns about quality of care as well as potential abuse and human rights violations of older people (WHO, 2015). One key issue is the extent to which older people are involved in their admissions. This issue is not widely researched in high income countries, with the exception of studies related to dementia, surrogate decision-making and diminished mental capacity (Chang, Schneider and Sessanna, 2011; Shanley, 2017). Some high income countries have developed mental capacity and "deprivation of liberty" legal codes concerning the capacity of the individual to make decisions about admission, as well as the freedoms they are permitted once admitted (The Law Society, 2015). In the UK and most other European countries these codes refer to the European Convention of Human Rights, which stipulates that an older person can only be admitted to a care home without informed consent when: (i) a trained assessor concludes that the person lacks the capacity to decide where to live or make decisions about their care arrangements; (ii) the person is of "unsound mind"; (iii) it is in the person's best interests to live and receive care in the care home and (iv) the consequent deprivation of liberty is necessary and proportionate to the risks that they would face otherwise.

Across high-income countries there is an expectation that care homes possess and follow a clear admissions protocol explicitly requiring the fully-informed and voluntary consent of older people being admitted. However, the limited available research suggests that, irrespective of this expectation, some care home residents feel they have been wrongfully excluded from the decision to admit them (Johnson, Popejoy and Radina, 2010). In cases of diminished mental capacity, there is increased focus on appropriate alternatives, paying particular attention to the rights of older people and the potential exposure of care homes to litigation (Kapp, 1998). The authors are only aware of two academic studies that explicitly address these issues in low and middle income countries (LMICs). Both were conducted in Argentina.

Until recently, residential care provision in Argentina was largely limited to a small number of publicly funded or charitable facilities for destitute older people (Redondo and Lloyd-Sherlock, 2010). Over the past decade, there has been a rapid extension and diversification of residential services (Gascón and Redondo, 2014). These are known locally as "*geriátricos*" or "care homes", and no distinction is usually made between different kinds of residential facilities. In 2010 Argentina's Union of Gerontological Service Providers estimated that the country contained 6,000 care homes for older people, which were mainly run on a private for-profit basis. The 2010 national census recorded 86,441 people living in registered residential care facilities for older people, of whom 70.3 per cent were women. These figures are likely to underestimate the true scale of residential care, due to the large numbers of unregistered care homes.

In 2004/5 a survey was conducted of 101 privately-run residential care homes in the city of Buenos Aires (Redondo and Lloyd-Sherlock, 2010). The study included interviews with care home managers, a questionnaire administered to 300 residents (excluding those with cognitive impairments) and more detailed, semi-structured interviews with an additional 10 residents. The survey found that over a quarter of residents felt they had had any say in the admission decision (Redondo and Lloyd-Sherlock, 2010). The survey was restricted to care homes included on official registers, and more than half of the homes approached refused to participate. Media reports indicate that many care homes operate on a clandestine basis and go unrecorded on official registers. Reliable data on the number of these unregistered care homes are not available, but in 2010 it was claimed that at least 600 such homes existed in the city of Buenos Aires alone. Consequently, there is likely to be a heavy response bias in the 2004/5 survey.

In 2013/14 Argentina's Ministry of Social Development published the country's first ever national survey of residential care homes (Roqué et al, 2016). The survey covers 1,803 facilities, which is half the total number identified in the 2010 Census. As such, the Ministry claims that the sample is nationally representative. Nevertheless, the survey authors admit that its findings are likely to have a positive bias, since the participation of care homes in the survey was entirely voluntary. Data were mainly derived from pre-arranged visits and interviews with care home directors, rather than from unannounced visits or from interviews with other staff, residents or residents' families.

TABLE 1 ABOUT HERE.

Table 1 presents selected findings from the 2013/14 survey. Strikingly, only 17 per cent of care home directors reported they required some form of informed consent from the older person before admitting them. In 62 per cent of cases permission from a relative was reported as sufficient for admission, and in 23 per cent of cases the consent form was indicated as completed by someone working in the care home itself. Failure to apply informed consent does not appear to result from high proportions of admissions involving diminished mental capacity. In 47 per cent of homes in the survey, fewer than four out of ten residents had been diagnosed with moderate or severe cognitive impairment. It is very likely that the proportion of cognitively impaired residents was lower at the time of admission and that this condition developed subsequently. A fifth of care home directors responded that they did not admit older people who were care dependent. This calls into question the very purpose of such care homes. Table 1 also indicates that significant numbers of care homes were falling well short of acceptable quality standards, in terms of both facilities and treatment of residents. For example, few care homes contained individual bedrooms, which begs the question why an older person without obvious care needs would willingly give up their personal privacy for life in a care home. Studies from high-income countries show older care home residents express a strong preference for individual rooms (Calkins and Cassella, 2007).

Study design and methods

The data presented here are taken from a wider study of LTC quality, which was not exclusively related to admissions practices. This wider study provides a detailed assessment of the quality of both residential and domiciliary care services for a single city. This is a methodological strength, inasmuch as the issues of admissions and consent emerged from the data, rather than from a prior research focus. A key goal of this wider study design was to minimise response bias, such as through the exclusion of lower quality providers or unverified testimony from care home managers.

The wider study developed a customised research design, focussing on a single city: La Plata, 35 miles south of Buenos Aires, Argentina. This selection was in part opportunistic, reflecting established networks with local stakeholders, but also reflected the benefit of studying a delineated urban setting in depth. La Plata is a medium-sized city of 650,000 people (70,000 aged 60 or more) and is relatively prosperous by national standards. In 2016 it was estimated by local key informant health and social care professionals that the city contained around 60 care homes for older people, of which all but two were run by private organisations. These ranged from informal “boarding house” care homes with untrained staff, to luxury nursing homes, which claimed to have a full range of therapeutic services. In 2016 prices ranged from around US\$460 a month for the former to over US\$2,600 for the most expensive provision.

Our study applies and combines a range of different qualitative methods, with data collection conducted sequentially (Figure 1). We began by reviewing available data and grey literature relating to LTC in La Plata. This stage of data collection occurred alongside interviews with 9 local key informants, including hospital staff working in geriatric care, local government officials responsible for care services, representatives of local NGOs with interests in LTC, and the director of a private care home (not included in the subsequent survey). They spoke in personal capacities and their contributions were fully anonymised. There were no refusals. The interviews assessed personal knowledge of LTC services in La Plata and perceptions of service quality.

We then selected two “pensioner clubs” from around 100 such clubs in La Plata.¹ Selection was opportunistic (through local contacts), and included a club in a relatively poor neighbourhood and another in a lower-middle district. We contacted the presidents and organising committees of each club and gave them a description of the project. Further information was provided in each club’s weekly general meeting, during which members were invited to participate in focus group discussions, which took place in private rooms in the clubs. Reflecting the wider interests of the main study, the focus group guide did not make specific reference to admissions issues. It assessed participants’ general knowledge and perceptions of different local care homes and other LTC services. Questions referred to patterns of LTC service use, experiences of these services, reasons for using services, sources of information about services and perceptions of service quality.

The subsequent and most innovative aspect of the study design was a clandestine audit conducted by pensioners living in La Plata. We recruited six pensioners from an established local “Elder Activist Network” which had previously studied local amenities for older people,

as part of a World Health Organisation initiative (IADB, 2015). These “pensioner-researchers” were trained to undertake observational research on care homes in their own neighbourhoods. Preparation included training sessions led by members of the project team, of whom one was a locally-based, qualified social worker. Initial sessions provided general information about the study, and allowed pensioner-researchers to work alongside the authors to develop a structured questionnaire and agree a suitable approach. A final session included a more detailed review of the guide, mock interviews, discussion about how to establish contact with care homes and the selection of homes to be visited.

The agreed approach, partly developed in advance of the training sessions and modified during them, first involved pensioner-researchers telephoning local care homes with an enquiry about a fictitious family member in need of institutional care. This was based on the following scenario:

I am looking for somewhere to look after my sister. She has some problems with her behaviour and can't manage things for herself at home.

The fictional sister's “behavioural problems” were left intentionally vague in the phone call, and may or may not have entailed dementia. Having obtained some information, the pensioner researchers made personal visits to the care homes, to ask a representative of the home further questions and conduct observational research. These questions were led by a structured questionnaire (see Appendix 1 for translation), which refers to a range of issues, including general features of the care home (size, location, type of services provided and so forth), admissions procedures and requirements, and perceived quality based on interview and observations during the visit. Interviewees were selected opportunistically, in terms of which member of care home staff hosted the pensioner-researchers. In some cases they were owners, in others they were employees of varying levels of seniority. The pensioner-researchers conducted 30 interviews in separate homes, selected from a list developed in earlier in the study. These account for roughly half of all care homes in the city. Efforts were made to cover the full range of prices and conditions, and care homes with previous links to the pensioner-researchers were excluded. Only one care home refused to participate and this was on the grounds that it had no available places. During fieldwork, the research team remained in frequent contact to offer support and advice.

The surrogate patient approach presents important ethical challenges, as the researchers misrepresented their true identities and did not obtain informed consent from the research subjects (care home directors and employees). However, it is accepted that this method is ethical where (i) it does not expose research subjects to harm; (ii) the waiver of consent is necessary to obtain scientifically valid data; (iii) the potential social value of the knowledge to be gained from the research is substantial and (iv) participants will be given information subsequent to the study (Rhodes and Miller, 2012; Pager, 2007). This study met all these criteria and full ethical approval was obtained from the relevant committee of the University of East Anglia (that was relevant to the main author). The study also ensured that the research design did not contravene Argentinian law.

The final component of the study design involved repeat interviews and a focus group with key informants, to share and discuss initial anonymised study findings. These meetings were informal and covered the full range of topics included in the study. Lastly, an open, public dissemination meeting, publicised by local media, was held in a prominent venue in central La Plata.

This mixed study design generated a complex set of different types of data, aiming to provide a rich, contextualised case-study and to reduce response bias. It does, however, create challenges for interpretation and reconciliation. Our main analytical strategy was triangulation across the different data and we sought out data that contradicted or did not fit with more general assertions. The risk of either positive or negative bias was not eliminated. For example, in the follow-up meeting pensioner-researchers commented: “I had a sense that they are used to this sort of visit, that they are forewarned and cover up a lot of things” and “There was some reticence in responding to my questions”. Several of the narratives from the focus groups conducted at pensioner clubs included a strong element of self-justification when referring to personal experiences. Conversely, negative bias may result from the study team’s own prior perceptions of problematic admissions procedures in the city of Buenos Aires.

The analytical strategy was based on a framework approach, which facilitates comparison across different forms of qualitative data and different types of respondent (Smith and Firth, 2011). We then conducted thematic analysis of the full transcripts of the qualitative data (in the original Spanish) using manual coding, guided by our research interests and insights from the wider literature. Among other issues, admissions and consent were found to be prominent themes across all forms of the data. Preliminary interpretations of the data were shared with key informants during the second wave of interviews and the follow-up focus group, in order to both assess their validity and further develop the enquiry. This phase of the study included more focussed discussion of prominent themes. Analysis was also shared at the public dissemination meeting, further supporting validation. Our interest in admissions and consent was reinforced by the national survey findings, published after the completion of our fieldwork (Roqué et al, 2016).

This paper applies a simple analytical framework to understanding admissions practices across the different forms of data. First, it considers the decision to admit an older person, including the grounds for the decision and who is involved in taking it, as well as the procedures involved in the admission process. We then consider the process of selecting a suitable care home, taking into account selection criteria and participation in this decision. The paper goes on to consider specific cases where admission was perceived by key informants to have been quite clearly coercive, considering the prevalence of such practice. In the discussion section, we explore contextual factors, which may contribute to the main study findings and consider the extent to which older people’s interests are safeguarded by state agencies or other organisations.

Results

The admission decision and procedures

The two pensioner club focus groups provided testimonies from participants about personal experiences of admitting a family member to a care home. These accounts were framed by self-justifying narratives such as:

I brought my mother here from Santa Fe [240 miles north] when she was 90... I had a lot going on at home and my husband was working in Buenos Aires. That meant she would have had to be on her own... So the first thing we did, before bringing her here, was to find her a place [in a care home]. We wanted somewhere near my house, so I could visit. I sorted out a room for her there, with all her pictures, just like the bedroom in her own house... Just for her, with a TV, photos of her grandchildren and everything. I visited her every day and it was really great... When Mum used to visit our house, after a little bit she'd say "take me back". Because she had people to talk with there, people to sing with.

This informant emphasised the suitability of the care home, including unusually a private room, and the apparent willingness of her mother to remain there. However, at no point in the discussion did the informant make reference to her mother's involvement in the decision and the apparent grounds for her admission were mainly a need for company rather than specified care requirements. In neither focus group did any participant refer to an older person's involvement in the admission decision, and there seemed to be little awareness that this was, or might be, an issue.

Less explicit motives for admission were more evident in several testimonies of other focus group participants. According to one:

Towards the end we couldn't care for my mother, so we put her in a care home... We couldn't manage, because we were both working. And she had a very strong character... She was a very active person, but she couldn't get out to run errands... She could still walk about the house, but she needed someone with her all the time... And with her strong character - when you manage everything at home yourself, you don't want someone else taking over. It's not easy... She adapted to the care home because it's a good one. She was only there a short time before she died.

In this account, no reference was made to any cognitive impairment of the older person (which might have precluded her involvement in the admission decision). The narrative indicates that the informant's mother did not have a high level of care dependency. Rather, her "strong character" and the preparedness of her family to give up their time appeared to play the critical role. While family members did not directly comment on their own preparedness to provide care, they made wider observations about changing attitudes in their neighbourhoods:

The concept of the family has changed. Putting people in care is normal now. In the past it was quite another thing: nobody would put a parent in a care home.

Again, it is telling that the informant referred to “putting people in a home”, suggesting an accepted norm that older people should not necessarily be involved in this decision. This perception was widely echoed in the testimonies of other respondents.

The clandestine audit provided additional insights about procedures for admitting older people into residential care. Only two of the 30 care homes surveyed said they would contact or see the older person before admission. In general, care home staff emphasised the ease and simplicity of admissions procedures. Typically, this required the signature of a relative, a signed contract for payment and access to the older person’s medical records. Of the two care homes requiring a meeting before admission, one said this was to ensure that the potential resident would fit in and was not a “trouble-maker”. Only two care homes claimed to provide any kind of service to facilitate the transition to living in a residential setting. Of those, one was unable to provide details and the other said it entailed the older person making initial visits on an hourly-paid basis.

Finding a care home

There was little evidence that the decision to admit older people into care homes permitted selectivity in terms of general features of care homes or the services they offered. Our wider data on local LTC services found that alternatives to domiciliary care, such as day centres, were very limited and, although some families were able to hire paid carers, the quality of that service was generally perceived as very poor. Consequently, there was often a stark choice between unsupported family care and admission to a residential care home. At the same time, the documentary analysis, key informant interviews and pensioner club focus groups indicated an acute shortage of care home places. There were long waiting lists for most local care homes and family members sometimes felt required to choose between quality and immediate availability. According to one focus group participant;

Two years ago, I wanted to put my mother in a home, but there were no places available. Two or three homes put me on a waiting list... The only one with places was just here on Calle Nirvana.... But I didn’t care for it. It had about 300 residents... It’s so big and there didn’t seem to be many people working there. There was this huge living area downstairs and the residents were sitting around, with two or three people looking after them.... Some residents just sat there at the tables; others stared out of the windows... I wasn’t able to go upstairs, where a lot more people who are seriously disabled are kept.

Key informants reported that there was a major shortage of places, with long waiting lists and admitted they sometimes resorted to sending people to homes more than 50 miles from the city. At the same time, family members referred to difficulties obtaining information about the availability of places and the quality of care in local homes. As there

was no centralised source of information, several focus group participants commented that they were obliged to visit homes and form their own judgements.

I went round all the care homes myself. I went inside and chose the one I liked the look of most. Because there isn't any care home that you would say is actually nice... I think they're all legal.

The availability of places was particularly limited for people with complex care needs, such as dementia. In some cases, these people remained for long periods in hospitals. According to one focus group participant:

My mother died 18 months ago and had senile dementia. ... The time came when she didn't recognise me anymore... She also had serious heart problems, so they admitted her to Mosconi de Berisso hospital. She was there for three months.... Then the doctor discharged her... Then she was admitted to San Juan de Dios Hospital for an irregular heartbeat and, well, she died there.

This was echoed in the key informant interviews, in which respondents noted that finding a suitable place for long-stay hospital patients was often challenging. A local health professional commented;

We had a patient who had suffered a heart attack... He was in here for a long time. His only relative was a brother in Almirante Brown [20 miles away]... When he got better we had to send him back to the same boarding house he'd come to us from. A boarding house!... We sent the brother to a government care home in Almirante Brown to see if they could take him. We did all the paperwork, sent all the documentation, so that he would get on the waiting list... But we didn't succeed.

Almost all the care homes in the clandestine audit claimed they would accept people with any health condition or functional limitation, including dementia. However, the majority required access to the person's medical records before finalising their decision. In the follow-up meetings, all key informants and the pensioner researchers were highly sceptical that care homes would in fact accept people with dementia. Of the four homes that mentioned specific conditions, two responded that they did not accept older people with incontinence, one that residents must be mobile and one that they only accepted women without cognitive impairments.

Across the study data set, finding a place in a care home, ideally without compromising too much on quality, emerged as a challenging and vexed experience. The possibility that the older person might have some say or exercise some choice in this search never arose in testimonies, either explicitly or implicitly.

Cases of potential coercion

Independently of each other, and without prompting, informants from local hospitals, regulatory agencies and charities all referred to the coercive admission of older people to

care homes by family members who sought to obtain their property. Testimonies from social workers, NGO officials and health professionals included the following examples:

Last week I had to get involved in a case where the daughter had changed the locks... We sent a report to the Family Court, so that they could intervene. Once we do that, it's out of our hands. The lady concerned was placed in a care home, since she had previously been in a hospital bed, but was completely healthy. She just didn't have anywhere to go back to, and her daughter kept the house.

We had a case who is diabetic and obese and was living in her own house with a carer quite happily, until her grandson got married. The girlfriend got pregnant and what did the family decide to do? Go and live at grandma's house... shove her into a care home and not even visit her at weekends... She died a few days ago, because she'd gone into such a grim place, locked up. I can't imagine what conditions they kept her in.

Today, an old lady phoned us to be placed in a care home, even though she had her own place... She has a granddaughter.... [who] made it clear that she was not going to look after her... We always pay special attention to the economic aspects of these cases. This kind of thing has happened with other older people before. [When the old lady was admitted] the house was left empty... It's obvious that the granddaughter is cashing in her pension and is probably living in the house or renting it out.

Discussion

Assessing the appropriateness of care home admissions is a complex challenge in all countries. Interpreting protocols may require an element of discretion and nuanced judgement on the part of decision-makers, and data on actual practices are very limited. Despite these challenges, and the limitations of the research design, this paper indicates that admissions practices for care homes in Argentina are often problematic. These practices require effective independent oversight and scrutiny, but there is little evidence that this occurs.

There is international evidence that, given a say in the decision, many older people would prefer to remain living at home, rather than permanently admitted to a residential care home (WHO, 2015). Research from other societies that theoretically place a high cultural value on inter-generational family support stress the emotional effects on older people of being placed in care (Lee, 1999). A separate study of older people conducted in Buenos Aires in 2001 found that only 15 per cent felt that being admitted into a care home was an acceptable possibility for them as they became more care dependent (Fassio, 2007). This is hardly surprising, given the widely held and it would seem justified perception that the quality of care in many care homes is very poor.

A number of contextual factors contribute to the coercive admission of older people into care homes. These include a general lack of alternative, community-based long term care services for older people. As such, relatives of dependent older people often face a stark

choice between unpaid family care or seeking admission into a residential facility. A similar context of “all or nothing” options for long term care have been observed across low and middle income countries and this calls for more provision of domiciliary and community services (WHO, 2015).

As in most of Latin America, Argentine inheritance law is based on the Napoleonic legal code, whereby the properties of the deceased are transferred directly to their children, not their surviving spouse (Martínez, 2016). In a situation where an older couple jointly own their home, a surviving partner only retains ownership of half. The surviving partner is not guaranteed continued use of the property and, if the children insist, will be required to sell it. Additionally, once the older person is admitted to a care home, or if they are certified as legally incompetent, the children obtain full control of the property. This legal system places surviving spouses, most of whom are female widows, in a highly vulnerable position.

At the same time, more limited economic opportunities for younger generations in Argentina restrict their ability to obtain housing of their own, which may increase pressure to wrest control of accommodation from older relatives (Freyre, 2014). By contrast, older generations, especially men, are more likely to have had secure lifetime formal employment, as well as access to subsidised mortgages and, in some cases, free public housing through different government programmes operating between the 1940s and 1970s (Gobierno de Buenos Aires, no date). In 2010, 84 per cent of Argentines aged 65 and over were homeowners, compared to 60 per cent of people aged 25 to 44 (INDEC, 2010).

As one senior policymaker put it:

These days, people don't even view this practice as abusive. The problem is that it is completely legal... The older person doesn't see it as an infringement of their rights. They just see it as a natural part of being old. The situation has come to be seen as normal. You get old, the children need a place of their own, so you just sell your house and go into a care home.

A further contextual factor permitting coercive admission to care homes is the limited capacity of state agencies to safeguard the rights of older people. A number of different government and parastatal agencies have responsibility for regulating care homes in La Plata. The local Ministry of Health's regulatory model focusses on the physical conditions of care homes, rather than on the treatment of residents. Different social insurance funds have some oversight of the care homes with which they have contracts, but inspections are sporadic and penalties for infringing legal requirements are only weakly enforced. In any case, none of these regulatory agencies pay attention to the processes whereby residents are admitted. La Plata also contains a number of NGOs and government agencies concerned with the protection of human rights. Of these, only one, the Defensor del Pueblo de la Provincia de Buenos Aires (DPBA), has a specific interest in admissions into care homes. DPBA's engagement with this issue is very limited, however. First, its remit only extends to state or social security -run facilities, thus excluding the large majority of private care homes in the city. Secondly, it has limited resources and a very wide remit, including domestic violence against women, policing standards, historical human rights abuses, environmental

protection and consumer rights. As such, it has limited capacity to deal with human rights abuses related to care homes admission.

There has been a wave of recent legislation in Argentina. In 2015, the National Secretariat of Children, Adolescents and the Family of the Ministry of Social Development issued a minimum set of standards for those residential care homes, which it directly administers. These include guiding principles, such as respect for residents' dignity and privacy. They also emphasise the importance of promoting residents' independence, including their involvement in decision-making. However, none of the guidelines refer specifically to admissions procedures and they only refer to decision-making after an older person has been admitted. More importantly, only eight care homes in Argentina are directly run by this state body and are therefore subject to these standards.

For the large majority of care homes, local governments have the lead legislative responsibility for ensuring the adequacy of standards. The most recent legal code for the Province of La Plata is Law 14,263 enacted in 2011. As with the national legislation, this focusses on the rights of older people once they have been admitted. The law requires care homes to possess health records and follow up forms for all residents, but does not require admissions procedures to consider the functional status of older people or to ensure for informed consent. Also, the law makes no specific reference to the rights of people with cognitive impairment. Following the dissemination of our research findings to policy-makers, changes to these legal provisions are now under formal consideration.

Conclusion

This paper applies an innovative research design to provide an in-depth case study of long-term care (LTC) services in the city of La Plata, Argentina. The case study reveals numerous problems relating to care home admissions, which in some cases amount to abuse, criminal behaviour and the infringement of fundamental human rights. There appears to be little public awareness of these issues and so the paper calls for immediate action to raise their profile as a matter of urgent public concern.

The paper has revealed a number of problematic practices. First, it shows that, despite an overall shortage in supply, a substantial proportion of older people admitted to care homes are not highly care-dependent. This raises questions about the grounds for admitting them. In some cases, this may be due to homelessness or the genuine unavailability of family members to provide low-level care. More problematically, however, admission may be more a consequence of limited family willingness to care or efforts by relatives to usurp ownership of property and to (mis)appropriate pensions.

Both the national survey and the La Plata case study indicate that care home owners and staff sometimes appeared to collude with family members in inappropriately admitting residents. Less than a fifth of home managers in the national survey reported that they required consent from the older person, even though almost all admitted individuals who were not significantly cognitively impaired. Given the positive bias of the national survey,

the real proportion of owners who require this consent may well be lower, as was the case in La Plata.

A number of contextual factors exacerbate older people's vulnerability to coercive care home admission. Many of these factors are equally in evidence elsewhere in Latin America and beyond. They include a failure of state agencies to develop appropriate legal frameworks to safeguard rights, and their limited capacity to enforce whatever safeguards do exist. Increased economic opportunity gaps between older people and younger generations, minimal state support for family carers and an inheritance law which fails to protect the interests of surviving spouses also increase the risk of coercive admission. More generally, LTC in general remains a low priority for policy-makers, relative to other aspects of social policy for older people. Responsibility is mainly delegated to local government and cuts across different agencies, leading to fragmentation and neglect. Similarly, public awareness of the issue would appear to be very limited, in terms of both recognising the prevalence of coercive admission and, most worryingly, acknowledging that the practice is abusive. Media coverage is minimal and civil society organisations are not engaged with this issue.

Not all of Argentina's contextual factors are equally present in high-income country settings, but it would be complacent to assume that coercive admission does not occur there too. In the early 1990s a number of studies referred to widespread "granny dumping" (an unhelpful but evocative term) in the USA and Japan (Wilson, 1992; New York Times, 1992). Since then, the issue has received virtually no attention. Several gerontological studies focus on the emotional anguish and stress experienced by family members involved in the admission decision and take a sympathetic approach (Reuss, Dupuis and Whitfield, 2005; Nolan and Dellasega, 2000). While this may be valid in many cases, the possibility that family members are complicit in coercive admissions for more self-interested reasons is not considered. This seems odd, given the large number of studies on financial exploitation and other forms of elder abuse.

Regardless of the quality of care individuals receive once they have been admitted into a residential care home, inappropriate admission represents an abuse of fundamental human rights. This paper indicates, for the first time, that this practice, which can entail elements of kidnap and false imprisonment, appears to be widespread in countries like Argentina. To date, it has received scant recognition from policy-makers, human rights organisations or academics. There is an urgent need to conduct comparative research in other countries, in order to both establish the extent of abuses and to raise awareness. If the proportion of population in residential care facilities in Argentina in 2010 is representative of Latin America and the Caribbean, this represented around 1.2 million people. And if the Argentine experience of admissions is representative of this region, hundreds of thousands of older people will be experiencing this form of abuse.

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Table 1. Selected findings from national survey of residential LTC facilities (2013/14)

Item	Percent of care homes surveyed (n=1803)
Admission and composition of residents	
Only admit older people who are not care dependent	20
Require consent of older person for admission	17
Contain no residents with moderate/severe cognitive impairment	11
Fewer than 40% of residents with moderate/severe cognitive impairment	47
Fewer than 60% of residents with any level of care dependency	36
Indicators of service quality	
Residents not permitted to personalise bedrooms	43
Unsatisfactory appearance of residents (cleanliness, clothing, etc.).	16
No flexibility in daily routine (eating, bathing, bedtime)	13
Residents not permitted to go outside unattended	44
Dirty appearance and unpleasant smelling	11
Some bedrooms lacking windows	17
No smoke detectors	45
Unsatisfactorily heated	24
Inadequate conditions of building	31
Problematic noise levels	61
No games available for residents	31

Source: Roqué et al (2016).

PING AND MAPPING

INTERPRETATION AND SHARING OF

RESULTS KNOWLEDGE, PERCEPTIONS AND

EXPERIENCE

Informant interviews (n =10)

Follow-up key informant interviews (n =5)

Focus group discussions (n = 9+5)

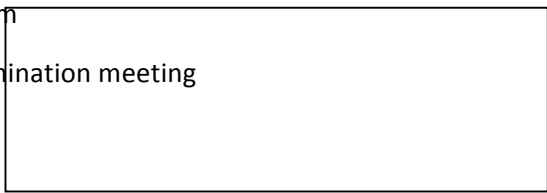
Focus Group with key Informants (n = 6)

Follow-up meeting with clandestine

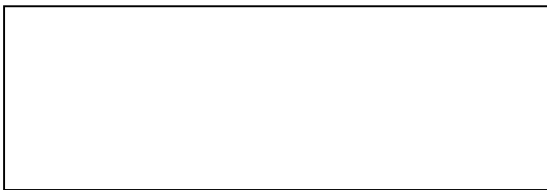
research team

Public dissemination meeting

Figure 1. Overall research design.



January to March 2016



March to May 2016



June to July 2016



August 2016 to March 2017

These clubs are community organisations run by pensioners and mainly offer leisure and social activities. They do not have a particular focus providing services for people with functional impairment and therefore are not part of the local LTC infrastructure in a way that community day centres in other countries are.