



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



I am really pleased to introduce this report compiled by my colleagues in the International Longevity Centre network around the world.

It comes at a time of welcome growth for the network, as the implications of longevity and demographic change feed through into policy in very different societies and cultures. Each country represented in this report has its unique perspective on the challenges for human rights posed by ageing societies, and has reached a different stage in the evolution of mechanisms to address this critical issue.

As Chief Executive of ILC UK I acknowledge with great thanks the support of BT in producing this report, and in hosting the conference at which it will be launched. I hope that readers find our contributions of interest and help in their own work as, with the arrival of the CEHR, the debate on human rights enters a new era.

With good wishes

A handwritten signature in black ink, reading 'Sally Greengross' in a cursive script.

Baroness Sally Greengross  
Chief Executive  
ILC UK

It is with great pleasure that I welcome you to the BT auditorium. We are delighted to be hosting the ILC Global Alliance's conference, 'Human Rights in An Ageing World'.

We at BT have for some time been mindful of the reality of the changing global demographics. We recognise that business success is only maximised when you have a combination of skills, experience, commitment, personal interaction and commercial sense. That is why we value and encourage the diverse solutions that mixed age teams deliver to our customers. Different people have different skills and experiences and by working together across generations we can all grow and develop.

I wish you every best wish for a successful event.

Aaron McCormack  
BT Age Champion and CEO of BT Conferencing

## Introduction

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

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

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

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

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

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

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

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

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

UK  
South Africa  
France  
Dominican Republic  
Israel  
India  
Japan  
Netherlands  
Argentina  
USA



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

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

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

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

## Pensions

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

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

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

## Social Care and Health

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

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

**UK**  
**South Africa**  
**France**  
**Dominican Republic**  
**Israel**  
**India**  
**Japan**  
**Netherlands**  
**Argentina**  
**USA**



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

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

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

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

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

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

**UK**  
**South Africa**  
**France**  
**Dominican Republic**  
**Israel**  
**India**  
**Japan**  
**Netherlands**  
**Argentina**  
**USA**



## Discrimination

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

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

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

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

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

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

## Labour market, assets, inter-generational contract.

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

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

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

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

UK  
South Africa  
France  
Dominican Republic  
Israel  
India  
Japan  
Netherlands  
Argentina  
USA



Within families, grandparents are playing an ever more crucial role. Recent research suggests a figure of £6.8bn is saved by using grandparents as child-minders.

If our aim is to maintain a cohesive society in which the rights of all generations are protected, the legitimacy of the inter-generational contract is vital; policymakers must monitor and evaluate when the challenge to this legitimacy becomes so severe as to warrant a response.

## Migration

Europe has seen enormous economic and demographic change over the past 25 years, resulting in much greater workforce participation by women. This drives inward migration, in domestic service, care services, and food production, with serious implications for the source countries, in many of which basic human rights are more precarious to start with, and the mechanisms to defend them scant or non-existent. Traditional social and family structures are undermined by the labour migration of the principal wage earners, often placing a heavy burden on older generations. We who benefit must be sensitive to the unintended consequences of the migration flow northwards: it is not, as it is often portrayed, a simple win/win economic equation if, for

example, 2/3 of the women in South America work outside their country of domicile.

## Close

We increasingly recognise that we live in an inter-dependent world. As history of the 20th century – and particularly Europe's – shows, nothing endangers the most fundamental human rights more effectively than rapid economic and social destabilisation.

A rights-based approach can shift emphasis from people as passive recipients of remote services to individuals active in shaping the services they need, and accepting of responsibility for them. It has the potential to transform our public service landscape in the UK.

But a note of caution. We are a long way from a pro-human rights culture in Britain: public scepticism is due partly to some headline-grabbing test cases and the distorting effect of immigration, security and terrorism judgements, wherein convicted criminals and others whose presence in the UK is certainly not, in the traditional phrase, 'conducive to the public good', have nevertheless been rewarded, in effect, with continued residency here after successfully raising HR challenges to their removal (and to detention). I doubt very much whether the public will be convinced that

policy-makers are serious about defending their 'rights for real' unless this paradox can be resolved.

UK

South Africa

France

Dominican Republic

Israel

India

Japan

Netherlands

Argentina

USA



## Author:

Baroness Sally Greengross OBE is Chief Executive of the International Longevity Centre UK. She also co-chairs the Alliance for Health and the Future.

Baroness Greengross has been a crossbench (independent) member of the House of Lords since 2000. She is a member of the Lords Social and Consumer Affairs sub-committee G and chairs two All Party Parliamentary Groups: Corporate Social Responsibility and the group for Grandparents and Extended Kin.

She is chair of the Experience Corps, and also chair of UCL's advisory group for the English Longitudinal Study on Ageing. She is Patron of Beginnings, an initiative to encourage the employment of people with disabilities, and is a board member of HelpAge International, among many other charity interests. She is a Trustee of the Resolution Foundation, President of the Pensions Policy Institute and Honorary Vice President of the Royal Society for the Promotion of Health.

Baroness Greengross was Director General of Age Concern England from 1987 until 2000, and is now their Vice President. Until 2000, she was also joint chair of the Age Concern Institute

of Gerontology at Kings College London and Secretary General of EuroLink Age. At Age Concern she established many innovative programmes and was also responsible for building Age Concern Enterprises into a multi-million pound business.

Baroness Greengross holds honorary doctorates from seven UK universities.

## Appendix:

summary of ECHR articles (from 'Rights for Real')

### The European Convention on Human Rights: relevance to older people using public services

Convention Article	Application to older people
<b>Article 2</b> Right to life	<ul style="list-style-type: none"> <li>■ Decisions about life-saving health care treatment</li> <li>■ End of life issues</li> <li>■ Deaths through negligence in hospitals and care homes</li> </ul>
<b>Article 3</b> Prohibition of inhuman and degrading treatment	<ul style="list-style-type: none"> <li>■ Elder abuse</li> </ul>
<b>Article 5</b> Right to liberty	<ul style="list-style-type: none"> <li>■ Restrictions on older people's movements in care homes</li> </ul>
<b>Article 6</b> Right to a fair hearing	<ul style="list-style-type: none"> <li>■ Decision-making processes affecting services for older people</li> </ul>
<b>Article 8 (1)</b> Right to respect for private and family life, home and	<ul style="list-style-type: none"> <li>■ Decisions about care in old age (whether it is provided in the home, in a care home correspondence)</li> <li>■ Remaining with partner at home or in same care home</li> <li>■ Effects of care home closure</li> <li>■ Poor quality care falling short of degrading treatment</li> <li>■ Consent to medical treatment</li> <li>■ Adoption of grandchildren</li> <li>■ Use of personal information</li> </ul>

UK

South Africa

France

Dominican Republic

Israel

India

Japan

Netherlands

Argentina

USA





# ILC South Africa

## Background

Under apartheid, South Africa had one of the worst human rights records. The majority of its citizens were disenfranchised on grounds of race and colour, and their human rights violated in numerous arenas. Older persons lived through the entire 44 years of apartheid, and the majority suffer the cumulative effects of racial discrimination and unequal access to resources and opportunities, and consequent socio-economic disadvantage. In April 1994, the first fully democratic elections voted an African National Congress (ANC)-led government into power, and the new Government set about right away redrafting legislation and reforming policy in virtually all arenas. In 1996 the country adopted a progressive new Constitution and Bill of Rights, which emphasises equitable human rights for all citizens. Several initiatives have contributed moreover to building a human rights culture for older persons.

In line with international human rights covenants and treaties, the Constitution and Bill of Rights include civil and political rights (CPR) and economic, social and cultural rights (ESCR). The Constitution and comprehensive legislation are aimed pertinently at combating unfair discrimination. However, while the Constitution prohibits age discrimination, it does not stipulate rights for older persons.

The ESCR cover a wide range of socio-economic rights, which the State is compelled to fulfil. The Government has a duty thus to provide a range of services to meet the socio-economic needs of the poorest and most vulnerable citizens, within the constraint of available resources. Its current strategic plan aims to promote the goals of sustainable development and to redress past imbalances, through a macro policy approach to service delivery that integrates socio-economic development.

Although specific new legislation exists to protect older persons' rights (the Older Persons Act 13 of 2006), gaps remain in the implementation of constitutional and legal provisions and practices in law. Older persons are not mentioned in the agendas of relevant strategies of any ministry, nor in poverty, development, HIV/AIDS and other national agendas. A main obstacle to the implementation of these rights is that the Government purportedly lacks financial resources. As the Government has an obligation to protect vulnerable citizens, it should prioritise resource allocation to ensure that older persons' rights are realised progressively and fully.

The South African Human Rights Commission (SAHRC), mandated to translate the Constitution's human rights vision into reality, notes that while some significant success has been achieved in the pursuit of equality, deep divides remain in human development: specifically, between rich and poor, black and white, old and young, and urban and rural areas.<sup>1</sup>

### Older persons and human rights

The majority of South Africans are poor and vulnerable and need protection and service provision. For them to enjoy spiritual fulfilment, freedom and material security, their CPR and ESCR need to be honoured. Only limited recognition of and access to their ESCR has materialised thus far, but the State does provide them social protection in the form of non-contributory, albeit means tested, social old age pensions. Eligible women age 60 years and over and men age 65 years and over receive monthly pension benefits of approximately US\$120, as well as free or discounted health care at public sector facilities. A downside of the social pension programme however is that other vulnerabilities and responses needed tend to be sidelined.

### Note

1. The authors have drawn in part on a key address, entitled "Developments in South Africa located in an African context: Bridging the divide between North and South," given by Jody Kollapen, Chairperson of the SAHRC, to the International Federation on Ageing 8th Global Conference, in Copenhagen, Denmark on May 30 – June 2, 2006.

UK  
South Africa  
France  
Dominican Republic  
Israel  
India  
Japan  
Netherlands  
Argentina  
USA



# ILC South Africa

The *Madrid International Plan of Action on Ageing (2002)* and the *African Union's Policy Framework and Plan of Action on Ageing (2003)* provide a comprehensive framework for advancing older persons' rights and interests, and the Government has made some progress in implementing recommendations in the plans since the Second World Assembly on Ageing. However, most lobbying, law reform, social mobilisation, litigation and law making processes in the years following democracy paid little attention to older persons. Then, towards the end of the 1990s, the media began to expose the plight of older persons who are abused in their homes, communities or residential care facilities. In 2000 a Ministerial Committee of Inquiry report documented numerous instances of abuse, neglect and marginalisation, which stirred the social conscience of the nation and started a process which culminated in the enactment of specific legislation to protect older persons' rights.

The *Older Persons Act 13* of 2006 provides a comprehensive framework for the protection of older persons' rights and the creation of mechanisms and structures within communities, to ensure that their welfare and safety are safeguarded, their interests advanced and their status maintained. While the Act deals with the plight of vulnerable older persons

effectively and prohibits abuse specifically, it aims additionally, through a developmental approach, to empower them by encouraging the initiation of programmes and services to advance their well-being and integration. Moreover, it provides for the protection of older persons' rights as recipients of services provided by the State and the regulation of state subsidised residential care facilities.

The Department of Social Development, which has primary responsibility for older persons' well-being, has come some way in ensuring that their dignity, safety and participation are protected – albeit under an “abuse,” and therefore vulnerability, mantle. However, it has not foregrounded their rights to participate in development processes and share in the benefits of development – except rhetorically. Older persons continue to be viewed largely as welfare recipients and a “burden,” or drain, on scarce resources, and not as a development resource. Nonetheless, their contributions to family and community life are being gradually acknowledged.

Other successes achieved relating to the advancement of older persons' rights include the establishment of the South African Older Persons' Forum in 2005, spearheaded by the SAHRC in partnership with stakeholders.

The Commission has contributed moreover to the development of “policy directions,” although the country still lacks a national policy on ageing, and to the achievement of “commitment” from various government agencies responsible for older persons. But despite the efforts and new legislation, the situation of older persons has hardly improved visibly.

## Key issues

Numerous challenges faced by the country and citizens as a whole, such as underdevelopment, poverty, unemployment and the effects of HIV/AIDS, contribute to a lag in the realisation of older persons' rights. In addition, many experience the consequences of rural to urban migration of younger kin, or where they follow migrant kin, displacement at an urban destination. Older women, in particular, are often burdened with the care of grandchildren whose parents are absent, and increasingly they assume responsibility for the care of persons infected with or affected by HIV/AIDS. The majority live in poor housing and many have difficulty in accessing health care, or are dissatisfied with treatment they receive at public health care facilities. Many experience the family care responsibility they shoulder as a burden and perceive it as a violation of their human rights.

UK

South Africa

France

Dominican Republic

Israel

India

Japan

Netherlands

Argentina

USA



# ILC South Africa

Institutional responses to the plight and needs of vulnerable older persons other than social protection have been less adequate. Public health care provision is unsatisfactory. The health system is currently deficient in numerous respects and experiences multiple strains due not only to a need to respond to the HIV/AIDS and tuberculosis epidemics, but also the need to cope with chronic staff shortages, low levels of worker satisfaction, inadequate resource allocation, and labour demands. Deficiencies include a shortage of trained health care workers, shortages of medications at clinics, long waiting periods for treatment, poor and inaccessible infrastructure, and a disregard for patients' rights. Health policy prioritises child and maternal care, and older persons' health care needs are marginalised. Their constitutional right to good quality health care is thus compromised because of biased policy and sectoral ills (a better word than ills?).

Another key area in which older persons are vulnerable to violation of their rights is gender inequality. In patriarchal African society, older women's rights to property inheritance are violated commonly and they are at risk of abuse, violence and exploitation. Although the constitutional and legal framework provides for the protection of their rights, African women in rural areas are subject to

the vagaries and iniquities of customary law, or indigenous law and custom, buttressed by male dominated tribal authorities, and the application of statutory law in their case may be less systematic. Older widows are especially vulnerable to violation of their right to succession, and may be evicted from a deceased husband's house and land by male family figures and left destitute.

Although discrimination on grounds of age is outlawed constitutionally, older persons are discriminated against routinely and subjected to stereotypes, marginalisation and inequality in numerous arenas. One such arena is that of mandatory retirement age, pegged at age 60 or 65, or even younger. An older person has virtually no chance of being retained in, or re-entering, the formal labour force. While employment policies provide for the protection of a full range of workers' human rights, they notably fail to mention age discrimination. An issue being challenged at present is the alleged unconstitutionality of the exclusion of men age 60–64 years from eligibility for a social pension – viewed as discriminatory and an infringement of their right to social security, equality and human dignity. The relevant ministry is opposing a court order application to declare the regulation and act discriminatory (it is unwilling to allocate additional resources

to meet the costs of pensions for men from a younger age), while human rights organisations are arguing that there is no justification for differentiation in the provision of social security benefits to men and women.

Other areas of potential or real violation of older persons' human rights may be identified similarly.

## Changes and mechanisms needed

Despite a progressive Constitution and a comprehensive legal framework to protect older persons' rights, their needs are invariably accorded a lower priority to those of children and the youth in resource allocation. Institutional adjustments are indicated, as are changes in key policies required, to ensure that older persons' rights are honoured. Equally, older persons need to be enabled to assert their rights better, and to this end awareness raising and their continuing empowerment to know and exercise their rights are indicated. Older persons are not yet represented institutionally – at least, not effectively. The South African Older Persons Forum primarily offers itself as an association for non-government organisations (NGOs) that serve older persons, rather than as a platform and a voice for older persons as primary stakeholders. Nevertheless, it brings together

UK  
South Africa

France  
Dominican Republic  
Israel  
India  
Japan  
Netherlands  
Argentina  
USA



# ILC South Africa

structures, stakeholders, interest groups, the Government and civil society, to speak as a single structure, engage in dialogue, lobby, advance policy changes and law reform, and monitor matters affecting older persons.

NGOs have the capacity to mobilise and empower older persons to represent themselves and to advocate for the advancement of their rights and interests; they also have the power to enforce the State to implement ESCR to benefit older persons. Indeed, the non-justiciability (is this a word?) of ESCR should not be a barrier to their enforcement in courts of law; activism through several mechanisms can achieve new commitment and action on the part of the Government and its agencies to implement the rights. Much of what has been achieved thus far to improve older persons' situations has been due to NGOs' efforts; thus they constitute an effective mechanism for change in this regard.

Non-governmental organisations, the Government and older persons are therefore key agencies and actors to effect changes, in partnerships, towards strengthening a human rights culture and affording older persons a better deal, as well as constructing a more equitable society and achieving development goals inclusive of older persons in the

processes. Finally, the SAHRC continues to have a central role in promoting the protection, development and attainment of older persons' rights and in monitoring and assessing observance of their rights; additionally, it advises the Government on steps it should take to meet its obligations and commitments to vulnerable older citizens.

## Authors:

**Monica Ferreira**, DPhil, is President of International Longevity Centre-South Africa (ILCSA). She retired as the director of The Albertina and Walter Sisulu Institute of Ageing in Africa in the Faculty of Health Sciences at the University of Cape Town at the end of 2006. ILCSA is affiliated to the Institute. Her disciplinary training was in Sociology and she has worked in African Gerontology for over 30 years.

**Sebastiana Kalula**, MBChB, MRCP, MMed, MPhil, is Deputy President of ILCSA and acting director of the Institute of Ageing in Africa. She heads the Division of Geriatric Medicine within the Institute, and contributes to the improvement of geriatric health care in sub-Saharan African countries.

UK

South Africa

France

Dominican Republic

Israel

India

Japan

Netherlands

Argentina

USA



## Background

**The striking increase in longevity is a new venture of humanity and a privilege of our nations as long as the human rights of the ageing population remain respected. Recommendations based on the principles of human rights of the United Nations were elaborated by agencies within the UN and the council of Europe. But these organizations have no mandatory rights towards specific nations. Each country has to establish and to put into practice its own laws and policies.**

In 2001 a European group of specialists was mandated by the committee of European ministers to make recommendations for improving the quality of life of the elderly<sup>1</sup>. Their report argues in favor of a global approach to care (medical and social) that should be pluridisciplinary, accessible, and centered on the person whose personal choices and preferences should be respected.

Independently of the principles of human rights, scientific studies demonstrated the same final objective in terms of quality of life for the elderly. Three elements are considered as necessary for guaranteeing a successful ageing<sup>2,3</sup>: the absence of disease and disabling conditions, maintaining physical and cognitive capacities, and the active involvement of

seniors in society.

With this in mind, recent gains in life expectancy do not constitute gains in quality of life for seniors unless they are associated with satisfactory health, numerous interpersonal relationships and an ability to maintain a productive social role, which is usually thought of in terms of volunteer work in the community or family care giving, but it also includes participation in the labour market<sup>4</sup>. It has been demonstrated that the well-being of seniors depends to a great extent on their ability to play a role in the labour market when they choose to do so<sup>5</sup>.

In France, in 2005<sup>6</sup>, 21 percent of the 62 million inhabitants were 60 years old and over. The mean life expectancy at birth is continuously progressing up to nearly 78 years for men and nearly 85 years for women. As in other nations, there will be a continuous increase in the 65 +, 75 + and 85 + populations until 2020 but the percentage of the population under the age of 60 years, though decreasing, remains rather high, probably as a result of the maintained fertility ratio at 1.9, one of the highest in Europe.

France has one of the highest life expectancies and one of the highest healthy life expectancies within Europe. But all people do not enjoy this

equally: in addition to the differences in life expectancy between men and women there are differences based on employment and geography. There is a five year difference in life expectancy at 60 between the white collar and blue collar workers and life expectancy at birth is five years lower in the North than in the Paris region. A very important factor in life expectancy is labour market activity with the risk of mortality of unemployed people being threefold higher than for the active population.

Paradoxically, France has the lowest rate of employment activity of older people. The recommendations that came out of the European Council in Stockholm in 2001 established an objective of employment rate of 50% for the 55–64 age group by the year 2010<sup>7</sup>.

## References

1. La personne âgée dans le droit international et européen des droits de l'homme –A.EVRARD– les éditions namuroises– p54 et suivantes
2. Rowe,J.W., & Kahn,R.L. (1997). Successful aging. Gerontologist 37(4), 433–440.
3. Bowling,A. (2007). Aspirations for Older Age in the 21ST Century: What is Successfull Aging? Int.J Aging Hum.Dev. 64(3), 263–297.
4. O'Reilly,P., & Caro,F.G. (1994). Productive aging: an overview of the literature. J Aging Soc.Policy 6(3), 39–71.
5. Bellaby,P. (2006). Can they carry on working? Later retirement, health, and social inequality in an aging population. Int.J Health Serv. 36(1), 1–23.
6. Bulletin Epidémiologique Hebdomadaire–n°5–6/2006
7. Stockholm European Council: presidency conclusions, 24/03/2001 n°100/1/2001, [http://www.consilium.europa.eu/ueDocs/cms\\_Data/docs/pressData/en/ec/00100-r1.20ann-r1.en1.html](http://www.consilium.europa.eu/ueDocs/cms_Data/docs/pressData/en/ec/00100-r1.20ann-r1.en1.html)

UK  
South Africa

France

Dominican Republic

Israel

India

Japan

Netherlands

Argentina

USA



In 2005, between 55 and 64 years of age, employment rates varied greatly between the European countries, ranging from 31.4% in Italy to 59.5 % in Denmark and 37.9% in France which still remains six points behind the European average (EU 15) of 44.1 % despite a recent trend upward<sup>8</sup>.

If nothing is implemented before 2010 to increase employment activity of older people, the predictable consequence will be an alarming decrease in the worker to retiree ratio resulting in economic difficulties in funding pensions and the healthcare system. The risk of impoverishment of the elderly population will increase and put in danger the collective and individual rights to a successful healthy and active ageing.

In order to allow all elderly dependent persons to enjoy the same rights as any other citizen, the challenge of the French Policy on Successful Ageing is to simultaneously promote health and activity as a long term perspective.

The Government has therefore a double priority:

1. Promoting high quality Long Term Care systems at affordable costs for all age groups needing assistance either at home or in institution.
2. Improving social integration and activity of the healthy senior population.

## Promoting High Quality Long Term Care systems

The 2003 heat wave which resulted 15 000 deaths mainly among isolated elderly citizens raised awareness in the general population and policy makers on the issues and vulnerabilities of older people. This resulted in both the strengthening of existing policies and the introduction of new proposals.

### 1. An Emergency Plan was drawn up:

Better coordination between the different State and regional services, an improvement in the alert systems, a reorganization of the emergency services and an attempt to identify vulnerable persons and, in particular, isolated elderly who are not usual care users.

This plan intends, with specific adjustments, to cope with any emergency situation, heat waves or winter cold, terrorist attacks, bird influenza etc...

### 2. Successive launches of laws favouring the elderly: the law “Vieillesse et Solidarité”<sup>9</sup> in 2004 complemented by the law “Solidarité- Grand Âge” in 2006<sup>10</sup>

One of the most important outcomes was the creation de novo of a new branch of the

Social Security System. This branch covers the risk of dependency and offers part of the financing of long term care either at home or in institutions.

A new Agency was set up, called “Caisse Nationale de Solidarité pour l'autonomie”, CNSA. It is financed by the Health System for medical costs (the Health System covers all persons living in France) and by a new system for the remaining costs: 9 billion € for the 2004–2008 period, funded not from general taxation or social-insurance type solution but from the revenue of an extra work day called “Solidarity Day” for all employees and a 0.3% tax for the employers. The CNSA is independent of any other agency and finances care needs of the dependant elderly and of the younger disabled persons. For example:

- The care costs of dependency (restrictions in Activity of Daily Living and social care such as housekeeping, meals on wheels etc...) either at home or in institutions through a specific allowance called APA (personalized allowance for autonomy). In 2006, 770,000 beneficiaries of this allowance were living at home and 210,000 institutionalized.

## References

8. Eurostat, Taux d'emploi des travailleurs âgés : [http://epp.eurostat.ec.europa.eu/portal/page?\\_pageid=1996,39140985&\\_dad=portal&\\_schema=PORTAL&screen=detailref&language=fr&product=STRIND\\_EMPLOI&root=STRIND\\_EMPLOI/emploi/em014](http://epp.eurostat.ec.europa.eu/portal/page?_pageid=1996,39140985&_dad=portal&_schema=PORTAL&screen=detailref&language=fr&product=STRIND_EMPLOI&root=STRIND_EMPLOI/emploi/em014)
9. <http://www.picardie.sante.gouv.fr/planvieil.htm>
10. [http://www.personnes-agees.gouv.fr/point\\_presse/d\\_presse/plan\\_solidarite/dossier\\_de\\_presse.pdf](http://www.personnes-agees.gouv.fr/point_presse/d_presse/plan_solidarite/dossier_de_presse.pdf)

UK  
South Africa

France

Dominican Republic

Israel

India

Japan

Netherlands

Argentina

USA



The maximal amount of money an individual could receive monthly is: 1,189, 80 € if in GIR 1 (the lowest grade of the autonomy scale called AGGIR); 1,019, 83 € if in GIR 2; 764,87 € if in GIR 3 and 509,91€ if in GIR 4. Besides the public funding provided by the agency, income-related co-payments are required. Board and lodging are not covered in nursing homes; users are charged according to their ability to pay,

- The improvement of services in nursing homes (hiring of nurses and nurses helps, social activities etc...).
- New nursing homes or new beds in existing ones (20,000 beds for the period 2004–2007).
- Day care and respite care units.

Total expenditures on Long Term Care represent a little more than 1% of GDP (15 billion €).

3. **A Geriatric Specialty** was established in September 2003 and a Geriatric University Plan was implemented in 2005 in order to double the number of Professors of Geriatrics from now to 2010. The objective was to improve the geriatric training of GPs, specialists, nursing home physicians, and all professionals taking care of frail elderly. In addition, geriatric acute care units are

being set up in all hospitals with emergency wards, the number of rehabilitation beds is increasing and the hospital long term care units for patient with unstable severe chronic diseases will be better staffed and equipped. Networks between hospital care and community care are strongly recommended and financed.

4. **Shifting the balance toward home-based care is promoted by the government** and home services are expanding to give a choice to the older persons (Scénario du libre choix); the number of recipients is increasing by 4,000 each year. The contribution of a family member or other informal carers is often necessary and services to support carers include psychological assistance, specific information on care giving, day care centres and institutional temporary respite care.

The creation of a new check system, 'chèque emploi service universel' (CESU), co-financed by employers and communities will also facilitate the payment of the social workers by the community. (can we find out how? Might be useful to say)

5. **An Alzheimer Plan<sup>11</sup> was implemented** to cope with the age-related increase in the prevalence of Alzheimer's disease and related disorders, which represent 70% of the causes of institutionalisation and 72% of the requests of the APA allowance. The Plan is aimed at raising the rate of early diagnosis (presently at 50%) by increasing the number of Memory Clinics (263 up to 600) and the number of Resources and Research Memory Centres (24 up to 40). The second objective is to train GPs, professionals, patients and caregivers, and to support families and informal carers (specific Alzheimer day care centres and respite care). Another important objective is to better fund research in all aspects of Alzheimer's disease.

In sum, these new measures should greatly improve the condition of the frail and dependent elderly.

## References

11. [http://www.sante.gouv.fr/htm/actu/alzheimerpresse/accueil\\_dp.htm](http://www.sante.gouv.fr/htm/actu/alzheimerpresse/accueil_dp.htm)

UK  
South Africa

France

Dominican Republic

Israel

India

Japan

Netherlands

Argentina

USA



**Changing the image of ageing and promoting the social integration of the healthy senior citizens in the community and the workforce of the country is another priority for human rights in an ageing society.**

The goal is to ensure people's future financial security, health and quality of life, enabling them to be productive members of society throughout their lives.

Key objectives are being pursued:

- Promoting health prevention throughout life.
- Reforming Employment Policy after 55 years of age.
- Changing the image of ageing and favouring relationships between the generations.

## 1. Health promotion and prevention:

Most age-related diseases may be related to modifiable risk factors and then accessible to prevention. Prevention is still successful after the age of 60 but it should be started before the age of 20 years by promoting healthy lifestyles.

A National Program "Programme Bien Vieillir"<sup>12</sup> ("Aging Well"), based on nutrition, physical activity and social integration, was created in 2003. This program is to be implemented locally by municipalities.

A new systematic comprehensive geriatric assessment at the age of 70 has been implemented to detect all risk factors likely to lead to disabling diseases.

## 2. Reforming Employment Policy after 55 years of age.

Reforms are under way aimed at improving the incentives and opportunities for older people to play a part in the labour market for longer, and tackle the various disincentives and barriers to employment facing older workers.

This requires action by both the public authorities and social partners in the following areas:

- Reform retirement and social welfare systems to strengthen work incentives (progressive retirement, new contracts, simultaneous working/retiring). The French pension system is based on the pay-as-you-go principle and its financing is mainly ensured by contributions from workers and employers. As the retirement pension schemes are affected by contrasting demographic tendencies, it has to be reformed to reflect shifts over time in the structure of their contributing and retired populations. A capitalization scheme will be proposed to individuals to complement this "repartition" system.

- Encourage change in attitudes of employers and workers.
- Adapt employment protection rules to promote employment of older workers.
- Promote training for upgrading skills and acquiring new ones.
- Improve access to high-quality employment services for older job seekers.
- Improve working conditions.

Recently, ILC France put forward an innovative **Healthy Working Life Expectancy Indicator** (HWLE) in Europe<sup>13</sup>.

It offers a model of successful ageing combining two essential dimensions: the absence of disease and disability and the employment of seniors, which is one of the major elements of their active involvement in society. The construction of this indicator is based on calculation methods conventionally used for healthy life expectancies. By applying it to the data from the European Community Household Panel, we were able to compare the number of years lived between 50 and 70 years in good health and employment in 12 countries.

## References

12. [http://www.sante.gouv.fr/htm/pointsur/nutrition/bien\\_vieillir.pdf](http://www.sante.gouv.fr/htm/pointsur/nutrition/bien_vieillir.pdf)
13. Healthy Working Life Expectancies (HWLE) at age 50 in Europe: a new indicator Lièvre Agnès Jusot Florence, Barnay Thomas, Sermet Catherine, Brouard Nicolas, Robine Jean Marie, Brieu Marie-Anne, Forette Françoise-JNHA submitted

UK  
South Africa

France

Dominican Republic

Israel

India

Japan

Netherlands

Argentina

USA





On average in Europe, among the 20 years available between 50 and 70 years old, men spend 14.1 years in good health (70.5%), of which about one half are at work, and women 13.5 years (67.5%) in good health, of which about one third (35%) are at work. Therefore, it should, in theory, be possible to increase working life expectancy between 50 and 70 years old, especially for women, by reallocating years in good health from retirement to work. These results suggest that for increasing working life expectancy, it is not necessary to keep unhealthy people working longer. In addition, the countries where healthy working life expectancy of seniors is the highest are also the countries where the levels of employment of seniors are very high. Such evidence underlines the essential role that employment maintenance and retirement policies have on the number of years spent healthy and at work. Furthermore, the major differences in health between the countries also suggest that health policies have an important role to play.

The HWLE indicator will enable European ageing conditions to be monitored, just as healthy life expectancy indicators do with regard to health status alone. It could also be applied to the forthcoming data from the SILC survey, a longitudinal European survey based on the experience of the European panel.

### 3. Changing the image of aging and favouring relationships between the generations

Healthy and productive ageing brings with it enormous individual, economic and societal benefits to improve human rights in an ageing society. It offers an optimistic perception of the longevity revolution in our societies. This positive image of ageing must be spread over the media (television, newspapers, magazines, etc.), schools and university programmes. Society must stop considering the demographic evolution as a burden when it is an opportunity for all generations to live together.

The government intends to favour all intergenerational experiences: skill sharing, tutoring, and volunteering, mixing young and elderly people, multigenerational projects creating suitable work for older and younger people in a wide range of forms of employment. Some experiences of "integrated lodging" including young parents and children, disabled elderly, healthy retired persons and common services for all, show how this may generate close relationships between the generations.

### 4. Fighting against discrimination and maltreatment.

In 2004, the government implemented an agency against discrimination, the HALDE (Haute Autorité de Lutte Contre les Discriminations et pour l'Egalité) with the following free toll number: 08 1000 5000.

In 2006<sup>14</sup>, 30,954 calls were registered. Employment discrimination represents 42.8% of the complaints. Ethnical discrimination is described as the most important issue in 35% of these cases. The second one concerns age discrimination mainly for senior employees sacked from their companies before the age of retirement.

### References

14. Rapport annuel 2006 de la Halde au Président de la République- Dossier de presse- [www.halde.fr](http://www.halde.fr)

UK  
South Africa

France

Dominican Republic

Israel

India

Japan

Netherlands

Argentina

USA



In March 2007, the government implemented a budget of 5 million € to fight against the elder mistreatment. The abuse category concerns maltreatment both at home or in institutions, negligence, abandonment, lack of respect against the elderly, verbal and physical aggression, and legal and financial swindles. The plan was undertaken with two main objectives:

- Develop the culture of good practices in the institutions with the creation of a governmental agency of “bientraitance”.
- Facilitate the claim of mistreatments through a free toll number of a well-known association, ALMA<sup>15</sup>. In 2005, 11,313 calls were received, half of them concerning maltreatments: psychological (25%), financial (19%) or physical (17%)

**In conclusion**, the ethical challenges of the French government and the French citizens are to simultaneously organize outstanding care for the frail elderly and to promote healthy and active ageing in order to allow all people, regardless of their age, to enjoy fulfilling lives, at home, at work and in their communities. It is with these conditions that human rights for all and specifically for the elderly will be respected.

## Authors:

**Professor Francoise Forette, MD**, has been Professor of Internal Medicine and Geriatrics at the University Paris V, CHU Cochin – Necker, since 1994. She has been CEO of the International Longevity Centre–France (ILC–France) since 1995 and Co–Chair of the Alliance for Health and the Future since 2003. Her other roles are as Director of the French National Foundation of Gerontology since 1982, President of the Board of Directors of the Hôpital Broca since 2002 as well as being an Elected Member of the Council of Paris since 2001. She is also a Special adviser on aging to the Minister of Health and the Minister of Social Security, Elderly, Family and Disabled persons since 2005.

**Marie–Anne Brieu, MD**, graduated at the University of Paris, France. She was for two years Senior Registrar in Cardiology at the Hospital das Clinicas, Sao Paulo, Brazil. Upon her return to France, she occupied different executive positions in the pharmaceutical industry. She served as secretary general of the International Longevity Center–France (ILC–France) from 1995 to 2003. She is presently Scientific Director of ILC–France and of the Alliance for Health and the Future.

## References

15. <http://www.alma-france.org>

UK  
South Africa  
**France**  
Dominican Republic  
Israel  
India  
Japan  
Netherlands  
Argentina  
USA



# ILC Dominican Republic

## Introduction

On December 10, 1948, the General Assembly of the United Nations adopted and proclaimed the Universal Declaration of Human Rights which comprised 30 articles involving all aspects of life of an individual. It recognizes the right to an adequate standard of living and to have insurance in situations of deprivation including old age. The international Agreement on Economic Social and Cultural Rights, 1966, is the most comprehensive article on the right to health care in an international law: signatories recognize the right of every person to enjoy the highest level of physical and mental health (Article No. 12). Neither of these documents recognize however any specific right of the elderly, probably because at the time they were written the ageing phenomenon had not reached today's dimensions. The Plan of Action, 1982, is the first policy tool to look at the consequences and impact of ageing in society. But not even this document recognizes any specific human right for the elderly though it recognizes the right to work, to education and to have a pension.

Over the past several decades a massive change has taken place in a key demographic area of the planet's human population: AGE. Due to the trend of lower birth rates and lower

death rates, according to the United Nations Department of Economic and Social Affairs, one out of every ten people on the planet is now 60 years of age or older. If the current trend continues, by the year 2050 one out of every five people will be aged 60 years or older. Additionally, the oldest old are the most rapidly expanding segment of the elderly population. Currently, the oldest old are 11% of the 60 plus age group and will grow up to 19% by 2050.

These demographic trends create unique challenges for all people, particularly for the governments of nations around the world. Elderly individuals are often subject to discrimination and abuse because they are perceived as easily taken advantage of. There is also a prevalent belief among many that elderly persons are worthless in today's fast paced, globalized, and increasingly industrialized world. With the number of elderly people on earth at any one time rising rapidly, there is an increased urgency to address the rights and roles of the elderly in the world.

### Which rights should we focus on?

The rights of aged persons can be broken down into three main categories: **protection**, **participation and image**. Protection refers to securing the physical, psychological, and emotional safety of elderly persons with

regards to their unique vulnerability to abuse and ill treatment. Participation refers to the need to establish a greater and more active role for older persons in society. Image refers to the need to define a more positive, less degrading and discriminatory idea of who the elderly are and what they are capable of doing.

An elderly person's right to security is particularly vulnerable to violation: it includes the right to health care if we, due to old age, are unable to afford or pursue health care individually. Although many countries currently have universal health care systems, these are beginning to feel the strain of an increasingly aged population and the question arises about how they will be maintained in the future. In the USA, for example, there are federally and state-subsidized health care programs only for those who are indigent, disabled or elderly, and rising health care costs are threatening their survival.

Elderly individuals have also the right to non-discrimination. Frequently they are thought to be useless to society because some need more care than the average person. Such stereotypes can lead to degrading treatment, inequality and even abuse.

UK  
South Africa  
France  
**Dominican Republic**  
Israel  
India  
Japan  
Netherlands  
Argentina  
USA



# ILC Dominican Republic

Similarly, their right to participation is sometimes threatened due to prevailing negative images, and they are often not given the same opportunities as others to be productive members of society.

In all possible violations of human rights we must pay particular attention to women. They are at greater risk of having their rights violated partly because, historically, women are more vulnerable towards violence and abuse due to their traditionally subordinate position in most cultures. Taking into account that 55% of older persons are women and that in the oldest old group 65% are women, especial considerations must be given to the effect of sex on the likelihood of rights violation and abuse.

10 years ago, the Organization for Economic Cooperation and Development (OECD), in its report "Ageing Populations: The Social Policy Implications" predicted that the average annual growth rate of the population of member states would decrease from 0.5% during the decade 1980–1990 to 0.3% during the decade 2040–2050. The eventual decline of the total population would be accompanied by changes in the age structure of the population. In 60 years (1980–2040) the average proportion of persons aged 65 and over will have increased from 12.2% to 21.9% of the total population

while the average proportion of those under 15 will have fallen from 23.4% to 18.3%.

The most significant aspect of the growing percentage of elderly people in the population is the marked increase in those aged 85 and over, in which group there are a large number who are severely impaired physically and/or mentally. In general, demand for health and social care rises sharply with age: 1% of those aged 75–79 have severe disabilities compared with 41% of those aged 85 and over.

For some time now economic support for the elderly has been perceived to be a critical issue for societies with welfare systems. The reasons are well known. The percentage of the population who are elderly is increasing as we have seen, while the percentage of those who are generating wealth is decreasing. More particularly, the percentage of the frail elderly who are dependent on others is increasing precisely when the state's welfare resources are under stress, both because of the changing population profile and because of levels of unemployment in advanced societies.

## The Dominican Republic's Reality

The Dominican Republic is in a process of demographic transition. Declining pregnancy and mortality rates have been notably rapid.

The global rate of pregnancy went down from 7.4 children per woman (1950–1955) to 2.73 (2000–2003). Life expectancy increased 24 years in the same period (1950–2000) and child mortality dropped from 149 death /1000 to 34/1000.

These three indicators show the great demographic changes taking place in the country that have translated into a slower population growth rate and a changing society.

At the moment the population is still relatively young. The projections however show that while in the year 2000 33.5% of Dominicans were less than 15 years old and those over 60 were less than 7%, the 2002 National Census shows that the older population rose to 8% while those under 15 showed practically no change. In the next decades, older age groups will continue to increase at a greater rate than others and it is estimated that for the year 2025 it will reach 12% and this percentage will double for 2050.

UK  
South Africa  
France

**Dominican Republic**

Israel  
India  
Japan  
Netherlands  
Argentina  
USA



# ILC Dominican Republic

Other facts on the older people in the Dominican Republic include:

- 51% of older people live in extended families. Only 14% of them live on their own as a result of personal choice or to because of abandonment.
- Older people occupy an important role in the family. 64% of them continue being heads of their homes.
- Illiteracy among older adults in the DR reaches 30% in men and 35% women and this increases in those over 75 years of age. No doubt this is a factor that limits quality of life.
- Older people continue to work since access to the pension is not guaranteed. According to the 2002 census, 47% of older Dominicans were economically active, and in men this rose to 65%. This indicates that for a large percentage of our population the only way to survive is to continue being active in the labor force.
- Only 12% of older people have a pension in urban areas and this decreases down to 3.4% in rural areas; women, who are at a greater disadvantage. Additionally, many older people have no income at all and comparing data from 1997 and 2001 the situation seems have worsened rather than having improved

Considering the above we can surmise that human rights of older people in the Dominican Republic are far from being respected. The lack of financial security, the absence of comprehensive state policies that address the needs of the elderly including access to health, treatment, education and greater participation in society are the main difficulties that the elderly encounter.

It is also important to emphasise the high incidence of abuse especially in the most deprived areas of the city of Santo Domingo. This is an issue that has to be brought out to the open and dealt with in the best possible way.

The recognition by the government of its obligation to ensuring the human rights of older people would be the first step to start a new era, but for that we have to establish our priorities and be transparent about cost implications. To date the government has shown no interest in facing this issue, but perhaps with the advent of the social security system (anticipated this year) at least some of the rights will be imposed. It is unfortunate that many governments do not understand that there can be no democracy without universal social justice. When our governments can understand that, we will have a much better world.

## Author:

**Dr Rosy Pereyra** is Executive Director of the ILC Dominican Republic.

## Selected References

1. Amnesty International 2007. Human Rights and Service Learning
2. Gormally, Luke. Human Dignity and Respect for the Elderly. 2<sup>nd</sup> International Meeting of Bioethic. Grenada, 1998.
3. Huenchuan Sandra, Paredes Mariana, González Daniela. Future Scenarios of Policies for Older People in the Dominican Republic. The Persistent Demand for Basic Rights. CEPAL. Santiago de Chile, 2007.
4. Northern Ireland Assembly Research and Library Service. Human Rights and Older People. Research Paper Nov. 2001
5. Pelaez Martha, Ferrer Marcela. Public Health and the Human Rights of the Elderly. Acta Bioetica 2001.
6. Wu Yu Qin. The Rights of the Elderly in Taiwan. Journal of Elderly Welfare Support Union, 2001

UK

South Africa

France

**Dominican Republic**

Israel

India

Japan

Netherlands

Argentina

USA



## Background – Values and Orientations

The state of Israel was established after the Holocaust, in 1948, as a Jewish and democratic state. Since then, these two value systems have been the ethical sources for social guidance in daily life. Legislation processes and courts have been trying continuously to find the appropriate balance between the fundamental principles, derived from both the Jewish and democratic value systems, as well as between the state's interest and the individual's interest. An additional, quite dominant set of values, that directed Israel's political leaders, and shaped many of its institutions, was a strong socialistic ideology. Social solidarity, a principle deeply rooted in both the Jewish and socialistic orientations, was one of the cornerstones of the new nation, the influence of which has been apparent in all areas of life. Israel's legal system thus reflects a combination of these three value systems: The traditional Jewish laws and values, such as prohibiting labor on the Sabbath and mandating filial responsibility to elderly parents; Western liberal constitutional laws which protect human and civil rights on a universal basis such as, political rights, the right to property, privacy, personal autonomy, right over one's body, and the right for quality and dignity of life; and social-democratic welfare state laws such as

universal social security, old-age pensions, national health care insurance and national long-term care (Shachar, 1995).

### Laws of Significance to Older People Social Security:

Israel has a National Social Security System that aims at transferring resources from the better off to the needier. All elderly citizens (men aged 70+ and women 65+, and according to income test, men aged 65+ and women 60+) are eligible for a basic pension benefit from Israel's National Security Institute. Elders who live solely on this minimal pension (about \$400 a month) are eligible for supplementary financial support from the government – up to 13% of the average national income for a single person and 17% for a couple. Some Holocaust survivors are eligible for economic assistance from the Treasury. In addition, social services are provided according to need by the Ministry of Welfare and local municipalities. Elderly Israelis, especially elderly new immigrants, are a relatively poor population group, 27% of them received supplementary financial support at the end of 2005 (Mashav, 2006). These laws reduce the poverty in Israel, however, under the prevailing cost of living in Israel, old persons with such income levels still have difficulties in meeting their basic needs such as food, heating, utilities and prescription drugs.

### Health Care:

Israel's health care system is one of the institutions that were based on the socialistic orientation and its principle that unlimited health services should be provided according to one's needs, and paid for according to one's ability. Therefore, since the establishment of the state, the Israeli health care system has been mostly public, covering about 94% of the population, and financed through a system of payroll progressive taxes and general taxation.

In 1995, the National New Health Care Law (NHCL) was passed. Under this law, every Israeli citizen is insured and eligible to a basket of health services, including hospitalization, ambulatory services and medications. Services are provided by 5 sick funds which have to provide a uniform health services basket, but are allowed to add services to this basket. Every citizen must pay health tax to a governmental agency – The Israeli National Insurance Institute. The tax is based on income and progressive up to a certain level. The state is responsible for transferring funds to the sick funds. In order to balance the expenses of the sick funds, the funds are allocated to the sick funds on the basis of a capitation formula, in which the number of members in each fund and their age are included.

UK  
South Africa  
France  
Dominican Republic  
**Israel**  
India  
Japan  
Netherlands  
Argentina  
USA



Considering that more than 30% of the expenditures on health care services are allocated for use by the 10% of elderly persons aged 65+, the sick funds are paid significantly more for elderly recipients than others according to age. The responsibility for providing psychiatric and geriatric long-term care was planned to be transferred to the sick funds, but currently, these services still remain under the responsibility of the Ministry of Health. This partition of responsibilities regarding long-term care creates significant problems to the patients, their families and their formal caregivers.

Despite many achievements of the new health care law, it has created new problems for Israelis. The cost of medical services has remained high and the citizens' personal expenses for health care services have even increased. Currently, physicians and patients often have to deal with monetary problems regarding aspects of care that are not included in the health basket. Israelis are reluctant to accept the new procedure of a limited 'health care basket,' which actually limits the availability of and accessibility to health services, mainly for the poor, contradicting dominant Jewish and socialistic values. These issues have, therefore, become a source for constant political debates in the Knesset (the Israeli parliament).

*The Community Long-Term Insurance Law* was implemented in 1988. Guided by universal and discretionary principles, this law was passed in order to address the needs of disabled elderly persons, a rapidly growing population group. Under this law, elderly persons who need assistance in performing activities of daily living receive personal and domestic help in their homes, by homecare workers managed by public and private agencies, financed by the government. These services are limited to a maximum of 15 hours per week, which is not enough for many elderly citizens. Some of these services are also provided in community day-care centers for disabled elderly. Supplementary services are provided according to need and level of income of the needy elder and his/her adult children.

Both laws, the National Health Insurance Law and the NHCL, do not fully address health care needs and needs arising from the disability of elderly persons. For example, dental services are expensive and are not covered by the National Health Insurance Law.

One of the major unresolved problems is long-term care. Currently, a multiplicity of public and private services exists, overlapping in terms of responsibility, ownership, provision of different kinds of services, entitlement

criteria, and financing, creating duplications and fragmentation in continuity of care. These are confusing to the disabled persons, their families, and their formal caregivers, and reduce accessibility of the existing services.

*The Elderly Citizens' Act* (enacted in 1989) grants elders financial benefits such as discounts on local taxes, tickets for cultural events and public transportation.

The *Sick Leave Act* of 1993 protects family caregivers at their workplace by ensuring full dismissal compensation in case of resignation due to parental illness and a paid absence leave up to six days per year.

### Human Rights

In the first decade of its existence, Israel was a relatively young society, with less than 4% of the population aged 65+, and in the process of building a new nation. The main challenges at that time were to address the basic economic and security needs of its population, as well as establishing social institutions, and absorbing massive waves of holocaust survivors and other poor immigrants. In the second decade, two main laws, applicable to the aged were enacted: The *Law of Legal Competence and Guardianship*, in 1962, and *The Law for the Defense of Protected Persons*, in 1966.

UK  
South Africa  
France  
Dominican Republic  
**Israel**  
India  
Japan  
Netherlands  
Argentina  
USA





The Law of Legal Competence and Guardianship defines legal incompetence and provides tools to welfare authorities for taking care of interests of persons who are unable to care for themselves, including the ability to appoint a guardian for the incompetent person. The Law for Defense of Protected Persons was the first to explicitly mention old people. This law allows welfare officers of the court to intervene and take care of vulnerable elderly persons, based on their professional assessments, by using compulsory injunctions granted by the courts. Both laws granted relatively much power to the welfare authorities and professionals such as doctors, nurses, and social workers in taking care of vulnerable persons including children, retarded, insane and elderly persons. Over the years, these laws were often criticized for being too paternalistic, giving insufficient weight to the autonomy and liberty of older persons (Doron, Alon & Offir, 2004). Amendment 26 to the Penal Code (1989) defined clearly for the first time, a wide range of harmful behaviors typical of elder abuse as criminal acts deserving criminal punishment. This group of laws and The *Law for the Prevention of Violence in the Family* (1991) enables professionals to take care of helpless elderly persons and renders protection from abuse, and neglect by commission or omission. However, some forms of abuse are

either not covered or only partially covered, as for example, economic exploitation (Doron, et al., 2004)

In the 1990's, two important laws relevant to human rights were passed in Israel: One of these laws is the *Basic Law: Human Dignity and Liberty* (1992), enacted in Israel in 1992. This law states that "Every person is eligible to protection of life, body and dignity" (section 4). Personal autonomy, the rights to human dignity, to bodily integrity, and to privacy derive from this basic law (Shalev, 2000). One of the specified purposes of this law was to "anchor in a Basic Law the values of the State of Israel as a Jewish and democratic state" (section 1A).

The second law is The Patient's Rights Law, enacted in 1996. According to this law that expresses the principles of the rights for liberty and human dignity, including personal autonomy and privacy, a medical treatment which is given to the patient without his/her explicit consent can be considered a criminal assault. The Patient's Rights Law of 1996 was an outcome of changes in public opinion, including an increasing resistance to the paternalistic orientation prevailing in the delivery of medical care, and the erosion of trust in doctors which started with the long physicians' strike of 1983. This law formally

regulates doctor-patient relationship, and ensures, among other patients' rights, open channels of doctor-patient communication, which is often lacking, especially in the case of elderly persons.

The *End-of-Life Care Law* was passed in 2005, and was enacted in December 2006. This is the first Israeli law to regulate end-of-life care. This law recognizes the right of patients to die with dignity in accordance with their beliefs and preferences through the use of advance directives. The law requires doctors and medical institutions not only to comply with patients' wishes, but also to assist their patients in realizing these rights. This law addressed a growing need of the Israeli public to openly deal with end-of-life care dilemmas and prevailing practices (Carmel, 1999; Carmel, 2002). Israeli physicians often avoided open communication with patients about death and dying, and very rarely discussed the use of life-sustaining treatments with them (Carmel, 2002). They did, however, withhold and withdraw life-sustaining treatments from terminally ill patients, often without consulting patients or their family members (Carmel, 1996; Sonnenblick, Gratch, Raveh, Steinberg & Yinnon, 2003). The scope of both practices was unknown, because formal policy or documentation of such cases rarely existed.

## Selected References

1. Carmel, S. (1996). Behavior, attitudes, and expectations regarding the use of life-sustaining treatments among physicians in Israel: An exploratory study. *Social Science & Medicine*, 43, 955-966.
2. Carmel, S. (1999). Life-sustaining treatments: What doctors do, what they want for themselves and what elderly persons want. *Social Science & Medicine*, 49, 1401-1408.
3. Carmel, S. (2002). Euthanasia: Attitudes, wishes and behavior of the public, patients and physicians. *Harefua: Journal of the Israel Medical Association* (Hebrew), 141, 538-543.
4. Doron, I. (2004). Aging in the shadow of the law: The case of elder guardianship in Israel.
5. *Journal of Aging and Social Policy*, 16(4), 59-77.
6. Doron, I., Alon, S. & Offir, N. (2004). Time for policy: Legislative response to elder abuse and neglect in Israel. *Journal of Elder Abuse & Neglect*, 16(4), 63-82.

UK  
South Africa  
France  
Dominican Republic  
**Israel**  
India  
Japan  
Netherlands  
Argentina  
USA





The majority of the public and elderly people, however, expressed wishes for open doctor–patient communication on end-of-life care matters and involvement in decision making processes (Carmel, 2002). Decision processes regarding end-of-life care, therefore, depended mainly on personal and religious characteristics of the physician, the patient, and the families involved in each specific case (Carmel, 1996; 2002; Wenger & Carmel, 2005). Significant changes in physicians' orientations and practices are needed in order to implement the End-of-Life Care Law. It will therefore, take a long time until this law will be assimilated.

## Necessary Changes

In general, Israel has liberal legislation for ensuring safety, dignity and privacy for all, including old persons. The main problem in Israel is not the lack of human rights laws, but insufficient implementation and assimilation of the existing laws. Increasing the means and developing new and efficient mechanisms for enacting the existing laws is needed (Doron et al., 2004). An optional mechanism involves extending the scope of governmental and institutional practical guidelines to professional and nonprofessional caregivers in all the existing health and social services. These guidelines should include practical ways for empowering old persons, and requests

to enact them, accompanied by incentives for caregivers' adherence, and follow up procedures.

Parallel to these initiatives, more efforts have to be invested in increasing elderly persons' awareness of their rights and the practical ways to become actively involved in reclaiming their rights in case of need, whether in the medical system or in other national, public or private services, including the use of available legal planning tools.

In addition, in order to address the unsuccessfully addressed current needs, such as long-term care and continuum of care, amendments have to be made to the current laws. For example, adding long-term care to the basket of services will significantly reduce the fragmentation in care and the multiplicity of organizations involved in providing it. Another example is adding to the current law a reference to abuse in the institutional context and financial abuse, hence covering all possible ways of abuse and neglect. Changes in these domains will ensure access to comprehensive, continuous, and efficient care for all, provide more efficient protection for elderly persons, enhance active involvement of elderly persons in claiming their rights and improve quality of life for senior citizens in Israel.

## Author:

Sara Carmel– MPH, PhD, is Professor of medical sociology and gerontology, the president of the Israel Gerontological Society and Director of the Center for Multidisciplinary Research in Aging at Ben-Gurion University, and the Israel National Fund for Research in Aging. She is the author of over a 100 scientific publications, and has served in national and international committees for academic and policy affairs. Prof. Carmel has established the first MA programs in Sociology of Health and in Gerontology in Israel, and the Israel National Fund for Research in Aging at the Ministry of Elder Affairs. Her recent research focuses on preferences and practices regarding end-of-life care among the public, elderly persons, patients, formal and informal care givers. She has also studied doctor–patient relationship and communication, evaluation of health and welfare services, as well as effects of gender, culture, immigration, and additional psychosocial factors on elderly persons' will to live, health, well-being and survival.

## Selected References

7. Mashav (2006): The elderly in Israel: Statistical abstracts. Jerusalem: Brookdale Institute & Eshel.
8. Shachar, Y. (1995). History and sources of Israeli law. In A. Shapira, & K.C. DeWitt-Arar (Edts), Introduction to the law of Israel (pp. 1–16). Boston: Kluwer Law International.
9. Shalev, C. (2000). Paternalism and autonomy in end of life decision making: The Israeli Formative ambivalence. Israel Yearbook on Human Rights.
10. Sonnenblick, M., Gratch, L., Raveh, D., Steinberg, A. & Yinnon, A. (2003). Epidemiology of decision on life sustaining treatment in the general internal medicine division. Harefuah:
11. Journal of the Israeli Medical Association (Hebrew), 142(10), 650– 653.
12. Wenger, N.S. & Carmel, S. (2005). Physicians' religiosity and end-of-life care attitudes and behaviors. The Mount Sinai Journal of Medicine, 71(5), 335–343.

UK  
South Africa  
France  
Dominican Republic  
**Israel**  
India  
Japan  
Netherlands  
Argentina  
USA



## Introduction

Human beings are born equal in dignity and rights by virtue of their humanity. These human rights are inalienable and inherent in all human individuals and they have been articulated and formulated in what we call Human Rights. These rights have been translated into Legal Rights, established according to the laws both national and international. The basis of these legal rights is the consent of the governed, that is those who are the subject of human rights.

Human rights and fundamental freedoms allow us to fully develop and use our human qualities, our intelligence, our talent, and our conscience for the satisfaction of our social, economic, spiritual and other needs. They are based on mankind's increasing demand for a life in which the inherent dignity and worth of each human being will receive respect and protection. Violation of human rights and discrimination within family, friends, society, and at the workplace increases the mental harassment and the psychological pressure on the person who suffers this violation.

### Human Rights and the Elderly

Today, longevity of mankind has brought in its wake several problems and issues of great concern to all of us, especially to the elders. Throughout the world, as has been observed, as the numbers of senior citizens increases,

the support system for the maintenance and sustenance of life and living of the elderly is not keeping pace with the changes. Besides this, the fast-paced modern life-style of the younger generations with their materialistic approach creates an environment with which the elders find it difficult to cope with.

In such a situation, the elders find themselves isolated, alienated, depending on others for some of their basic needs, all of which is an affront on their right to live with dignity. Rapid urbanization and industrialization has resulted in the emergence of materialistic and individualistic values which leave no place for traditional values of respect, concern, consideration and patient understanding. All of this creates a scenario which directly affects the human rights of any individual, that is, to live with dignity. Empowerment of the elderly to ensure their participation in social and economic development of the nation is also necessary.

### The Indian Perspective and Human Rights of the Elderly

India, since ancient times, has always had the family and its elders at the core of its social and economic fabric. Modernization through industrialisation has led to the rapid erosion of the very basic value of respect for the elderly and the breakup of the joint family system,

especially in the urban settings. Due to this, the young people of today have not much time for the seniors, very often do not even want to interact with the elders, do not even consider their own aged parents as their responsibility.

#### The Right to live with dignity and the Right to Family Life:

This loss of respect and concern for the elderly is a direct denial of the human right to live life with dignity and respect. **In India, thus the right to live with dignity would be an important right which every self-respecting senior citizen would like to have. A corollary of this right that every Indian senior would like to enjoy, given the traditional Indian scenario, is the right to a family life.**

#### The Right to Financial Security:

One cannot live a life with dignity unless one has an adequate financial support system even after retirement. The Indian situation is such that the government pension system is available only for a limited few of the organized government sector. For the rest of the sections of population ageing, especially the unorganized sector, with no job or employment, life can be a misery. **Thus, the right to financial security is another right that every Indian senior citizen would like to enjoy.**

UK  
South Africa  
France  
Dominican Republic  
Israel  
**India**  
Japan  
Netherlands  
Argentina  
USA



For this, the government of India needs to re-look at its pension policy, its schemes of cash assistance or social security on a broader and more in-depth level.

### **The Right to Health:**

Every human being is entitled to this right to health but, for the elders, this right becomes all the more acute and grave because they suffer from some diseases, disabilities, ailments or frailties, which make them dependent on others for this right. Some of the seniors need assisted living, some need help for carrying out their daily chores and in such instances, the necessary assistance in the form of trained caregivers or dedicated help is greatly lacking. In India, the health support system, right from the grassroots level, that is at the primary health centre level, is sadly and unfortunately not equipped to deal with the geriatric health problems of the seniors. The right to health is a primary need in India.

The Indian Government's key policy initiatives are:

Ageing as an issue of concern for the Indian government has seen its emergence only in the nineties. The Indian National Policy on Older Persons (NPOP) was one of the first specific initiatives taken up by the Government of India in January 1999. This policy provides a broad

framework for inter-sectoral collaboration and cooperation both within the government as well as between the government and the non-governmental agencies. In particular, the policy has identified a number of areas of intervention—financial security, healthcare and nutrition, shelter, education, welfare, protection of life and property etc, for the well-being of older persons in the country. Amongst others, the policy also recognizes the role of the NGO sector in providing user friendly affordable services to complement the endeavours of the State in this direction. While recognizing the need for promoting productive ageing, the policy also emphasizes the importance of family in providing vital non-formal social security for older persons.

### **Review of the Government Policy Initiatives**

An important observation about the NPOP is that this policy was formulated without consulting an adequate representation of the senior citizens' organizations or associations. This is also true about the new bill tabled in Parliament – 'The Maintenance, Care and Security of Older Persons' – which has also been framed without adequate efforts made to consult the senior citizens' organizations and get their opinions and suggestions with regard to the provisions of the proposed bill.

*It is crucial that while formulating or framing policies with regard to ageing, senior citizens be consulted and their participation in this process would make a policy more effective and positive.*

Similarly, the NPOP has constituted an autonomous National Council for Older Persons which is headed by the Minister for Social Justice and Empowerment to promote and co-ordinate the concerns of older persons. The Council includes representatives of relevant Central Ministries and the Planning Commission. Five states are represented on the Council by rotation. Adequate representation was to be given to non-official members representing non-governmental organizations, academic bodies, media and experts on ageing issues from different fields.

Though all this was proposed and such a Council has been set up, yet this did not get the necessary momentum as the members of the Council attend the meeting, listen to what the government has to say and the matter ends there. The Council effectively has no authority.

UK  
South Africa  
France  
Dominican Republic  
Israel  
**India**  
Japan  
Netherlands  
Argentina  
USA



The need is to make this Council truly more active, participatory and involved and I would also state that there is a need to set up such Councils or Advisory Boards for Ageing at the State level also. There should be adequate representation on these boards or Councils of the office-bearers of the national and state level senior citizens' organizations and associations. This would ensure effective participation of the senior citizens in the implementation process of the policies of ageing.

Another drawback with regard to ageing policies in India is the lack of state policies being framed and implemented at the state levels. Except for a couple of states, no other state has even got a draft policy on ageing in place. Himachal Pradesh is the state that formulated this policy quite early on and the Central Bill mentioned above has been drafted on the basis of this state policy. Thus it is necessary that each state drafts its bill and gets the policy on ageing in place.

A most important change needed with regard to the NPOP is that it has no specific budget for implementing its provisions and without this budget the policy has no teeth. The NPOP also has no implementation authority which could implement the provisions and, here too, the NPOP fails to be effective and useful. Further still, one more lacunae in the NPOP is that there is no penalty specified if these provisions are not adhered to or implemented.

Special focus on old-age pensions or cash assistance needs to be made as in India there is no system of social security. The NPOP needs to address this issue at a comprehensive level covering even the unorganized sectors.

In conclusion, I would like to state that the NPOP has not really achieved the objectives that had been set up, precisely because of the factors mentioned above. If some of the above drawbacks are addressed and rectified, then, the NPOP would move in the required direction of promoting participatory, healthy and qualitative ageing for the senior citizens.

## Author:

**Dr. S. D. Gokhale** is President of the ILC India, and President Emeritus of CASP. He is a former President of International Federation on Ageing.

UK  
South Africa  
France  
Dominican Republic  
Israel  
**India**  
Japan  
Netherlands  
Argentina  
USA



## Introduction

Compared internationally, Japan is considered to have a highly developed framework of laws and systems that form a foundation for supporting human rights and the social security system which is composed of the pension, healthcare, and long-term care systems. The percentage of older persons in Japan who think that they are discriminated against is low, and the Japanese people in general sense that they are guaranteed a certain level of safety and a certain standard of living. (based on what survey?)

This paper describes the current status of Japan's frameworks and systems to support human rights and suggests that continued economic growth is indispensable for Japan to maintain such systems in the future. In addition, this paper draws the conclusion that resolution of the various issues caused by 1) the change and diversification of the Japanese people's values in the postwar period and 2) the rapid aging of Japanese society combined with the decline in the birthrate is of highest priority for Japan to ensure that the situation surrounding older persons is improved and that their human rights continue to be valued in the future.

## The Human Rights of Older Persons: A General Overview

Before World War II, Japan had a patriarchic, feudalistic society focused on the family. A certain level of consideration, affection, and concern for others was achieved in the mutual assistance system in local communities. However, compared to the modern awareness of human rights, undoubtedly Japan before the War had a low level of human rights awareness. With the strong determination of the Japanese people to achieve economic reconstruction after World War II, the transformation of Japan into a modern, democratic society was a major national goal, and the development of a social security system was vigorously pursued as a national project. Socially as well, human rights awareness and democratic thinking swept through the country with great vigor and took strong root as the nation shed its patriarchic family system and increased its awareness of rights that value each individual.

In this context, the social security system in Japan developed rapidly from the 1960s, and the programs supporting older persons have reached a world-class level in terms of both volume and quality. Many older persons today have been able to fully reap the benefits of these dynamic changes, but various challenges

are expected to arise in the future in respect to the social context surrounding older persons. I would like to suggest here that the chief causes of these future issues are the lack of societal consensus about ageing policy and the rapid decline in the birthrate in our nation.

## Key Issues Related to the Human Rights of Older Persons in Japan

### Right of Older Persons to Safety

In general, Japanese today enjoy a high level of safety. Crime and traffic accident statistics reveal an aspect of the safety experienced in Japan. The nationwide crime statistics compiled by police indicate that the number of injuries/attacks by a third party decreased by about 23 percent from 2002 to 2005, from 2.486 million cases to 1.92 million. The number of cases in which an older person aged 65 or over was harmed has dropped from 225,000 to 179,000.

Traffic accident fatalities in the same period declined by about 17 percent from 8,326 to 6,871 over the same period, with older persons accounting for 3,144 and 2,924 respectively<sup>1</sup>.

## References

1. National Police Agency, Crime in Japan and Traffic Statistics (2000–2006).

UK  
South Africa  
France  
Dominican Republic  
Israel  
India  
Japan  
Netherlands  
Argentina  
USA



These findings show that society in general is becoming safer. If we consider the fact that the number of older persons increased by 8.6 percent over that same period, it is clear that the safety level has improved for older persons as well.

## Right of Older Persons to Healthcare and Health

Japan has a universal healthcare system composed mainly of the Employees' Health Insurance system for employed persons and their families and the National Health Insurance System for the rest. A large portion of retirees are covered by the latter. Those 70 years of age pay lower co-payments than the rest of the population. Patients can select the providers of healthcare services. Japan's healthcare system appears to function effectively given that total medical expenditures stood at 8.0 percent of GDP in 2004 despite Japan's high ageing rate<sup>2</sup>.

The Long-Term Care Insurance System aims at all members of society to join together to support older persons through the end of their lives. Initiated in April 2000, services include in-home services, institutional services, and preventive care. The system is financed by insurance premiums required of Japanese citizens aged 40 or over and government subsidies. As of March 2007, recipients numbered about 4.499 million<sup>3</sup>. The Long-

Term Care Insurance System aims to protect and advocate the rights of older persons in the community as well as training programs on the older persons' rights for those working at long-term care facilities.

Since 2005, the government and ruling parties have advocated the Health Frontier Strategy, a health promotion plan to extend the healthy life expectancy of the Japanese people. Under the Health Frontier Strategy, measures to counter lifestyle-related diseases and services to prevent the need for long-term care are being implemented, with the aim of extending healthy life expectancy by about two years during the decade from 2005 to 2014.

## Right of Older Persons to a Proper Standard of Living

The employment rate of older persons is high in Japan, at 63.9 percent for those aged 55 to 64<sup>4</sup>. To further expand employment opportunities for older persons, the revised Law Concerning the Stabilization of Employment of Older Persons came into force in fiscal 2006. Under the revised law, a company that presently imposes mandatory retirement on its employees is obligated to (1) raise the retirement age from the currently common 60 to 65 in steps by April 2013, (2) introduce a viable plan to continue the employment of post-retirement age workers,

or (3) abolish the retirement practice. The total unemployment rate for those aged 55 to 64 in April 2007 was 2.9 percent for men and 1.0 percent for women<sup>5</sup>.

The figures for 2004 were 5.5 percent and 3.0 percent, respectively. These figures suggest the employment situation of healthy older persons is improving thanks to employment promotion measures mentioned above and the recovery of the economy.

Japan's universal pension scheme is an essentially two-tiered system similar to that of the United Kingdom. It is composed mainly of 1) The National Pension System for All and 2) the employees' pension for salaried workers. The latter is further divided into the program for the private sector and public sector employees. The income replacement ratio for a model Japanese household in which the head of household is employed for forty years is about 59 percent today, and policy makers hope to stabilize that figure at about 50 percent in around 2023. There are a total of 38.6 million pension beneficiaries in Japan. The annual per capita income of elderly households is 1.9 million yen\*, making it slightly lower than the annual per capita income of all households, which stands at 2.0 million yen. Pension income makes up 71.9 percent of the income of elderly households<sup>6</sup>.

## References

1. OECD, OECD Health Data 2006.
2. Ministry of Health, Labour and Welfare, Monthly Report on the Actual Condition Survey Concerning Long-Term Care Benefits (March 2006).
3. OECD, Labour Market Statistics – INDICATOR and Employment Outlook 2006.
4. Ministry of Internal Affairs and Communications, Labour Force Survey (April 2007).
5. Ministry of Health, Labour and Welfare, Comprehensive Survey of Living Conditions of the People on Health and Welfare (2005).
6. Ministry of Health, Labour and Welfare, Comprehensive Survey of Living Conditions of the People on Health and Welfare (2005).

\* 1GBP=248JPN, 1 USD=122JPN, 1 EUR=248JPN, July 2007

UK  
South Africa  
France  
Dominican Republic  
Israel  
India  
Japan  
Netherlands  
Argentina  
USA



In addition to the national pension programs, the public assistance system provides livelihood aid, housing aid, medical aid, and other assistance for low-income persons of all ages. In 2004, recipients totaled about 1.375 million (1.1 percent of the population), and of those, 38.2 percent were 65 years old or over. A total of 27.0 percent of recipients are elderly living alone, with men accounting for 10.8 percent and women making up 16.3 percent<sup>7</sup>.

**Right of Older Persons Not to Be Subject to Discrimination**

Trends in age-based discrimination by age group are indicated in the table below. These statistics are from the 2003 Public Opinion Survey on the Protection of Human Rights released by Japan’s Cabinet Office. Common examples of human right violation for Japanese’ include employment and age discrimination, abuse, being subject to fraudulent activities, and inability to enjoy the minimum level of living standard constitutionally guaranteed.

Have You Ever Experienced a Human Rights Violation?						
Age	20s	30s	40s	50s	60s	70+
Yes	12.1%	17.1%	17.6%	13.6%	16.0%	6.1%
No	87.9%	82.9%	82.4%	86.4%	84.0%	93.9%

The figures shown above for the “60s” category show that compared to other age categories, more people in this age group have experienced a violation of their human rights. This result is probably attributable to the tight labor situation for middle-aged and elderly persons in 2003: Many in their sixties could not obtain their desired employments in that year. The satisfaction level of people seventy or over, is high because they are supported by the pension, healthcare, and long-term care systems available for older persons in Japan.

**Right of Older Persons to Not Suffer Abuse or Inhumane Treatment**

The Adult Guardianship Law, which aims to protect people who have impaired decision-making faculties, came into effect at the same time as the start of the Long-term Care Insurance System (April 2000). The Civil Code of 1896 provides for the protection of those with diminished decision-making faculties, and the Adult Guardianship Law was established with human rights in mind. This law gives the guardian power of attorney to manage various aspects of the ward’s affairs if his or her decision-making faculties have diminished. Between 2000 and 2005, only about 90,000 people used this system. It is thought that it will take time for this system to spread and take root widely in Japan<sup>8</sup>.

The Elder Abuse Prevention and Caregiver Support Law came into force in April 2006. This law is one of a series of laws legislated recently to protect human rights, including the Domestic Violence Prevention Law of 2001 and the revised Child Abuse Prevention and Treatment Act of 2004. The Elder Abuse Prevention and Caregiver Support Law made it a requirement for anyone who discovers that an older person aged 65 or over is subjected to abuse (including physical, sexual and emotional abuse, neglect or financial exploitation) by a family or professional caregiver to report the incident to the municipal government. The law also requires that the municipal government investigate the facts and take measures to protect and provide shelter for the abused older person. In addition, to reduce the strain on caregivers, municipal governments are required to provide consultations, guidance, advice, and other necessary support to caregivers. Since this law came into force recently no official overall review has been conducted yet. According to a newspaper, about 10,000 cases of abuse were reported during the one year that the law was in effect<sup>9</sup>.

**References**

- 7. Ministry of Health, Labour and Welfare, Nationwide General Survey of Recipients of Public Assistance (2004).
- 8. Supreme Court of Japan, Overview of Adult Guardianship Cases, 2000–2005.
- 9. Yomiuri Shimbun, “Local Government Questionnaire on Long-Term Care Insurance” (2007).

- UK
- South Africa
- France
- Dominican Republic
- Israel
- India
- Japan
- Netherlands
- Argentina
- USA



## The Changes Needed and Mechanisms to Resolve the Issues

With changing times, however, Japan must re-evaluate, revise, and implement further systems and laws and make further efforts to raise awareness. Japan also has to make efforts of improving public morals through home and school education.

The ratio of the taxation and social security burden in Japan was 37.8 percent in 2005<sup>10</sup>. The social security system is currently functioning with reasonable efficiency, but it is clear that benefits under the program will keep increasing in the future with the aging of society. For that reason, Japan must reform and streamline its various systems. Continued economic growth is imperative to guarantee the sustainability of the system. To achieve this, it is particularly vital that we promote the internationalization of finance, and develop competitive industry and technology by raising Japan's R&D strength in various fields, and increase income from overseas.

Moreover, if the decline in the birthrate and the aging of society continue as they have been, Japan will be unable to prevent a decrease in its working-age population and there is the danger that this will have a negative impact on economic growth. To prevent this, Japan

needs to increase its population by raising total fertility rate which was 1.32 in 2006<sup>11</sup>.

Before closing, I would like to mention that, in addition to these various measures, it is crucial that we make efforts to enhance older persons' subjective sense of well-being. In such a longevity society where life expectancy at birth is 78.6 for men and 95.5 for women, unlike the conventional stereotype of older persons, they are in reality a diverse group consisting of unique individuals<sup>12</sup>. Amid the social changes described earlier, older persons are being called to contribute to society through various activities based on their values. I would like to offer the following as a future goal of the people of Japan: to create a society where both healthy elderly and those requiring long-term care can pursue their well-being and purposes in life and continue to be actively and proudly involved in their community and society.

## **Author:**

**Shigeo Morioka** is President of the International Longevity Center-Japan which was founded in 1990 based on the proposal of Robert N. Butler. Mr. Morioka was president and CEO as well as chairman of the board of Yamanouchi Pharmaceutical Co., Ltd. (current Astellas Pharma Inc.) for about twenty years until he assumed his present position in 1991. He has served in a number of key positions in the pharmaceutical industry in Japan and abroad, including as chairman of the Federation of Pharmaceutical Manufacturers' Associations of Japan, chairman of the Japan Pharmaceutical Manufacturers Association, chairman of the Fair Trade Council of the Ethical Pharmaceutical Drugs Manufacturing Industry, and executive vice chairman of the International Federation of Pharmaceutical Manufacturers Associations. In 1999, he was awarded Japan's Order of the Rising Sun, Gold and Silver Star.

## **References**

10. Materials prepared for the Committee on Social Security Review (2006).
11. Ministry of Health, Labour and Welfare, Complete Life Table (2006).
12. Ministry of Health, Labour and Welfare, Vital Statistics (2006).

UK  
South Africa  
France  
Dominican Republic  
Israel  
India  
Japan  
Netherlands  
Argentina  
USA





# ILC Netherlands

## Introduction

The discussion on human rights in The Netherlands is seldom associated with older people, perhaps because the Dutch assume that compliance with international conventions should go without saying. Even so, it is worth using human rights as a yardstick to judge the situation in the Netherlands, and, in these times of great changes in the role and responsibilities of government authorities, institutions and industry, particularly important to safeguard the interests of vulnerable groups in society. This article takes a look at a number of areas where the law in the Netherlands is developing, partly autonomously and partly under the influence of European and international conventions and agreements. We take a look at equal opportunities and employment, productive involvement, integration versus segregation, diversity in the care of older persons and end of life issues.

The Netherlands has a strong social tradition in which varying political coalitions have legislated to provide an extensive social safety net, the two most noticeable features of which were a generally respected three-pillar pension system and a national insurance scheme to protect against incapacity for work. The principles of non-discrimination and equal opportunities took root from the 1960s. Initially, policies focussed on gender; later in the 1990s, after

fierce battles and lobbying from a variety of interest groups, the criteria were broadened to include ethnic background, handicap, age and sexual orientation.

The breakthrough came in 1997 when the European Union included a broad non-discrimination article in the Treaty of Amsterdam, encompassing age and handicap. The Treaty, and the resulting European Guideline issued in 2003 (no. 78), prompted the Netherlands to become one of the first countries to pass an Equal Treatment on Grounds of Age at Labour Act which took effect on 1 May 2004. The Netherlands has since then gained some experience in how to deal with the EU directive and has built up case law on this subject. We must remember, however, that this law does not apply to the supply of goods and services. This will be a future hurdle to be taken to ensure that financial services, for example, are included within the scope of the article.

### The Scope of the Law

The Dutch Equal Treatment at Labour Act is comprehensive, including recruitment and selection, appointment, employment mediation, training courses, promotion, dismissal, employment conditions and working conditions. It is not permitted to discriminate

by, for example, including an age restriction in a job advert or descriptions such as young, youthful or older. Any indirect discrimination is also not permitted such as the mention of seniority or number of years of experience because salary, vacation entitlement or protection from dismissal could be related to such aspects. The law makes an exception for statutory policies relating to the job market (for example a minimum income for youngsters and regulations to protect young workers such as a ban on night work) or dismissal due to reaching retirement age (now 65 years) or an older age agreed to, or the fixing of age limits for entry to and withdrawal from pension schemes. Discrimination on the grounds of age is also permitted if it can be objectively justified, and the means be fitting and necessary. In the event of a dispute, an employee or employer can request the Equal Opportunities Commission to test the case of age discrimination against the law. The Commission gives judgments that carry considerable weight. If the discriminating party does not follow up this judgment, it is possible to take them to court.

UK  
South Africa  
France  
Dominican Republic  
Israel  
India  
Japan  
Netherlands  
Argentina  
USA



# ILC Netherlands

## Reconnaissance

In December 2006 the Expertise Centre Age and Life Course ([www.leeftijd.nl](http://www.leeftijd.nl)) published an interim investigation into judgments given by the Equal Opportunities Commission. In 46 judgments related to age discrimination in employment, it appeared that more than 50% concerned reorganisations and dismissal. In 85 judgments on access to the job market, it appeared that two thirds of the cases concerned recruitment and selection. Employers very often apply age restrictions unjustifiably when recruiting personnel. Knowledge gained during court cases is passed on to the social partners in the form of check lists and advice. This information can then be used in discussions on employment conditions or industrial agreements. Nevertheless, it remains difficult to provide hard evidence of age discrimination in job applications. Cases brought before the courts usually concerned the suspicion of age discrimination in involuntary dismissals (football referees who want to keep on refereeing, employees who want to continue working after they have reached the age of 65, or pilots, firemen or casino workers who dispute the age restrictions applying to their jobs). It's early days yet to be talking about trends in these examples of case law, but it is clear that the lack of available

sanctions in the law is a weakness. According to the United Nations 'full and strict application of human rights must be enforced for all citizens'.

## Social protection

In international comparisons, The Netherlands scores highly in the field of social protection. However, this situation requires some clarification. According to figures from the above mentioned Expertise Centre Age and Life Course, high expenditure in companies for social purposes is mostly spent on the older section of the work force. The protection of older workers was mainly visible in a shorter working week, more holidays, fewer shifts etc. Early retirement became an instrument for tackling youth unemployment during the 1990s. But this led to a negative image of older employees being more interested in leaving the labour market than continued productive working life; it also led to marginalisation which explains why unemployed persons aged 45 and older have a very small chance of returning to the job market. The Equal Treatment Act will eventually have to be applied as a tool of force to achieve productive involvement.

## Productive ageing

Some significant trends are developing. The first is that employment organisations and voluntary work organisations in the Netherlands are bidding farewell to the traditional approach to older workers. Partly as a result of an increased life expectancy, employees aged 55–65 generally have a high level of work ability and employability so that continuing in employment has long since been justified. The Finnish researcher Ilmarinen has demonstrated that as age increases, so does the diversity of work ability and employability in all professions. Even though older workers tend to develop more chronic complaints as they age, most employees with complaints still manage to retain their level of productivity by working in a more intelligent way. And employees working in teams compensate each other's imperfections, often automatically. This would appear to make age in itself an ineffectual criterion for policy in many cases. This criterion will eventually disappear from collective labour agreements and company or sector agreements and will make way for criteria based more on the employee as an individual. We will therefore shift from passive ageing towards productive ageing. Employees will no longer be 'sitting out their time' but will move on to a dynamic second period in their

UK  
South Africa  
France  
Dominican Republic  
Israel  
India  
Japan  
**Netherlands**  
Argentina  
USA



# ILC Netherlands

career (with investments to support transitions and the prevention of risks). Pension schemes and other employment conditions should no longer form an obstruction to transitions and a dynamic job market for older employees.

## From aftercare to prevention

A second trend is indicated by the transition of a health service providing aftercare to a system of preventive care. By applying preventive measures we can ensure that people do not become ill or incapacitated for work prematurely. We want to prevent people from losing their ability to work and therefore their employability. During the entire course of a person's life we want to pay attention to their ability to age in good health while remaining productive. The primary health care system and industrial health services also have many tasks in this respect. The Dutch social security system was founded on the entitlement to receive care and benefits in the event of illness and handicap. Apart from the soaring cost of this, great numbers of employees also were identified as being incapacitated for work. When discussing human rights and 'adequate health care', an extra accent should be placed on the 'right to preventive care i.e. a health care system aimed at prevention'.

The ILC UK concept Health Literacy (from early childhood education to the transfer of knowledge on geriatric health care)<sup>1</sup>. would appear to be significant in this respect. So is the Finnish Workability Concept that is aimed at maintaining the ability of older employees to work. ILC Netherlands is also active in these areas to gain a better awareness of people in the third age in particular. This age group will have to consciously create an environment for themselves, their children and grandchildren in which they themselves, and not domineering institutions, determine their individual options in areas of participation, health and care.

## From age segregation to integration

Respecting people in their right to participate means offering space, opportunities and freedom to everyone so that age diversity and the quality of human relationships become the norm within all organisations. This diversity should also be reflected in politics, culture and media where older people should be able to develop the characteristics of their generation. Diversity as a basic principle should have a counterpart in other areas. We could think about building 'Silver Cities' or large-scale communities just for older people. But is segregation the solution? It is argued that in mixed housing areas the different generations compensate each other's weaknesses with each

other's strengths. The small-scale problems associated with being young or growing old can be dealt with within residential areas. This is also true for many ICT solutions in the fields of care, participation and ways to spend time and for policies that stimulate the transfer of culture between generations.

Going back as far as medieval times, the Netherlands has always had many ways to care for older people, such as poor houses and homes for the elderly. From the 1950s onwards, the construction of old people's homes and nursing homes got under way to fulfil the entitlement of people to receive care and as part of the development of the welfare state. A relatively large number of older people live in sheltered housing such as homes for the aged and nursing homes. But this situation is now also under pressure because of the high costs and the desire of older people to remain living independently at home for longer. Given the demographic facts, we can assume that in the future much more care will be provided to vulnerable older people in their own homes and that large-scale facilities will be replaced by small-scale alternatives. The Netherlands is facing a period of major change. The old public domain of collectively organised facilities will make way for a private market in the supply and demand of facilities in which a government-

## References

1. I. Kickbusch, S. Wait, D. Maag, P. McGuire, I. Banks: Navigating Health: The Role of Health Literacy, ILC-UK, September 2006

UK  
South Africa  
France  
Dominican Republic  
Israel  
India  
Japan  
**Netherlands**  
Argentina  
USA



# ILC Netherlands

regulated health insurance system will play a prominent role. We face a decrease in public facilities and a growth in new ways to bear the public and private costs of necessary care.

The UN Plan for Action on Ageing 2002 contains an important message: 'Advancing health and well-being into old age and ensuring enabling and supportive environments.' The latter presupposes much attention for the role of family members and informal carers. Monitoring the 'care ability' of informal carers plays a key role in the quality of care and keeping costs under control. Prevention here does not mean waiting resigned until the situation gets out of hand and hospital admittance is required, or violence is used in hopeless situations against vulnerable elderly people. We will have to identify the problems of vulnerable elderly people in the micro situation in good time and take preventive action.

## End of life issues

In the creation of an enabling and supportive environment for ageing people, we cannot ignore the particular difficulties of the final stage in life. The simultaneous occurrence of several chronic illnesses and sometimes the loss of mental faculties (dementia) in the last years of life requires the sensitive handling

of issues involving life and death. These issues have been discussed for a long time in the Netherlands, resulting in an Act in 2002 to regulate the actions of physicians when terminating life in situations of "unbearable and hopeless suffering". Such intervention is only permitted if the criteria are clearly met, including conditions of careful practice, and may only arise from a voluntary and carefully considered request from a patient who has been fully informed and has fully understood the course of his or her illness and the possibilities to treat it. Both the physician and the patient must be convinced that there is no other reasonable solution. A second, independent physician must also have visited the patient and confirmed in writing that the conditions of careful practice have been met. The actions to terminate life must be carried out with great medical care and the euthanasia must be reported afterwards to the local authority coroner and a regional review commission. If the acting physician has not fulfilled the requirements disciplinary proceedings can follow.

One of the aims of this legislation was to attempt to bring into the open the practice that already existed, thereby making it possible to deal with the wishes of patients concerning the end of their life in all openness and with due

care. There has been much debate concerning the desire for the strong involvement of the medical profession in determining professional standards, quality requirements and the advancement of expertise. But contrary to what is often thought abroad, only few very old people actually make use of these provisions, perhaps because of the extensive investments that have been carried out in the development of palliative care. Good palliative care, after all, prevents the need to actively end life.

To summarise: when discussing the social systems that are the consequence of the human rights we support, it would appear that ideas on preventive care are gaining ground. There is work here for the health service and for the ILC.

## Author:

**Ger Tielen**, Managing Director, ILC Netherlands. After completing his studies, Ger Tielen (58) worked in technology and journalism. In 1998, he started working in the field of ageing, initially as information officer for several senior citizen's organisations. He was closely involved in the co-ordination of activities for the European Year of Older People in 1993. Between 1996 and 2001 he was the Director of the Netherlands Platform Older People and Europe. From 2001 until 2004 he was the Executive Secretary of the

Taskforce Older People and Labour. Ger Tielen has been instrumental in founding Seniorweb Netherlands and the SESAM Academy (training for former senior managers to work for and support managerial tasks in NGOs). Ger Tielen is presently co-director of Demin, Bureau for Demographics and Innovation in The Hague and managing director of ILC Zorg voor Later (Netherlands).

UK  
South Africa  
France  
Dominican Republic  
Israel  
India  
Japan  
Netherlands  
Argentina  
USA



# ILC Argentina

## Introduction

Human rights within the UN conventions and the 1991 UN Principles for Older Persons provide a framework for developing equitable policies and practice. Yet millions of older people mainly in the developing world are still denied their rights. They experience isolation, poverty, violence and abuse and have limited access to health services, education and legal protection. With no regular income older people are even forced to work in low-paid or demeaning jobs to provide for themselves and their dependants.

Today, concern about this important area has driven a worldwide effort to increase awareness of the problem and encourage development of treatment and prevention programs.

It is predicated on the belief that elders are entitled to live out their advancing years in peace, dignity, good health, and security.

Regarding gender, older women are also disproportionately represented among the very old and the most disadvantaged as they constitute the “inevitable caregivers”.

They have more chances of being widowed, to have a poor education, nutritional status, restricted access to services, and the labor market in earlier life often left them with very few resources in their old age.

Ageing affects men and women in different ways, as they have different roles throughout their lives, leading them also to different experiences and needs in old age.

Many of these differences are related to unequal power relationships, and gender-related issues may vary between different societies and cultures.

Women may experience a lower status than men leading them not only to a poorer nutritional diet, but also to less access to education, higher risk of sexual violence, physical abuse, and exclusion from decision-making (Ageways 59, 2002)

Policies and programs that do not address gender issues, those relating to the way that society treats people according to whether they are male or females are bound to promote inequality.

Structural inequalities in both, the developed and developing countries that have resulted in low wages, high unemployment, poor health services, gender discrimination, and lack of educational opportunities have contributed to the vulnerability of older persons.

The majority of Argentinean elders that had been interviewed and so many others, “affirm that societal abuse” is the most frequent type of abuse, at least in most of the Latin Americans developing countries. (*WHO-INPEA, 2002*).

### Societal abuse (Structural)

is the lack of adequate health and social policies, bad practice and non-fulfillment of the existing legislation, presence of social, community and cultural norms which disqualify and give negative images of ageing ,causing harm or distress to an older person and expressed as discrimination, marginality and social exclusion. (*INPEA Latin American, Chile, CEPAL-CELADE, 2003*).

Violations to human rights might have serious consequences for health.

Health policies and programs can either promote or violate human rights in the way that they are designed or implemented.

Vulnerability and impact of ill-health can be reduced by taking steps to respect, protect and fulfill human rights.

UK  
South Africa  
France  
Dominican Republic  
Israel  
India  
Japan  
Netherlands  
Argentina  
USA



# ILC Argentina

These are relevant to a great many health issues, including prevention and treatment of multiple diseases, access to clean water and adequate sanitation, medical confidentiality, access to education and information regarding health, vital drugs availability; and taking care of marginalized and vulnerable groups such as the very old, racial minorities, refugees and people with disabilities.

Going back more than 50 years ago Mrs. Eva Perón promoted and produced the first ever ***“Rights for the Aged”*** in Buenos Aires, Argentina, 1948.

**Argentinean concrete actions to ensure elders benefit from the full range of internationally accepted Human Rights.**

**Government of the City of Buenos Aires  
National Direction of Social Policies for Elders, Ministry of Social Development:**

- To guarantee adequate social protection and a decent minimum income to all elders 70+, independently of their formal contribution to the National Retirement Pension scheme throughout their working life (since 2005). This reduced elders living in situation of poverty from 32.8% (2002) to 17.3%.

- To provide accessible and free health care for all older people (since 2005).
- To provide a National Nutrition Program which includes pregnant females and children in need as well as older people 60 and over? (since 2003).
- Try to put an end to Discrimination and Violence against older people (since 1998). Recent research, (March 2007) done by the INADI showed 84% of discrimination, 62% to elders.
- To support older people in their role as carers (since 2001).
- The right to access safer environments, adequate facilities and habitat (formally since 2006).
- Make credit, employment, training and education schemes available to people regardless of their age (since 2003).
- Empowerment of elders (since 2002).
- Supporting and strengthening advocacy providers.

Investment in the productive and social capacities of elders is likely to yield far-reaching results for all ages, in terms of community welfare, social cohesion and economic productivity. (*Help Age, 2002*)

**Improve and change policies required to enable older people to better assert their Human Rights.**

- To inform and educate elders in good time about their rights and let them know about easy ways to access to services and adequate places in case of need.
- Securing a right of access good-quality advocacy and upgrading older people's information and services.
- Established the Federal Council of Elders (2003).
- Argentina as well as other developing countries should try to design unique public integrated policies by meeting basic needs for food, shelter, economic security and health care.
- Outlawing abusive customs, initiating community programs to stimulate social interaction, creating new social networks and promoting solidarity and social support while working with the elders to create “self-help” programs.
- Responsible agencies must collaborate and form partnership, ensuring less duplication and waste of resources and enhanced trust and promotion of reliable and adequate services.

UK  
South Africa  
France  
Dominican Republic  
Israel  
India  
Japan  
Netherlands  
**Argentina**  
USA



# ILC Argentina

- Older people's rights can be promoted at different levels, from individual and family to international. However, national governments have a key responsibility to create an enabling environment for fulfilling older people's rights. To do this, older people's rights need to be embedded in national constitutions, legislation and budgets.

Practical ways to enable older people to access the services and entitlements linked to those rights must also be included and budgeted for in national policy frameworks, increasing security and poverty reduction plans.

I believe this is a wonderful opportunity to remember that:

**Article number 5, from the Political Declaration, (UN Second Assembly on Ageing, Madrid, 2002)**

Reaffirms to spare no effort to promote democracy, the protection of Human Rights and other fundamental freedoms, without any violence, abuse and neglect.

- Older people should enjoy a life of fulfilment, health, security, and with an active participation in the economic, social, cultural, and political life of their societies.
- Government's Representatives committed themselves to eliminate all forms of discrimination, including Age and Gender discrimination, and to create enough support services to face and deal with elder abuse and cases of mistreatment.
- Living with dignity should be enhanced in all human beings, without negatives stereotypes.
- Governments are also being encouraged to develop and fund a National comprehensive strategy and Agenda to prevent, detect and intervene in elder abuse.
- The International Plan of Action execution is Government's primary responsibility and they should have the effective and efficient collaboration from locals and national governmental dependencies, from international agencies, elderly people and their organizations, civil society, including NGOs and the private sector.

The International Plan of Action "firmly expects as well as demands" a change of attitudes, policies and practices in all sectors *"considering the fast ageing of the world, not as a great problem or disaster, but as the great challenge and achievement of the 21st Century"*

And, I would add, taking into account the enormous potential of the world's elders.

UK  
South Africa  
France  
Dominican Republic  
Israel  
India  
Japan  
Netherlands  
**Argentina**  
USA



# ILC Argentina

## Author:

**Dr Lia Susana Daichman** obtained her Medical Degree at the Faculty of Medicine, Cordoba National University in 1970. She continued her Postgraduate training in Geriatrics and Psycho Geriatrics in the UK before returning to Argentina and attending the Postgraduate Course on Gerontology and Geriatrics at the Buenos Aires National University where she obtained her Specialist Degree in 1980. She also re-certified her Specialist Degree in Geriatrics for the second time at the Argentinean Medical Association (year 1996 and 2001) and at the National Academy of Medicine, Buenos Aires, Argentina.

Dr Daichman was a Senior Registrar in Geriatrics at the Italian Hospital (1977 – 1980), Medical Director of the Jewish Old People Home, (1980 – 1982), Consultant to the Psycho-geriatric Department at the Liga Israelita Argentina (1983 – 1986), and has been a Medical Adviser to the Social Services and to the Coordinating Council of the Jewish Community, Buenos Aires since 1984.

She has published several papers in Journals and book chapters on Gerontology and Geriatrics nationally and internationally, and has carried out Gerontological Research at the CONICET, the Belgrano University of Buenos Aires and with the WHO, Geneva, during the last fifteen years. Her research and advocacy has been focused on Elder Abuse and Neglect, Discrimination, Human Rights, Ethical issues and Caregiving in Geriatric Care. She has permanently participated as a lecturer, director and organizer of postgraduate courses, national and international conferences on gerontology and geriatrics and has been a guest and keynote speaker at national and international gerontological congresses.

She has been Associated Professor on Psychology on Ageing at the Faculty of Psychology, Belgrano University since 1991, and Coordinator of the Specialist Postgraduate Course on Geriatric Medicine from the University of Buenos Aires since 1995, a founder member of the Buenos Aires Gerontological Society, full member of the Argentinean Medical Society (1979), the British Geriatrics Society (1977), the USA National Committee for the Prevention of Elder Abuse (1993), the Gerontological Society of America (GSA), Honorary member of several gerontological national and Latin American societies and of the Executive Board of the Argentinean Society of Gerontology and Geriatrics since 1990.

She was re-elected President to the Buenos Aires Gerontological Society, in office till July 1994 and has been working as a Consultant in Gerontology and Geriatrics at the Instituto Argentino de Diagnóstico y Tratamiento, since 1988. Since July 2001, at the World Congress of Gerontology in Vancouver, Canada she has been Chair of INPEA (International Network for the Prevention of Elder Abuse), NGO with UN Consultative Status and, since 2005, President of ILC-Argentina.

UK  
South Africa  
France  
Dominican Republic  
Israel  
India  
Japan  
Netherlands  
Argentina  
USA





## Introduction

The status of human rights in America is best exemplified by a 2006 study of age discrimination in various domains conducted by the ILC-USA. The results were as follows:

### Health Care Discrimination

60 percent of adults over 65 do not receive recommended preventive services, and 40 percent do not receive vaccines for flu and pneumonia. They receive even less preventive care for high blood pressure and cholesterol.

Only 10 percent of people aged 65 and over receive appropriate screening tests for bone density, colorectal and prostate cancer, and glaucoma. This despite the fact that the average age of colorectal cancer patients is 70, more than 70 percent of prostate cancer is diagnosed in men over 65, and people over 60 are six times more likely to suffer from glaucoma.

Chemotherapy is underused in the treatment of breast cancer patients over 65, even though for many of these patients it may improve survival.

Older Americans are the biggest users of prescription drugs, yet 40 percent of clinical trials between 1991 and 2000 excluded people over 75 from participating.

Older patients are significantly underrepresented in clinical treatment trials for all types of cancer, and most notably in trials for treatment of breast cancer.

20 percent of Americans 65+ are emotionally disturbed, but mental health care focuses mainly on young people.

In 2005, the U.S. Congress completely eliminated funding for geriatrics education and training in the 2006 Labor-Health and Human Services appropriations bill. The programs had been funded at \$31.5 million 2005.

### Discrimination in Nursing Homes

Nine out of ten nursing homes are inadequately staffed.

54 percent of nursing homes fail to meet minimum standards, yet only 0.5 percent of nursing homes nationwide are cited and penalized for patterns of widespread problems that cause harm to residents.

\$7.6 billion a year, an 8 percent increase over current spending, is needed to reach adequate staffing levels.

Nursing homes need 77,000 to 137,000 registered nurses, 22,000 to 27,000 licensed

practical nurses and 181,000 to 310,000 nurse's aides to reach recommended staffing levels.

### Discrimination in Emergency Services

60 percent of victims identified from Hurricane Katrina were age 61 or older.

Within 24 hours following the 9/11 terrorist attacks, animal advocates were on the scene rescuing pets, yet older and disabled people were abandoned in their apartments for up to seven days before ad hoc medical teams arrived to rescue them.

### Elder Abuse

1 million to 3 million Americans aged 65+ have been injured, exploited, or otherwise mistreated by someone on whom they depend for care or protection.

Estimates of the frequency of elder abuse range from 2 percent to 10 percent.

Only one out of six incidents of elder abuse, neglect, exploitation, and self-neglect is brought to the attention of authorities.

Only 21 states report that they maintain an elder abuse registry/database on perpetrators substantiated cases, and less than half of states maintain a central abuse registry.

UK  
South Africa  
France  
Dominican Republic  
Israel  
India  
Japan  
Netherlands  
Argentina

USA



It is estimated that each year 5 million older Americans are victims of financial exploitation, but only 4 percent of cases are reported. Many of these cases involve the unauthorized use of older person's assets and the transferring power of attorney to an older person's assets without written consent.

## Workplace Discrimination

The national General Social Survey reports that perceived discrimination due to age increased from 6.0 percent to 8.4 percent for workers overall, and from 11.6 percent to 16.9 percent for workers 65 and older from 1977 to 2002.

In 2004, the U.S. Equal Employment Opportunity Commission (EEOC) ruled that employers can deny health benefits to retirees at age 65 without violating age discrimination laws.

The Economic Policy Institute reports that during economic downturns, a disproportionately large percentage of long-term unemployed workers (25.6 percent) are over the age of 45 because they must overcome age discrimination in the labor market.

To improve job prospects, 63 percent of applicants say they would leave dates off their resume to hide their age, and 18 percent say they would undergo cosmetic surgery.

About 10 percent of the 17,837 age-discrimination claims filed in 2004 with the EEOC were related to hiring.

As a result of the 2001 Supreme Court Case *Kimel v. Florida Board of Regents*, state government employees cannot sue employers for monetary damages that violate the Age Discrimination Employment Act.

## Discrimination in the Media

Less than 2 percent of prime-time television characters are age 65 or older, although this group comprises 12.7 percent of the population.

Middle-aged and older white male writers have joined women and minorities on the sidelines, as white men under 40 get most of the jobs writing for Hollywood's television and film industry. In both feature film and television, employment and earning prospects for older writers have declined relative to the opportunities available to younger writers.

## Ageist Gender Inequality

- 11 percent of male characters on television between 50 and 64 are categorized as "old" versus 22 percent of female characters.
- 75 percent of male characters on television 65 and older are characterized as "old" versus 83 percent of female characters 65 and older.
- Only one-third of older characters on prime-time television are women.

According to one study, approximately 70 percent of older men and more than 80 percent of older women seen on television are portrayed disrespectfully, treated with little if any courtesy, and often looked at as "bad."

UK  
South Africa  
France  
Dominican Republic  
Israel  
India  
Japan  
Netherlands  
Argentina

USA



## Hope

These acts of discrimination can be restated as rights, which older persons should be able to enjoy.

Older Americans want the rights to health care equal to the young. They want to be treated with dignity in nursing homes. Needless to say, they want to receive emergency services as necessary. They do not want to be subject to abuse of any kind. Older people want to be appropriately and proportionately represented in the media.

To accomplish these goals requires legislative, financial and cultural changes. To ensure health care, including nursing home, community and home care, requires new funding and enforcement of laws already established. Freedom from abuse requires passage of a new law which has been introduced in Congress entitled The Elder Justice Act. Workplace discrimination must be met by the passage of an amendment to the Civil Rights Act of 1964 that includes older persons as a protected class. All of these efforts require financial (budgetary) support. The right to appropriate representation in the media requires a change in cultural attitudes.

All these changes depend upon strong private

sector and political advocacy. At this time, there are no powerful advocates working on behalf of the human rights of older persons in public life, including our legislation. Nor is there any evident pressure for change.

## Author:

Robert N. Butler, M.D., is President and Chief Executive Officer and Co-Chair of the Alliance for Health and the Future of the International Longevity Center – USA, and professor of geriatrics at the Brookdale Department of Geriatrics and Adult Development at the Mount Sinai Medical Center in New York City.

From 1975 to 1982 he was the founding director of the National Institute on Aging of the National Institutes of Health. In 1982 he founded the first department of geriatrics in a U.S. medical school.

In 1976 Butler won the Pulitzer Prize for his book *Why Survive? Being Old in America*. He is co-author (with Dr. Myrna I. Lewis) of the books *Aging and Mental Health* and *Love and Sex After 60*. He is presently working on a book *Life Review* and has completed *The Longevity Revolution*.

In 2003 he received the Heinz Award for the Human Condition.

UK  
South Africa  
France  
Dominican Republic  
Israel  
India  
Japan  
Netherlands  
Argentina  
USA



## **ILC Global Alliance**

**ILC Argentina** – [liadaichman@fibertel.com.ar](mailto:liadaichman@fibertel.com.ar)

**ILC Dominican Republic** – [rosy.pereyra@verizon.net.do](mailto:rosy.pereyra@verizon.net.do)

**ILC France** – [www.ilc-france.org](http://www.ilc-france.org)

**ILC India** – [www.ilcindia.org](http://www.ilcindia.org)

**Israel** – [www.cmra.bgu.ac.il](http://www.cmra.bgu.ac.il)

**ILC Japan** – [www.ilcjapan.org](http://www.ilcjapan.org)

**ILC Netherlands** – [www.ilczorgvoorlater.com](http://www.ilczorgvoorlater.com)

**ILC South Africa** – [www.ilcsa.uct.ac.za](http://www.ilcsa.uct.ac.za)

**ILC UK** – [www.ilcuk.org.uk](http://www.ilcuk.org.uk)

**ILC USA** – [www.ilcusa.org](http://www.ilcusa.org)

**ILC Global Alliance Secretariat** – [masakoo@ilcusa.org](mailto:masakoo@ilcusa.org)

## **Report produced by:**

### **ILC UK**

22–26 Albert Embankment

London UK SE1 7TJ

Tel: + 44 (0) 20 7735 7565

email: [info@ilcuk.org.uk](mailto:info@ilcuk.org.uk)

Grateful thanks to our sponsors

