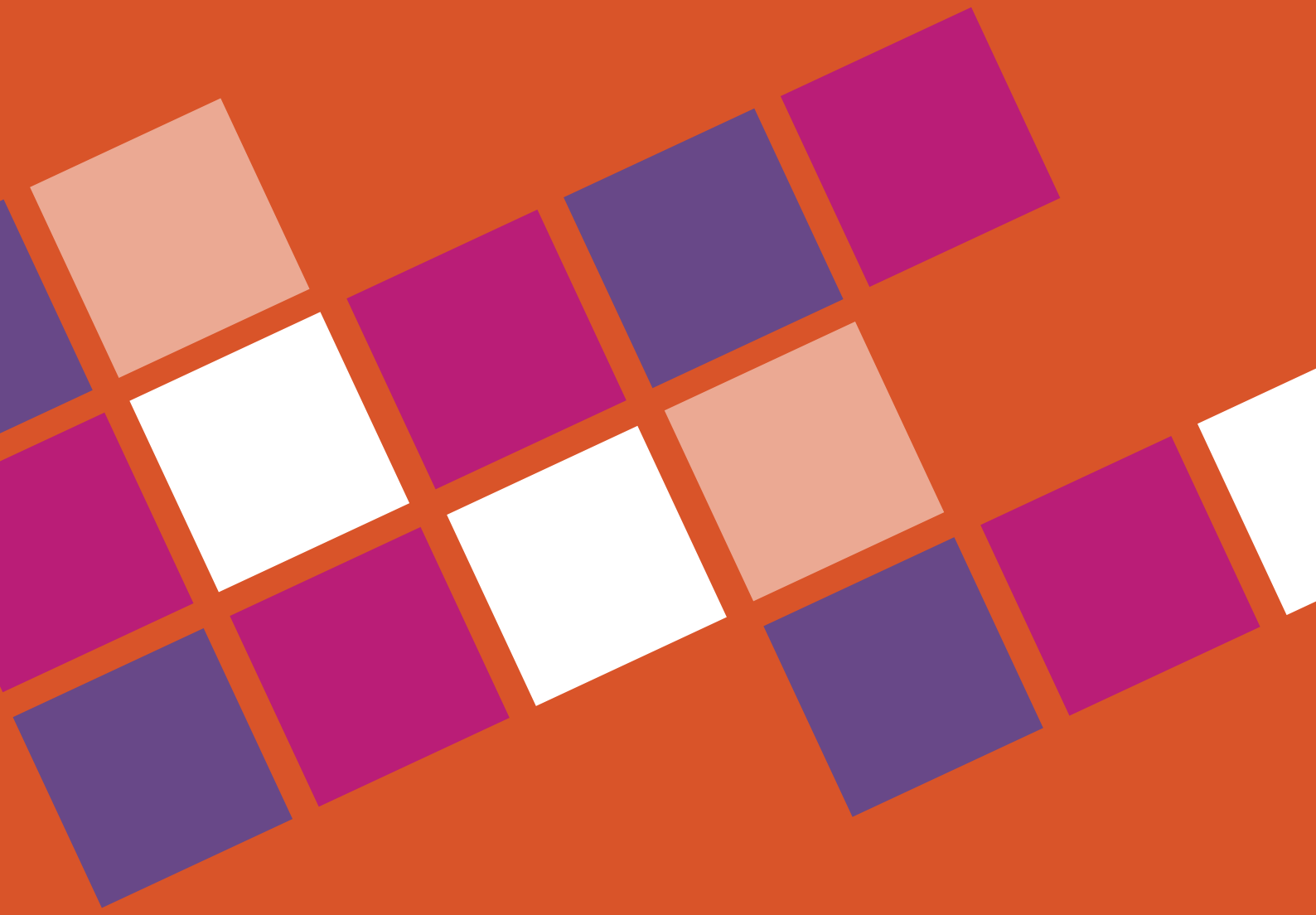
Care in Old Age: Legal Perspectives



older & bolder

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"The papers in this report were prepared to inform Older & Bolder's advocacy on health and social care."

FOREWORD

This report presents four research papers on legal aspects of older people's right to care. The papers have been prepared for Older & Bolder on a pro bono basis by a group of legal professionals working through the Public Interest Law Alliance (PILA), a project of the Free Legal Advice Centres (FLAC).

Older & Bolder is an alliance of 7 NGOs in the age sector which championed the rights of older people and advocated on their behalf between 2006 and 2013. The members of the alliance are: Active Retirement Ireland, Age & Opportunity, Alzheimer Society of Ireland, The Carers Association, Irish Hospice Foundation, Irish Senior Citizens Parliament and Senior Help Line – Third Age. Older & Bolder is closing in June 2013 but its member organisations will maintain their work to advance the situation of older people in Ireland.

The papers in this report were prepared to inform Older & Bolder's advocacy on health and social care. In February 2011, the members of the alliance agreed a shared policy position on access to health and social care for older people. This position was set out in ***One for All, Age Friendly Health and Social Care: Principles and Experience***, a paper which formed the basis of Older & Bolder submissions to influence the new Programme for Government. Between March – July 2011, Older & Bolder conducted a follow-up national consultation with older people to ascertain their views on key health issues. The findings were published in a report, ***Older People Speak Up on health, social care and the future of healthcare financing in Ireland*** and laid the foundation for a national campaign, ***Make Home Work, The right to age well at home.*** This campaign, launched by Older & Bolder in November 2011 was designed to run until November 2012. In fact, the level of support for the campaign from older people was such that it continued into 2013. Though Older & Bolder is closing, the ***MAKE HOME WORK*** campaign will continue in the future under the leadership of The Carers Association. All of these papers remain available on Older & Bolder's archived website, **www.olderandbolder.ie**

The purpose of the current report is to make legal research - originally prepared as a resource to Older & Bolder in July 2011 – available to a wider audience. The opinions expressed in the papers are those of the authors and do not necessarily reflect the views of Older & Bolder.

Rebecca Lacy's paper examines the 1970 Health Act (as amended) showing that the Act confers on individuals a right to in-patient hospital care but no right to community care. Susan Carey's paper examines legal definitions of 'care' in relation to older people in a number of jurisdictions and in Ireland. Clara O'Sullivan's paper describes the role of a Community Visitor programme in monitoring residential care institutions in Australia and analyses the legislative protection afforded to whistle-blowers. Sophia Purcell's paper analyses European and international perspectives on age as set out in selected legislation, international instruments and case law.

I would like to thank all those involved in the preparation of this report:

- Ms. Lianne Murphy, Project Officer, PILA;
- The authors of the papers: Ms. Susan Carey, BL, Ms. Rebecca Lacy BL, Ms. Clara O'Sullivan, practising solicitor and Ms. Sophia Purcell BL;
- The staff of Older & Bolder: Ms. Patricia Conboy, Director, Mr. Diarmaid O'Sullivan, Campaign Researcher and Ms. Mary Cleary, Administration Manager.

We hope that readers will find these papers useful and that they will inform continued advocacy in support of the rights and entitlements of older people.

Owen Keenan,
Chairperson, Older & Bolder

"The purpose of the current report is to make legal research available to a wider audience."

THE RIGHT TO CARE

An Examination of Irish Health Care Legislation

Rebecca Lacy
Barrister At Law

Introduction

What appears to have been occurring within the Irish health services in recent decades is an approach which treats the existing legislation with insufficient respect while, at the same time, treating policy positions as if they have the force of law.

In 2000, Kevin Murphy, Former Ombudsman and Information Commissioner, presented a report before the Dáil and Seand titled "Nursing Home Subventions". Part of the response at the time was a commitment by Government that, insofar as the legal entitlements of older people to nursing home care might be unclear, there would be legislative action to put these matter beyond doubt. In August 2009, Emily O'Reilly, Current Ombudsman and Information Commissioner, reported that she was receiving complaints about access to nursing home care which were no different to those Kevin Murphy received in 2000 or that of his predecessor, Michael Mills, received as far back as 1985. There appears to exist a fundamental difference of opinion between the Office of the Ombudsman, on the one hand, and the HSE, on the other hand, regarding the correct interpretation of the relevant legislation.

In the research I have undertaken on the right of access to care, provided for under Irish legislation, I will begin with an analysis of the Health Act 1970 (as amended) (hereafter known as "the 1970 Act") on the basis that subsequent amendments have not altered the fundamental scheme of the Act in general terms.[1] Thereafter I will examine how the Courts have interpreted the 1970 Act, the definitions contained therein and the obligations on the State to provide same. Finally I will proceed to discuss the recent Nursing Home Support Scheme Act 2009 (hereafter referred to as the "NHSS Act").[2]

1 p. 54 "Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland", Office of the Ombudsman

2 An analysis of the legislation applying to older people's access to Medical Cards falls outside the scope of this paper.

Health Act 1970 (As Amended)

The law under the Health Act 1970 (as amended) is unclear and does not provide a transparent picture of what rights are conferred on individuals regarding their health care. **"The principle of the Rule of Law presupposes that those who are affected by a law should be able to ascertain its meaning and effect. A system of language and law understood by only a few, where only a few have the ability to make authoritative statements about what is and is not permitted under the law, cedes power to those few."**[3]

Part IV of the 1970 Act deals specifically with the range of services to be provided and identifies to whom, and on what terms, the services will be provided. This Part is broken in six sections, which I propose to deal with individually below with regard to the purpose of this paper.

(a) Chapter I of Part IV – Heath Act 1970:

Chapter 1 identifies two separate categories of persons falling within the ambit of the Act; full eligibility (medical card holders) and those with limited eligibility.

Section 45 (consolidated) of the 1970 Act provides for the following:

> *"(1) A person in either of the following categories and who is ordinarily resident in the State shall have full eligibility for the services under this Part—*
>
> *(a) adult persons who, in the opinion of the Health Service Executive, are unable without undue hardship to arrange general practitioner medical and surgical services for themselves and their dependants,*
>
> *(b) dependants of the persons referred to in paragraph (a).*
>
> *(2) In deciding whether or not a person comes within the category mentioned in subsection (1)(a), the Health Service Executive shall have regard to the person's overall financial situation (including the means of the spouse, if any, of that person in addition to the person's own means) in view of the person's reasonable expenditure in relation to himself or herself and his or her dependants, if any..."*

As can be seen above, full eligibility is granted by way of a means test, upon application to the HSE, where a person is unable to arrange GP/Surgical service for oneself and their dependants without undue hardship. It is unclear what the definition of "undue hardship" is and it seems this section is left without clear definition to allow the HSE to shift the goal posts where finances are limited.[4]

3 Statutory Drafting and Interpretation: Plain Language and the Law, Law Reform Commission, 2000 [LRC 61 - 2000]

4 Subsection (5A) of the 1970 Act states that "with effect from 2 March 2009 a person also shall have full eligibility for the services under this Part if the person attained the age of 70 years before 1 January 2009 and is ordinarily resident in the State, so long as the person's gross income does not exceed the relevant gross income limit under section 45A". Section 45A was recently amended (April 2013), giving new guidelines in relation to the relevant gross income limit.

Subsection (7) provides that any persons who do not have full eligibility status and who are not ordinarily resident in the State, may apply to their relevant health board, under this section, for consideration to avail of a service in circumstances where they cannot provide said service for themselves without undue hardship.

In relation to persons who qualify as having limited eligibility, Section 46 (consolidated) provides as follows:

> *"46. Any person ordinarily resident in the State who is without full eligibility shall, subject to section 52 (3), have limited eligibility for the services under this Part."*

This section is relatively clear and therefore, subject to Section 52(3), every person who ordinarily resides in the State, and who does not qualify for full eligibility, qualifies as having limited eligibility.

Section 47 provides for an appeal of the decision of the HSE in relation to which category one falls under.

Having identified the categories of persons within the ambit of the Act, Part IV proceeds on a chapter-by-chapter basis to deal with specific services.

(b) Chapter II of Part IV – Heath Act 1970:

Chapter 2 deals with in-patient and out-patient services.

In-patient:

Section 51 and 52 provide for as follows:

> *"51. In this Part "in-patient services" means institutional services provided for persons while maintained in a hospital, convalescent home or home for persons suffering from physical or mental disability or in accommodation ancillary thereto."*[5]

> *"52. (1) A health board shall make available in-patient services for persons with full eligibility and persons with limited eligibility."*

On the face of it, it seems therefore that the State has an obligation, through legislation, to provide all persons with in-patient services. Section 52 clearly states that a health board shall make available in-patient services and can be interpreted as meaning the State has an obligation to provide same.

However Section 53 states that in-patient services may be subject to charge. This Section has been amended the said Section 53 by the Health (Amendment) Act 2005 and can be consolidated as follows:

5 In *Re Maud McInerney [A Ward of Court]* the Supreme Court interpreted this section as including nursing home care.

"53. (1) Subject to subsection (1A), charges shall not be made for in-patient services made available under section 52 except as provided for in subsection (2).

(1A) Charges shall be made for long-term residential care services in accordance with the Nursing Homes Support Scheme Act 2009.

(2) Notwithstanding anything in the Health Acts 1947 to 2004 but subject to subsections (3), (4) and (6), the Minister shall, with the consent of the Minister for Finance, make regulations—

(a) providing for the imposition of charges for in-patient services in specified circumstances on persons to whom the in-patient services are provided or on specified classes of such persons, and

(b) specifying the amounts of the charges or the limits to the amounts of the charges to be so made.

Subsection 3 sets out specific categories of persons who will not be subject to a charge and include persons under the age of 18 years, women in respect of motherhood, persons detained involuntarily under the Mental Health Acts, persons in hospital for the care and treatment of acute ailments and persons who have contracted Hepatitis C. This section very clearly does not include persons of full eligibility and as such, persons within this category may be subject to a charge.

Subsection 4 provides the following:

(4) The Health Service Executive may reduce or waive a charge imposed on a person under regulations made under subsection (2) on or after the enactment of this subsection if the Health Service Executive is of the opinion that, having regard to the financial circumstances of that person (including whether or not that person has dependants), it is necessary to do so in order to avoid undue financial hardship in relation to that person.

Subsection 6 provides that, for the first 30 days of in-patient service, a charge not greater than 80% of the maximum weekly rate of the old age (non-contributory) pension may be charged.

The effect of Section 53 of the 1970 Act is that any person, whether fully eligible or having limited eligibility, may be subject to a charge for in-patient services. Subsection 3 outlines the circumstances where no charge will be imposed and very clearly does not include those of full eligibility. Subsection 4 provides that the HSE may reduce or waive a charge imposed on a person by having regard to the financial circumstances of that person (including whether or not that person has dependants) or where it is necessary to do so in order to avoid undue financial hardship in relation to that person. This Section, again, is somewhat unclear as to what exactly "undue financial hardship" is and what exact relevant financial circumstances should be taken into consideration.

Subsection 6 provides that, for the first 30 days of in-patient care, a charge must not exceed 80 per cent of the maximum of the weekly rate of the old age (non-contributory) pension. The HSE has recently, as of July 2011, issued National Guidelines regarding charges for in-patient services. This is a comprehensive breakdown of in-patient care provided for by the State and the calculation of the charges liable on persons who avail of such services.

Section 54 provides that in-patient services may be provided at the choice of the person receiving care. However this is subject to the consent of the Minister.

Out-Patient:

In relation to out-patient services, provided for under Section 56, there have been numerous amendments and these may be consolidated as follows:

> *"56. (1) For the purposes of this section "out-patient services" means institutional services other than in-patient services provided at, or by persons attached to, a hospital or home and institutional services provided at a laboratory, clinic, health centre or similar premises, but does not include—*
>
> *(a) the giving of any drug, medicine or other preparation, except where it is administered to the patient direct by a person providing the service or is for psychiatric treatment, or*
>
> *(b) dental, ophthalmic or aural services.*
>
> *(2) A health board shall, subject to any regulations relating to the services under this section made by virtue of subsection (5), make out-patient services available for persons with full eligibility and persons with limited eligibility..."*

Subsection 1 clearly defines out-patient service and further, excludes specific instances which do not come within the definition. Out-patient services shall be made available for all persons, both of full and limited eligibility. Persons who are of full eligibility are not subject to a charge as set down in subsection (i) however charges may be imposed upon persons who are of limited eligibility.

(c) Chapter III of Part IV – Heath Act 1970:

Chapter III deals with general medical services. It provides that a health board

> *"shall make available without charge a general practitioner medical and surgical service for persons with full eligibility."*[6]

Section 58 was amended in the 2005 Act as follows:

> *"58. (1) The Health Service Executive shall make available without charge a general practitioner medical and surgical service for a person in any of the following categories—*

6 Section 58 of the Health Act 1970

(a) persons with full eligibility

(b) adult persons with limited eligibility for whom, in the opinion of the Health Service Executive, and notwithstanding that they do not come within the category mentioned in section 45(1)(a), it would be unduly burdensome to arrange general practitioner medical and surgical services for themselves and their dependants, and

(c) dependants who are ordinarily resident in the State of the persons referred to in paragraph (b)."

In assessing whether or not a person comes under category (b), the HSE will take into consideration a person's overall financial situation, including the means of any spouse.[7]

Chapter III further provides that a health board *"shall make arrangements for the supply without charge of drugs, medicines and medical and surgical appliances to persons with full eligibility"*[8] and for a subsidy scheme towards same costs in the case of those with limited eligibility.[9]

In relation to a nursing service, Section 60 specifically states that *"a health board shall, in relation to persons with full eligibility and such other categories of person and for such purpose as may be specified by the Minister, provide without charge a nursing service to give to those persons advice and assistance on matters relating to their health and to assist them if they are sick."* This section is clear that there is an obligation on the State to provide medical card holders with a "nursing service".

Section 61 provides that a health board may provide a home help service to *"assist in the maintenance at home"* of a sick or infirm person, but for such assistance, would not be able to live at home and such service may be with or without charge at the discretion of the board. This Section states that a *"health board may"* and therefore does not confer any positive obligation upon the State to provide this service.

(d) Chapter V of Part IV – Heath Act 1970:

Chapter IV deals with services for mothers and children and is therefore not relevant to this research.

Chapter V deals with other services providing that a *"health board shall make dental, ophthalmic and aural treatment and dental, optical and aural appliances available for persons with full eligibility"*.[10] Charges for these services may be prescribed by Ministerial regulation but will not apply in the case of persons with full eligibility.[11]

7 Section 58(2) of the Health Act 1970 (as amended)

8 Section 59(1) of the Health Act 1970

9 Section 59(2) of the Health Act 1970

10 Section 67(1) of the Health Act 1970

11 Section 67(4) of the Health Act 1970

Finally Section 69(1) provides that a health board shall provide for the payment of maintenance allowance to disabled persons over sixteen years.

From the abovementioned summary of Part VI of the Health Act 1970 (as amended) it is clear that the Act provides for as follows:

1. certain specified services which must be provided and for other services which may be provided;

2. categories of persons to whom specified services must be provided and, in some instances, a category of persons to whom a specified service may be provided;

3. the imposition of charges in the case of specified services provided to specified categories of persons;

4. the full range of specified services being made available free of charge to medical card holders;

The Irish Courts' Interpretation of the 1970 Act (As Amended):

There are several hundred legal actions outstanding in which older people who have had to avail of private nursing home care, in the absence of public nursing home places, are seeking to be compensated by the State for costs incurred in private care. "At the time of writing, we understand none of these cases have gone to hearing and judgment in the High Court."[12]

The Department of Health contends that Section 52 of the Health Act 1970 is not to be understood as conferring a right to in-patient services on any individual person nor as placing an obligation on the HSE to provide in-patient services to any individual person.

The issue was raised in Tierney & Ors v North Eastern Health Board[13] and concerned Section 38 of the 1970 Act and whether or not the North Eastern Health Board had the power to discontinue maternity services at Monaghan General Hospital.

In the course of Denham J's (now Chief Justice), (with which the other two Judges concurred) judgment she distinguished between the duty of a health board to provide certain services and the separate question of where such services should be provided. She identified Section 52 as relevant when considering and construing the statutory provisions.

12 p. 57 "Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland" Office of the Ombudsman

13 [2010] IESC 43

> *"A fundamental duty of the respondent [health board], as stated in s.52, is to provide impatient services for persons of full eligibility and persons with limited eligibility. Section 52 clearly provides that a health board shall make available inpatient services for persons with full eligibility and with limited eligibility"*

In her overall conclusion of the relevant Section, she stated that whilst health boards have a duty to provide certain services, including in-patient services and maternity services, there is flexibility within the legislation as to where these services should be provided.

The interpretation of section 52 was touched on in the Supreme Court in the matter of Re Article 26 and the Health (Amendment) (No. 2) Bill 2005 where the Act was attempting to provide a retrospective legal basis for the charging of medical card holders, over a period of 30 years, for the provision of in-patient services in public nursing homes.

It appears the Court took it as self-evident that section 52 requires the health boards (HSE) to provide in-patient services.

> *"The sum total of these provisions is that, by the legislation of 1970 ... the Oireachtas required and has continued to require Health Boards, at all times prior to the passing of the Bill, to make in-patient services available without charge to all persons 'suffering from physical or mental disability'. While the individual circumstances of patients will vary enormously in terms of age and physical and mental capacity, it is obvious that, by enacting the Act of 1970, the Oireachtas was concerned to ensure the provision of humane care for a category of persons who are in all or almost all cases those members of our society who, by reason of age, or of physical or mental infirmity, are unable to live independently. They are people who need care. Even without the benefit of statistical or other evidence, the Court can say that the great majority of these persons are likely to be advanced in years. Many will be sufferers from mental disability. While some will have the support of family and friends, many will be alone and without social or family support."*[14]

Section's 56 (out-patient) and 60 (home nursing) have also been the subject of comprehensive judgments in the Superior Courts. The structure and language, as can be seen above, is very similar to that of section 52.

In *C.K. V Northern Area Health Board*[15] Finnegan P. noted the mandatory nature of both sections 56 and 60 and held, having regard to the level of service provided under these two sections that, on both counts, the Health Board was 'in breach of it's statutory duty to P.K." This matter was appealed to the Supreme Court where the Health Board was successful but on the specific grounds that the High Court was mistaken in the view:

14 [2005] 1 IR 105

15 [2002] 2 IR 545

(a) that out-patient services included the provision of services in the patient's home and

(b) that the home nursing service required the provision of "a long term virtually full-time (or even extensive part-time) nursing service for disabled persons in their own homes".

Therefore we can conclude from this judgment that sections 56 and 60 confer a positive duty on the State. However the extent of that duty is somewhat undefined. It is clear that out-patient services do not include home care and further, home nursing services do not extend to full-time services in one's own home.

The Supreme Court gave no ruling on the claim that *"the provisions of section 56 [and section 60] of the Health Act 1970, as amended, do not give rise to individually enforceable statutory rights in the applicant".*

Therefore the High Court's ruling remains current law in relation to the two sections. Having considered the above judgments, one can reasonably conclude that sections 52, 58 and 60 would be interpreted by an Irish Court as conferring statutory obligations on the HSE and enforceable rights on individuals.

Nursing Homes Support Scheme Act 2009:

The Nursing Homes Support Scheme Act 2009 (or the NHSS Act), widely known as the Fair Deal Scheme, has been in operation in its entirety since 27th October 2009. It provides for the establishment of a scheme known as the Nursing Homes Support Scheme under which financial support may be made available to persons in respect of long term residential care out of resources allocated to the HSE for the purposes of the Scheme. This replaces the Subvention Scheme which had been in existence since 1993.

(a) Part 1: (Section 1 – 4)

Part I deals mainly with the interpretation of the Act and specifically of note is the definition of "care services" which is intended to include "maintenance, health or personal care services, or any contribution thereof."[16]

"Long term residential care services" is not to include medically acute care and treatment in an acute hospital, respite care, rehabilitative care – for a period of less than 12 consecutive months, or periods in the aggregate amounting to less than 12 months within a period of 24 consecutive months – or out-patient services made available pursuant to section 56 of the Health Act 1970.

16 S. 3 Nursing Homes Support Scheme Act 2009

(b) Part 2: (Sections 5 – 14)

Section 6 applies to the persons who may apply for State support under the Scheme and includes persons ordinarily resident in the State for whom an application for a care needs assessment has been made, persons whom the HSE has determined need care services, who is in existing care services by the Executive or an approved nursing home.

Section 7 deals with the care needs assessment which identifies whether or not a person needs long-term nursing home care. Subsection 4 states that upon receipt of an application for a care needs assessment *"the Executive shall, as soon as reasonably possible, make arrangements for a care needs assessment to be carried out."*. This is the first mention with regards to time and provides the State with a flexible approach to waiting lists. One would anticipate however that the Courts would take a restrictive interpretation of the term "reasonably possible" considering the sector of society to which this Act applies. In the recently published National Service Plan 2013, the HSE has indicated that it anticipates that "a placement list will be in operation and new places offered under the NHSS as funding becomes available in line with legislation".[17] It remains unclear as to the length of time one may now have to wait for a place under the NHSS.

In the case of long-stay care for older people, when the service needs to be provided will depend on an assessment of the particular person. An assessment of a person's care needs comprises of an evaluation of the following factors:

(a) the person's ability to carry out the activities of daily living, including:

(i) the cognitive ability,
(ii) the extent of orientation,
(iii) the degree of mobility,
(iv) the ability to dress unaided,
(v) the ability to feed unaided,
(vi) the ability to communicate,
(vii) the ability to bathe unaided, and
(viii) the degree of continence of the person.

(b) the family and community support that is available to the person,

(c) the medical, health and personal social services being provided to or available to the person both at the time of the carrying out of the assessment and generally,

(d) any other matter that affects the person's ability to care for himself or herself, and

(e) the likelihood of a material alteration in the circumstances referred to in paragraphs (a) to (d) during the lifetime of the person.[18]

17 http://www.hse.ie/eng/services/Publications/corporate/NSP2013.pdf

18 S. 7(6) Nursing Homes Support Scheme Act 2009

A care assessment may include an examination of the person by a registered medical practitioner, a registered nurse, an occupational therapist or a chartered physiotherapist or any combination thereof.[19] Thereafter the Executive considers the report "as soon as practicable after its receipt" and makes a determination. 10 working days thereafter the Executive must write to the person who was assessed indicating the outcome of same.

Interestingly, section 11 states as follows:

> *"Where a care needs assessment is carried out, this shall not be construed as meaning that the Executive will provide or will arrange for the provision of any service identified in the assessment as being appropriate to meet the needs of the person or that the Executive has an obligation to provide or arrange for the provision of any such service."*[20]

This subsection is attempting to avoid any obligation the State may have arising out of the contents of the care assessment report. However this piece of legislation is in direct conflict with the duties and obligations conferred on the State, as discussed above, through the Health Care Act 1970 (as amended).

Section 9 deals specifically with the application for State support and requires a person, who has been approved under section 6, to complete a specified form for State support under the Scheme. Where the person is a member of a couple, the applicant and their partner must furnish all information at the request of the Executive in connection with the application.[21]

Section 10 provides that where an application is received, the Executive will make arrangements for a financial assessment to be carried out by a suitable person who shall prepare and furnish a report. This assessment is split under 3 headings (as set down in Schedule 1 of the Act): income, cash assets and relevant assets.

Income includes any earnings, pension income, social welfare benefits/ allowances, rental income, income from holding an office or directorship, income from fees, commissions, dividends or interest or any income which a person has deprived themselves of in the 5 years leading up to their application. An asset is any material property or wealth, including property or wealth outside of the State.

Within the legislation, assets are divided into two distinct categories, namely Cash Assets and Non-Cash Assets. Cash Assets include savings, stocks, shares and securities. Non-Cash assets include all forms of property other than cash assets, for example a person's principal residence or land. In both cases, the assessment will also look at assets which a person has deprived themselves of in the 5 years leading up to their application. If a person is a member of a couple, the assessment will be based on half of the couple's combined income and assets. A couple is defined as (a) a married couple who are living together or (b) a heterosexual or same-sex couple who are cohabiting as life partners for at least three years. The assessment will not take into account the income of other relatives such as children.

19 S. 7(7) Nursing Homes Support Scheme Act 2009

20 S. 7(11) Nursing Homes Support Scheme Act 2009

21 S. 9(2) Nursing Homes Support Scheme Act 2009

Section 11 deals with the determination of the above-mentioned application, and states that where a decision has been made, the Executive has 10 working days to inform the person to whom the application concerns. If a person qualifies as needing care services and further, a determination has been made that State support be paid in respect of such person, the support is only effective as of the date of determination.[22]

Under Section 12 an appropriate amount of State support will be provided for care services to an applicant who qualifies after the above-mentioned financial assessment.

The appropriate amount is based on the outcome of the financial assessment and either State support or ancillary State support may be granted. The scheme involves a co-payment arrangement between the applicant and the State. The person will contribute up to 80% of assessable income and up to 5% of the value of any assets they own towards the cost of their care. The State will then pay the full balance of the cost. However, the first €36,000 of a person's assets, or €72,000 for a couple, will not be counted in the financial assessment.[23] The principal residence will only be included in the financial assessment for the first 3 years of a person's time in care. This is known as the 15% or "three year" cap. It means that a person will pay a 5% contribution based on their principal residence for a maximum of three years regardless of the time they spend in nursing home care. After three years, even if they are still getting long term nursing home care, they will not pay any further contribution based on the principal residence.

There are a number of safeguards provided for under the Act. Firstly an applicant will not pay more than the actual cost of care. Secondly the applicant will keep a personal allowance of 20% of their income or 20% of the maximum rate of the State Pension (non-Contributory) whichever is greater. Finally, for the purposes of the assessment of a couple, the applicant will retain the maximum weekly amount of State pension (Non Contributory) together with 20 per cent of the maximum weekly amount of State pension (Non-Contributory) at the date of the application for State support.

(c) Part 3: (Sections 15 – 20)

Part 3 deals with the Nursing Home Loan ("Ancillary State Support"). This occurs in instances where an applicant possesses assets, including land and property in the State, and agrees to make a 5% contribution based on such assets, payment of which may be deferred. The Nursing Home Loan is effectively a loan advanced by the State which can be repaid at any time but will ultimately fall due for repayment on the applicant's death. Its purpose is to ensure that the applicant does not have to sell assets, such as their house, during their lifetime. In order to apply for the Nursing Home Loan, a person must provide written consent to having a Charging Order registered against their asset. The Charging Order is a simple type of mortgage which secures the money loaned by the HSE.

22 S. 11(5) Nursing Homes Support Scheme Act 2009

23 Schedule 1 Part 3 Nursing Homes Support Scheme Act 2009

(d) Conclusion and observations:

The Nursing Home Support Scheme Act 2009 is still in a very early stage of realization and the full effects of same remain to be seen.

Emily O'Reilly, Current Ombudsman and Information Commissioner made the following comments, November 2010, in relation the Act:

1. In practical terms, it represents an improvement for many older people and their families;

2. It appears not to take reasonable account of the needs of families where there is a mortgage to be paid and ordinary household expenses to be met;

3. It is not at all apparent that the creation of the new category of service (LTRCS i.e. long term residential care services) modifies the existing definition of in-patient services; if the Oireachtas had intended to change the definition of in-patient services, it would have done so explicitly;

4. It does not affect the right to inpatient services of those requiring long-stay care whose needs are greater than those captured in the definition of LTRCS;

5. It does not deal, one way or the other, with the issue of whether the right to in-patient services is a legally enforceable right;

6. It is a poorly drafted Act which fails to meet any reasonable standard of clarity and is unlikely to be comprehensible to the average citizen or, indeed, even to the "reasonably well-educated layperson";

7. After less than a year of its operation, there are worrying indications that the NHSS Act is being applied in a minimalist manner which may, ultimately, be found to be incorrect.

Review of the Nursing Home Support Scheme

Minister for State for Older People Kathleen Lynch announced in April 2012 that the Nursing Home Support Scheme was to be reviewed.

1. The Terms of Reference for the review of the Fair Deal nursing home support scheme, as referred to above, are as follows:

    a. To examine the on-going sustainability of the Nursing Homes Support Scheme,
    b. To examine the overall cost of long-term residential care in public and private nursing homes and the effectiveness of the current methods of negotiating/setting prices,
    c. Having regard to 1. and 2. above, to consider the balance of funding between long-term residential care and community based services,
    d. To consider the extension of the scheme to community based services and to other sectors (Disability and Mental Health), and
    e. To make recommendations for the future operation and management of the scheme.

The Department of Health published a "Summary of Submissions Received in Inform the Review of the Scheme" in December 2012.[24] The review of the scheme is continuing at the time of writing.

Findings and Conclusions

2. Section 45 of the Health Act 1970 (as amended) (hereafter referred to as "the 1970 Act") provides that persons who, in the opinion of the Health Service Executive (hereafter referred to as "the HSE") are unable, without undue hardship, to arrange general practitioner medical and surgical services for themselves fall into a category of full eligibility.

3. Section 51 of the 1970 Act defines 'in-patient' services and was interpreted by the Supreme Court of Ireland to include nursing home care.

4. Section 52 of the 1970 Act clearly states that the HSE shall make available in-patient services for all persons in the State. This has been interpreted by the Irish Courts as a duty and/or obligation on the State to provide in-patient services. There is flexibility within the legislation as to where these services should be provided.[25]

5. Section 53 of the 1970 Act allows the HSE to impose a charge on all persons, with the exception of specific persons but not including those of full eligibility, for in-patient services.

24 http://www.dohc.ie/publications/pdf/FairDeal2012.pdf?direct=1

25 *Tierney & Ors v North Eastern Health Board*

6. Section 56 of the 1970 Act provides that the HSE is under an obligation, as set down in subsection 2, to provide outpatient services for all persons, of both full and limited eligibility. Persons of full eligibility are to avail of such services without a charge; whilst a charge may be imposed on persons who do not have full eligibility.[26]

7. Section 58 provides that the HSE will provide without a charge a general practitioner medical and surgical service for persons with full eligibility and persons where it would be unduly burdensome to arrange for the services of same.

8. Section 60 specifically and clearly states that there is an obligation on the State to provide, without charge, medical card holders with a nursing service.[27]

9. Under the Nursing Homes Support Scheme 2009 (hereafter referred to as the "NHSS Act"), "care services" is defined to include "maintenance, health or personal care services" only. A person still has entitlements under the Health Act 1970 in addition to the provisions of the NHSS Act.

10. There are more than 300 cases currently before the High Court in which people are seeking compensation for the costs incurred in having to avail of private nursing home care where (as claimed by the Plaintiffs) they should have had care provided by the HSE.[28]

26 In *C.K. V Northern Area Health Board* the Supreme Court held that out-patient services did not include the provision of services in the patient's home.

27 In *C.K. V Northern Area Health Board*, the Supreme Court held that nursing service did not include the provision of a "long term virtually full-time (or even extensive part-time) nursing service for disabled persons in their own homes".

28 p. 3 "Who Cares? - An Investigation into the Right to Nursing Home Care in Ireland" Office of the Ombudsman

LEGAL DEFINITIONS OF 'CARE' IN RELATION TO OLDER PEOPLE

Susan Carey
Barrister at Law

Introduction

The purpose of this paper is to research and outline any legal definitions of 'care' in relation to older people to include legislative provisions and/or judicial decisions in various jurisdictions.

I have confined my research to Australia, Scotland, and the United Kingdom. In addition, I looked at any definitions relating to 'care' and older people in Irish law.

Key findings

- The term 'care' is seldom defined in and of itself in any legislative provisions relating to older people or indeed relating to any group of people.
- A definition of 'care' in relation to older people is instead found under the guise of the terms 'personal care', 'health care', 'social care', 'community care', 'long term care', 'care homes', and 'care services'.
- Although a wide search of judicial decisions for definitions of 'care' was conducted very little, bar two UK decisions, was of relevance to this research and so this research focused mainly on legislative provisions.
- In Australia '**care**' is defined as *'services, or accommodation and services, provided to a person whose physical, mental or social functioning is affected to such a degree that the person cannot maintain himself or herself independently'*[1].
- **'Personal care'** is defined in Scotland as *'care which relates to the day to day physical tasks and needs of the person cared for (as for example, but without prejudice to that generality, to eating and washing) and to mental processes related to those tasks and needs (as for example, but without prejudice to that generality, to remembering to eat and wash)'*.[2]
- In the UK '**health care**' is defined as *'all forms of health care provided for individuals, whether relating to physical or mental health, and also includes procedures that are similar to forms of medical or surgical care but are not provided in connection with a medical condition'*.[3]
- '**Social care**' in the UK includes *'all forms of personal care and other practical assistance provided for individuals who by reason of age, illness, disability, pregnancy, childbirth, dependence on alcohol or drugs, or any other similar circumstances, are in need of such care or other assistance'*.[4]
- In Ireland, a comprehensive definition of **'long-term care residential care'** was introduced with the Fair Deal or Nursing Home Care Scheme to include maintenance, health or personal care services.[5]

1 Schedule 1 of Aged Care Act 1997 (*as amended Aged Care Amendment Acts 2000-2011*)
2 s 2(28) Regulation of Care (Scotland) Act 2001
3 S 9(2) Health and Social Care Act 2008
4 *Ibid*
5 s 3 Nursing Home Support Scheme Act 2009

Australia

With over one million older Australians receiving some form of aged care and support each year,[6] 'aged care' is firmly on the agenda of the Australian Government and this is primarily reflected in the title of their Department of Health which was renamed the Department of Health and Aging in 2001[7]. Since the Government set about reforming the system of aged care in the 1950's and again in the 1980's in response to the changing needs and demands of older people, various legislative provisions relating to caring for older people have been introduced.

The three main governing acts in Australia for aged care include the Aged or Disabled Persons Care Act 1954, the Home and Community Care Act 1985, and the Aged Care Act 1997 (*as amended Aged Care Amendment Acts 2000-2011*). Of most relevance to this research was the Aged Care Act (hereinafter referred to as the 1997 Act) where a definition of 'care' in and of itself is to be found.

The Aged Care Act 1997

'**Care**' is defined in Schedule 1 as

> *"services, or accommodation and services, provided to a person whose physical, mental or social functioning is affected to such a degree that the person cannot maintain himself or herself independently".*

'**Aged care**' is also defined in Schedule 1 as

> *...care of one or more of the following types*
> *(a) Residential care;*
> *(b) Community care;*
> *(c) Flexible care.*

An '**aged person**' is defined in section 2 as

> *'a person who has attained the age of 60'.*

The 1997 Act, along with its set of principles providing further details of the provisions, reflects the Australian Government's commitment to a national aged care system. The 1997 Act legislates for the provision of *inter alia* residential care and regulates control of funding in the area of care to older Australians.

6 Productivity Commission 2011, *Caring for Older Australians: Overview, Report No. 53*, Final Inquiry Report, Canberra

7 http://www.health.gov.au

Section 41 3 sets out the meaning of '**residential care**'.

> *Residential care is personal care or nursing care, or both personal care and nursing care, that:*
> *(1) (a) is provided to a person in a residential facility in which the person is also provided with accommodation that includes:*
> *(i) appropriate staffing to meet the nursing and personal care needs of the person; and*
> *(ii) meals and cleaning services; and*
> *(iii) furnishings, furniture and equipment for the provision of that care and accommodation; and*
> *(b) meets any other requirements specified in the Residential Care Subsidy Principles.*
> *(2) However, residential care does not include any of the following:*
> *(a) care provided to a person in the person's private home;*
> *(b) care provided in a hospital or in a psychiatric facility;*
> *(c) care provided in a facility that primarily provides care to people who are not frail and aged.*

Section 45-3 defines '**community care**' as

> *'care consisting of a package of personal care services and other personal assistance provided to a person who is not being provided with residential care'.*

Section 49 3 defines '**flexible care**' as

> *'care provided in a residential or community setting through an aged care service that addresses the needs of care recipients in alternative ways to the care provided through residential care services and community care services'.*

The objects of the Aged Care Act 1997 are set out in Section 2.1 and are as follows

> *2 (1)(a) to provide for funding of aged care that takes account of:*
> *(i) the quality of the care; and*
> *(ii) the type of care and level of care provided; and*
> *(iii) the need to ensure access to care that is affordable by, and appropriate to the needs of, people who require it; and*
> *(iv) appropriate outcomes for recipients of the care; and*
> *(v) accountability of the providers of the care for the funding and for the outcomes for recipients;*
> *(b) to promote a high quality of care and accommodation for the recipients of aged care services that meets the needs of individuals;*
> *(c) to protect the health and well-being of the recipients of aged care services;*
> *(d) to ensure that aged care services are targeted towards the people with the greatest needs for those services;*
> *(e) to facilitate access to aged care services by those who need them, regardless of race, culture, language, gender, economic circumstance or geographic location;*
> *(f) to provide respite for families, and others, who care for older people;*

(g) to encourage diverse, flexible and responsive aged care services that:
(i) are appropriate to meet the needs of the recipients of those services and the carers of those recipients; and
(ii) facilitate the independence of, and choice available to, those recipients and carers;
(h) to help those recipients to enjoy the same rights as all other people in Australia;
(i) to plan effectively for the delivery of aged care services that:
(i) promote the targeting of services to areas of the greatest need and people with the greatest need; and
(ii) avoid duplication of those services; and
(iii) improve the integration of the planning and delivery of aged care services with the planning and delivery of related health and community services;
(j) to promote ageing in place through the linking of care and support services to the places where older people prefer to live.
(2) In construing the objects, due regard must be had to:
(a) the limited resources available to support services and programs under this Act; and
(b) the need to consider equity and merit in accessing those resources.

Caring for Older Australians

A recent report entitled *Caring for Older Australians*[8] defined '**aged care**' in its glossary as

> *"A range of services required by older persons (generally 65 years and over (or 50 years and over for Indigenous Australians)) with a reduced degree of functional capacity (physical or cognitive) and who are consequently dependent for an extended period of time on help with basic ADLs[9]. Aged care is frequently provided in combination with basic medical services (such as help with wound dressing, pain management, medication, health monitoring), prevention, reablement or palliative care services"[10].*

'**Care recipient**' was defined as

> *"a person who is receiving care and support, either in the community, in their own home or in a residential aged care facility"[11].*

'**Community care**' was described as being

> *"provided to people with functional restrictions who mainly reside in their own home. It also applies to the use of institutions on a temporary basis to support continued living at home — such as community care centres and respite. Community care also includes specially designed, 'assisted or adapted living arrangements' for people who require help on a regular basis while guaranteeing a high degree of autonomy and self-control"[12].*

8 Productivity Commission 2011, *Caring for Older Australians: Overview*, Report No. 53, Final Inquiry Report, Canberra

9 Activities of Daily Living

10 Productivity Commission 2011, *Caring for Older Australians: Overview*, Report No. 53, Final Inquiry Report, Canberra

11 ibid

12 ibid

Scotland

Similar to Australia, Scotland is relatively progressive in terms of its legislative provisions in relation to older people and care. On the 1st July 2002 with the enactment of the Community Care and Health (Scotland) Act 2002, free personal care and nursing care (FPNC) was introduced into Scottish law. Free Personal Care is a legal entitlement for people aged 65 or over who have been assessed as having personal care needs that require services to be put in place. Free Nursing Care is similar but is available to people of all ages who are assessed as requiring nursing care services[13].

The main legislative provisions which are of relevance to this research and its quest to find legal definitions of 'care' can be found in the Regulation of Care (Scotland) Act 2001 which sets out a definition of 'personal care'.

Regulation of Care (Scotland) Act 2001

Care services

(28) In this Act, unless the context otherwise requires—

> *"someone who cares for" (or "a person who cares for") a person, means someone who, being an individual, provides on a regular basis a substantial amount of care for that person, not having contracted to do so and not doing so for payment or in the course of providing a care service;*
>
> *"vulnerability or need", in relation to a person, means vulnerability or need arising by reason of that person—*
> *being affected by infirmity or ageing;*
> *being, or having been, affected by disability, illness or mental disorder;*
> *being, or having been, dependent on alcohol or drugs; or*
> *being of a young age;*
>
> ***"personal care" means care which relates to the day to day physical tasks and needs of the person cared for (as for example, but without prejudice to that generality, to eating and washing) and to mental processes related to those tasks and needs (as for example, but without prejudice to that generality, to remembering to eat and wash);*** *and*
>
> *"personal support" means counselling, or other help, provided as part of a planned programme of care.*

It is this definition of 'personal care' that is referred to in the Community Care and Health (Scotland Act) 2002 which provides for free social care to include personal care.

13 http://www.scotland.gov.uk/Resource/Doc/305166/0095748.pdf

Community Care and Health (Scotland) Act 2002

Regulations as respects charging and not charging for social care

(1) Subject to subsection (2)(a) below, a local authority are not to charge for social care provided by them (or the provision of which is secured by them) if that social care is—

(a) personal care as defined in section 2(28) of the Regulation of Care (Scotland) Act 2001 (asp 8);

(b) personal support as so defined;

(c) whether or not such personal care or personal support, care of a kind for the time being mentioned in schedule 1 to this Act; or

(d) whether or not from a registered nurse, nursing care.

(2) The Scottish Ministers may (either or both)—

(a) by regulations qualify the requirements of subsection (1) above in such way as they think fit;

(b) by order amend schedule 1 to this Act.

There are, however, care services for older people that do not fall under the definition of personal care. According to a National Statistics Publication for Scotland entitled *Free Nursing and Personal Care Scotland*[14]

> *'people aged 65 and over can no longer be charged for personal care services provided in their own home. They can however be charged for domestic services such as help with shopping or housework but any charge would be subject to a financial assessment'.*

UK

Although the UK does not provide us with a definition of 'care' in and of itself in its legislative provisions, it does however provide us with some interesting definitions relating to care and older people. The most recent and significant legislative provision for the purpose of this research can be found in the Health and Social Care Act 2008 which sets out the distinction between 'health care' and 'social care'.

Health and Social Care Act 2008

Section 9 sets out the following

> *9(2) "Health care" includes all forms of health care provided for individuals, whether relating to physical or mental health, and also includes procedures that are similar to forms of medical or surgical care but are not provided in connection with a medical condition.*
>
> *(3) "Social care" includes all forms of personal care and other practical assistance provided for individuals who by reason of age, illness, disability, pregnancy, childbirth, dependence on alcohol or drugs, or any other similar circumstances, are in need of such care or other assistance.*

14 http://www.scotland.gov.uk/Publications/2010/07/01130955/2

This legal division of 'health care' and 'social care' had previously been emphasised in two UK judicial decisions including *Reg. V. North and East Devon H.A., Ex p. Coughlan*[15] and *R (on the application of Grogan) v Bexley NHS Care Trust and others* [16]which dealt with the issue of statutory rights of older people to accommodation and funding for accommodation for older people respectively.

Another legislative provision that is of relevance to this research is the Care Standards Act 2000 which sets out a definition of 'care homes'.

Care Standards Act 2000

Care homes.

> *(1) For the purposes of this Act, an establishment is a care home if it provides accommodation, together with nursing or personal care, for any of the following persons.*
> *(2) They are—*
> *(a) persons who are or have been ill;*
> *(b) persons who have or have had a mental disorder;*
> *(c) persons who are disabled or infirm;*
> *(d) persons who are or have been dependent on alcohol or drugs.*
> *(3) But an establishment is not a care home if it is—*
> *(a) a hospital;*
> *(b) an independent clinic; or*
> *(c) a children's home,*
> *Or if it is of a description excepted by regulations.*

National Service Framework – for Older People

In the *National Service Framework – for Older People*[17], the terms 'long term care', 'residential care', 'social care', and 'intermediate care' were all defined in its Glossary Section.

> ***Long-term care** refers to support services provided over a prolonged period of time or on a permanent basis to adults who have difficulties associated with old age, long-term illness or disability. Care may be provided in residential settings such as nursing homes or in people's own homes over a prolonged period of time or on a permanent basis*[18]*.*

> ***Residential care** refers to nursing homes and residential care homes that provide around-the-clock care for vulnerable adults who can longer be supported in their own homes. Homes may be run by local councils or independent organisations. Admissions to residential care can be made on a temporary or permanent basis*[19]*.*

15 [2001] QB 213

16 [2006] EWHC 44

17 *National Service Framework – for Older People* UK Department of Health (March 2001)

18 *Ibid*

19 *Ibid*

Social care *is provided by statutory and independent organisations and describes a wide spectrum of activities which support and help people live their daily lives. It can include: intimate personal care, managing finances, adapting housing conditions, and help attending leisure pursuits*[20].

Intermediate care: *A new layer of care, between primary care and specialist services is being developed to help prevent unnecessary hospital admission, support early discharge and reduce or delay the need for long-term residential care. Older people will be the main but not exclusive beneficiaries of these services. Older people will have access to a new range of intermediate care services at home or in designated care settings, to promote their independence by providing enhanced services from the NHS and councils to prevent unnecessary hospital admission and effective rehabilitation services to enable early discharge from hospital and to prevent premature or unnecessary admission to long-term residential care*[21].

Ireland

Similar to the UK, Ireland offers no definitions of 'care' in its legislative provisions but a number of Acts dealing with older people may be of relevance, particularly the Nursing Home Support Scheme Act 2009 which provides us with a valuable definition of 'long term residential care' to include maintenance, health or personal care services.

Nursing Homes Support Scheme Act 2009

Long-term residential care is defined in Section 3 as

(a) subject to paragraph (b), means—
(i) maintenance, health or personal care services, or any combination thereof, provided by or on behalf of the Executive to a person
(I) whilst the person resides in and is maintained in a facility—
(A) that is publicly designated in writing by the Executive as a facility predominantly for the care of older people, which designation shall, subject to section 33 (2), specify the health or personal care services to be provided at that facility, and
(B) in which nursing care is provided on the basis that at no time should there be less than one registered nurse present in the facility who is available to provide nursing care for the persons maintained in the facility, and
(II) subject to subsection (2), for—
(A) a period of not less than 30 consecutive days, or
(B) periods in the aggregate amounting to not less than 30 days within a period of 12 consecutive months, or

20 *Ibid*
21 *Ibid*

(ii) maintenance, health or personal care services, or any combination thereof, provided to a person whilst the person resides in and is maintained in an approved nursing home—

(I) in which nursing care is provided on the basis that at no time should there be less than one registered nurse present in the approved nursing home who is available to provide nursing care for the persons maintained in the approved nursing home, and

(II) subject to subsection (2), for—

(A) a period of not less than 30 consecutive days, or

(B) periods in the aggregate amounting to not less than 30 days within a period of 12 consecutive months

(b) does not include—

(i) medically acute care and treatment in an acute hospital,

(ii) respite care,

(iii) rehabilitative care for

(I) a period of less than 12 consecutive months, or

(II) periods in the aggregate amounting to less than 12 months within a period of 24 consecutive months, or

(iv) out-patient services made available pursuant to section 56 of the Health Act 1970

Health and Social Care Professionals Act 2005

The Health and Social Professionals Act, which provides for the regulation of the care profession, gives an interesting description of the care activities carried out by health and social care professionals.

4 (3) A health or social care profession is any profession in which a person exercises skill or judgment relating to any of the following health or social care activities:

(a) the preservation or improvement of the health or wellbeing of others;

(b) the diagnosis, treatment or care of those who are injured, sick, disabled or infirm;

(c) the resolution, through guidance, counselling or otherwise, of personal, social or psychological problems;

(d) the care of those in need of protection, guidance or support.

Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2010

The 2010 Regulations, which govern the registration and inspection of residential care services for older people, does not offer any definitions of 'care' but does provide for a detailed section on the provision of health care and end of life care.

Health Care

9 (1) The registered provider shall ensure that all appropriate health care is facilitated and that each resident is supported on an individual basis to achieve and enjoy the best possible health.

(2) The person in charge shall ensure that:

(a) where medical treatment is recommended and agreed by a resident that it is facilitated;

(b) when a resident requires physiotherapy, chiropody, occupational therapy, or any other services as may be required, access to such service is facilitated by the registered provider or by arrangement with the Executive; and

(c) a resident's right to refuse treatment shall be respected and documented and the matter brought to the attention of the resident's medical practitioner.

(3) The Executive may provide services (being services of a kind provided by or on behalf of the Executive for the purposes of its functions) to a designated centre at the request of the registered provider upon such terms, charges and conditions and to such extent as the Executive may determine, following discussion with the registered provider of the centre.

(4) The registered provider shall ensure that records are maintained of all referrals and follow-up appointments.

End of Life Care

14. (1) The registered provider shall ensure that the designated centre has written operational policies and protocols for end of life care.

(2) The person in charge shall ensure that when a resident is approaching the end of their life:

(a) appropriate care and comfort are given to the resident to address their physical, emotional, psychological and spiritual needs;

(b) his or her religious and cultural practices, insofar as is reasonably practicable, are facilitated;

(c) the resident's family and friends, insofar as is reasonably practicable, are facilitated to be with the resident when they are dying and overnight facilities are available for their use; and

(d) whenever possible, that each resident's choice as to the place of death, including the option of a single room or returning home, is identified and facilitated.

(3) The person in charge shall ensure, whenever possible, that in the event of the sudden death of a resident:

(a) the resident's death is managed/responded to with dignity and propriety;

(b) their religious and cultural practices, insofar as is reasonably practicable, are facilitated; and

(c) the needs of the resident's family, next-of-kin and friends, insofar as is reasonably practicable, are accommodated.

(4) The person in charge shall ensure respect for the remains of deceased persons and make arrangements, in consultation with the deceased resident's family, for the removal of remains.

Conclusion

This research focused on definitions of 'care' in relation to older people. Having examined legislative provisions in Australia, Scotland, the UK and Ireland, with only one specific definition of 'care' in and of itself to be found in Australia, it is clear that there is a gap in legislation dealing with care of older people. Alongside this, although a wide search of judicial decisions for definitions of 'care' was conducted very little, bar two UK decisions, actually dealt with the meaning of 'care'. However, despite this, definitions including 'personal care', 'health care', 'social care', 'community care', 'long term care', 'care homes', and 'care services' are of relevance in defining care in relation to older people in general.

So why is the term 'care' not defined in and of itself by legislatures? It is often thought that the term 'care' is quite vague and subjective and this may be a valid reason for the absence of its definition in legislation. However, on looking at Australian legislation, it clearly illustrates that 'care' can be defined in and of itself and a lot could be learnt from its succinct and valuable provisions dealing with 'aged care' and indeed from the Scottish legislative provisions dealing with 'personal care' in their Regulation of Care (Scotland) Act 2001.

"It is clear that there is a gap in legislation dealing with care of older people."

THE COMMUNITY VISITOR PROGRAMME

Office of the Public Advocate – Victoria, Australia

Clara O'Sullivan
Solicitor (admitted in Ireland and Australia)

Introduction

The aim of this paper is to examine the volunteer taskforce known as Community Visitors who operate under the Office of Public Advocate in Victoria, Australia. Having worked as a lawyer in Melbourne, Australia for a number of years, I was very impressed by this model which I encountered through my work and which regularly brought me in contact with older people in care.

I have also included a short discussion on the protection afforded whistleblowers under the current legislation in place in Victoria.

Key findings

- The Office of the Public Advocate in Victoria, Australia has an effective model in place known as the Community Visitor Program. This is a volunteer taskforce that acts as an aide to exposing corrupt or improper conduct on the ground in residential care institutions.
- The Community Visitors visit residential services and monitor and report on the adequacy of the service provided in the interests of residents and patients.
- They work in pairs and spend between 10 to 15 hours a month visiting facilities
- They can report any improper conduct or violent behaviour against residents and patients.
- There is a very comprehensive reporting structure in place to enable any issues identified to escalate through the proper channels.
- Community Visitors are afforded statutory protection by whistle-blowing legislation currently in place in Victoria[1] which applies to any person who makes a protected disclosure about improper conduct by a public officer or public body.

1 Whistleblowers Protection Act 2001 VIC

The Community Visitor Program

Ben Bodna, Victoria's first Public Advocate, created the Community Visitors Program 25 years ago in order to protect the rights of the state's most vulnerable people - those living with intellectual disabilities, mental illnesses and/or dementia. The role of the volunteer taskforce he established to inspect the residences in which these people lived, is now firmly planted in Victorian legislation. Community Visitors are created under three acts of Parliament.[2] The volunteers come from a range of occupations and backgrounds.

The Office of the Public Advocate[3], which is responsible for promoting and protecting the rights of people with a disability in Victoria, manages the Community Visitors Programme. The Office of the Public Advocate sits within the Department of Justice, but is independent of government and reports to the Victorian Parliament.

Appointed by the Victorian Governor in Council, Community Visitors are created under three Acts of Parliament: The Mental Health Act 1986, The Health Services Act 1988, and the Disability Act 2006.

Community Visitors are volunteers empowered by law to visit Victorian accommodation facilities for people with a disability or mental illness at any time, unannounced. They monitor and report on the adequacy of services provided, in the interests of residents and patients.

Community Visitors visit:

- Community Residential Units (CRUs)
- Supported Residential Services and
- Mental Health facilities

The legislation is extremely clear on the functions of the volunteers and so I have taken the liberty of quoting directly from the legislation in order to elaborate on their role.

Each Community Visitor

(a) holds office for a period of 3 years;
(b) is eligible for re-appointment at the end of the term of office;
(c) is entitled to be paid any fees and travelling and other allowances fixed by the Governor in Council[4]

Functions of a Community Visitor

The functions of a Community Visitor are to visit any premises where a disability service provider is providing residential services in the region for which the community visitor is appointed and to inquire into -

2 The Mental Health Act 1986, the Health Services Act 1988 and the Disability Act 2006

3 OPA

4 Disability Act 2006 Section 28(2)

(a) the appropriateness and standard of premises for the accommodation of residents;
(b) the adequacy of opportunities for inclusion and participation by residents in the community;
(c) whether the residential services are being provided in accordance with the principles specified in section 5;
(d) whether information is being provided to residents as required by this Act;
(e) any case of suspected abuse or neglect of a resident;
(f) the use of restrictive interventions and compulsory treatment;
(g) any failure to comply with the provisions of this Act;
(h) any complaint made to a Community Visitor by a resident.[5]

Visiting a residential service

When visiting a residential service premises, Community Visitors must produce identification and explain the role of Community Visitors and the purpose of the visit to residents and staff. They must respect the rights of residents if they indicate that they do not wish to discuss anything with the Community Visitor.

(1) A Community Visitor may visit any premises at which a disability service provider is providing a residential service with or without any previous notice at the times and periods that the community visitor thinks fit.
(2) A residential institution must be visited at least once every month by a Community Visitor for the region in which the residential institution is located.
(3) The Minister[6] may direct a Community Visitor to visit the premises at which a disability service provider is providing a residential service at the times that the Minister directs.[7]

Powers of inspection

Community Visitors are friendly but forensic. On arrival they will check and record details such as: Is the medicine cabinet locked? What's in the fridge? What activities are planned for today? What is on the menu? Have the care plans for the residents been updated in the past six months? Are they stored somewhere the staff can find them?

(1) A Community Visitor is entitled when visiting a disability service provider providing a residential service to -
  (a) inspect any part of the premises in which the residential service is being provided;
  (b) see any resident;
  (c) make enquiries relating to the provision of services to the residents;
  (d) inspect any document relating to any resident which is not a medical record and any records required to be kept by or under this Act;
  (e) inspect any medical record relating to a resident with the consent of the resident or the resident's guardian.

5 Ibid at s30

6 Minister for Community Services

7 Ibid 4 at s129

(2) If a Community Visitor wishes to perform or exercise, or is performing or exercising, any power, duty or function under this Act, the disability service provider and any member of the staff or management of the residential service must provide the community visitor with such reasonable assistance as the Community Visitor requires to perform or exercise that power, duty or function effectively.

(3) A disability service provider or member of the staff or management of a residential service must—
(a) reasonably render assistance when required to do so under subsection (2);
(b) give full and true answers to the best of that person's knowledge to any questions asked by a Community Visitor in the performance or exercise of any power, duty or function under this Act.
60 penalty units.[8]

In January 2011, these volunteers had lodged 86 reports of violence against people with cognitive impairments or mental illness over the past four years.[9] Often the Community Visitor will persist where a staff member might be fobbed off with reassurances by the Health Department. For example, in one Melbourne facility as recently as March 2011, it was the dogged persistence of a Community Visitor that prompted an inquiry by the Ombudsman into an assault on a disabled man by his carers. This instance would otherwise have been kept under wraps in a departmental cover-up.

Public Advocate Colleen Pearce states that *"(Community) Visitors are at the pointy end of volunteering....it's not the warm and fuzzy end. They work very hard protecting the rights of the people they visit."*[10] She also comments that being chained or locked up is one of the most significant issues still facing people with disabilities. It has been reported as occurring in mental health services, residences for the intellectually disabled and even in nursing homes.[11]

Secrecy Provision

Privacy laws keep the work of the Community Visitors anonymous: they cannot discuss what they discover with their relatives or friends and their reports are stripped of identifying details. Any information gained will only be used for the purpose of performing any official duties and carrying out responsibilities under the Act. Exceptions to this include circumstances where a document may be required for court proceedings.

8 Ibid s130

9 "When the Visitors Call", The Age, 27 July 2011

10 Ibid

11 Ibid

(1) Unless subsection (2) applies, a person who is or has been, at any time, a Community Visitor must not, either directly or indirectly make a record of, or divulge or communicate to any person, or make use of, any information that is or was acquired by the person because the person is or was appointed as a Community Visitor, for any purpose, except to the extent necessary for the person—
  (a) to perform any official duties; or
  (b) to perform or exercise any function or power under this Act.

(2) Subsection (1) does not prevent a person from—
  (a) producing a document to a court in the course of criminal proceedings or in the course of any proceedings under this Act; or
  (b) divulging or communicating to a court, in the course of any proceedings referred to in paragraph (a), any matter or thing coming under the notice of the person in the performance of official duties or in the performance of a function or in the exercise of a power referred to in subsection (1); or
  (c) producing a document or divulging or communicating information that is required or permitted by any Act to be produced, divulged or communicated, as the case may be, if, where the document or information relates to the personal affairs of another person, that other person has given consent in writing.[12]

Reports by Community Visitors

Information gathered is compiled in a report that is submitted to the Community Visitors' Board at least twice a year.

(1) The Community Visitors for a region must at least twice a year submit a report to the Community Visitors Board on visits made since the last report.
(2) The Minister may require the Community Visitors Board to report to the Minister on any matter specified by the Minister at the time and in the manner directed by the Minister.
(3) The Community Visitors Board may at any time submit a report to the Minister if the Community Visitors Board considers that any matter should be considered personally by the Minister.
(4) A Community Visitor may at any time submit a report to the Community Visitors Board containing any recommendations that the community visitor considers should be considered by the Community Visitors Board[13]

12 Ibid 4 at s36

13 Ibid s34

Community Visitors Board

(1) The Community Visitors Board established by section 61 of the Intellectually Disabled Persons' Services Act 1986 is continued under this Act.

(2) The Community Visitors Board consists of—
  (a) the Public Advocate; and
  (b) 2 Community Visitors elected in accordance with the regulations by community visitors.

(3) The functions of the Community Visitors Board are to—
  (a) represent Community Visitors;
  (b) prepare and circulate publications explaining the role of Community Visitors;
  (c) supervise the training of Community Visitors;
  (d) report a matter to the Public Advocate or the Minister;[14]
  (e) refer a matter under section 33;
  (f) prepare an annual report.[15]

Resolving Issues that Arise

During each visit Community Visitors complete a Record of Visit which outlines general comments based on their observations(see Appendix 1). If there are issues that arise during the visit that cannot be resolved, these must be listed on the Record. They follow up on these issues during subsequent visits. If the issue is not within the parameters of the Community Visitor, it may be referred to the Regional Convenor. The Regional Convenor will respond using an issues response form (see Appendix 2).

Every effort should be made to resolve issues at the most local level possible.

- The Regional Convenor will raise unresolved matters with the appropriate senior staff member nominated by the service at a regular liaison meeting or urgent meeting. If the matter can be satisfactorily resolved, then the resolution will be documented and no further action will be taken.
- The Regional Convenor can request the CVP Unit Coordinator to refer to the department's senior management in the region, as appropriate, matters or issues of concern that have not been resolved satisfactorily.
- The CVP will notify the disability service provider if issues are to be raised with the department's senior management or others.
- Following this, for serious unresolved issues, it may be necessary for the CVP Unit Coordinator to refer the matter to the CVP Manager and/or the Community Visitors Board.
- Where serious allegations are involved, the CVP Manager will refer the matter to the appropriate authorities immediately. Where possible and appropriate, the disability service provider will be notified. This includes any issue that places the physical or psychological health or wellbeing of a resident at risk.
- Section 33 of the Disability Act permits the Community Visitors Board to use its discretion to refer a matter reported by a Community Visitor to be dealt with by any other person, including:

14 Minister for Community Services

15 Ibid 4 s34

a. the Secretary
b. the Disability Services Commissioner
c. the Senior Practitioner
d. the Ombudsman.[16]

There is a very structured way of ensuring that issues are escalated through each channel until dealt with at whatever level is appropriate (See Community Visitors Reporting Flowchart at Appendix 3).

Whistle blowing Legislation in Victoria

In 2001, The Whistleblowers Protection Act 2001 was enacted in Victoria. This legistlation was repealed on 13 February 2013 and replaced by the Protected Disclosure Act 2012 ('the Act'). The main objective of the Act is to encourage and facilitate the making of disclosures of improper conduct by public officers and public bodies and to establish a system for matters to be investigated.

What is most striking about the legislation is the wide spectrum of people who are protected by the Act. It is not just those in public bodies but individuals who are external to a public body. Disclosures about public bodies can be, and are made, by a variety of people who would include independent contractors, hospital/aged care facility visitors (including Community Visitors) and patients. The Act applies to public bodies which includes Public Hospitals and State Funded Residential Care Services; and to Public Officers which includes employees. The Act provides protection from detrimental action to any person affected by a protected disclosure whether it is a person who makes a disclosure, a witness, or a person who is the subject of an investigation.

The Act is just one part of the new integrity system for Victoria. The Independent Broad-Based Anti-Corruption Commission Act 2011 provided for the establishment of the Independent Broad-based Anti-Corruption Commission (IBAC). In certain cases, disclosures relevant to the Protected Disclosure Act 2012 must be made directly to IBAC.

Who may make a disclosure and who may it be made about?

Any person may make a disclosure about improper conduct by public bodies and public officers. The terms improper conduct, public body and public officer are defined in section 3 of the Act.

The types of bodies about which a person may make a disclosure include:

- government departments and agencies
- public hospitals
- state-funded residential care services

16 Protocol Between Disability Service Providers and Community Visitors Program (2009)2.2.3

How may a protected disclosure be made?

Part 2 of the Act provides that a person may make a disclosure:

- orally
- in writing
- electronically
- anonymously.

This means that disclosures may be received from anonymous sources, including unverified email addresses, phone calls, by facsimile, in a conversation or meeting. If the disclosure is made orally, the public body should ensure that contemporaneous notes are made of the disclosure.

If the disclosure comes from an email address from which the identity of the person making the disclosure cannot be determined, the disclosure should be treated as an anonymous disclosure.

Any person can submit an allegation or complaint. The Act does not require the individual to be an employee of the public body they are complaining about, or a public sector employee. The complaint must be made by an individual and not by a company, organisation or group of people.

To whom must a protected disclosure be made?

Part 2 of the Act provides that a person must make a disclosure to the appropriate person or body for it to be a protected disclosure under the Act. As a general rule, a disclosure must be made to the public body that the complaint relates to, or to IBAC.

Therefore, public bodies can only receive disclosures that relate to the conduct of their own members, officers or employees. If a public body receives a disclosure about an employee, officer or member of another public body, the disclosure has not been made in accordance with Part 2 of the Act. The public body should advise the person making the disclosure of the correct person or body to whom the disclosure must be made. In such circumstances they should generally be advised to make their disclosure to IBAC.

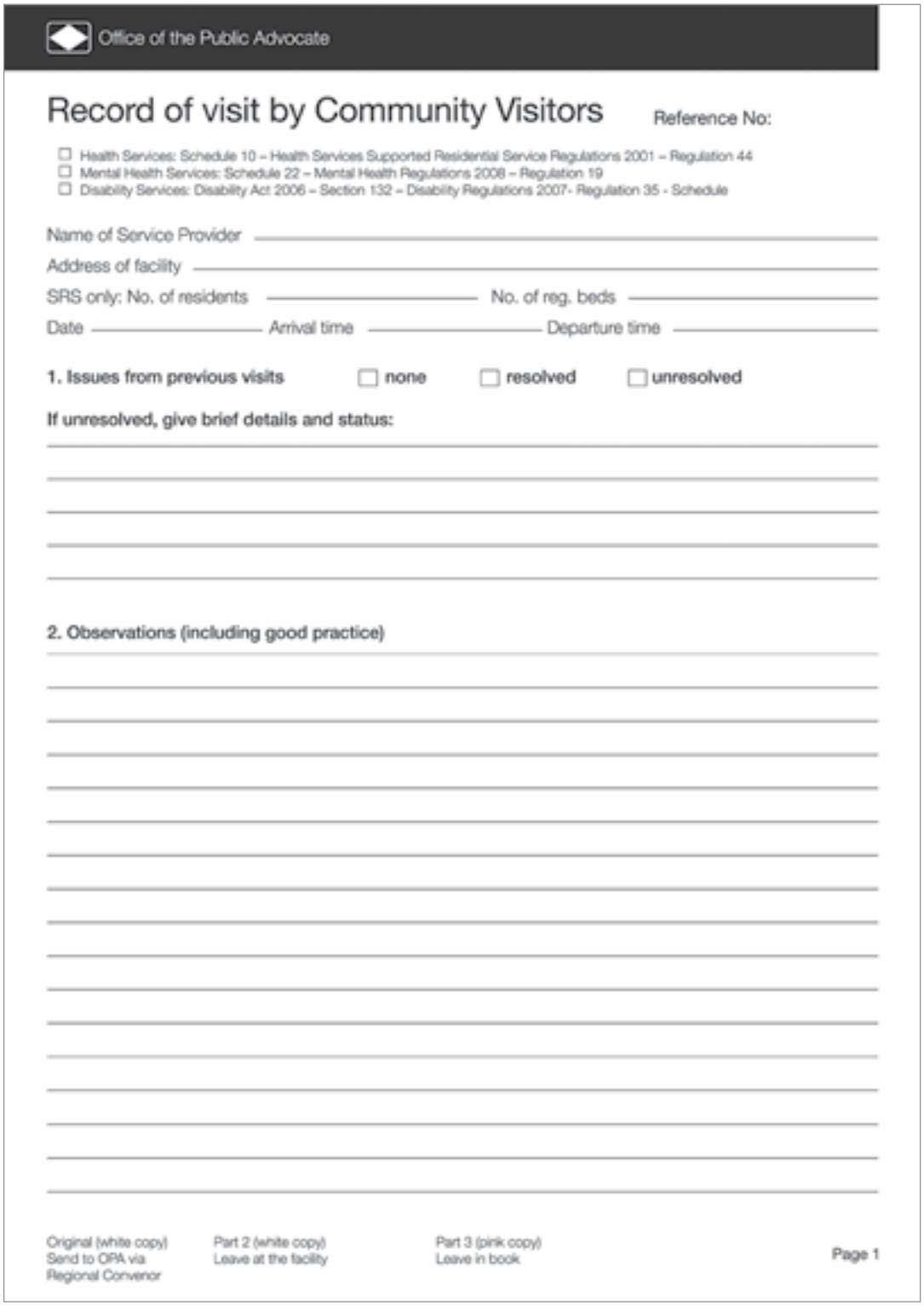
Conclusion

Given the obstacles facing nurses and other healthcare workers who blow the whistle under the current legislation in Ireland, it is enlightening to see what measures have been taken in Victoria, Australia.

The Community Visitors Program is an extremely effective way of monitoring standards in the health care sector. It is in place for over 25 years and has proven to be an exceptionally cost effective way for the Victorian Government to ensure that there is a model in place to identify problems and deal with them through this organisational structure. All matters - from the seemingly trivial to the extremely serious - are open to scrutiny by the unexpected visitor.

Appendix 1

Record of Visit by Community Visitors Form



Office of the Public Advocate

Record of visit by Community Visitors Reference No:

- ☐ Health Services: Schedule 10 – Health Services Supported Residential Service Regulations 2001 – Regulation 44
- ☐ Mental Health Services: Schedule 22 – Mental Health Regulations 2008 – Regulation 19
- ☐ Disability Services: Disability Act 2006 – Section 132 – Disability Regulations 2007- Regulation 35 - Schedule

Name of Service Provider _____

Address of facility _____

SRS only: No. of residents _____ No. of reg. beds _____

Date _____ Arrival time _____ Departure time _____

1. Issues from previous visits ☐ none ☐ resolved ☐ unresolved

If unresolved, give brief details and status:

2. Observations (including good practice)

Original (white copy) Send to OPA via Regional Convenor

Part 2 (white copy) Leave at the facility

Part 3 (pink copy) Leave in book

Page 1

Reference No:

3. Matters discussed during visit / issues and matters for attention (please number)

Tick if written response required

SRS only - notification required ☐ yes ☐ no

Name of person in charge (print)

Signature of person in charge

Names of Community Visitors (print)

Signatures of Community Visitors

Original (white copy) Send to OPA via Regional Convenor

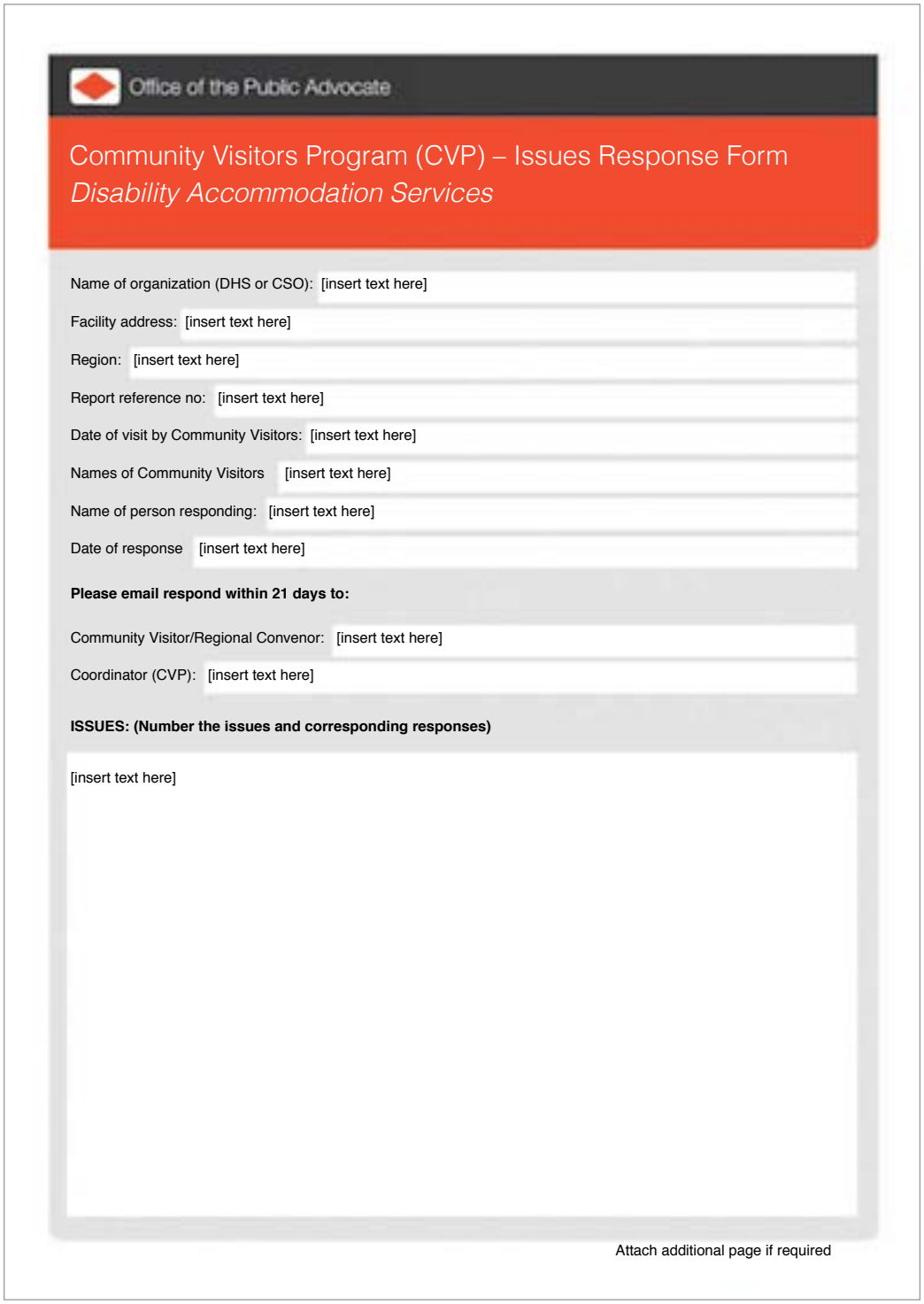
Part 2 (white copy) Leave at the facility

Part 3 (pink copy) Leave in book

Page 2

Appendix 2

Community Visitors Program – Issues Response Form



Office of the Public Advocate

Community Visitors Program (CVP) – Issues Response Form
Disability Accommodation Services

Name of organization (DHS or CSO): [insert text here]

Facility address: [insert text here]

Region: [insert text here]

Report reference no: [insert text here]

Date of visit by Community Visitors: [insert text here]

Names of Community Visitors [insert text here]

Name of person responding: [insert text here]

Date of response [insert text here]

Please email respond within 21 days to:

Community Visitor/Regional Convenor: [insert text here]

Coordinator (CVP): [insert text here]

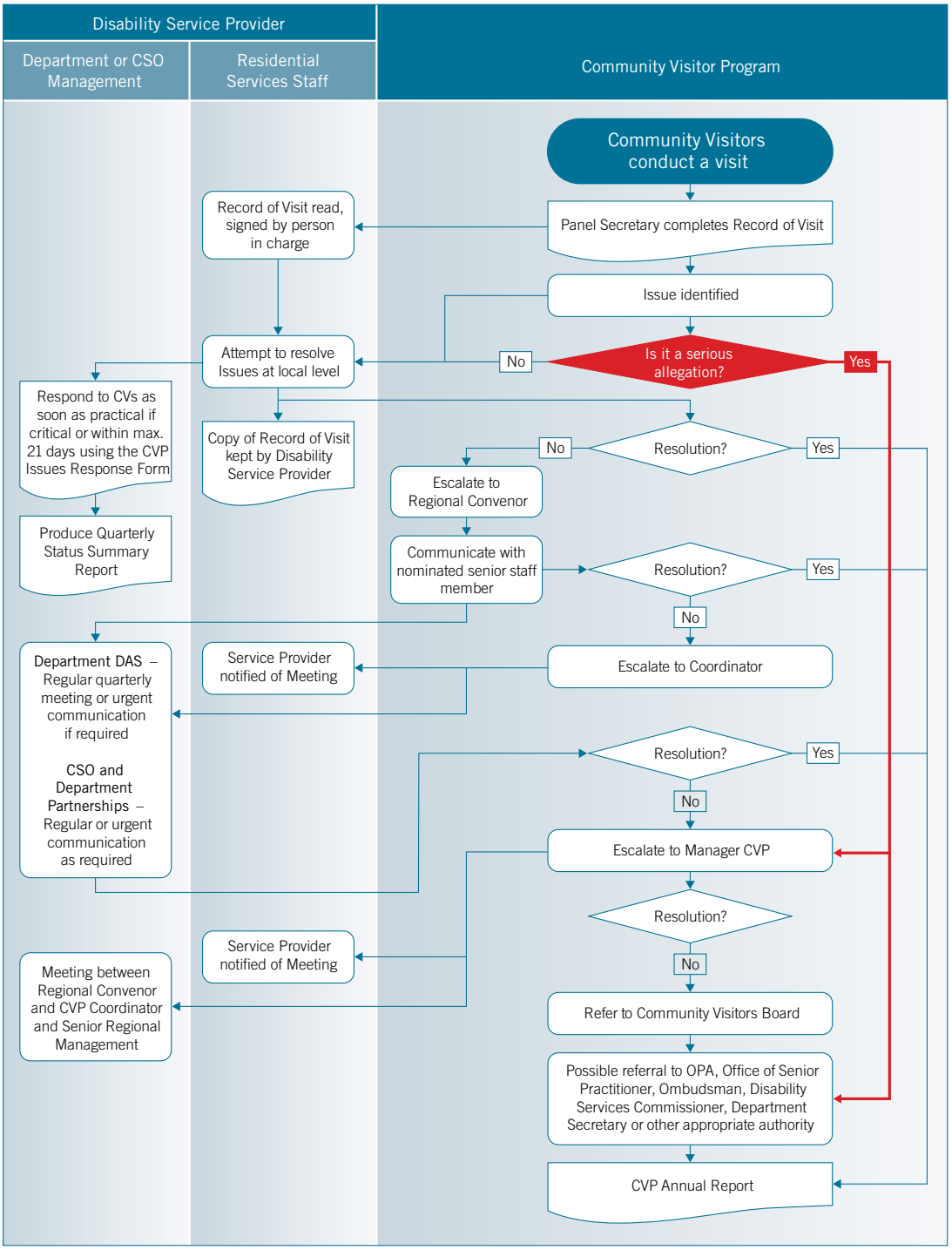
ISSUES: (Number the issues and corresponding responses)

[insert text here]

Attach additional page if required

Appendix 3

Community Visitors reporting flowchart



"It is enlightening to see what measures have been taken in Victoria Australia."

EUROPEAN/ INTERNATIONAL PERSPECTIVES ON AGE AND ITS DEFINITION

Sophia Purcell BL

Introduction

This research focuses on the human rights of older people from a European perspective. I have focused the research on assessing the legislation, international instruments and case law that would be relevant to Older & Bolder.

Key findings

The main findings from my research are that:

- There are a number of International instruments which have given specific rights to older people.
- Most useful in this context is the European Convention on Human Rights and how in practical terms it is transposed in the UK through the Human Rights Act 1998.
- The main concern of the jurisprudence of the European Court of Justice relating to the rights of older people is that concerning mandatory retirement ages. The case taken by Age Concern in the UK illustrates how an NGO can advocate for the rights of older people in the EU.
- The Charter of Fundamental Rights of the EU in Article 25 recognises the rights of older people and therefore provides a platform to challenge European and Irish legislation that does not respect that right.
- The Council of Europe now has a number of instruments assessing and protecting the rights of older people.
- A great emphasis is now placed on the concept of dignity.

European Court of Justice Jurisprudence

Age discrimination is the most useful subject matter in which to assess the rights of older people under European law. Directive 2000/78, establishing a general framework for equal treatment in employment and occupation, prohibits age discrimination and a number of the decisions have assessed the Directive in the light of mandatory retirement ages. Even if there is a mandatory retirement age, this can be permitted if it is objectively justified by the standards set down by the Directive. The concept of objective justification is therefore a key one and the test is still that as set out by the European Court of Justice (ECJ) in *Bilka Kaufhaus v Weber von Hartz*[1]. It has three elements:

(i) the discrimination must be for the purpose of pursuing a legitimate objective;
(ii) the means used must be appropriate to achieve that objective; and
(iii) the means used must be proportionate to that objective.

In *Palacios de la Villa v Cortefel Services SA*[2], the Spanish government argued that the retirement age was adopted at a time of high unemployment to achieve the labour market objective of limiting unemployment for younger people. The ECJ held that[3]:-

> *"... the prohibition on any discrimination on grounds of age, as implemented by Directive 2000/78, must be interpreted as not precluding national legislation, such as that at issue in the main proceedings, pursuant to which compulsory retirement clauses contained in collective agreements are lawful where such clauses provide as sole requirements that workers must have reached retirement age, set at 65 by national law, and must have fulfilled the conditions set out in the social security legislation for entitlement to a retirement pension under their contribution regime, where*
>
> 1. *– the measure, although based on age, is objectively and reasonably justified in the context of national law by a legitimate aim relating to employment policy and the labour market, and*
> 2. *– it is not apparent that the means put in place to achieve that aim of public interest are inappropriate and unnecessary for the purpose."*

In the *Age Concern Case*[4], the court noted that that Directive 2000/78 is designed to lay down a general framework in order to guarantee equal treatment in employment and occupation to all persons, by offering them effective protection against discrimination on one of the grounds covered by Article 1, which include age.[5] A lobby group in England for older persons sought to

1 [1986] E.C.R. 1607

2 C-411/05, [2007] E.C.R. 1-8531

3 At para.77

4 *The Queen, on the application of: The Incorporated Trustees of the National Council on Ageing (Age Concern England) Secretary of State for Business, Enterprise and Regulatory Reform,* (Case 388/07).

5 At para. 23.

challenge Regulations adopted by the UK which provided for a compulsory retirement age. The ECJ, in considering whether the national legislation was contrary to the Directive, gave guidance on when exclusions from age discrimination could be allowed under the Directive.

The court drew attention to the fact that although the right to non-discrimination protected by the Directive was a fundamental one, States had a broad discretion with respect to the manner in which they implemented Directives. The court further held that it was apparent from art.6(1) that the legitimate aims which could justify derogation from the non-discrimination principle were social policy objectives, such as those related to employment policy, the labour market or vocational training and were clearly distinguishable from personal aims of employers. The court set out that it was for a national court to decide whether a provision which allowed employers to dismiss workers who have reached retirement age, such as those related to employment policy, the labour market or vocational training, was justified by "legitimate" aims within the meaning of art.6(1) of the Directive.

The first successful challenge was seen in *Domnica Petersen v Berufungsausschuss für Zahnärzte für den Bezirk Westfalen-Lippe*[6]. In that case Ms Petersen challenged national legislation providing for a limit of age of 68 for the exercise of the activity of dentist as a public panel dentist in Germany.

The German government made the argument that one of the objectives of the national legislation was to protect the health of patients included in national health insurance. It was also to preserve the financial solvency of the public health insurance system and to achieve the aim of ensuring opportunities for new generations to practise as a dentist. However, the legislation placed no restrictions on persons acting as dentists in a private capacity.

The ECJ held, applying a chain of reasoning which we have already seen in *Palacios* and Age Concern, that:

- Discrimination must be justified by legitimate aims within article 6;
- The Directive does not preclude national measures where the aim is to share out employment opportunities between generations;
- The measure adopted must, however, be appropriate to the aim and necessary to achieve it.

Accordingly, the ECJ held that the Directive precluded a national measure setting a maximum age for practising as a public panel dentist on the basis of decline in the performance of the dentist due to age, as the dentist was not restricted from practising as a non-panel dentist.

In *Rosenbladt v Oellerking Gebäudereinigungsge mbH*[7], the ECJ confirmed that a German law which permitted the compulsory retirement of workers entitled to a pension, where set out in a collective agreement, justified age discrimination. The ECJ noted in particular that the provision in question was the result of an agreement negotiated between employees' and employers' representatives exercising their right to collective bargaining.

6 (C341/08, judgment of January 12, 2010).

7 (Case C-45/09, October 12, 2010)

The background to this challenge was the termination of the contract of employment due to compulsory retirement. Mrs Rosenbladt had worked as a part-time cleaner in an army barracks for 39 years. Since 1994 she had been employed by a private firm, Oellerking. A collective agreement was in place which was applicable to the commercial cleaning sector allowing for compulsory retirement when workers reached 65 or when they became entitled to a pension. When Rosenbladt turned 65 she told her employer that she wanted to keep her 10-hour-a-week cleaning job. Her contract stated that, in accordance with the relevant collective agreement, her contract would end at the end of the month in which she claimed a retirement pension, or, at the latest, at the end of the month in which she reached 65. In accordance with that clause, her employer gave her notice of termination on the ground that she had reached retirement age. Although German law permits automatic termination of contracts at pension age where agreed in a collective agreement, Rosenbladt argued that this was unjustifiable age discrimination. The matter was referred to the ECJ.

The ECJ held that the law permitting compulsory retirement did not breach the prohibition on age discrimination in the EU Equal Treatment Framework Directive. The German government argued that its laws were entirely consistent with the Directive's demands that any forced retirement be justified. This was accepted by the ECJ. It noted the German government's arguments that the lawfulness of clauses on automatic termination of contracts on retirement reflected a *"political and social consensus which has endured for many years in Germany"*. It accepted that this consensus was based primarily on the notion of sharing employment between the generations which directly benefits young workers by making it easier for them to find work, which is otherwise difficult at a time of chronic unemployment and has the advantage of not requiring employers to dismiss employees on the grounds that they are no longer capable of working and avoiding "the humiliation of older workers". The ECJ held that the rights of older workers are, moreover, adequately protected as most of them wish to stop working as soon as they are able to retire, and the pension they receive serves as a replacement income once they lose their salary (at para.43).

The ECJ noted that the legislation at issue in this case was not based only on a specific age but also took account of the fact that the persons concerned are entitled to financial compensation by means of a replacement income (in the form of a retirement pension at the end of their working life). It also noted that the mechanism of automatic retirement was not unilateral and was instead based on agreement, between employers and employees, or collectively through the social partners.

Significantly, in concluding the ECJ held that the application of compulsory retirement in collective agreements is not, as such, exempt from review by the courts but, in accordance with the requirements of the Directive, the collective agreement setting a compulsory retirement age must itself be objectively justified by a legitimate aim such as employment policy, or labour market and training objectives. It was also seen as significant by the court that the national legislation did not prevent workers from continuing to work beyond retirement age and did not deprive workers who have reached retirement age of protection from age discrimination where they wish to continue to work and seek a new job (at para.74).

The ECJ accepted that, especially for part-time cleaning workers, a policy of automatic retirement can cause significant hardship. But it said that because those workers could still work, either for the same or another company, the law was a fair balance. Ultimately, therefore, the ECJ held that German law, and the collective agreement in the cleaning sector, were justified and the actions taken under it proportionate.

A month after *Rosenbladt*, the court ruled again in *Georgiev v Tehnicheski Universitet – Sofia, filial Plovdiv*[8] on compulsory retirement constituting age discrimination. In this case Mr Georgiev began his employment with the Technical University of Sofia in 1985 as a lecturer, where he was employed until his compulsory retirement from the role of professor in 2009 at the age of 68.

Upon reaching 65, Mr Georgiev's indefinite employment contract as a lecturer was terminated and he was awarded a one-year fixed-term contract to extend his employment. This contract was renewed in 2007, following which Mr Georgiev was appointed to the position of professor. In 2008, a further one-year extension was granted to Mr Georgiev's employment, providing him with a third year of employment beyond the default retirement age for such a role. In 2009, as required by national law, having reached the age of 68, the University terminated the employment relationship with Mr Georgiev.

Mr Georgiev brought two claims against the University in the Bulgarian courts in relation to him having to work the last three years of his employment under a fixed-term contract, while such contracts were not imposed on younger workers, and also in relation to his compulsory retirement at the age of 68.

The Bulgarian national court referred the issues to the European Court of Justice (ECJ) asking for guidance on whether the national law was inconsistent with European law and, if so, whether the national legislation should be revoked.

The ECJ decided that the policy aims being sought could potentially justify the compulsory retirement age of 68 for professors and the use of fixed-term contracts for employees above the age of 65. In deciding this, the ECJ found it compelling that the imposition of the national legislation was not simply based on age but also on the fact that by the age of 65 professors had also attained the right to a retirement pension (which the ECJ described as "financial compensation"). However, the issue was referred back to the Bulgarian national court to decide:

- Whether, on the facts of this claim, the social policy aims sought could actually be met by a compulsory retirement age and the use of fixed-term contracts; and
- Whether the inconsistency of its application (in that some employees were not required to retire at 68 or to work under fixed-term contracts from the age of 68) could undermine the justification.

In relation to the use of fixed-term contracts, it was also noted by the ECJ that the legislation allowed professors a choice of whether to retire with a pension or to continue working beyond the default retirement age. The ECJ saw this choice as a relevant factor in deciding whether the legislation was a proportionate means of achieving a legitimate aim.

8 ((C-250/09; C-268/09) Second Chamber, November 18, 2010)

We can see that taking specifically, retirement ages and age discrimination in an employment context, that the European Court of Justice has in recent years come down more in favour of the rights of older persons and that mandatory retirement ages must be objectively justified and not discriminatory. This is only in the context really of economic rights that it has been useful but in a more general context, we must look to the European Court of Human Rights in Strasbourg for guidance.

European Convention on Human Rights

As the European Convention on Human Rights has now been incorporated into domestic Irish law by way of the **European Convention on Human Rights Act 2003**, it is very relevant to ascertain the rights of elderly people provided by that Convention. As was noted by the UK report on The Human Rights of Older People in Healthcare[9]:-

> *"A culture of respect for human rights in society is crucial. The protection of and respect for human rights are the responsibility of all of us in society. People who work for public authorities, whether they work for the Government or a local hospital, also have a legal duty under the HRA [Human Rights Act 1998; equivalent UK legislation] to protect and respect the human rights of the people to whom public services are provided…*
>
> *The Human Rights Act gives legal force to the concepts of dignity, respect, equality and fairness. It therefore has more teeth than any governmental initiative focusing on the need for dignity in care. The HRA's functions are to provide a legal framework for service providers to abide by and to empower service users to demand that they be treated with respect for their dignity."*

A number of the articles are therefore relevant in this context. The main rights that are applicable to older people are:

- Respect for family life, home and correspondence (art.8)
- Prohibition on inhuman or degrading treatment (art.3)
- Right to life (art. 2)
- Enjoyment of Convention rights must be guaranteed without discrimination on any ground (art.14).

The following rights may also be applicable in certain circumstances:

- Right to liberty (art.5)
- Freedom of thought, religion, expression and association (arts. 9-11).

Article 2 of the Convention provides that everyone's right to life shall be protected by law.[10] The corollary of the right to life is the duty to protect life. The state has a positive duty to take steps to safeguard the lives of those within the jurisdiction. Therefore there is a high onus on the State to positively protect the right to life of its older citizens.[11]

9 House of Lords and House of Commons Joint Committee on Human Rights; 18th report of session 2006-07. At pp. 32 and 33.

10 Note that the right to life is enshrined in the Irish Constitution and given greater protection in Irish law but this matter is not assessed in this research.

11 In this regard, furthermore it is worth noting that the Irish Constitution has a very high emphasis on the right to life and the positive steps to be taken by the State to protect that right.

Article 3 of the Convention provides that:-

> *"No one shall be subjected to torture or inhuman or degrading treatment or punishment."*

The Court has repeatedly affirmed in its judgments that there is a positive obligation on the State to take steps to protect everyone from degrading treatment. This is relevant to the rights of elderly people living in institutions. In defining torture, a helpful starting point is the UN's definition of torture in the 1975 Declaration which states that:-

"Torture constitutes an aggravated and deliberate form of cruel, inhuman and degrading treatment or punishment."

This means that someone should not be tortured or treated in an inhuman or degrading way in any circumstances, as this right may never be breached, restricted or limited. Article 3 is not just about torture. The ban on inhuman or degrading treatment can be very relevant for older people and encompasses (a) inhuman treatment meaning treatment causing severe mental or physical harm (b) degrading treatment means treatment that is grossly humiliating and undignified. The prohibition against torture and inhuman or degrading treatment is absolute and cannot be opted out of under any circumstances.

In assessing the minimum requirement of the severity of inhuman treatment and torture, the Strasbourg court in the decision of Ireland v. United Kingdom[12] made reference to the following factors:-

"The assessment of this minimum is, in the nature of things, relative; it depends on all the circumstances of the case, such as the duration of the treatment, its physical or mental effects and, in some cases, the sex, ***age and state of health of the victim****, etc." [Emphasis added.]*

In considering whether a treatment is "degrading" within the meaning of Article 3, regard must be paid as to whether its object is to humiliate and debase the person concerned and whether, as far as the consequences are concerned, the treatment adversely affected his or her personality and in what manner.[13] However, the absence of any purpose to humiliate or debase cannot conclusively rule out a finding of a violation of Article 3.[14]

Article 5 relates to the right to liberty and security and states:-

> *"Everyone has a right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law."*

12 18 January, 1978, (1979-80) 2 E.H.R.R.1 at para. 30.

13 *Raninen v Finland,* Judgment of 16 December 1999

14 *V. v United Kingdom*, No.24888/94

In general older people in nursing homes, public or private, cannot be regarded as "detained" persons. The Strasbourg Court has found that there was no deprivation of liberty within the meaning of Article 5 of the Convention in a case involving an eighty-four- year-old woman who had been brought to a care home in Switzerland following concerns about her self- neglect in it's decision in *HM v. Switzerland*[15]. The Court noted that the applicant had had an opportunity to receive care in her own home, but that she and her son had refused to co-operate. Subsequently, her living conditions had deteriorated to such an extent that the authorities had decided to take action. The appeals commission carefully reviewed the circumstances of the case and decided that the nursing home in question, which was in an area familiar to the applicant, could provide her with the necessary care. The applicant was also able to maintain social contact with the outside world while in the home. The Court further noted that, after the applicant had moved to the nursing home, she had agreed to stay there. The Court concluded that the applicant's placement in the nursing home was a responsible measure taken by the competent authorities in the applicant's own interests, in order to provide her with the necessary medical care and adequate living conditions. It did not, therefore, amount to a deprivation of liberty within the meaning of Article 5.

Article 8 reads:

> *"1. Everyone has the right to respect for his private and family life, his home and his correspondence.*
>
> *2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others."*

Article 8 recognises the right of people to participate in the life in their community. The right to respect for private life has been interpreted to include a right to physical and psychological integrity.[16] As was stated by the English High Court[17]:-

> *"Claims under article 8 are necessarily affected when the individual brings his own private life into contact or close connection with other protected interests. Now that is precisely what A and B are doing when they assert that public authority – ESCC – and employees of a public authority – their carers – are under a duty to provide them with domestic care of the most personal and intimate nature. I simply do not see how in this almost uniquely personal context persons in A and B's situation can seek to rely upon the rights afforded to them by article 8 without allowing that their carers have, at least in some respects, corresponding rights which have to be brought into the equation. If article 8 protects A and B's physical and psychological integrity – and it plainly does – then equally article 8(2) must, as against A and B, protect their carers' physical and psychological integrity. And if article 8*

15 Judgment of 26 February 2002

16 X and Y v Netherlands (1985) 8 EHRR 235

17 A & Ors, R (on the application of) v. East Sussex County Council & Anor [2003] EWHC 167 (Admin) by Munby J.

protects A and B's dignity rights – and in my judgment it does – then equally article 8(2) must protect their carers' dignity rights."

Placement of older people in care homes providing residential or nursing care can raise a number of issues with regards to family life, private life and home. Separating older couples by sending them to different care homes or by moving a person into a care home but not allowing their partner to join them clearly raises issues under the right to respect for family life. The right to respect for private life also needs to be considered when older people are forced to move into a residential care home when they would prefer to remain living at home.

And Article 13 reads:

"Everyone whose rights and freedoms as set forth in this Convention are violated shall have an effective remedy before a national authority notwithstanding that the violation has been committed by persons acting in an official capacity."

Therefore the HSE which could be construed as an organ of the State, has an obligation under s.3 of the European Convention on Human Rights Act 2003 to perform its functions in a manner compatible with the State's obligations under the Convention. As nursing homes, both public and private are licensed by the HSE, the argument can be made that the State is therefore responsible for the standard of care provided by both publicly and privately funded nursing homes.

It is interesting and relevant to note the report in the UK on *The Human Rights of Older People in Healthcare*[18] which recognised the following rights as relevant to those in health care:

- Malnutrition and dehydration (Articles 2, 3 and 8 ECHR)
- Abuse and rough treatment (Articles 3 and 8)
- Lack of privacy in mixed sex wards (Article 8)
- Lack of dignity especially for personal care needs (Article 8)
- Insufficient attention paid to confidentiality (Article 8)
- Neglect, carelessness and poor hygiene (Articles 3 and 8)
- Inappropriate medication and use of physical restraint (Article 8)
- Inadequate assessment of a person's needs (Articles 2, 3 and 8)
- Too hasty discharge from hospital (Article 8)
- Bullying, patronising, and infantilising attitudes towards older people (Articles 3 and 8)
- Discriminatory treatment of patients and care home residents on grounds of age, disability and race (Article 14)
- Communication difficulties, particularly for people with dementia or people who cannot speak English (Articles 8 and 14)
- Fear among older people of making complaints (Article 8)
- Eviction from care homes (Article 8).

18 The House of Lords and House of Commons Joint Committee on Human Rights, 18th Report of Session 2006-07, (http://www.publications.parliament.uk/pa/jt200607/jtselect/jtrights/156/156i.pdf).

Relevant English Jurisprudence applying the ECHR

The **Human Rights Act 1998** incorporated the ECHR into law in the UK. Therefore it is relevant to assess how the English courts have applied the principles under the Convention in this context. Our English counterparts, as they do not have a written constitution or any document setting out the rights of its citizens has turned to the ECHR on many occasions to advocate for human rights and to set standards that public bodies must adhere to.

In *YL v. Birmingham City Council*[19], a very interesting case in the context of this research, the claimant was an 84-year-old suffering from Alzheimer's disease and in respect of whom the first defendant council had a duty under section 21 of the National Assistance Act 1948 to make arrangements for providing residential accommodation. Pursuant to its powers under section 26 of the 1948 Act, the council contracted with the second defendant company, an independent provider of health and social care services, for the claimant to be placed in one of its care homes, which accommodated both privately funded residents and those whose fees were paid by the council in full or in part. The claimant's fees were paid by the council, save for a small top-up fee paid by her relatives. The company subsequently sought to terminate the contract for her care and remove her from the home. The case centred on whether the private home was exercising functions of a public nature in providing care and accommodation and therefore subject to the Human Rights Act 1998.

It is interesting to note that Lord Scott, in the House of Lords stated [20]:-

> *"A number of the features which have been relied on by YL and the intervenors seems to me to carry little weight. It is said, correctly, that most of the residents in the Southern Cross care homes, including YL, are placed there by local authorities pursuant to their statutory duty under section 21 of the 1948 Act and that their fees are, either wholly or partly, paid by the local authorities or, where special nursing is required, by health authorities. But the fees charged by Southern Cross and paid by local or health authorities are charged and paid for a service. There is no element whatever of subsidy from public funds. It is a misuse of language and misleading to describe Southern Cross as publicly funded. If an outside private contractor is engaged on ordinary commercial terms to provide the cleaning services, or the catering and cooking services, or any other essential services at a local authority owned care home, it seems to me absurd to suggest that the private contractor, in earning its commercial fee for its business services, is publicly funded or is carrying on a function of a public nature. It is simply carrying on its private business with a customer who happens to be a public authority. The owner of a private care home taking local authority funded residents is in no different position. It is simply providing a service or services for which it charges a commercial fee.*

19 [2008] 1 A.C. 95

20 At pp.108 and 109.

The position might be different if the managers of privately owned care homes enjoyed special statutory powers over residents entitling them to restrain them or to discipline them in some way or to confine them to their rooms or to the care home premises. The managers do, of course, have private law duties of care to all their residents and these duties of care may sometimes require, for the protection of a resident, or of fellow residents, from harm, the exercise of a degree of control over the resident that might in other circumstances be tortious. When the Mental Capacity Act 2005 comes into force acts of that sort, in relation to persons who lack mental capacity, may attract a statutory defence to any civil action (see sections 5 and 6 of the Act). This, however, really does no more than place common law defences of self-defence or necessity on a statutory basis and does not, in my opinion, advance any argument about the "public nature" of the function being carried on by care homes.

An argument heavily relied on in support of the appeal has been a comparison of the management of a local authority care home with the management of a privately owned care home. There is no relevant difference, it is pointed out, between the activities of a local authority in managing its own care homes and those of the managers of privately owned care homes. The function of the local authority is unquestionably a function of a public nature, so how, at least in relation to residents the charges for whom are being paid by the local authority, can the nature of the function of the managers of a privately owned care home be held to be different? So the argument goes. There are, in my opinion, very clear and fundamental differences. ***The local authority's activities are carried out pursuant to statutory duties and responsibilities imposed by public law. The costs of doing so are met by public funds, subject to the possibility of a means tested recovery from the resident. In the case of a privately owned care home the manager's duties to its residents are, whether contractual or tortious, duties governed by private law. In relation to those residents who are publicly funded, the local and health authorities become liable to pay charges agreed under private law contracts and for the recovery of which the care home has private law remedies.*** *The recovery by the local authority of a means tested contribution from the resident is a matter of public law but is no concern of the care home."[Emphasis added.]*

He then went onto note in assessing the difference between the duty owed by a public home provided by public funds and a private home entered into contractually that[21]:-

"It has been suggested that vulnerable elderly residents in care homes are in need of the extra protection that potential liability of private care home managers under section 6 of the 1998 Act would provide, and that section 6(3)(b) should be given a wide and generous construction accordingly. There is nothing, in my opinion, in this suggestion. It is common ground that it is a responsibility of government and, through government, of local authorities to establish a regulatory framework to provide legal remedies to those in care homes whose rights under the Convention might be breached by those in charge of them (see the cases cited by Lord Mance in paras 93 and 94 of his opinion).

21 At p.110.

This regulatory framework is in place. A feature, or consequence, of it is that an obligation by Southern Cross to observe the Convention rights of residents is an express term of the agreement between the council and Southern Cross and is incorporated into the agreement between Southern Cross and YL. Any breach by Southern Cross of YL's Convention rights would give YL a cause of action for breach of contract under ordinary domestic law. No one has suggested that the contractual arrangements between the council and Southern Cross and between Southern Cross and YL are not typical. There is, in my opinion, no need to depart from the ordinary meaning of "functions of a public nature" in order to provide extra protection to YL and those like her."

In the dissenting opinion of Baroness Hale, she stated that[22]:-

"Positive obligations arise under each of the articles most likely to be invoked by residents in care homes. Article 3 may afford them protection against inhuman and degrading treatment. Article 8 may afford protection against intrusions into their privacy, restrictions on their contacts with family and the outside world, and arbitrary removal from their home. Article 5 may afford protection against deprivation of liberty. Regrettably, examples abound in the literature (I hasten to add, none of it with reference to the company involved in this case) of care homes where acts which might well amount to breaches of articles 3 or 8 are commonplace but might not amount to the criminal offence of ill-treatment or neglect."

She then stated that[23]:-

"Another important factor is the public interest in having that task undertaken. In a state which cares about the welfare of the most vulnerable members of the community, there is a strong public interest in having people who are unable to look after themselves, whether because of old age, infirmity, mental or physical disability or youth, looked after properly. They must be provided with the specialist care, including the health care, that they need even if they are unable to arrange or pay for it themselves. No-one can doubt that providing health care can be a public function, even though it can also be provided purely privately. This home was providing health care by arrangement with the National Health Service as well as social care by arrangement with the local social services authority. It cannot be doubted that the provision of health care was a public function.

Another important factor is public funding. Not everything for which the state pays is a public function. The supply of goods and ancillary services such as laundry to a care home may well not be a public function. But providing a service to individual members of the public at public expense is different. These are people for whom the public have assumed responsibility. There may be other residents in the home for whom the public have not assumed responsibility. They may not have a remedy against the home under the Human Rights Act, although there may well be circumstances in which they would."

22 At p.117

23 At p.119

Further it is interesting to note that she stated that:-

> *"The fact that other people are free to make their own private arrangements does not prevent a function which is in fact performed for this person pursuant to statutory arrangements and at public expense from being a function of a public nature. People are free to provide their own transport rather than to use the publicly provided facilities. People are free to arrange their own health care rather than to use the National Health Service. Nor does the fact that people pay for or towards the service they receive necessarily prevent its provision being a function of a public nature. National Health Service dentistry is no less a function of a public nature because those patients who can afford to do so pay for it. I accept that not every function which is performed by a "core" public authority is necessarily a "function of a public nature"; but the fact that a function is or has been performed by a core public authority for the benefit of the public must, as Lord Nicholls pointed out in Aston Cantlow [2004] 1 AC 546, para 12, be a relevant consideration."*

Lord Mance stated in noting that it would distinguish between patients in the same home if some were protected by the Convention and others not that[24]:-

> *"A private care home company provides services for residents in its care homes, which do not—and should not—depend in their nature or quality on the person with whom it contracts to provide such services. Age Concern England in a memorandum dated January 2006 annexed to the Joint Committee of the House of Lords and House of Commons of March 2007 was aware of this, and observed that "it would also be inequitable if self-funders—who pay higher fees (often called the 'self-funders rate')—had less legal protection than residents whose lower fees are met by the local authority": para 3.5. Age Concern's only antidote was to recommend some form of legislation: paras 8.4 to 8.5. In my view, however, a submission which leads to such a distinction being drawn under section 6(3)(b) of the 1998 Act is inherently questionable. Care homes would be bound to be, and to make their staff, aware of the distinction between Human Rights Convention protected and other residents. If it came to an issue like closure of a wing of a home or relocation of some residents during works, there could be an incentive (it might be argued even a legal duty) to give priority to the wishes and demands of publicly funded residents. To distinguish between different residents in the same care home on the basis of their ability to make the relevant contractual arrangements necessary to gain entry to the home appears undesirable."*

Therefore we can see from this decision that even though a nursing home may be privately run, if it is in part publicly funded (as so many are in this country), then it can be seen that they do owe a duty to the residents to complete its activities in accordance with the ECHR and to respect the Convention rights of its residents. In this case, as the company was running on a commercial basis rather than being subsidized by public funds, it was not a public authority within the meaning of the Human Rights Act 1998 and therefore did not have to exercise its functions in accordance with the Convention. The case has not since been discussed in any further cases but it is a useful example of how the House of Lords has assessed the rights of those in care under the Convention.

24 At p.138

The UK report on *The Human Rights of Older People in Healthcare*[25], has shown us the usefulness of domestic legislation incorporating the ECHR. It is interesting to note the comments when it states that:-

> *"We believe that many people, particularly older people in hospitals and care homes, do not want to feel that they have to demand treatment that they should be able to take for granted. One of the Act's purposes is to grant a power to service users to hold public authorities accountable to respect Convention rights. We recognise that there are people who, together with their families and advocates, can make good use of this power."*[26]

Therefore, the Convention and its applicability under the European Convention on Human Rights Act 2003 can be the most useful tool in advocating on behalf of those that are in care and furthermore in assessing the duties to provide care under the Convention.

Charter of Fundamental Rights of the EU

The European Union Charter of Fundamental Rights sets out in a single text, for the first time in the European Union's history, the whole range of civil, political, economic and social rights of European citizens and all persons resident in the EU.

These rights are divided into six sections:

- Dignity
- Freedoms
- Equality
- Solidarity
- Citizens' rights
- Justice

They are based, in particular, on the fundamental rights and freedoms recognised by the European Convention on Human Rights, the constitutional traditions of the EU Member States, the Council of Europe's Social Charter, the Community Charter of Fundamental Social Rights of Workers and other international conventions to which the European Union or its Member States are parties.

Article 25 of the Charter recognises the rights of older people and states:-

> *"The Union recognises and respects the rights of the elderly to lead a life of dignity and independence and to participate in social and cultural life."*[27]

25 Referred to above.

26 At p. 30.

27 As noted, this Article draws on Article 23 of the revised European Social Charter and Articles 24 and 25 of the Community Charter of Fundamental Social Rights of Workers. Of course, participation in social and cultural life also covers participation in political life. Discrimination is further prohibited in Article 21 on the grounds of age.

This referenced the **European Social Charter**[28] which in Article 23 noted:-

> *"The right of elderly persons to social protection (and) with a view to ensuring the effective exercise of the right of elderly persons to social protection, the Parties undertake to adopt or encourage, either directly or in co-operation with public or private organisations, appropriate measures designed in particular:*
>
> - *to enable elderly persons to remain full members of society for as long as possible, by means of:*
> *(a) adequate resources enabling them to lead a decent life and play an active part in public, social and cultural life;*
> *(b) provision of information about services and facilities available for elderly persons and their opportunities to make use of them;*
>
> - *to enable elderly persons to choose their life-style freely and to lead independent lives in their familiar surroundings for as long as they wish and are able, by means of:*
> *(a) provision of housing suited to their needs and their state of health or of adequate support for adapting their housing;*
> *(b) the health care and the services necessitated by their state;*
>
> - *to guarantee elderly persons living in institutions appropriate support, while respecting their privacy, and participation in decisions concerning living conditions in the institution."*

Article 23 overlaps with other provisions of the Charter, which protect elderly persons as members of the general population, such as Article 11 (Right to protection of health), Article 13 (Right to social and medical assistance) and Article 12 (Right to social security). Article 23 requires states to make focused and planned provision in accordance with the specific needs of elderly persons. One of the primary objectives of Article 23 is to enable elderly persons to remain full members of society. The expression "full members" means that elderly persons must suffer no ostracism on account of their age. The right to take part in society's various fields of activity should be granted to everyone active or retired, living in an institution or not.

There has not to date been a wide range of discussion on Article 25. However, Advocate General Bot in *Joao Filipe da Silva Martins v Bank Betriebskrankenkasse*[29] stated the following:-

> *"With regard to elderly persons reliant on care, I think that the pursuit of those objectives is of very particular importance. Indeed, as now enshrined in Article 25 of the Charter of Fundamental Rights of the European Union, the elderly have the right to lead a life of dignity and independence. I am of the view that, for those elderly persons who lose their autonomy, respect for that independence should take the form of as wide a choice of lifestyles and care provision as possible. (28) If many elderly persons decide to return to their State of origin in order to be near to and benefit from the support of their family, those persons*

28 Of 1961 and 1996.

29 Case 388-09. Opinion delivered 13 January, 2011.

must not, quite apart from their disability and sometimes their precarious situation, be hindered in their movement by the loss of the rights which they were legitimately able to acquire during their professional activity.[30]"

We can see therefore that he placed great emphasis on the dignity and independence of those older people in care. It is the first time that the rights of older people in the EU have been addressed separately and distinctly. The EU Charter is binding only at the level of the EU institutions or, in the case of member states, only where they are implementing EU law but as was stated by the Ombudsman *"it is reasonable to expect that the values and principles enshrined in the Charter should be reflected in member states' laws and public services."*[31]

Council of Europe

The European Social Charter is a Council of Europe treaty which guarantees social and economic human rights. It was adopted in 1961 and revised in 1996. Article 11 of the European Social Charter states:-

"With a view to ensuring the effective exercise of the right to protection of health, the Contracting Parties undertake, either directly or in co-operation with public or private organisations, to take appropriate measures designed inter alia:

1. *to remove as far as possible the causes of ill-health;*
2. *to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;*
3. *to prevent as far as possible epidemic, endemic and other diseases."*

Article 13 provides that:-

"With a view to ensuring the effective exercise of the right to social and medical assistance, the Contracting Parties undertake:

1. *to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition;*
2. *to ensure that persons receiving such assistance shall not, for that reason, suffer from a diminution of their political or social rights;*
3. *to provide that everyone may receive by appropriate public or private services such advice and personal help as may be required to prevent, to remove, or to alleviate personal or family want;*
4. *to apply the provisions referred to in paragraphs 1, 2 and 3 of this article on an equal footing with their nationals to nationals of other Contracting Parties lawfully within their territories, in accordance with their obligations under the European Convention on Social and Medical Assistance, signed at Paris on 11th December 1953."*

30 At para.77.

31 April 2011- Too Old to be Equal? (http://www.ombudsman.gov.ie/en/Reports/InvestigationReports/April2011-TooOldtobeEqual/Name,13966,en.htm)

Recommendation R(87) on the Screening and Surveillance of Elderly Persons noted that older people seek greater autonomy and independence. It stated that governments of member states should encourage older people, in full respect of their freedom of choice, to undergo screening and for this purpose provide them with incentives, such as free screening, and motivate them through clear and simple information on the possibilities and benefits of screening. It stated that governments of member states should encourage general practitioners to play a greater role in the screening and surveillance of older people, particularly in making them aware of the benefits of screening and in establishing contact with them, and to maintain a good system of recording consultations and treatment, to allow them to follow up their older clients and ensure a proper evaluation of the screening. It also stated that they should give every possible incentive to community nurses to take initiatives in the surveillance of older people and encourage all health staff who are involved in the care of, or are in contact with, older people to obtain information on their social situation. It also stated that they should take special measures to reach those groups of older people who are most at risk and follow them appropriately.

Recommendation 1796 on the Situation of Elderly Persons in Europe (2007), observed that that in a Europe where the population is rapidly ageing, a number of challenging issues need to be met with fair and sustainable solutions, which are not detrimental to the rights of the individual but which render beneficial changes to society as a whole, and equip it to meet the needs and expectations of all citizens. It stated that the need to review, and if necessary, reform pension systems, to improve democratic participation of older people, to examine issues relating to health and care policies are amongst other, wide-ranging issues which require attention. It acknowledged and deplored the fact that older people may be more vulnerable to discrimination in various contexts such as employment, access to health care or financial services and strongly encourages member states to ensure that non-discrimination legislation also applies on grounds of age.

Recommendation 1294 on the medical and welfare rights of the elderly; ethics and policies notes the economic situation present at that time (1994) in central and eastern Europe making it impossible to draw up any long-term plan for social protection. It was noted that what it demanded was urgent action to preserve minimum social protection, centred on the most vulnerable sections of the community, and in particular on older people; these social priorities are essential in order to ensure that the transition is politically viable. Short term minimum measures it stated were:-

> *"i. to guarantee adequate minimum incomes for the vulnerable core of the community (the unemployed, the sick, the disabled and the elderly) in order to avoid tension and conflict;*
> *ii. to combat the deterioration of the public health system and to maintain or establish simple structures for primary health care (community health centres for example), which are less expensive and financially accessible for people with very low incomes, such as the elderly;*
> *iii. to develop local services for the elderly and introduce or develop training for welfare workers;*
> *iv. to make public social services more effective so as to provide real support for the community and families."*

United Nations

Article 55 of the Charter of the **United Nations** states:-

> *"With a view to the creation of conditions of stability and well-being which are necessary for peaceful and friendly relations among nations based on respect for the principle of equal rights and self-determination of peoples, the United Nations shall promote:*
> 1. *higher standards of living, full employment, and conditions of economic and social progress and development;*
> 2. *solutions of international economic, social, health, and related problems; and international cultural and educational cooperation; and*
> 3. *universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion."*

The **Universal Declaration of Human Rights** states in article 22 that:-

> *"Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality."*

Article 25(1) states that:-

> *"Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."*

Article 27(1) states that:-

> *"Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits."*

The **UNHCR 1951 Convention on the Status of Refugees** states in article 24(1) that:-

> *"The Contracting States shall accord to refugees lawfully staying in their territory the same treatment as is accorded to nationals in respect of the following matters:*
> *(a) In so far as such matters are governed by laws or regulations or are subject to the control of administrative authorities: remuneration, including family allowances where these form part of remuneration, hours of work, overtime arrangements, holidays with pay, restrictions on home work, minimum age of employment, apprenticeship and training, women's work and the work of young persons, and the enjoyment of the benefits of collective bargaining;*
> *(b) Social security (legal provisions in respect of employment injury, occupational diseases, maternity, sickness, disability, old age, death,*

unemployment, family responsibilities and any other contingency which, according to national laws or regulations, is covered by a social security scheme), subject to the following limitations:

(i) There may be appropriate arrangements for the maintenance of acquired rights and rights in course of acquisition;

(ii) National laws or regulations of the country of residence may prescribe special arrangements concerning benefits or portions of benefits which are payable wholly out of public funds, and concerning allowances paid to persons who do not fulfil the contribution conditions prescribed for the award of a normal pension."

The **International Covenant on Economic, Cultural and Social Rights** states in article 9 that:-

"The States Parties to the present Covenant recognize the right of everyone to social security, including social insurance."

Article 11(1) states that:-

"The States Parties to the present Covenant recognize the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions. The States Parties will take appropriate steps to ensure the realization of this right, recognizing to this effect the essential importance of international co-operation based on free consent."

Article 12 states that:-

"1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

(b) The improvement of all aspects of environmental and industrial hygiene;

(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness."

The **Declaration on the Rights of Disabled Persons** states at article 9 that:-

"Disabled persons have the right to live with their families or with foster parents and to participate in all social, creative or recreational activities. No disabled person shall be subjected, as far as his or her residence is concerned, to differential treatment other than that required by his or her condition or by the improvement which he or she may derive therefrom. If the stay of a disabled person in a specialized establishment is indispensable, the environment and living conditions therein shall be as close as possible to those of the normal life of a person of his or her age."

Article 10 states that:-

> *"Disabled persons shall be protected against all exploitation, all regulations and all treatment of a discriminatory, abusive or degrading nature."*

The government can be held accountable by means of reports on it's performance under the Convention by the **UN Disability Committee**. Among the rights for persons with a disability included in the Convention are the following: an equal right to life; a right to own and inherit property, to control their financial affairs and have access to financial services; not to be deprived of their liberty "unlawfully or arbitrarily"; not to be forcibly institutionalised; a right to privacy and access to medical records; removal of barriers to accessing the environment, transport, public facilities and communication; and the right to live independently. Signatory States would also be required to make essential equipment affordable, end discrimination relating to the right to marriage, family and personal relationships; and to have equal access to education, employment, public life and cultural life.

The **Declaration on the Elimination of Violence Against Women** notes that the General Assembly is concerned that *"some groups of women, such as women belonging to minority groups, indigenous women, refugee women, migrant women, women living in rural or remote communities, destitute women, women in institutions or in detention, female children, women with disabilities, elderly women and women in situations of armed conflict, are especially vulnerable to violence."*

The **UN General Recommendation No. 27 on older women and protection of their human rights** noted that age is one of the grounds on which women suffer multiple forms of discrimination. It states that both men and women experience discrimination based on old age, but older women experience ageing differently. The impact of gender inequalities throughout their lifespan is exacerbated in old age and is often based on deep rooted cultural and social norms. The discrimination that older women experience is often a result of unfair resource allocation, maltreatment, neglect and limited access to basic services. The discrimination older women experience is often multidimensional, with age discrimination, compounding other forms of discrimination based on sex, gender, ethnic origin, disability, levels of poverty, sexual orientation and gender identity, migrant status, marital and family status, literacy and other grounds. Older women who are members of minority, ethnic or indigenous groups, or who are internally displaced or stateless often experience a disproportionate degree of discrimination.

Many older women face neglect as they are considered no longer active in their productive and reproductive roles and are seen as a burden to their families. Furthermore lack of or limited access to health care services for diseases and geriatric conditions such as diabetes, cancer, in particular the most prevalent forms of cancer among older women, hypertension, heart disease, cataract, osteoporosis and Alzheimer prevent older women from enjoying their full human rights.

Older women are often discriminated against through lack of opportunity to participate in political and decision-making processes. Lack of identity documentation as well as transportation means may prevent older women from voting. In some countries, older women may not form or participate in associations

or other non-governmental groups to campaign for their rights. Further, mandatory retirement ages may differ for women and men with women being forced to retire earlier, which may cause discrimination against older women, including those who wish to represent their Governments at the international level. The rights to self-determination and consent regarding health care of older women are not always respected. Social services, including provisions for long term care, for older women might be disproportionately reduced when public expenditure is cut. Postmenopausal, post-reproductive and age-related physical and mental health conditions and diseases tend to be neglected in research, academic studies, public policy and service provision. Information on sexual health, HIV and AIDS is rarely provided in a form that is acceptable, accessible and appropriate for older women. Many older women have no private health insurance or are excluded from State-provided schemes because they have not contributed to schemes during a lifetime of work in the informal sector or in unpaid care.

It then recommended that older women must be regarded as an important resource in society and it is an obligation for States parties to take all appropriate measures, including legislation, in order to eliminate their discrimination. States parties should adopt gender-sensitive and age specific policies and measures, including temporary special measures in line with article 4 (1) and general recommendations No. 23 and No. 25, to ensure that older women participate fully and effectively in the political, social, economic, cultural, civil and any other field in their societies. It also recommended that States parties should provide older women with information on their rights and how to access legal services. They should train the police, the judiciary as well as legal aid and paralegal services on the rights of older women and sensitize and train public authorities and institutions on age- and gender-related issues that affect older women. Information, legal services, effective remedies and reparation must be made equally available and accessible to older women with disabilities. States parties have an obligation to ensure that older women have the opportunity to participate in public and political life and hold public office at all levels and that older women have the necessary documentation to register to vote and run as candidates for election.

In relation to health, it made a number of recommendations. States parties should adopt a comprehensive health care policy for the protection of the health needs of older women in keeping with General Recommendation 24 on women and health. This should ensure affordable and accessible health care to all older women through, where appropriate, the elimination of user fees for them, the training of health workers in geriatric illnesses, the provision of medicine to treat age-related chronic and non-communicable diseases, long term health and social care, including care that allows for independent living, and palliative care. This should also include interventions promoting behavioural and lifestyle changes to delay onset of health problems, such as healthy nutritional practices and active living, and affordable access to healthcare services, including screening and treatment for diseases, in particular those most prevalent among older women. Health policies must also ensure that health care provided to older women, including those with disabilities, is based on the free and informed consent of the person concerned. . States parties should adopt special programmes tailored to address the physical, mental, emotional, and health needs of older women with special focus on women belonging to minorities and women with disabilities and those tasked with caring

for grandchildren and other young family dependants due to the migration of young adults or caring for family members living with or affected by HIV/AIDS.

The **UN Convention on the Rights of Persons with Disabilities (2007)** is also relevant. Article 16(2) of the Convention states[32]:-

> *"States Parties shall also take all appropriate measures to prevent all forms of exploitation, violence and abuse by ensuring, inter alia, appropriate forms of gender- and age-sensitive assistance and support for persons with disabilities and their families and caregivers, including through the provision of information and education on how to avoid, recognize and report instances of exploitation, violence and abuse. States Parties shall ensure that protection services are age-, gender- and disability-sensitive."*

While Ireland has signed this Convention, it has not yet ratified it and it is not binding on the State in any sense. A State signing the Convention, in effect, says that it is its intention to take steps to be bound by it at a later date. Signing also creates an obligation, in the period between signing and ratification, to refrain from acts that would defeat the object and purpose of the Convention.

In 1991, the UN produced the **"UN Principles for Older Persons"** which are a declaration rather than a binding legal instrument. However, they are an important and powerful statement of the human rights protection afforded to older people, and are designed to influence national policy and therefore could be useful when advocating on behalf of older people for greater rights.

UN Principles for Older Persons

Independence

1. Older persons should have access to adequate food, water, shelter, clothing and health care through the provision of income, family and community support and self-help.
2. Older persons should have the opportunity to work or to have access to other income-generating opportunities.
3. Older persons should be able to participate in determining when and at what pace withdrawal from the labour force takes place.
4. Older persons should have access to appropriate educational and training programmes.
5. Older persons should be able to live in environments that are safe and adaptable to personal preferences and changing capacities.
6. Older persons should be able to reside at home for as long as possible.

32 There are a number of other provisions which may be relevant but are not discussed. In this context, it may be helpful to read the Convention in full.

Participation

7 Older persons should remain integrated in society, participate actively in the formulation and implementation of policies that directly affect their well-being and share their knowledge and skills with younger generations.
8 Older persons should be able to seek and develop opportunities for service to the community and to serve as volunteers in positions appropriate to their interests and capabilities.
9 Older persons should be able to form movements or associations of older persons.

Care

10 Older persons should benefit from family and community care and protection in accordance with each society's system of cultural values.
11 Older persons should have access to health care to help them to maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness.
12 Older persons should have access to social and legal services to enhance their autonomy, protection and care.
13 Older persons should be able to utilize appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and secure environment.
14 Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives.

Self-fulfilment

15 Older persons should be able to pursue opportunities for the full development of their potential.
16 Older persons should have access to the educational, cultural, spiritual and recreational resources of society.

Dignity

17 Older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse.
18 Older persons should be treated fairly regardless of age, gender, racial or ethnic background, disability or other status, and be valued independently of their economic contribution.

United Nations Working Group

The Open-ended Working Group on Ageing for the purpose of strengthening the protection of the human rights of older persons was established by the United Nations on the 21 December, 2010. After the first working session it issued a report on the 17th May, 2011. It heard statement by representatives from many different jurisdictions (including Northern Ireland and the UK) but there was no representation from Ireland.[33]

33 The Open-ended Working Group on Ageing continues to meet. See: http://social.un.org/ageing-working-group/

Overall there was recognition at the meetings of the particular nature of some human rights challenges faced by older men and women that had thus far not been adequately addressed. Also agreed was that significant gaps existed in the protection afforded to the human rights of older persons, including in current data collection but also on statistics and specific information provided by States at the international level to treaty monitoring mechanisms. Without these tools, it was harder to ensure effective monitoring and to assess the fulfilment of all human rights without discrimination. Delegations noted the need to tackle implementation gaps at the national and international levels and offered views on some measures to achieve stronger results. Some delegations also identified normative gaps and called attention to the weaknesses of a fragmented system in providing effective protection. Furthermore, some delegations, non-governmental organizations and experts called for a binding instrument in addition to dedicated mechanisms and further measures to address these gaps.

Delegates expressed views on the need to devote attention to particular issues, such as those related to access to and availability of health services or further consideration of retirement ages. Some delegations made reference to the importance of long-term care, including as it related to housing and transportation policies to enhance independent living, and the need to provide technologies and support devices to the elderly. For some delegations it was also important to stress active ageing and to recognize the contribution older persons continue to make to their communities and to society at large. Empowerment of older persons was observed as a central dimension of their human rights and participation in development. The resolution adopted by the General Assembly[34] among other things:

1. Encourages Governments to pay greater attention to building capacity to eradicate poverty among older persons, in particular older women, by mainstreaming ageing issues into poverty eradication strategies and national development plans, and to include both ageing-specific policies and ageing-mainstreaming efforts in their national strategies;
2. Invites Governments to conduct their ageing-related policies through inclusive and participatory consultations with relevant stakeholders and social development partners, in the interest of developing effective policies creating national policy ownership and consensus-building;
3. Calls upon Governments to ensure, as appropriate, conditions that enable families and communities to provide care and protection to persons as they age, and to evaluate improvement in the health status of older persons, including on a gender-specific basis, and to reduce disability and mortality;
4. Encourages Governments to continue their efforts to implement the Madrid Plan of Action and to mainstream the concerns of older persons into their policy agendas, bearing in mind the crucial importance of family intergenerational interdependence, solidarity and reciprocity for social development and the realization of all human rights for older persons, and to prevent age discrimination and provide social integration;

34 In a report dated 4th February, 2011. (http://social.un.org/ageing-working-group/).

5. Recognizes the importance of strengthening intergenerational partnerships and solidarity among generations, and in this regard calls upon Member States to promote opportunities for voluntary, constructive and regular interaction between young people and older generations in the family, the workplace and society at large;
6. Invites Member States to ensure that older persons have access to information about their rights so as to enable them to participate fully and justly in their societies and to claim full enjoyment of all human rights;
7. Calls upon Member States to develop their national capacity for monitoring and enforcing the rights of older persons, in consultation with all sectors of society, including organizations of older persons through, inter alia, national institutions for the promotion and protection of human rights where applicable;
8. Also calls upon Member States to strengthen and incorporate a gender perspective into all policy actions on ageing, as well as to eliminate and address discrimination on the basis of age and gender, and recommends that Member States engage with all sectors of society, including women's groups and organizations of older persons, in changing negative stereotypes about older persons, in particular older women, and promote positive images of older persons;
9. **Further calls upon Member States to address the well-being and adequate health care of older persons, as well as any cases of neglect, abuse and violence against older persons, by designing more effective prevention strategies and stronger laws and policies to address these problems and their underlying factors;**
10. Calls upon Member States to take concrete measures to further protect and assist older persons in emergency situations, in accordance with the Madrid Plan of Action;
11. Also encourages the international community to support national efforts to forge stronger partnerships with civil society, including organizations of older persons, academia, research foundations, community-based organizations, including caregivers, and the private sector, in an effort to help to build capacity on ageing issues;
12. Recommends that Member States reaffirm the role of United Nations focal points on ageing, increase technical cooperation efforts, expand the role of the regional commissions on ageing issues and provide added resources for those efforts, facilitate the coordination of national and international non-governmental organizations on ageing and enhance cooperation with academia on a research agenda on ageing.

Dignity as a Concept in International Human Rights Instruments and Statutes

The concept of dignity is prominent in the **Universal Declaration of Human Rights** 1948: -

> *"Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world, Article 1: All human beings are born free and equal in dignity and rights."*

The preambles to both the **International Covenant of Civil and Political Rights (ICCPR) and the International Covenant on Economic Social and Cultural Rights (ICESCR)** 1966 state: -

> *"[…] in accordance with the principles proclaimed in the Charter of the United Nations, recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world, Recognising that these rights derive from the inherent dignity of the human person."*

The **EU Charter of Fundamental Rights** devotes the whole of its first chapter to dignity. That chapter, containing the first five Articles of the Charter, declares that human dignity is inviolable, and asserts the rights to life, to integrity of the person, the prohibition of torture and inhuman or degrading treatment or punishment and the prohibition of slavery and forced labour.

The European Court of Human Rights has held in the decision of *Pretty. v. U.K.*[35] that the very essence of the ECHR is respect for human dignity and human freedom. Without in any way negating the principle of sanctity of life protected under the Convention, it is under Article 8 that notions of the quality of life take on significance. Many people are concerned that they should not be forced to linger on in old age or in states of advanced physical or mental decrepitude which conflict with strongly held ideas of self and personal identity.

The Council of Europe **Recommendation Concerning the Legal Protection of Incapable Adults**[36] provides a more detailed (and modern) statement of rights. The Recommendation adopts as its fundamental principle, underlying all other principles, "respect for the dignity of each person as a human being." It requires that the laws, procedures and practices relating to the protection of adults lacking capacity should be based on respect for their "human rights and fundamental freedoms."

The concept of dignity alone is something that is recognised by the courts and by international instruments pertaining to human rights. Therefore it is a concept at the core of human rights considerations and a matter highly relevant when assessing the human rights of older people. Indeed it has been specifically recognised by case law and in this regard, it is worthwhile to note the comments of Munby J., in the English High Court when he stated in the decision of *A & Ors, R (on the application of) v East Sussex County Council & Anor:*[37]-

> *"The first is human dignity. True it is that the phrase is not used in the Convention but it is surely immanent in article 8, indeed in almost every one of the Convention's provisions. The recognition and protection of human dignity is one of the core values – in truth the core value – of our society and, indeed, of all the societies which are part of the European family of nations and which have embraced the principles of the Convention. It is a core value*

35 (2002) 35 E.H.R.R. 1.

36 Recommendation No R (99) 4 of the Committee of Members to Member States on Principles Concerning the Legal Protection of Incapable Adults (adopted February 23 1999).

37 [2003] EWHC 167 (Admin).

of the common law, long pre-dating the Convention and the Charter. The invocation of the dignity of the patient in the form of declaration habitually used when the court is exercising its inherent declaratory jurisdiction in relation to the gravely ill or dying is not some meaningless incantation designed to comfort the living or to assuage the consciences of those involved in making life and death decisions: it is a solemn affirmation of the law's and of society's recognition of our humanity and of human dignity as something fundamental. Not surprisingly, human dignity is extolled in article 1 of the Charter, just as it is in article 1 of the Universal Declaration. And the latter's call to us to "act towards one another in a spirit of brotherhood" is nothing new. It reflects the fourth Earl of Chesterfield's injunction, "Do as you would be done by" and, for the Christian, the biblical call (Matthew ch 7, v 12): "all things whatsoever ye would that men should do to you, do ye even so to them: for this is the law and the prophets"."

Dignity is a core human rights principle, and lack of dignity is often at the heart of instances of human rights abuses in health and social care – for example, a lack of dignity is a common theme in the above examples of abuse and neglect. Closely linked to dignity is privacy – while the two concepts are distinct, privacy can be viewed as an essential aspect of dignity.

Other examples include:

- Mixed sex wards
- Privacy and dignity during personal care, e.g. bathing, undressing
- Privacy while using the toilet
- Sensitive medical advice being given when other patients can overhear
- Care home residents being fed whilst on the commode

International Instruments

The **ILO[38] Recommendation no.162 Concerning Older Workers** states at para. 3 that:-

"Each Member should, within the framework of a national policy to promote equality of opportunity and treatment for workers, whatever their age, and of laws and regulations and of practice on the subject, take measures for the prevention of discrimination in employment and occupation with regard to older workers."

Paragraph 5 states that:-

"Older workers should, without discrimination by reason of their age, enjoy equality of opportunity and treatment with other workers as regards, in particular:

(a) access to vocational guidance and placement services;

(b) access, taking account of their personal skills, experience and qualifications, to--

(i) employment of their choice in both the public and private sectors: Provided that in exceptional cases age limits may be set because of special requirements, conditions or rules of certain types of employment;

38 International Labour Organisation

(ii) vocational training facilities, in particular further training and retraining;
(iii) paid educational leave, in particular for the purpose of training and trade union education;
(iv) promotion and eligibility for distribution of tasks;

(c) employment security, subject to national law and practice relating to termination of employment and subject to the results of the examination referred to in Paragraph 22 of this Recommendation;
(d) remuneration for work of equal value;
(e) social security measures and welfare benefits;
(f) conditions of work, including occupational safety and health measures;
(g) access to housing, social services and health institutions, in particular when this access is related to occupational activity or employment."

In this context, it appears that the rights given to citizens of member states of the EU would be greater and therefore the Directive on equal treatment prohibiting age discrimination (discussed above) would be more useful.

Conclusion

There are a very large number of international instruments that are useful when advocating for the rights of older persons. We can see that in recent years, greater recognition has been given to the human rights of older persons specifically when the dignity and autonomy of older people is recognised in the EU Charter. The most useful tool though for those who are presently receiving care and are dependant on others is the ECHR which is incorporated into Irish law by the ECHR Act 2003. This research has aimed to set out the main treaties and instruments that would be relevant to Older & Bolder but as it is such a wide ranging subject, it does not pertain to be exhaustive. As stated above, any matter can be addressed in further detail but it is hoped that it will be a useful reference tool. I have included an appendix with some documents that may be useful for further reference but which could not be addressed in this paper due to time constraints.

Appendix

Additional Information Sources

1. *The European Report on Preventing Elder Maltreatment,* World Health Organisation regional office for Europe, 2011. (Available on http://www.preventelderabuse.eu/european/3/1/45/1/get.aspx).

2. *The European Charter of the rights and responsibilities of older people in need of long-term care and assistance,* June, 2010, Age Platform Europe. (http://www.age-platform.eu/en/daphne).

3. *Your Human Rights: A Guide For Older People,* 2nd Ed., British Institute of Human Rights (http://www.bihr.org.uk/sites/default/files/Older%20people%20guide%20second%20edition%20FINAL.pdf).

4. *Human Rights of Older People in Healthcare,* House of Lords and House of Commons Joint Committee on Human Rights, 18th report, (http://www.publications.parliament.uk/pa/jt200607/jtselect/jtrights/156/156i.pdf).

5. *The protection and promotion by national human rights structures of the rights of the elderly ,* Workshop Debriefing Paper, 15-16 September, 2009. (http://unipd-centrodirittiumani.it/public/docs/The_Ederly_definitivo.pdf)

6. *The Human Rights of the Elderly: An Emerging Challenge.* Frederic Megret. (http://www.cardi.ie/userfiles/Human%20Rights%20of%20the%20Elderly.pdf)

7. *EURAG Charter for the Elderly* (http://eurageurope.org/eurag/charter/)

www.olderandbolder.ie

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