

## Equality and inclusion: a question of rights and responsibilities.

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As the House of Lords Select Committee on Public Service and Demographic Change in their report "Ready for Ageing" rightly highlighted an ageing population is likely to provide an increasing challenge for the delivery of health and social care services in the future (House of Lords Select Committee 2013). Such questions need urgent engagement and their report calls for rapid Government action, a White Paper in this area before the next election along with the establishment of two new Commissions addressing first, the issues of pensions, savings and equity release and secondly the health and social care system and how its funding should be changed to serve the needs of an ageing population. In what is a short punchy and in many respects useful document what is missing in the broader engagement with the question of the rights and responsibilities of the older person, both nationally and internationally and indeed how the language of human rights should frame this debate. While the House of Lords Select Report rightly recognises the issue of discrimination in the context of ageing it is submitted there is much more which can and indeed should be explored in relation to these questions. Ageism has been a source of concern for many years. As Butler wrote

“Ageism can be seen as a process of systematic stereotyping of and discrimination against people because they are old, just as racism and sexism accomplish this for skin colour and gender. Old people are categorized as senile, rigid in thought and manner, old fashioned in morality and skills. Ageism allows the younger generations to see older people as different from themselves, thus they subtly cease to identify with their elders as human beings.”  
(Butler 1969)

In evidence to the Policy Commission [Dr Gallagher](#) stated that there is evidence of indirect discrimination in the NHS. The structure of hospitals ends up disadvantaging the elderly even though they are for the majority of patients. In this section we attempt to engage with questions of fundamental human rights and equality and how they may assist in framing the debate concerning ageing policy and access to services over the next few years.

### INTERNATIONAL POLICY DEVELOPMENTS

The question of ageing has been actively on the international policy agenda since 1982. In that year the General Assembly of the United Nations convened the first World Assembly on Ageing in 1982 which produced the *Vienna International Plan on Ageing* (UN 1982). This stated that the member states

“1. Do solemnly reaffirm their belief that the fundamental and inalienable rights

enshrined in the Universal Declaration of Human Rights apply fully and undiminished to the ageing;  
and

2. Do solemnly recognize that quality of life is no less important than

longevity, and that the aging should therefore, as far as possible, be enabled to enjoy in their own families and communities a life of fulfilment, health, security and contentment, appreciated as an integral part of society.

In addition specific objectives were set

“(a) To further national and international understanding of the economic, social and cultural implications for the processes of development of the aging of the population;

(b) To promote national and international understanding of the humanitarian and developmental issues related to aging

(c) To propose and stimulate action-oriented policies and programmes aimed at guaranteeing social and economic security for the elderly, as well as providing opportunities for them to contribute to, and share in the benefits of, development;

(d) To present policy alternatives and options consistent with national values and goals and with internationally recognized principles with regard to the aging of the population and the needs of the elderly; and

(e) To encourage the development of appropriate education, training and research to respond to the aging of the world's population and to foster an international exchange of skills and knowledge in this area. “

This was followed by the UN Principles for Older Persons in 1991(UN 1991). The principles addressed questions from access to adequate food, water and health care, to being able to live in safe adaptable environments and live at home as long as possible. The principles also stated that older persons should remain integrated into society and

“10. Older persons should benefit from family and community care and protection in accordance with each society's system of cultural values.

11. Older persons should have access to health care to help them to maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness.

12. Older persons should have access to social and legal services to enhance their autonomy, protection and care.

13. Older persons should be able to utilize appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and secure environment.

14. Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives. “

15. Older persons should be able to pursue opportunities for the full development of their potential.

16. Older persons should have access to the educational, cultural, spiritual and recreational resources of society.

Dignity

17. Older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse.

18. Older persons should be treated fairly regardless of age, gender, racial or ethnic background, disability or other status, and be valued independently of their economic contribution. “

The United Nations is actively considering rights and ageing. It has established what is known as the Open Ended Working Group on Ageing. The UN has called for Governments to

“mainstream the concerns of older persons into their policy agendas, bearing in mind the crucial importance of family intergenerational interdependence, solidarity and reciprocity for social development and the realization of all human rights for older persons, and to prevent age discrimination and provide social integration; (UN 2010)

It also suggests that member states should

“ensure that older persons have access to information about their rights so as to enable them to participate fully and justly in their societies and to claim full enjoyment of all human rights “(UN 2011)

In addition it goes onto state that it

“Further calls upon Member States to address the well-being and adequate health care of older persons, as well as any cases of neglect, abuse and violence against older persons, by designing more effective prevention strategies and stronger laws and policies to address these problems and their underlying factors” (UN 2011)

Speaking in September 2011 Anand Grover, the UN Special Rapporteur on the right to health, said that a “right to health approach” to ageing is indispensable to mitigate the consequences of an ageing society and ensure that older persons enjoy the full range of human rights. (UN 2011B). While some older person’s rights may be specifically safeguarded on other Conventions such as the UN Convention on the Rights of Persons with Disabilities, it is suggested that reliance on this Convention would not be appropriate in this context. Moreover it is suggested that frailty should not be such a criteria here. As [Dr. Gallagher](#) commented in evidence to the Commission there is a difference between an older human being and a frail human being. ‘Age’ is an objective way to assess and apply rights. Frailty is more open to interpretation as that while many older persons may have physical or mental disabilities at some point it would not be appropriate for them to be considered.

In contrast to the United Nations Convention on the Human Rights of the Child there are still no international conventions on the rights of the elderly person. Nonetheless in more recent rights declarations there are provisions which make reference to the rights of the older person. The EU

Charter of Fundamental Rights contains specific reference to the rights of the elderly. Article 25 provides that

“The Union recognises and respects the rights of the elderly to lead a life of dignity and independence and to participate in social and cultural life.”

## **COUNCIL OF EUROPE ACTIONS AND THE OLDER PERSON**

The question of the rights of the older person are also addressed in the European Social Charter produced by the Council of Europe. Article 23 of the Charter concerns the right of elderly persons to social protection

“With a view to ensuring the effective exercise of the right of elderly persons to social protection, the Parties undertake to adopt or encourage, either directly or in co-operation with public or private organisations, appropriate measures designed in particular:

- to enable elderly persons to remain full members of society for as long as possible, by means of:
  - a. adequate resources enabling them to lead a decent life and play an active part in public, social and cultural life;
  - b. provision of information about services and facilities available for elderly persons and their opportunities to make use of them;
- to enable elderly persons to choose their life-style freely and to lead independent lives in their familiar surroundings for as long as they wish and are able, by means of:
  - a. provision of housing suited to their needs and their state of health or of adequate support for adapting their housing;
  - b. the health care and the services necessitated by their state;
- to guarantee elderly persons living in institutions appropriate support, while respecting their privacy, and participation in decisions concerning living conditions in the institution.”

The Steering Group on Human Rights of the Council of Europe (CDDH) established a working group comprised of experts from Council of Europe Member States which met for the first time in 2012 with the task of examining whether there should be the adoption of a non-binding document on the human rights of the elderly. Interestingly the Group took the approach that an appropriate definition of “elderly” was likely to prove appears difficult and unnecessary and were such a definition to be included it should not be age defined. Subsequently in 2013 the Group has produced a Draft Recommendation of the Committee of Ministers to Member States on the promotion of the human rights of older persons (Council of Europe 2013). This provides that its aim is “To ensure the full and equal rights and fundamental freedoms for older persons and promote respect for their dignity.” It makes reference to the importance of non- discrimination, autonomy and the prevention from violence and abuse. The draft also makes reference to rights in the context of social protection and employment. In the context of health care it provides that “member states should establish and guarantee that appropriate health and long term quality care is available”. The document makes also reference to be the need for respect for informed consent. In addition it states that there should be “sufficient residential care being provided where persons did not want to live in their own home.”

It is submitted that the adoption and implementation of international Conventions both at UN and Council of Europe level concerning the rights of the older person may prove a watershed moment in the way in which we view older persons in society. The need to afford special recognition and

protection to the rights and interests of older persons should be an integrally important moment in evolving policy and law in this area in the future. This does not of course mean that all such rights will equate to a right to demand access to resources in all situations and regardless of the interests of others. Difficult questions will still need to be addressed in relation to resource allocation and too in addition to accommodating a range of diverse needs. Nonetheless this will afford the opportunity to consider such issues afresh, a new approach to rights, not mandated through controversy and scandal but through pro-active engagement with fundamental values.

## **EU POLICY ON HEALTHY AGEING AND THE OLDER PERSON**

At EU level there is considerable evolution of policy concerning healthy ageing. So for example, the European Innovation Partnership on Active and Healthy ageing (European Commission) – pilot scheme that began in 2009 aims to increase Healthy Life Years (HLY) by 2 years by 2020. Healthy life years or disability-free life expectancy indicates the number of years a person of a certain age can expect to live without disability. 2012 was the European Year for Active Ageing and solidarity between Generations. (<http://www.age-platform.eu/en/2012-european-year-on-active-ageing-and-intergenerational-solidarity/141-european-year-2012>)

EU health law and policy is becoming increasingly influential in framing domestic responses in relation to health law and moreover the EU is engaging more generally with issues concerning fundamental human rights ( Hervey and McHale, 2004; McHale, 2010) and the further development of EU policy in this area is likely in the future. This will be the case regardless of the international approaches in this area. It is thus increasingly important that Government, policy bodies and health and social care providers are alive to the prospect of early engagement with the evolution of EU law and policy.

## **ENGLAND AND WALES: LAW, RIGHTS AND THE DELIVERY OF HEALTH CARE SERVICES**

As England and Wales becomes increasingly a multi-cultural and multi-faith society, new challenges arise for the delivery of health and care services. The movement from a predominantly white, Christian population with a broad homogeneity of beliefs has now translated into a myriad of different approaches and lifestyle choices. Recognizing such diversity is integral to respect for fundamental rights to respect for religious faith and belief. Involvement of family members can also involve very different dimensions in different faith traditions than is reflected in an individualistic care model in relation to ageing. Is it possible to accommodate a range of different faiths and belief traditions in designing health, care and other services for an ageing population in the future?

The passage of the Human Rights Act 1998 provided an opportunity to re-evaluate the relationship between faith, belief and health care law. Since the 1<sup>st</sup> October 2000, when the Human Rights Act 1998 came into force, English law must be interpreted consistently with the provisions of the European Convention of Human Rights. There is a specific obligation placed upon public bodies to act in accordance with the Convention provisions incorporated through the Act. In addition, where legislation is found to be incompatible with ECHR law, the English courts, while not empowered to strike down that legislation, may issue what is called a “declaration of incompatibility” ( S 4. Human Rights Act 1998), with the consequence that the government is then placed under considerable pressure to amend the law accordingly. Case law is required to be interpreted consistently with the provisions of the ECHR (s3 Human Rights Act 1998). Such ECHR interpretation does not only mean that the courts will be interpreting English law consistently with the Articles of the Convention themselves but it extends more broadly to encompass interpretation which is

consistent with the judgments of the European Court of Human Rights at Strasbourg. Various provisions may be relevant in this context such as Article 2, the right to life, Article 8, the right to privacy and Article 9, which concerns safeguarding conscience and belief. The European Court has held that the scope of Article 9 encompasses protection for a range of religious beliefs from a wide range of faiths. In addition section 13 of the Human Rights Act 1998 provides that

“If a court’s determination of any question under this Act might affect the exercise by a religious organization or its members collectively of the Convention right to freedom of thought, conscience and religion it must have particular regard to the importance of that right.”

There are however notable challenges in attempting to utilize Article 9 in the courtroom. This is partly because it is a “qualified” rather than absolute right. Article 9(2) has the effect that the main provisions in Article 9(1) may be overridden by public interest considerations such as public health and the prevention of crime and disorder. Respect for fundamental rights under the ECHR also encompasses safeguards for non-discrimination. Article 14 concerns the prohibition upon discrimination. However this Article is not a freestanding non-discrimination right. Instead claims under this provision will only succeed if it is also held that there has been the breach of another substantive Convention provision. (See e.g. *DPP v Pretty* [2002] 1 All ER 1.<sup>1</sup>) Over the thirteen years since the Act came into force it has not been utilised to develop a new jurisprudence in the English courts in relation to issues concerning respect for faith and belief in the context of patients or older persons and the constraints of Article 9 and Article 14 illustrate perhaps why this is the case. There is also no specific reference contained in the Convention to discrimination on the basis of or specific rights in relation to age. While the NHS Constitution embedded in the NHS through the S1C of the NHS Act, it does not fundamentally create new rights, rather it restates in a single document a range of existing legal rights along with pledges and aspirations.

In evidence to the Commission [Katherine Hill](#), Policy Adviser – Equalities & Human Rights Age UK suggested that there ought to be a right to healthy ageing and the key agenda would be to make this right more realisable. She suggested that the Human Rights Act has limits. So for example, she suggested that for example Article 2 of the HRA, which sets out the right to life made the Francis enquiry possible. However as she went on to say in the final report, the recommendations and solutions are not made in rights-based language. While the Francis Report takes questions about dignity and respect but does not talk about them as a matter of potential illegality (Francis 2013). Katherine Hill also suggested that patients should use the provisions of the NHS Constitution to further their rights. This could provide a framework for a paradigm shift, to make abstract human rights seem relevant to individual.

#### **ACCESSING NHS RESOURCES:**

To what extent can individuals require the provision of specific forms of care/treatment on the basis that this is mandated by their age, specific culture, faith or belief? Firstly, the courts have clearly stated that the decision to provide a specific course of treatment is a matter for clinical judgement as to appropriateness and not simply the preference of individual patients or their families. (*R (Burke) v GMC* [2006] QB 274) In the past challenges under the National Health Service Act 2006, section 3 and its predecessor section 3 of the National Health Service Act 1977 concerning the obligation of the Secretary of State to provide various health care services to the extent to which the Secretary of State considers necessary to meet all reasonable requirements met with mixed success. As Lord Denning stated in *ex parte Hincks*, in practice

“It cannot be supposed that the Secretary of State has to provide all the latest equipment. As Oliver LJ said in the course of argument it cannot be supposed that the Secretary of State has to provide all the kidney machines that are asked for or all the new developments such as heart transplants in every case where people have asked for them”.

*R (on the application of Rogers) v Swindon NHS Primary Care Trust and another* [2006] EWCA Civ 392. See further Newdick (2007)). However, the court is usually circumspect in its interpretation of decisions concerning NHS resource allocation. Moreover, if such cases are brought by way of judicial review of the legality of a treatment decision, they do not constitute an appeal against that decision. The advent of the Human Rights Act 1998 had very limited practical impact as to how such cases were resolved in practice and moreover none of these cases utilise as their justification discrimination on the basis of age, race or of faith or of belief. (*R v North West Lancashire Health Authority ex parte A D and G.* [2000] 1 WLR 977; *R (on the application of AC) v Berkshire West Primary Care Trust* [2011] EWCA Civ 247. *R (on the application of Alexander Thomas Condliffe) v North Staffordshire PCT* [2011] EWCA Civ 910. ) Instead such cases have been determined on very much standard judicial review principles.

The Health and Social Care Act 2012 which has led to major restructuring of the NHS extends the existing provisions under section 1 and places a duty of Secretary of State to promote comprehensive health service covering mental health as well as physical health. The duties under section 3 of the 2006 Act have been redrafted. Rather than being phrased in terms of ‘a duty to provide’, it instead refers to there being a duty to “exercise functions conferred by the Act so as to secure that services are provided in accordance with this Act”. This section is intended to reflect the reality of the provision of many NHS services where day to day provision is delegated by the Secretary of State to local providers of services, in the past NHS trusts. At primary care level there are now local “commissioning groups” driven by GP’s with the power to commission services for their local populations. The impact upon services and indeed the willingness of persons to challenge the provision of the services in relation to age, faith or belief criteria in particular can only be speculated at present. There is a possibility of greater inconsistencies between trusts in provision of services. Some of this may work positively, recognizing the challenges caused by diversity in society and geographical concentrations of particular faith groupings or indeed of particular larger numbers of older persons in certain parts of the countries. The impact of the new section 1C of the NHS Act which provides that there is a duty to have regard to the need to reduce inequalities between the people of England in respect of the benefits that may be obtained by them from the health service will be interesting. This provision may address concerns such as postcode prescribing.

In terms of delivery of services there remain challenges. As [Professor Newdick](#) noted in evidence to the Commission, individual may have duties and state has duties also to its citizens. This can include duties to the future generations as well as the citizens of today as Edmund Burke recognised 200 years ago. Dr Gallagher in evidence to the Commission commented that it would be wrong to link rights to healthcare directly to responsibilities in a health practice sense. People are fallible and vulnerable and poor health choices are not always under our control.

Professor Newdick in evidence stressed that it is critical that health and broader services are co-ordinated. Moreover as he commented provisions in the Health and Social Care Act focus specifically place duties on public bodies such as Monitor and NHS England to tackle inequality. Services have had a right to integrate between local authority services and NHS services prior to this but it did not

happen. This provides an opportunity and a challenge in relation to service provision. As Professor Newdick also commented the ambition to improve health and to close inequality gap is going against current requirement for budget cuts, so there is a need to focus resources into key areas. Dr Gallagher suggested that the NHS management language of targets (flow and throughput) is not a good fit with ageing and older people. There is a challenge presented by the diversity of older people and also of the health care workforce. She commented that Francis Reports and Patient Association identify older people at high risk of neglect in the care system and hospital.

## **EQUALITY LEGISLATION AND ACCESS TO SERVICES**

In practice it is possibly the case that longer term the Equality Act 2010 could prove more influential than the Human Rights Act in relation to claims concerning the provision of health and social care services to the older population. This legislation concerns discrimination across a range of protected characteristics including gender, sexuality, age, race and religion. It gives rise to the prospect of combined discrimination such as age and religious discrimination cases being brought together in the future. The Equality Act 2010 prohibits direct discrimination and indirect discrimination. Direct discrimination refers to treating one person worse than another person due to a protected characteristic.(s 12 Equality Act 2010) Indirect discrimination applies to actions taken which have a worse impact on those with a protected characteristic than upon a person without such a characteristic in a situation in which this cannot be objectively justified.( s19 Equality Act 2010). It also extends to victimisation, treating a person unfavourably in a situation in which they are/may be taking action under the Equality Act or may be supporting someone who is doing so. (S. 27 Equality Act 2010.) The Act covers individuals in the workplace and also relates to the provision of services. Oversight of the legislation is provided by a statutory body, the Equality and Human Rights Commission. Under section 149 of the Equalities Act 2010 specific statutory duties are also placed upon public authorities to foster equality. The section provides that

- (1) A public authority must, in the exercise of its functions, have due regard to the need to—
  - (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
  - (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
  - (c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

This is an important provision as it imposes heightened obligations upon public bodies in the area of equality rights. This is a provision which is however at present the subject of consultation by the UK Government. It remains to be seen whether it will ultimately survive. It is submitted that to remove it would be a retrograde step in a society where there is still much to do to facilitate and support the equality rights in the provision of health and social care. The need for “equal treatment’ is recognized in recent guidelines from the General Medical Council published in 2013(GMC, 2013).

These provide that

“Care and treatment must be provided in a non-discriminating manner. You must not express your personal beliefs (including political, religious and moral beliefs) to patients in ways that exploit their vulnerability or are likely to cause them distress” (para 54).



Similarly the guidelines go onto state that

“The investigations or treatment you provide or arrange must be based on the assessment you and your patient make of their needs and priorities and on your clinical judgment about the likely effectiveness of the treatment options. You must not refuse or delay treatment because you believe that a patient’s actions or lifestyle have contributed to their condition”. (para 57).

It also provides that

“You must not unfairly discriminate against patients or colleagues by allowing your personal views to affect your professional relationships or the treatment you provide or arrange. You should challenge colleagues if their behaviour does not comply with this guidance and follow the guidance in para 25” (para 59).

Discrimination actions may also be brought alongside Human Rights Act cases, [See e.g. *Eweida v UK* [2013] ECHR 37]. This highlights a more general issue namely that whether under the Human Rights Act 1998 or the Equality Act 2010 an individual’s claim to respect for individual rights needs to be set in the broader context of the rights and entitlements of others. A broader utilitarian calculation may mean that rights are outweighed in such a situation in the wider public interest.

## **EQUALITY, DIVERSITY AND AGEING: THE COMMISSIONER FOR OLDER PERSONS**

An additional approach which may be taken is the establishment of the Office of a Commissioner for Older Persons. The Equality and Human Rights Commission, established under the Equality Act 2010, provides an important mechanism through which the rights and interests of older persons in a multi-cultural society may be safeguarded and has already produced documents addressing ageing and the rights and interests of older persons. Nonetheless while the EQHRC has a critically important role to play there is a case for it operating alongside a new champion facilitating the promotion and protection of the human rights and interests of older persons. In the past Governments have appointed notable figures such as Baroness Joan Bakewell in relation to high profile roles championing the interests of older people. In the NHS context Professor Iain Phillip and Professor David Oliver have had roles as National Clinical Directors in this area. There is however a case for going beyond what ultimately can prove temporary political or NHS roles of this type. Jonathan Herring has suggested that one way in which older persons interests may be more effectively represented is through the appointment of a “Commissioner” for older people. As he states they

“would ensure that older people’s interests were given effective recognition in the media and in government policy making. Further the commissioner would be able to develop an overview of the issue affecting older people and demonstrate how different forms of disadvantage compound each other. Finally, it would provide a way of investigations being undertaken in areas where it is feared that older people are abused but which have not been proved.” (Herring 2009).

The creation of an older person’s Commissioner was also subsequently advocated by Baroness Joan Bakewell in 2012 who tabled an ultimately unsuccessful amendment to the Health and Social Care Bill to that effect. It has also been supported by a recent CentreForum report (Burstow, 2013). Wales has had a Commissioner for Older People since 2006 (Commissioner for Older People (Wales) Act

2006). The Commissioner has the role of promoting the rights and interests of older people in Wales, challenging discrimination against older people in Wales, encouraging best practice in the treatment of older people in Wales and reviewing the law affecting the interests of older people in Wales. In Northern Ireland there has been a Commissioner since 2011 (Commissioner for Older People, (Northern Ireland) Act 2011). In 2012 the Welsh Commissioner has issued a number of reports highlighting important issues concerning the care of older persons. (See e.g. Older Person's Commissioner, Wales, 2012).

The advantages of such a Commissioner are that they can have a multifaceted role which has the potential to go much beyond the current scope of the Equality and Human Rights Commission. This does not mean that such a Commissioner should be seen as an alternative to the EQHRC rather a Commissioner for Older Persons can be regarded as complementary to the operation of such existing authorities. This Commissioner could have a formal co-opted seat on the Board of the EQHRC which would facilitate the work of the EQHRC in relation to age discrimination and other related "complex" discrimination issues involving age alongside gender, race and religion.

It would be essential that the Commissioner be seen not simply to provide a "voice" but also to have "teeth" and to be able to enable enforcement of measures. There is always the danger that well intentioned reports, even if highly publicised at the time lose impact subsequently. In this regard the nature and the role of the Commissioner needs to be more clearly defined and established than has been the case in relation to reports to date proposing its creation in the UK, helpful although those are in relation to placing the issue back on the table of public policy (Centre forum 2013).

The Commissioner should report to Parliament and there should be provision for an annual debate upon the Commissioner's Report. If abuses are revealed under Commissioner investigations these should be immediately the source of action by the Care Quality Commission and the Commission should report directly to Parliament as to the action taken following such a reference by the Commissioner. In other instances the nature of what the Commissioner discovered might lead to direct references to law enforcement authorities such as the Police. It would be essential that the role of Commissioner be held by a person of appropriate public standing and experience with the weight to carry forward their recommendations in the public eye.

If the Commissioner's role to carry real traction its scope of operation needs to be clearly defined. There are risks in letting it be a role solely defined by the contributor. It is notable that e.g. various reports of the Welsh Commissioner are underpinned by reference to the UN Principles concerning the rights of the older person. More than this is however needed for this role to truly progress. In Wales the Commissioner, Sarah Rochira is now heading an Advisory Group examining the case for the introduction of a Convention on the Human Rights of the Older Person (Welsh Government 2013, Older Persons Commissioner, Wales, 2013). It is submitted that this is really the critical issue. In many respects establishing a Commissioner without being clear as to the precise ground rules within which it is operating can be seen as "putting the cart before the horse". The Commissioner needs a firm legal framework within which to operate. This will involve engagement with more traditional and civil political rights but also with economic, social and cultural rights. There is also clearly an interface here with the broader debates concerning the UN Convention on the Rights of the Child (UN 1989) and also in that context with the operation of the work of the Children's Commissioner for England, established under the Children's Act 2004. These rights need to be

clearly stated, both positive and negative. Moreover the Commissioner will need to operate within not simply the domestic framework here but as we have seen in the context of Equality and Diversity more generally the prospective developing Council of Europe and UN initiatives in this area.

#### **RECOMMENDATIONS.**

- 1. The Policy Commission supports an active debate on the case for a Convention of Human Rights for the Older Person.**
- 2. The Policy Commission recommends that the human rights of older people should be at the heart of health and social care policy.**
- 3. The Commission supports the creation of a new statutory post of a Commissioner for Older People in England. This Commissioner should work closely with the Equalities and Human Rights Commission.**

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