



Human Rights in An Ageing World:
Perspectives from around the world



Introduction

The 1948 Universal Declaration of Human Rights was a direct response to the atrocities of World War 2. Appropriately, it was Europe that took an early lead by creating the first human rights treaty in the world, the European Convention on Human Rights and Fundamental Freedoms (ECHR), which came into force in 1953. It established the first mechanisms for bringing complaints on an international basis.

The UK was late in adopting the ECHR, incorporating it into UK law only in 1999 with the Human Rights Act. Throughout the 1980s Britain was the source of more cases brought under the ECHR than any other country bar Turkey, so adoption of the Convention was long overdue. We are still in the infancy of the Human Rights Act, and there is much work to be done to embed the culture of 'rights for real' in public policy; in the words of the former Secretary of State for Constitutional Affairs, Lord Falconer "...**all human beings should be treated with respect, equality and fairness. These principles, I believe, are the foundation of an equal, fair and civil society**".

We have fought for a long time, and against the odds, for a better deal for older people, in pension provision, equality of opportunity, equality of access to health and social care, the right to be treated at the same standards as other age groups.

But there persists the perception that older people are a separate and distinct group, however, with issues still presented in terms of the 'crisis' of an ageing population, the 'burden' the 'costs' of which devolve on to the younger employed.

The implications of ageing across the generations are only now starting to impact seriously on the political agenda in the UK. There are encouraging signs that policy makers are beginning to accept the need for strategic investment to enable people to contribute productively at all levels in society for as long as possible.

In his first Cabinet, Gordon Brown has created an Equalities Minister, who has announced that one of her priorities for action will be support for families that care for older members. In health care, for example, the NHS programme 'Tackling Health Inequalities' focuses on spearhead areas of the greatest health and social deprivation, containing some 44% of the BME population of England (percentage of total population 28%).

This year is a pivotal moment in the evolution of policy in the UK, with the advent, in October, of the new Commission for Equality and Human Rights. It will bring together in one organisation all the previously separate strands – gender, race, disability, and for the first time, age and faith. It will produce a 3-yearly report on human rights that will be laid before Parliament, independent of any Government Minister.

Something of 'hierarchy of equality' has evolved in the past 30 years, with some groups more successful than others at challenging discrimination – often because it happened within the workplace. The Equality Review, however, earlier this year, highlighted the multiple inequalities experienced by women from ethnic minorities, for instance, showing that the picture is now one of multiple and complex inequality.

Our aspirations for a society at ease with diversity, and at ease with its ageing, will throw up new and pressing challenges. It may not always be possible to deliver equality alongside human rights. In the UK, as with other European countries, debate on faith issues, particularly at the militant extreme, suggest fundamental schisms about the very concept of equality and adherence to human rights.

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Faith comes under the category of qualified rights, which can be restricted in order to protect the rights of others or the interests of the wider community, so long as any restriction is proportionate and has a legitimate aim. It will be interesting to see how this plays out in practice.

The changing relative sizes and evolving roles of the different generations will challenge the current intergenerational balance and the arrangements which have delivered social cohesion for many years are being called into question. There are common trends across the EU: a declining number of marriages, with people marrying at a later age; rising numbers of divorce; fewer children being born and those to older parents; more single-parent households, with a third of them encountering poverty and social deprivation; more than 12% of the EU population lives alone.

We must work towards a new intergenerational balance that invests in the young and provides more support to families while encouraging the older generations to remain active. The CEHR should provide the ideal mechanism for establishing, and advancing, the idea that we must maximise, and protect, the potential of every individual; it could, in time, drive a gradual shift in perceptions about ageing and inter-generational relationships.

Only in this way can we achieve social cohesion and deliver lasting human rights at all levels of our society.

Pensions

It is recognised that the state retirement pension (SRP) system, long one of the cornerstones of the post-war British welfare state, is unsustainable in its current form. The Pensions Bill 2007 marks a welcome recognition that time spent caring will qualify for SRP; this, and the reduction of the qualifying period to 30 years are reforms of particular benefit to women. However, there is still concern about the level of pensions saving generally, in particular amongst younger workers, and the disproportionate dependence on housing as an asset for later life.

Income is a key determinant of life expectancy, and under our human rights provisions there is an absolute right to life. Is there, therefore, a human right to as long a lifespan as possible? In UK, socio-economic factors underpin a ten year difference between the life expectancy of a middle class man in the south east and a manual worker in Scotland. Rights do not exist without responsibilities, so whose responsibility is it to ensure we reach our maximum potential lifespan? By what mechanisms do we remove such disparities? As the Government has raised

the qualifying age for state pension, these issues bite in a very real way.

Social Care and Health

Our system of funding long term care is equally acknowledged to be unsustainable, and creates artificial distinctions between what is health care and what is social care. In human rights terms, the distinction is irrelevant for someone in need of a bed bath, or help with eating. Recent Government initiatives, such as the Dignity in Care campaign, 2006, are very welcome, but as yet there has been no injection of money into social care equivalent to that received by the NHS in recent years.

Recently the UK Parliament's Joint Committee for Human Rights produced a report 'Older People and Healthcare' citing over a fifth of care facilities failing to meet even minimum standards: an entire 'culture change' is needed, the committee concludes.

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Indeed. A test case on social care has highlighted a critical example of the Human Rights Act in practice. Private care homes were judged to be exempt from the Act as falling outside the definition of 'public authority', despite most of their funding coming through public channels. This left the majority of older people receiving care unprotected by the Act. The Government should have legislated at the outset but has preferred to leave it to the courts to determine an outcome, and it has rumbled on now for over two years. The legal chess game may in the long term be the best way of producing a durable result, but in the meantime vulnerable people are left in a wholly unacceptable limbo.

Within the NHS, the National Service Framework, 2001, set standards across the health service, tackling age discrimination and provision of services on basis of need as sole criterion. Charging policies should be 'demonstrably fair' – but this aim has no force of law and is difficult to challenge.

The UK is confronting a major cultural shift towards funding of essential services in health and social care. Public spending curbs have brought us inexorably to rationing: the National Institute for Health and Clinical Excellence (NIHCE) was created to bypass 'postcode

prescribing' yet has created new ethical dilemmas about allocation of scarce resources. Some key pressure points are already obvious, with huge implications for the rights of older people. Prescribing drugs according to cost-effectiveness may be the opposite of the rights-based approach: decisions can condemn patients to deteriorate before the drug will be prescribed, as is the case with Aricept for dementia patients. Such crude calculations also ignore the wider social cost of carers lost to the labour market, and the impact of course on their health and rights. Quality Adjusted Life Years (QALYs), even when adjusted, militate against older people because the core criterion is 'how long will they live?'. Budgetary limitations on care home funding can lead to couples being separated, or having to move from somewhere they have become settled.

It is useful to compare the priority given by social services departments to children, where the 'the best interests of the child' is the guiding principle, with the relative lack of attention to older people's services. We need to shift focus from 'what standards can be delivered within this budget' to 'what standards meet human rights'. If we continue to see failures in terms of under-funding the more fundamental issue will continue to be ignored.

The main users of health care and help in daily living activities are old people who have reached the end of their life span. Thus, future needs for health and social care, and thus the main area in which human rights will be exercised, will primarily depend on the number of people entering the final phase of their life. There have been several attempts to legislate in the UK in recent years on the issue of assisted dying. Other European countries have evolved workable policy on this sensitive area, but in the UK we seem to have difficulty acknowledging the organic nature of death – a life stage like any other – and in placing the dignity and autonomy of the patient centre-stage. A human rights approach offers the opportunity to move the debate on from a medico-legal dilemma to one focussed on the dignity and rights of the person nearing death.

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Discrimination

Human rights can be breached either by direct or indirect action, or direct and indirect discrimination.

It can be difficult to prove ageism in health, given the problem of co-morbidity. Doctors do and should advise against futile treatment, or that which may harm the patient. But the fact that over 65s are excluded from mainstream mental health services, for example, is clearly discriminatory. It is essential that decisions are based on assessment of the individual and not generalisations about age or 'likely' outcomes.

Age barriers are more often implicit than explicit. They exist through deeply-entrenched behaviours and attitudes towards older people, often based on generalised assumptions about individuals' ability to benefit or capacity to perform an action. The EU Directive on age discrimination in employment is now implemented in the UK but we have yet to tackle discrimination in goods and services, which will be a much more difficult arena.

Key areas such as insurance to drive, and travel should be based on capacity, not age. Drivers under the age of 25 are responsible for many times the number of accidents (and, sadly,

fatalities) than any other age group, yet it is never seriously proposed to limit their right to drive. Women have fought for equal treatment but longer lifespan means more expensive annuities. The UK rejected the EU Commission's proposal to equalise treatment between men and women until life expectancies are more in line.

A Single Equality Bill is due to be brought in this autumn, to simplify and modernise existing anti-discrimination law. It must include greater protection for older people.

Labour market, assets, inter-generational contract.

There are still barriers to workforce participation, despite legislation such as the Work and Families Act which gives people the right to request flexible working around care responsibilities, and the enactment of the EU Directive on age discrimination. Arguably a society serious about respecting the capacities of each age group to contribute would have made it a right to receive flexible working, not just to request it.

Research published by ILC UK in August 2007 highlights the increasing use of property as means of asset-building. This has led to much higher borrowing, and consequently less money put into pensions, savings and other financial products intended to meet needs of older life.

At the same time there has been a large transfer of illiquid wealth, in the form of property values, from the young to middle aged groups.

An inter-generational contract underpins both the NHS and the pension system in UK, with most cost being borne by people of working age. This may now be at risk both because of the escalating property market, and rising personal debt. Younger groups are comfortable with high levels of debt: ability to borrow, and relatively low cost of borrowing, drives asset accumulation and also distorts career choice; 'living with debt' is built in to calculations about career and family formation. Across Europe, young people tend to stay longer in their parental home compared to previous generations, from 18% of 25-29 year olds in the UK to as many as 56% of Italian young people. This could be due to more years being spent in education, and poorer opportunities for younger people in labour and housing markets which make it more difficult for them to set up their own household.

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