Human Rights do not have a best before date
Support a U.N. Convention on the Rights of Older Persons

International Longevity Centre Canada (ILCC)

14th session of the Open-ended Working Group on Ageing

Guiding questions on the normative content related to right to health and access to health services

Definition

1 & 2. Please refer to the ILCC substantive input on the right to health and access to health services in Canada submitted to the 13th session of the OEWGA.

The right to health for older persons in Canada should be explicitly defined and implemented in an integrated federal and provincial legislative and policy approach in accordance with a UN convention on the human rights of older persons. The convention will provide the necessary comprehensive legal framework to protect the various interdependent and interrelated human rights, preventing the devaluing of the lives of older persons.

Scope of the right

An excellent summary of the normative dimensions of the right to health can be found here, at paragraphs 179 to 200.

3. a) The prohibition of all forms of discrimination against older persons based on age, alone or combined with other grounds, must apply to:

- The availability, accessibility, acceptability, and quality of physical and mental health services;
- Decisions on access to healthcare, triage, and lifesaving treatments;
- Changes to the availability, acceptability, or quality of medical services, including home visits and community care;
- Access to the benefit of healthcare programs including health promotion, prevention, adaptation, etc.;
- Medical research and routine data collection and reporting;
- Decisions relating to healthcare rationing;
- Evaluation of the health status of an individual; and

- Access to the determinants of health, including clean water and sanitation, nutrition and housing, access to health information, etc.

Further, consideration of the following must be mandated to reduce active and passive discrimination based on age, alone or combined with other grounds, in the making of law and policy in relation to the right to health:

- Propensity of exposure of older persons to neglect and abuse;
- Prevalence of social isolation; and
- Accessibility to physical, digital, and online services.

The above prohibitions and considerations must be included in education and training for all individuals legislating, planning and/or providing health services for older persons and must include anti-ageism awareness and prevention mechanisms.

b) The right to health should include explicit reference to the right to preventative, curative, rehabilitative, and palliative care, which should be equitably distributed regardless of a person's place of residence within the country. Adequate resources should be applied to ensure sufficient personnel are available to provide the care, and that care is not unreasonably restricted based on category of illness or cost.

c) The intersectoral and heterogenous needs of older persons must be considered in relation to the availability, accessibility, acceptability and quality of health facilities, goods, and services as well as health care and support, including aspects such as quality of care, long-term and palliative care. Critical to the quality of health services and facilities, including long-term care and homecare, will be legislated attention to the inherent dignity of the individual and prevention of violence and mistreatment.

Collection, interpretation, and publication of disaggregated health data for older persons separated by gender, age, race, disability, Indigenous status, socio-economic status, etc. will be essential to the ongoing and nuanced understanding of the health and wellness needs of older persons.

d) The person-centered right to give, withhold, or revoke free and informed consent on health matters and exercise legal capacity on an equal basis with others must be a component of the right to health. Legislated mandates to increase the potential for older persons to exercise capacity and prevent abuse will be critical (i.e.: supported decision making, and measures tailored to provide accessible information to older persons according to their needs to best allow a full understanding of the risks and benefits of treatment options).

e) Impediments to access to justice for older persons must be considered when designing and implementing remedies where the right to health is violated. Data collection on the number, type and resolution of complaints relating to violations of the right to health must be mandated. Domestically, effective remedies implemented pursuant to the Convention on the

Rights of Persons with Disabilities should be considered as potential models to be adapted, where applicable.

State obligations

4. In Canada, the right to health as implemented in domestic legislation must go beyond access to health care. The right must be iterative and dynamic, based on respecting the inherent dignity of the individual, and able to evolve to fully encompass the determinants of health. The definition, scope, and application of the right to health must be embedded in clear, authoritative legal sources.

Special considerations

5. The right to health does not stand alone but forms part of a broader, intersecting, and interrelated suite of rights that together will guard the dignity and humanity of older persons. Intersectionality and the heterogeneity of older persons as a group must be considered in drafting and implementing the right to health and the overall convention.

Implementation

7. In Canada, the lack of robust support for a convention on the rights of older persons from the federal and provincial governments, the high prevalence of ageism, and evidence of legislated disrespect for the self-determination of older persons are all challenges. The ongoing implementation of the Convention on the Rights of Persons with Disabilities is a promising indication of the potential impact of a convention on the rights of older persons.