Additional Chapter:
Elderly Care: Older people and the Law
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LEARNING CHECKLIST

By the end of this chapter, you should be able to:

- *Explain* the powers of the Court of Protection and substitute decision-makers in respect of adults who lack the legal capacity to make a decision, and *evaluate* the strengths and weaknesses of the current laws by reference to academic commentary and research
- *Explain* what legal powers are available to protect older people from abuse or harm
- *Critically discuss* the financial position of older people by reference to economic research reports
- *Critically discuss* the role of the state and the family, respectively, in supporting older persons, including by reference to moral claims, filial responsibility laws, and human rights instruments.

Scenario 1

Jean

Jean is a retired woman aged 76. She decides to move into a care home. In this chapter, we consider how Jean can fund residential care and what support from the state she may receive.

Scenario 2

Harry

Harry is aged 78 and has dementia which has progressed sufficiently that there are concerns about his capacity to manage his own affairs and to live independently. In this chapter, we consider Harry's care needs.

13.1 Introduction

In this book so far, we have considered how family law affects different families as they experience various types of life experience, from living with someone, having children, getting married, splitting up, experiencing abuse or harm, or joining a new family unit. This chapter brings together some of these by highlighting specific ways that these laws affect older people.[1] It also looks at some issues that are particularly relevant to older people such as mental capacity and decision-making, funding personal care, elder abuse, and age discrimination.

Before we do this, we need to first define who we are discussing. Who are older people?

13.1.1 Who are older people?

The Office for National Statistics tells us that 18.5% of people in England and 21.1% in Wales are aged 65 or over.[2] Around 2.5%of people in England and 2.7 % of those in Wales are aged at least 85, and of these, the majority - nearly 58% - are female, as women have longer average life expectancies than men.

In this chapter, when we refer to older people we will refer to anyone who is aged 65 or over. Although they are the older proportion of the population, most people would nevertheless consider them some way from being 'elderly'. Indeed, some of these people will still be working. The number of those aged 65 or over who are still in employment has been steadily rising and now stands at about 11%. In 1992, the earliest date for which the ONS collects these statistics, only half as many were still working than is the case now.[3] Some will be raising children, perhaps as kinship or foster carers or perhaps as part of a multi-generational household. They may be carers. They may be ill, or disabled, or like Fauja Singh, able to run a 10-kilometre marathon at the age of 101.[4] Older people are therefore diverse, just like the rest

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[1] I would like to thank the peer reviews for this chapter, and their detailed and positive feedback, Eugenia Caracciolo di Torella for her generosity in discussing what she teaches, and Brian Sloan for making some of his articles available. This chapter is dedicated to my great aunts and uncles, one of whom is an older carer, one of whom is in residential care, and one of whom required me to learn all about mental capacity law.

[2] Office for National Statistics, *Population estimates for the UK, England and Wales, Scotland and Northern Ireland mid 2020* (25 June 2021).

[3] Office for National Statistics, *Employment Rate 65+ people. Dataset: Labour Market Statistics Time Series (LMS)* (ONS 17 August 2021).

[4] 'Oldest Marathon Runner Fauja Singh's Final Race' (*BBC News*, 24 February 2013).

of society. With longer life expectancies, they may have a very different experience of old age than their forebears.

This diversity of experience and wellbeing poses some practical difficulties for the law. Unlike the clear child-adult dividing line of an 18th birthday, there is no age at which we render an older person subject to a set of laws that disable him or her from full participation in society. Accordingly, while some laws may be particularly helpful or relevant to older people, such as the Care Act 2014, there is no older person equivalent of the Children Act 1989 which provides a unified package of laws applicable to a particular demographic. Instead, a number of different pieces of legislation may be relevant, or partly relevant.

When considering the legislation in this chapter, therefore, do not fall into the trap of thinking that it is well designed for all older people. It may be what some of them need or want or choose, but not others. In particular, while some older people will need protection, we cannot assume that all do so. We should be aware that being old is used as a proxy for being incapable, for having certain viewpoints, and certain limitations, physical or mental, and certain wishes. We imbue discussions of age with assumptions about what a person can do or what they need. After all, it is easier for policy-makers to formulate policies or take measures by reference to demographic groups or characteristics. To some extent, this chapter, by drawing on statistics about the lives of older people, falls into the same trap of generalising about them. As you read this chapter, question some of the assumptions underlying the law and social policy as it relates to older people.

We will look first at those older people who lack the capacity to make their own decisions, or who need support to do so, before turning to consider what services older people may receive when they are in need.

13.2 The Court of Protection

The Court of Protection makes decisions about the best interests of adults who lack the capacity to make a particular financial or health/welfare decision for themselves. Much of its work therefore involves those who have lost capacity due to age or age-related conditions, but the Court deals with incapacitated adults of all ages. The definition of mental capacity is discussed in section 13.2.3 of this chapter.

Although the Court of Protection in its current form was established by the Mental Capacity Act 2005, the power of the monarch and later the courts to protect incapacitous adults has existed in one form or another since the statute De Prerogativa Regis [literally, 'the King's prerogative'] in or around 1324.[5] That Act provided that where a person should become what the law then called a lunatic, his property was to be safeguarded and used for his maintenance during the period of incapacity.[6] It is part of the same *parens patriae* jurisdiction that we discuss in relation to children in the focus: know-how box 'What is the Inherent Jurisdiction and Wardship?' in Chapter 9. As Blackstone wrote:

> But under the general name of *non compos mentis* (which Sir Edward Coke says is the most legal name) are comprised not only lunatics, but persons under frenzies; or who lose their intellects by disease; those that grow deaf, dumb, and blind, not being born so; or such, in short, as are by any means rendered incapable of conducting their own affairs. To these also, as well as idiots, the king is guardian, but to a very different purpose. For the law always imagines that these accidental misfortunes may be removed; and therefore only constitutes the crown a trustee for the unfortunate persons, to protect their property, and to account to them for all profits received, if they recover, or after their decease to their representatives. And therefore it is declared by the statute 17 Edw. II. c. 10 [the De Prerogativa Regis] that the king shall provide for the custody and sustentation of lunatics, and preserve their lands and the profits of them, for their use, when they come to their right mind: and the king shall take nothing to his own use; and if the parties die in such estate, the residue shall be distributed …to their executors or administrators.[7]

In the nineteenth century, a formal 'lunacy' court centralised what had previously developed from the King's prerogative into a system of local magistrate governance of the incapacitous. Juries determined whether someone was a lunatic before 1853; if they were, the Lord Chancellor was given increasing statutory powers to administer their assets. Stebbings has written that 'The utmost care and conservatism characterised the dealings of the Lunacy Court, since it was guided by the principle that if the patient recovered, he would find his estate exactly as it was before he became insane.'[8] The term 'lunacy' fell out of favour in the early twentieth century, and in 1947 the term Court of Protection was adopted to better avoid the stigma of

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[5] 17 Edward 2 c.9.

[6] C Stebbings, 'Protecting the Property of the Mentally Ill: The Judicial Solution in Nineteenth Century Lunacy Law' (2012) 71(2) *Cambridge Law Journal* 384.

[7] Blackstone's *Commentaries on the Laws of England 1765-1769*, Book One, Chapter 8: Of the King's Revenue: Branch 18.

[8] C Stebbings, 'Protecting the Property of the Mentally Ill: The Judicial Solution in Nineteenth Century Lunacy Law' (2012) 71(2) *Cambridge Law Journal* 384, 392.

lunacy and reflect the wide range of reasons (mental illness, age, frailty, physical illness, susceptibility to pressure by others) by which a person my become incapacitated. However, there was no legal power at all to decide whether particular medical treatment, or the cessation of medical treatment, was in P's best interests, and thus courts could only make declarations that a proposed act was lawful by virtue of the doctrine of necessity.[9] This was obviously unsatisfactory,[10] and so began a process of reform which culminated in the Mental Capacity Act 2005. Some elements of the inherent jurisdiction remain,[11] but most of the work of the Court of Protection is now governed by the statutory powers contained in this Act.

These powers better reflect the type of work now coming before the Court. Weston notes that over the course of the twentieth century the nature of the Court of Protection's work changed, so that 'the typical case … changed from one concerning a very wealthy, middle-aged individual detained as a person of unsound mind and diagnosed with mania or delusions, to an older person of unremarkable means, suffering from dementia and cared for at home or in a nursing facility.'[12] Although medical treatment cases are often the most high profile – especially when they concern incapacitous younger people - they account for a relatively small proportion of the Court's work. Lucy Series and colleagues found that 'the most common cases heard under the [Court's] welfare jurisdiction today concern: where a person should live; how they should be cared for; and questions about relationships such as whether contact with particular individuals should be restricted, and whether a person has the mental capacity to consent to sex or marriage.'[13]

The Court undertakes a number of different functions:

1. It appoints deputies to make decisions about the health and welfare and/or property and financial affairs of someone who lacks mental capacity, and deals with disputes about these things.

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[9] *Re F (Mental Patient: Sterilisation)* [1991] UKHL 1.

[10] See Law Commission, *Mentally Incapacitated Adults and Decision-Making: An Overview* (Law Com No 119, 1991) and its successors Law Com Nos 128, 129, and 130.

[11] *Re PS* [2007] EWHC 623 (Fam).

[12] J Weston, 'Managing Mental Incapacity in the 20th Century: A History of the Court of Protection of England & Wales' (2020) 68 *International Journal of Law and Psychiatry* 101524.

[13] L Series, P Fennell, J Doughty, and A Mercer, *Welfare Cases in the Court of Protection: A Statistical Overview* (Cardiff University 2017).

2. It hears applications for Statutory Wills (a Will for a person who has lost the capacity to make a Will) or to enable an incapacitous person to make a gift, and deals with disputes about these things.
3. It hears applications under the Mental Capacity Act 2005 to determine whether a person lacks the mental capacity to make their own decisions, and if so, what is in the person's best interests. It may make decisions about any aspect of the person's life, such as where they should live and what medical treatment they should receive.

We will consider each of these functions in turn.

13.2.1 Lasting powers of attorney and deputyships

A lasting power of attorney (LPA) enables a person with capacity - we will call him P, as this is the term used in the Court of Protection – to appoint one or more other people to make certain decisions for him if and when he loses the ability to make those decisions for himself.

There are two kinds of LPA. A property and financial affairs LPA appoints someone to manage P's finances. This could be a friend, relative, or someone with professional expertise such as a solicitor. More than one person can be appointed and the LPA will set out whether they must agree or whether they can each act independently. A health and welfare LPA appoints someone to make decisions about P's health and wellbeing, including potentially where they live and whether life-sustaining treatment should be withdrawn. (The scope of the powers will be set out in the document and the donor can include restrictions on the powers granted: s9(4)(b).) An LPA must be made by P while he or she still has capacity to do so, and filed with the Office of the Public Guardian. It comes into effect once P loses the capacity to manage their own money and/or health, when it must also be registered with the Court of Protection.

Before lasting powers of attorney, there were enduring powers of attorney under the Enduring Powers of Attorney Act 1985, in relation to property and financial affairs only. Some people may still have these, but it has not been possible to make a new one since October 2007.

If a person has already lost capacity, it is not possible to make an LPA. Instead, someone will need to apply to the Court of Protection to be appointed as a deputy. As decisions in the Court are based on what is in P's best interests, a deputy will only be appointed if in P's interests. It is obviously easier and cheaper that P makes an LPA rather than a court application for deputyship becoming necessary. It will also ensure – because P makes the appointment – that the attorneys are P's choice and that they make only types of decision that P wants them to be able to make.

The Office of the Public Guardian records lasting powers of attorney and maintains a list of Court appointed deputies. It is responsible for taking action if there are concerns about the actions of an attorney or deputy. This is because such role holders owe a number of fiduciary duties which are set out in the Mental Capacity Act Code of Practice.[14] Most notably, they must act in P's best interests. They cannot, for example, use P's money for their own benefit and must keep P's money separate to their own and account for any expenditure of P's money (although there is limited scope under s12 for P to make a gift to the attorneys). If they breach their duties, the Court of Protection has the power under s22 to remove them as attorney or deputy, and recover any improper expenditure. In *Public Guardian v DA and Others* (also known as *Re OL*), for example, two of OL's children were appointed as her attorneys.[15] Within six months, they had reduced her assets from £730,000 to having only £7,000 in her bank account and an interest of £86,000 in a house. The remainder had been utilised by her children for their own ends. They had taken 'colossal advantage' of their position.[16] The professional deputy appointed in their stead would have the job of recovering this money.

13.2.2 Statutory Wills

A Statutory Will is one made on behalf of someone who lacks the capacity to make their own Will. There are several reasons why a Statutory Will may be advisable. It may enable the estate to reduce its inheritance tax liability through careful planning. Sometimes an intended beneficiary has already died, or a specific legacy mentioned in the Will has already been sold or given to someone else, so that an alternative gift is desired.

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[14] Department for Constitutional Affairs, *Mental Capacity Act 2005 Code of Practice* (2007, rev 2020). Available at https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice Accessed 12 December 2021.

[15] [2015] EWCOP 41.

[16] At para [34] (Senior Judge Lush).

Statutory Wills and testamentary capacity are discussed in Chapter 5, along with claims under the Inheritance (Provision for Family and Dependants) Act 1975.

13.2.3 The Mental Capacity Act 2005

The determination of whether or not an adult has the capacity to make their own decisions is governed by the Mental Capacity Act 2005. A person may lack the mental capacity to make a decision 'if at the material time' he is unable to do so 'because of an impairment of, or a disturbance in the functioning of, the mind or brain' (s2).

Such impairment may be temporary or permanent. In the case of an older person, it may well be the result of dementia, for example, which is progressive and thus permanent. One study estimates that the number of people with dementia in the UK will increase from 885,000 in 2019 to around 1.6 million by 2040.[17]

There are five governing principles in the Act, which are set out in s1.

S1 Mental Capacity Act 2005

The principles

(1) The following principles apply for the purposes of this Act.

(2) A person must be assumed to have capacity unless it is established that he lacks capacity.

(3) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

(4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

(5) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.

(6) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

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[17] R Wittenberg, B Hu, L Barraza-Araiza, and A Rehill, *Projections of Older People with Dementia and Costs of Dementia Care in the United Kingdom, 2019–2040* (LSE Care Policy and Evaluation Centre 2019).

Presumption of capacity and supported decision-making

The Act starts from the premise that a person has the mental capacity to make a particular decision unless and until it is shown that he does not have the capacity. At any given time, he may have capacity for some simple decisions, but not capacity for more complex decisions. Having capacity to make a decision means that he has the ability to:

(a) understand the information relevant to the decision,

(b) to retain that information,

(c) to use or weigh that information as part of the process of making the decision, and

(d) to communicate his decision (whether by talking, using sign language or any other means).[18]

Although slightly different to the *Gillick* competence that we discussed in Chapter 9, it is a very similar concept.[19] It was a significant change from previous legislation and approaches to incapacity, which were not decision-specific: either P had capacity for anything, or capacity for nothing. A decision-specific approach empowers P to make such decisions as he can. (The flip side of this is that it creates uncertainty about 'which decisions, and when, require formal legal safeguards or even judicial approval.'[20])

P is not to be treated as unable to make a decision 'unless all practicable steps to help him to do so have been taken without success'. This emphasises the need to explain and facilitate P's understanding of the issues: he may be able to make decisions with appropriate support (known as 'supported decision-making').

Supported decision-making involves the provision of information to P in a way that is tailored to P's needs. For example, the information might be broken down into several parts and presented to P using simple language, assistive technology, or other communication tools such as videos. It might involve writing lists of pros and cons of a different step, or arranging for P to receive expert advice about those things. It might be as simple as taking additional time to

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[18] Section 3.

[19] See discussion of the differences in *X v An NHS Trust* [2021] EWHC 65 (Fam).

[20] Baker LJ et al., *Court of Protection Practice* (Jordan Publishing 2021) at [1.61].

answer P's questions or concerns, or providing the information in a location in which P is most comfortable and able to concentrate.[21]

The fact that P may subsequently make an unwise or foolish decision does not mean P lacks capacity: part of having capacity is being able to exercise the freedom to make one's own decisions even if some, perhaps most, others think the decision is bad or would weigh the relevant considerations differently.[22]

Where P lacks capacity

Where P lacks the capacity even with support, it will be necessary for decisions to be made by someone else. This is called 'substitute decision-making'. Irrespective of who is making the substitute decision, where P lacks capacity, any act or decision done pursuant to the Act must be in his best interests. You will be familiar with this concept from the Children Act 1989's welfare principle.

Section 4 of the Act sets out a list of factors that the substitute decision-maker or the Court of Protection must take into account in determining what is in P's interests. These include P's 'past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity), the beliefs and values that would be likely to influence his decision if he had capacity, and the other factors that he would be likely to consider if he were able to do so'. Ascertaining these may require the use of some of the tools mentioned above in the context of supported decision-taking, except here they are used for the purpose of ascertaining what P would want to decide if he had the capacity to do so.

In *Wye Valley NHS Trust v B* Peter Jackson J notes that

> once incapacity is established so that a best interests decision must be made, there is no theoretical limit to the weight or lack of weight that should be given to the person's wishes and feelings, beliefs and values. In some cases, the conclusion will be that little weight or no weight can be given; in others, very significant weight will be due.
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> This is not an academic issue, but a necessary protection for the rights of people with disabilities. As the Act and the European Convention make clear, a conclusion that a person

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[21] J Stavert, *Supported Decision-Making Good Practice Guide 2021* (Mental Health Commission for Scotland 2021). This refers to Scottish law rather than that of England and Wales, but the explanation and examples are useful.

[22] But see 13.6.1 for discussion of the use of the inherent jurisdiction in cases of abuse against capacitous adults and the human rights implications.

> lacks decision-making capacity is not an *"off-switch"* for his rights and freedoms. To state the obvious, the wishes and feelings, beliefs and values of people with a mental disability are as important to them as they are to anyone else, and may even be more important. It would therefore be wrong in principle to apply any automatic discount to their point of view.[23]

In *Wye* itself, P's wishes were so important that the judge decided that acting contrary to them would not be in P's best interests. However, in many other cases, P's wishes will be one aspect of his best interests but will not determine the outcome.

Key Case: *Wye Valley NHS Trust v B* [2015] EWCOP 60

Mr B was 73 years old and had a severely infected leg, a complication of diabetes. Without a foot amputation, he would die in a matter of days. As a result of a mental disorder, Mr B lacked capacity to make decisions about his medical treatment. However, he firmly opposed amputation and said he was not afraid of dying. In his judgment Peter Jackson J lists the pros and cons of declaring that it would be lawful to amputate Mr B's foot. In deciding that it was not in Mr B's interests to amputate, and that therefore it would not be lawful to do so, the judge considers Mr B's wishes and feelings, his beliefs and values:

> Mr B has had a hard life. Through no fault of his own, he has suffered in his mental health for half a century. He is a sociable man who has experienced repeated losses so that he has become isolated. He has no next of kin. No one has ever visited him in hospital and no one ever will. Yet he is a proud man who sees no reason to prefer the views of others to his own. His religious beliefs are deeply meaningful to him and do not deserve to be described as delusions: they are his faith and they are an intrinsic part of who he is. I would not define Mr B by reference to his mental illness or his religious beliefs. Rather, his core quality is his *"fierce independence"*, and it is this that is now, as he sees it, under attack.

> > Mr B is on any view in the later stages of his life. His fortitude in the face of death, however he has come by it, would be the envy of many people in better mental health. He has gained the respect of those who are currently nursing him.
> >
> > I am quite sure that it would not be in Mr B's best interests to take away his little remaining independence and dignity in order to replace it with a future for which he

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[23] [2015] EWCOP 60

> understandably has no appetite and which could only be achieved after a traumatic and uncertain struggle that he and no one else would have to endure. There is a difference between fighting on someone's behalf and just fighting them. Enforcing treatment in this case would surely be the latter.

Although Mr B did not have family or friends around him, the Mental Capacity Act says that the decision-maker should also take into account the views of those who are involved in P's life as to what would be in P's best interests, which may be different to what they would want for themselves.

Section 4 emphasises that what is in P's best interests cannot be decided 'merely on the basis of (a) the person's age or appearance, or (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests.' It would be wrong, for example, to assume that a very elderly P would decline medical treatment because of his advanced age, and equally wrong to assume that he would want treatment because most other people with that condition do. P must be treated as an individual, not as a stereotype, or a passive object of concern. In *Aintree University Hospitals NHS Trust v James*, Baroness Hale noted that while every case is different,

> in considering the best interests of this particular patient at this particular time, decision makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be; and they must consult others who are looking after him or are interested in his welfare, in particular for their view of what his attitude would be.[24]

The approach to best interests is therefore holistic. We can see the difference between medical best interests (narrow) and holistic best interests (looking at medical best interests *and* all of the other aspects of a person's interests such as social and autonomy interests) by considering the case of *SS v London Borough of Richmond Upon Thames and South West London Clinical Commissioning Group*.

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[24] [2013] UKSC 67 at [39].

Key Case: ***SS v London Borough of Richmond Upon Thames and South West London Clinical Commissioning Group*** **[2021] EWCOP 31**

This recent case is given as an example of the work of the Court of Protection rather than as a case that establishes precedent. Hayden J's judgment opens with this poignant description of SS's life and present situation:

1. 'The Court is concerned with SS, an 86-year-old woman currently residing in a care home. … SS has a diagnosis of dementia, and is objecting to her placement in the Care Home, believing that she still lives with her (long deceased) parents, and needs to return to their home and resume working at the job she held in her youth. She has no recollection of the property she owns, or of the majority of her life-story. I have been told that SS is a woman who has never married, does not have children and has no history of personal relationships. She lived with her parents for much of her life.

2. For a long time, she worked for the Lyons cake factory in Chiswick, as a secretary. At 4pm, every afternoon she grabs her handbag and jacket and prepares to return to her parents' home, believing that she is still at work. A member of the care staff discovered that at the Lyons factory a siren sounded at 4pm signalling home time. Her carers consider that in her own mind SS is living at some point in the late 1940's or early 1950's. When SS grabs her handbag and jacket the care staff deal with her gently and sensitively. Almost as soon as she leaves the care home, she becomes overwhelmed by the outside world. This is before she gets to the end of the garden.'

The issue before the court was whether SS should receive the COVID-19 vaccine (she was resistant to medical treatments of other kinds) and where she should live.

The expert consultant psychiatrist instructed to advise the court on whether SS had capacity reported that

> 'SS was able to understand the information provided, but unable to retain, use and weigh up this information. The information in relation to her care and accommodation needs was repeated in order to support SS to retain and use the information. However, SS was unable to repeat any of the salient aspects of the information discussed. I explored SS's views about where she wished to live. She explained that she was living in her own home and was visiting. I explained to SS that she was receiving support

> within a care environment. SS did not appear to retain this information. She did not use it as part of a decision-making process.'

You can see here that the psychiatrist is considering the criteria in s3 of the Act – that in order to have capacity SS needed to be able to understand, retain, and use or weight information relevant to her decision about where to live, and she could not do these things. In respect of the vaccination, she was equally incapacitous. However, she had consistently expressed strong opposition to vaccination in the past even though she had sought other forms of medical care through her life. Hayden J found that if she had been capacitous she would have chosen to refuse the vaccine as she had done with flu vaccines in recent years.

P had no close relatives. The testimony of her carers was that trying to vaccinate her against her will would require physical restraint or sedation. That would destroy her trust in her carers, which had been built up with difficulty and would be distressing. One suggestion was to persuade SS that her father wanted her to be vaccinated, as she (wrongly) believed that her father was still alive. The judge described this as 'disrespectful to her, not merely as the woman she once was but to the one she is now. Though undoubtedly a well-intentioned suggestion, it risks compromising her dignity and suborning her autonomy. It cannot, in my judgement, be in her best interests.'

Hayden J held that while it was in SS's medical best interests to have the vaccine because of the risk to her living in a care home, it was not in her best interests overall when considering non-medical factors too.

Many Court of Protection hearings are open to the public and can be observed online. This hearing was observed by a member of the public interested in the Court's work as part of the Open Court of Protection project, which encourages greater understanding of the work of the Court. You can find a blog post explaining this decision at: https://openjusticecourtofprotection.org/2021/05/04/why-covid-vaccination-is-not-in-this-care-home-residents-best-interests/ If you are interested in the work of the Court, why not join the project yourself?

The general defence

Although the Court of Protection, a deputy, or the donee of a lasting power of attorney may make decisions for P, the reality is that most substitute decision-makers will not have been appointed in any formal way at all. For example, an older person who is concussed after a fall may have no substitute decision-maker and may be unable to consent for themselves; nevertheless, doctors will need to provide emergency treatment in that person's best interests. The Act therefore provides what is known as a 'general defence' which is found in s5. It says that a person will not incur any liability where they provide care or treatment to another person if they have taken reasonable steps to establish whether P lacks capacity in relation to the matter in question and reasonably believe that P lacks capacity and that the act is in P's best interests. This enables a wide range of different people providing assistance to P to act in his best interests without committing a criminal offence such as assault. The *Mental Capacity Act Code of Practice* suggests that s5 is most likely to protect carers, including family carers and care workers; healthcare and social care staff; ambulance staff; housing workers; the police; and volunteer support workers, all people who may need to make urgent decisions about P's welfare.[25] However, note the requirements. Not only must the decision be in P's interests, but the person must have taken reasonable steps to establish whether P lacks capacity within the meaning of the Act, i.e., whether they have an 'impairment of, or a disturbance in the functioning of, the mind or brain' that renders them presently unable to make the decision (s2); and they must have a 'reasonable belief' that P does in fact lack capacity for that decision. Only when these requirements are satisfied does s5 provide a defence.

The final principle in s1 is that when considering any step that restricts P's rights or freedoms, it is necessary to ask whether there a less restrictive way of achieving his best interests. For example, this may involve attempts to provide P with support and information that will enable him to make his own decision about medical treatment rather than compelling him using force or sedation.

Scenario 2

Illustration 1: Harry

Harry is aged 78 and has dementia which has progressed sufficiently that there are concerns about his capacity to manage his own affairs and to live independently. Support should be

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[25] Department for Constitutional Affairs, *Mental Capacity Act 2005 Code of Practice* (2007, rev 2020) at para 6.20. Available at https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice Accessed 12 December 2021.

offered to enable Harry to make as many decisions as he can. He may have executed as lasting power of attorney for his health and welfare and/or for his property and financial affairs, which would enable the attorney to make decisions on those matters on which Harry no longer has capacity.

There will be a point where Harry lacks the capacity to enter into a power of attorney, and in such situation the Court of Protection could appoint a deputy for him. Whether the decision about Harry is being made by an attorney, a deputy, or a judge of the Court of Protection, that person must act in his holistic best interests.

We now turn to consider when and how the law allows a person to be deprived of his liberty.

13.2.4 Deprivation of liberty

Sometimes, it is in P's best interests to be deprived of his liberty. This is of course an enormous infringement upon his human rights.

In 2007, as a result of the case of *HL v United Kingdom* in the European Court of Human Rights, the Mental Health Act 2007 established safeguards for those people deprived of their liberty in care homes or hospitals. These are known as the Deprivation of Liberty Safeguards, or DOLS, and were inserted into the Mental Capacity Act 2005. They enable P to be deprived of his liberty in a care home or hospital as long as certain criteria are satisfied. Where P is not in either place, any deprivation of his liberty must instead be authorised by the Court of Protection.

Key Case: *HL v United Kingdom* (Application no. 45508/99) judgment 5 October 2004 [26]

HL was severely autistic and 'frequently agitated'. Following self-harming behaviour at a day centre, he was admitted to hospital and remained there for 5 months. He complied with treatment and was not formally detained under the Mental Health Act 1983, but nor would the hospital release him to his carers or let him see them in case he wanted to go home with them.

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[26] In the domestic courts this case was known as *R v Bournewood Community and Mental Health NHS Trust, ex parte L*; see [1999] AC 458 in the HL and [1998] 2 WLR 764 in the CA; the HC judgment appears to be unreported. The Lords found that HL had been detained but applied the common law defence of necessity.

The European Court of Human Rights held that HL had been deprived of his liberty unlawfully. Because he was an 'informal patient' he was not able to use the protections offered by the Mental Health Act 1983, which provided a way to challenge his retention. Article 5 ECHR provides that 'Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.' The availability of judicial review, declarations as to necessity, and the possibility of filing a writ of habeas corpus were insufficient to satisfy the requirements of Article 5. A revised more accessible way of challenging detention was needed.

Applications where P is resident in a care home or hospital

In order to deprive P of his liberty, the care home or hospital must seek authorisation for this from the local authority, which determines whether the following conditions are met:

- P is an adult (Sch A1 para 13) and suffering from a mental disorder within the meaning of the Mental Health Act 1983 or has a learning disability but not displaying seriously irresponsible conduct or abnormally aggressive behaviour and thus would not fall within the Mental Health Act (Sch A1 para 14).
- Restrictions are proposed for P's care and treatment.
- P lacks capacity to decide to decide whether or not he should be accommodated in the relevant hospital or care home for the purpose of being given care or treatment (Sch A1 para 15).
- The restrictions would deprive P of his liberty.
- The restrictions are in P's best interests, meaning that it is in his interests to be detained; it is necessary to prevent him being harmed; and it is a proportionate response to the likelihood and seriousness of that harm (Sch A1 para 16).
- There is no valid advance decision to refuse treatment or decision by a welfare deputy or someone appointed under a health and welfare lasting power of attorney (Sch A1 paras 18-20).

- P does not meet the criteria for being detained under the Mental Health Act 1983. If he does, he cannot be deprived of his liberty under the Mental Capacity Act as the 1983 Act prevails.[27]

All of these conditions must be met in order for P to awfully be deprived of his liberty, and the authorisation can last for up to one year. There is an urgent authorisation process too.

If authorisation is given, then a relevant person's representative is appointed to protect P's interests. This is often a family member. P or his representative can require the authorisation to be reviewed by the local authority (Sch A1 Part 10) or challenge the authorisation in the Court of Protection at any time (as can any other person with leave). Where the relevant person's representative is unpaid, such as a family member or friend, then an independent mental capacity advocate is available to help them.

Applications where P is resident elsewhere

As DOLS only applies to care homes and hospitals, where P is being detained elsewhere, an application must be made to the Court of Protection. The Court can authorise deprivation of liberty under ss4, 4A and 16 Mental Capacity Act. As with DOLS, is the person is eligible to be detained under the Mental Health Act that should be used instead.

What is a deprivation of liberty?

There are two elements to depriving someone of their liberty, and these were set out in the Key Case of *Cheshire West*:

1. Is the person subject to continuous supervision and control? and
2. Is the person free to leave?

If the answer to the first question is yes, and the second question no, the person is deprived of their liberty.[28]

Key Case: *P v Cheshire West and Chester Council; P and Q v Surrey County Council* [2014] UKSC 19

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[27] *J v Foundation Trust* [2009] EWHC 2972 (Fam).

[28] There may be some situations in which one but not the other is satisfied, but there is still a deprivation, such as if someone was able to move freely about a house but not leave it. Lady Hale mentions the possibility at para [49] of her speech in *Cheshire West*. However, government guidance treats both together as essential.

These were two cases joined on appeal and generally known as ‘Cheshire West’. In both cases, the issue was whether the person was being deprived of their liberty by measures taken to protect them.

In the first case, P had cerebral palsy and Down syndrome and lacked capacity to decide his own care. He lived in a bungalow which he shared with other residents and staff. He sometimes put his incontinence pads in his mouth and when he did so the carers used their fingers in his mouth to remove bits of the pad. To prevent him getting to his pads he was dressed in a onesie.

In the second case, two sisters with learning difficulties lacked the capacity to consent to their care. The first sister, P, lived with a foster carer who would have prevented her from leaving home if she tried to do so, because P could not cross roads safely. The second sister, Q, lived in a specialist home and would also have been prevented from leaving because she required constant supervision. Neither sister actually wanted to leave home.

The Supreme Court held that:

The term deprivation of liberty has the same meaning in this context as in Article 5 ECHR.

The ‘acid test’ [para 54] to be applied was whether the person was under continuous supervision and control and was not free to leave. This applied even if the purpose of the restriction was benevolent, and it applied not only to hospitals and care homes but also to deprivations authorised by court order, or in environments that were relatively normal for someone with the same type of disability, and applied irrespective of whether P objected.

It does not matter if they are being treated the same as others with the same disabilities. Per Lady Hale at [46]:

> But, as it seems to me, what it means to be deprived of liberty must be the same for everyone, whether or not they have physical or mental disabilities. If it would be a deprivation of my liberty to be obliged to live in a particular place, subject to constant monitoring and control, only allowed out with close supervision, and unable to move away without permission even if such an opportunity became available, then it must also be a deprivation of the liberty of a disabled person. The fact that my living arrangements are comfortable, and indeed make my life as enjoyable as it could possibly be, should make no difference. A gilded cage is still a cage.

In the first case, P was deprived of his liberty by the continuous supervision and control of him, including by restraint or by forcibly clearing out his mouth, and by the fact he was unable to go anywhere without his carers' sanction. Even though sisters P and Q liked their accommodation and did not wish to leave, they were deprived of their liberty.

The applicants in *Cheshire West* were happy in settings that to many extents mirrored living at home and which were considered to be environments that were very much in their best interests. Prior to *Cheshire West* it was not thought that such people were, in fact, being unlawfully detained. This meant that there were relatively few applications to the Court of Protection. But, as Gomersall writes, *Cheshire West*'s 'emphasis on supervision, monitoring and control encompasses the care arrangements for a vast array of service users living in their own homes, or in supported living accommodation'.[29] In holding that the subjects of the *Cheshire West* decision were being deprived of their liberty in circumstances that had not previously been considered as such, the Supreme Court decision had an immediate and significant effect on the number of Court of Protection applications that had to be made to enable local authorities and other care organisations to lawfully continue what they had unlawfully been doing. You can see the *Cheshire West* effect in Figure 13.1 below, which shows the number per quarter-year. There are now just under 5,000 deprivation of liberty applications made each year.

Figure 13.1 Deprivation of Liberty applications and orders, January to March 2008 to January to March 2021

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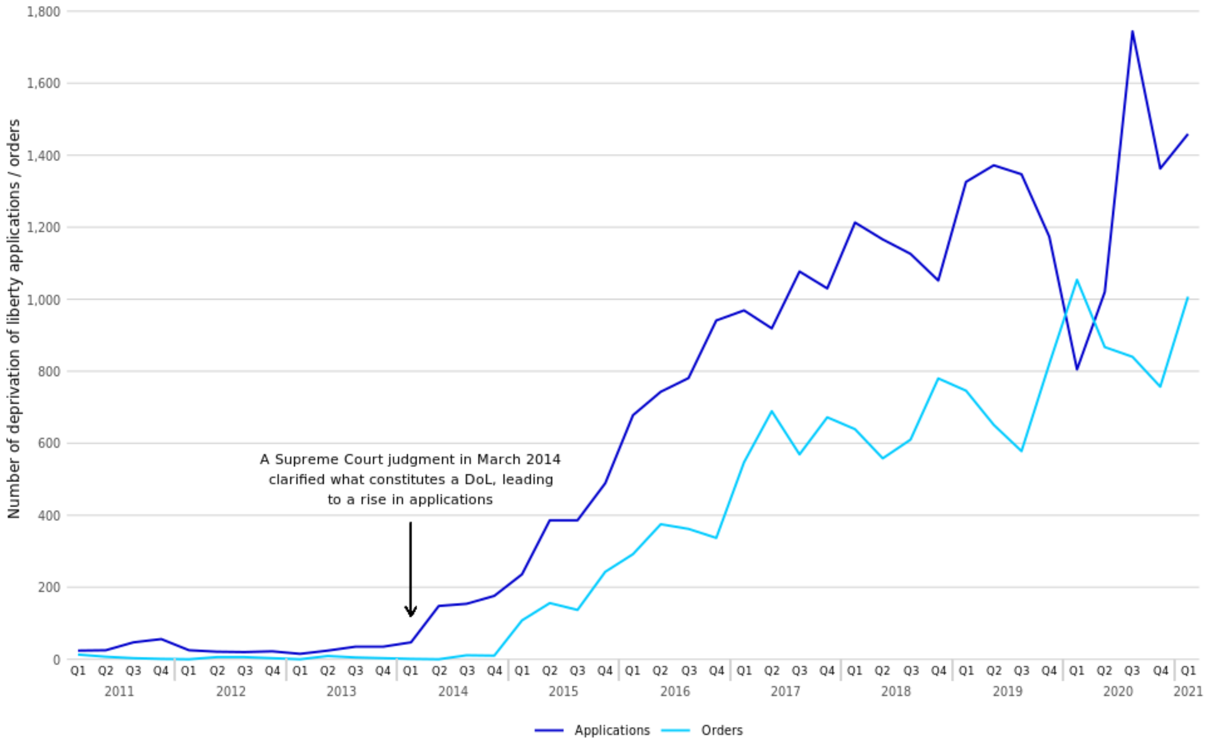
[29] H Gomersall, 'Deprivation of Liberty in the Home: The End of the "Fairytale"?' (2015) 45 (April) *Family Law* 437.



Source: © Crown copyright. Ministry of Justice, Family Court Statistics Quarterly: January to March 2021 (24 June 2021).

Cheshire West also increased the number of DOLS authorisation requests to local authorities, as those involved with a person’s care in a hospital or care home realised that the supervision or boundaries they were imposing amounted to a deprivation of liberty.

Referrals to local authorities peaked at around 13,000 in 2013/14 and then in 2014/15 [after *Cheshire West*] spiked beyond anyone's expectations to 137,540’.[30] This was not a one-off blip, as the number of applications has continued to rise and now amounts to about 256,610 applications per year.[31] The vast majority of DOLS authorisations are in respect of those aged 75 or above.[32]

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[30] L Currie, ‘Deprivation of Liberty Safeguards: A Personal Overview of the Safeguards Post Cheshire West’ (2016) 6(2) *Elder Law Journal* 181.

[31] NHS Digital, *Mental Capacity Act 2005 Deprivation of Liberty Safeguards 2020-21* (9 August 2021). Note that one area, Hackney, could not supply statistics due to a cyber-attack. Available at https://digital.nhs.uk/data-and-information/publications/statistical/mental-capacity-act-2005-deprivation-of-liberty-safeguards-assessments/2020-21 Accessed 1 September 2021.

[32]

For the effect of the pandemic on the number of DOLS applications made, please turn to the focus box *Think Critically: Human rights in the time of Covid* at section 13.7 of this chapter.

Future changes to the law

The Mental Capacity (Amendment) Act 2019 which is due to come into force in April 2022 replaces DOLS with 'liberty protection safeguards'.[33] This provides a simpler system in which the criteria are that

- P is aged 16 or above (not 18 per DOLS)
- P has a mental disorder
- P lacks the capacity to consent to the care arrangements
- The arrangements are necessary to prevent harm to P and are proportionate to the likelihood and seriousness of that harm.

One important change is that the safeguards will apply not only in care homes and hospitals but in domestic settings such as the person's own home or supported living facilities too. As with DOLS, the authorisation can be challenged in the Court of Protection.

13.2.5 Advance decisions

An advanced decision is often referred to as a 'living will'. Section 24 Mental Capacity Act 2005 defines it as 'a decision made by a person ("P"), after he has reached 18 and when he has capacity to do so, that if (a) at a later time and in such circumstances as he may specify, a specified treatment is proposed to be carried out or continued by a person providing health care for him, and (b) at that time he lacks capacity to consent to the carrying out or continuation of the treatment, the specified treatment is not to be carried out or continued.' It therefore enables P to decide ahead of time to refuse specified treatment in the future. The decision cannot be used to force doctors to provide any treatment or take any positive step to euthanise P. It simply entitles P to refuse treatment. That refusal may or may not result in his death.

For example, P could decide, while he has capacity to make that decision, that he does not want to be resuscitated if his heart stops, or he does not want to receive nutrition or hydration. Note

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[33] As this is a developing area of law, you may wish to keep an eye on https://www.gov.uk/government/publications/liberty-protection-safeguards-factsheets for the latest information. Accessed 31 August 2021.

that an advance decision is only applicable to life-sustaining treatment if P has explicitly stated in a signed, witnessed document, that he wants it to apply even if his life is at risk.

If the advanced decision is valid, it is binding on doctors, on court-appointed deputies, and on attorneys acting under pre-existing health and welfare powers of attorney. This means that it must be followed even if everyone believes that is in P's best interests to have that treatment. However, the treatment must be specified, even if in lay person's non-medical language.

If P has appointed a health and welfare attorney *after* making the advance decision, the decision will not apply if P has authorised the attorney(s) to give or refuse consent to the treatment to which the advance decision relates; and it will not apply if there are reasonable grounds for believing that circumstances exist which P did not anticipate at the time of the advance decision and which would have affected his decision had he anticipated them, or if P has done anything clearly inconsistent with the advance decision remaining his fixed decision (s25). P can also withdraw the decision at any time while he has capacity. If he has capacity when the advance decision would be triggered it is not relevant at all - he can make the decision then and there.

The Mental Capacity Act protects a doctor or other person from criminal or civil liability for carrying out treatment if the doctor did not know that a valid advanced decision existed, and for refusing to carry out treatment in P's best interests if he reasonably believes that an advanced decision refusing that treatment exists. Advance decisions should therefore be recorded in medical notes or by another method visible to doctors such a card in P's wallet or purse or even a tattoo.

Note that the Court of Protection can make a declaration about whether an advance decision exists, is valid, and is applicable to the proposed treatment. However, if the decision is valid and applicable, it cannot overrule the decision, even if it thinks that it would be in P's interests to have the treatment.

An advance decision is not to be confused with an advance statement, which is an expression of your wishes about how you would wish to be cared for if you lost capacity.

13.3 Social care under the Care Act 2014

Our population is getting older, and that has particular implications for the costs and structure of elderly care.

Section 1 of the Care Act 2014 imposes a statutory duty on local authorities to promote the wellbeing of those people to whom the Act applies. This includes not only the person whose welfare is the concern, but also any carer that they have. Although in this chapter we are only considering older people, the Act applies to any adult of any age.

Wellbeing is defined in s1(2).

Statutory extract s1 Care Act 2014

(1) The general duty of a local authority, in exercising a function under this Part in the case of an individual, is to promote that individual's well-being.

(2) 'Well-being', in relation to an individual, means that individual's well-being so far as relating to any of the following:

> (a) personal dignity (including treatment of the individual with respect);
>
> (b) physical and mental health and emotional well-being;
>
> (c) protection from abuse and neglect;
>
> (d) control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided);
>
> (e) participation in work, education, training or recreation;
>
> (f) social and economic well-being;
>
> (g) domestic, family and personal relationships;
>
> (h) suitability of living accommodation;
>
> (i) the individual's contribution to society.

(3) ….

Local authorities have two main functions under the Act:

1. Assessing and meeting the needs of adult individuals in the local authority area whom the local authority has reason to believe need care and support, and their carers.

2. Provision of services, facilities, or resources that can be offered that might reduce the need for support for individuals and their carers.

This is a similar approach to that taken in the Children Act 1989 with its duties and powers imposed on local authorities in relation to children in need of services, which also include the power to offer services designed to prevent the need for greater intervention (see Chapter 11).

The range of activities undertaken by councils or commissioned by them are commonly known as adult social care. Elsewhere in this textbook we have concentrated on children's social care, but adult social care is also a large part of local authorities' work. Councils may provide care for individuals, such as personal care to help someone get washed, dressed, and fed; day centres and care homes; reablement services to help those who are temporarily disabled regain independence; home adaptations and support to help people remain in their own homes; and information and advice. In addition to services for people who are in need of care as a result of injury, disability, or age, they also provide services to carers. These services are available to adults of any age, provided that they meet the criteria set out in the Care Act 2014, but in this chapter we focus specifically on the types of services that might be helpful to older people, and the cost – to society and to the older person – of providing that help.

13.3.1 Provision of services

The Care Act requires local authorities to offer services, facilities or resources which have the purpose of preventing, delaying, or reducing the need for support for older people and for their carers. Although councils have obligations in respect of adult social care, most councils commission other organisations to actually provide these services on the council's behalf. Indeed, there is a statutory obligation on local authorities to 'promote an efficient and effective' market in services for care and support with a view to ensuring that people can choose from a variety of services and providers (s5). The council may place someone in a care home, but that home may actually be run by a profit-making company. Meals delivered to older people may be from a local catering firm. Care at home may be delivered by a local care agency.[34] A local taxi firm may transport people to day care centres or social groups run by local charities. You may want to look at your local council's website to see the full range of services they coordinate. It may include day centres or social groups for the elderly, on-call help for those who fall during the night but do not need medical care, equipment for people with reduced mobility, adaptations to the home, domestic help, meals on wheels, and help managing money

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[34] By way of an example, look at Norfolk County Council's directory of services at https://communitydirectory.norfolk.gov.uk/ Accessed 6 September 2021.

among other things. Local authorities must also provide information about care and support, including what type of care might be available, such as residential care.

13.3.2 Care needs assessments

Under s9 Care Act 2014, the local authority has a duty ('must assess') any individual that the local authority thinks may have needs for care and support. This is known as a needs assessment, and it will identify what needs a person has, how those needs affect their wellbeing, and the outcomes that they want to achieve in their day-to-day life.

The threshold for eligibility for an assessment is therefore low – it must simply appear to the local authority that a person 'may have needs', even if the local authority thinks that the needs may be low or the person could fund what is necessary to meet their own needs. A capacitous adult may refuse an assessment. Where an adult refuses an assessment but does not have the mental capacity to do so, then the local authority must still undertake the assessment if they think it is in the person's best interests or they are experiencing or at risk of abuse or neglect (s11).

The assessment will consider what outcomes the individual seeks in their daily life in order to promote their wellbeing. Where the assessment shows that the person does need care and support, the next stage is to consider three questions that comprise the eligibility criteria. If the answer to each question is 'yes', the person is eligible by virtue of s 18 to have their care needs met, subject to their financial means.

The eligibility questions are:

1. Does the individual have needs arising from a physical or mental impairment or illness? Only these needs are relevant.
2. Do these needs mean the person is unable to achieve two or more of the outcomes listed below?

    Managing and maintaining nutrition
    Maintaining personal hygiene
    Managing toilet needs
    Being appropriately clothed
    Being able to make use of their home safely
    Maintaining a habitable home environment
    Developing and maintaining family or other personal relationships

Accessing and engaging in work, training, education or volunteering

Making use of necessary facilities or services in the local community, including public transport

Carrying out any caring responsibilities for a child.[35]

Each one of these outcomes involves a number of smaller steps. For example, making use of facilities or services in the local community may require a person to be able to find out about services, contact those services, and be able to travel to them (which depends on money and what transportation is available). Personal nutrition may involve being able to shop for food, knowing how to prepare, and store food safely, how to use a cooker, and being able to eat (difficulties swallowing can affect some elderly people).

A person cannot meet an outcome if they cannot do these activities at all, whether or not they have help; or if they can do it but they would need help or reminders, or doing the activity causes them significant pain, distress, or anxiety, or endangers them or someone else, or it takes them significantly longer than would normally be expected.[36]

3. Is there a *significant impact* on the person's wellbeing as a result of this? Wellbeing is defined in s1(2) Care Act 2014 as shown in the statutory extracts box, and encompasses physical, mental, economic, social, and emotional wellbeing; personal safety; a need to see others and maintain personal relationships; having suitable housing; being treated with dignity; and being able to contribute to society or participate in work, education, training or recreation. This is a holistic view of what it is to be well, which includes the capacity to take part in society and to have control over their own daily life.

   In sub-section (3), the Care Act 2014 emphasises the importance of looking at the individual as an individual rather than a stereotype, by requiring local authorities to 'have regard to' such factors as the individual's own views, feelings, beliefs, and the Act cautions that decisions should not be based 'only on the individual's age or appearance or any condition of the individual's or aspect of the individual's behaviour which might lead others to make unjustified assumptions about the individual's well-being'; to remember that the individual is usually best placed to understand their own wellbeing needs and to participate in decisions about their care; and while safeguarding them from neglect and abuse to

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[35] The Care and Support (Eligibility Criteria) Regulations 2015 (SI 2015/313).

[36] The Care and Support (Eligibility Criteria) Regulations 2015 (SI 2015/313).

'ensure that any restriction on the individual's rights or freedom of action that is involved in the exercise of the function is kept to the minimum necessary'. This is not an exhaustive list, and we have not set it out in full.

The statutory guidance notes that

> the concept of meeting needs recognises that everyone's needs are different and personal to them. Local authorities must consider how to meet each person's specific needs rather than simply considering what service they will fit into… Local authorities should adopt a flexible approach that allows for a focus on which aspects of wellbeing matter most to the individual concerned.[37]

Some individuals may be more affected by lack of social interaction than others; some may prize autonomy more than others; and for others wellbeing may be tied up with their ability to work or volunteer.

Note that the person's inability to meet their own needs must not merely harm their wellbeing, but do so *significantly* in order to trigger the state's duties. This could be through a significant impact on one area of life, or it could be that multiple smaller things, taken together, reach the level of being significant.

13.3.3 Meeting assessed needs

If the person passes all three questions, then they are eligible to have their care needs met by the state, subject to an assessment of their financial position.

The needs that a person has might include:

- Meals being delivered ('meals on wheels')
- Moving into a care home or sheltered housing
- Equipment to help with a disability such as a walking frame
- Adaptations to make a home suitable for someone with limited mobility such as widening a doorway for a wheelchair to fit through, ramps, or stairlifts, or bathroom handrails

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[37] Department of Health and Social Care, *Care and Support Statutory Guidance* (April 2021) at paras 1.10-1.11.

- Safety equipment such as a pendant alarm, worn around the neck and able to be pressed by a person who has fallen, or movement sensors
- A personal carer to help with bathing, eating, taking medication, or housework
- Transportation to appointments or social activities
- Attending a day centre.

While the local authority has a legal duty to meet needs, this does not mean that the local authority will meet those needs for free. It will also undertake a financial assessment to determine how much the person's assessed needs would cost and how much the person should pay towards this. Unless they are arranging for the person to live in a care home, the assessment will not include the value of their main or only home. The local authority will provide each person with a personal budget which is the amount it will cost the local authority to meet the person's needs on top of what the person has to contribute themselves (if anything). Some services can be arranged directly by the elderly person, as it is possible to ask that the personal budget be paid directly to them (Some people may hire their own care workers or personal assistant, for example. This is known as direct payment and is part of a government policy to 'give recipients control over their own life by providing an alternative to social services provided by a local council', but does expose the person to a greater risk of financial abuse.[38]

There are some needs that local authorities must meet without any charge irrespective of financial means. Local authorities cannot charge for adaptions to a home that cost less than £1,000 each; equipment to help with daily living; and up to six weeks of immediate care to help someone recover or maintain their independence at home.

The provision of services is optional for the individual. A person cannot be compelled to use services if they have the mental capacity to decide about that for themselves.

Scenario 2

Illustration 2: Harry

Harry is aged 78 and has dementia. His son, who is caring for him, asks the local authority to assess Harry's needs, and his own needs as Harry's carer. The local authority determines that Harry needs support and that this arises from a physical or mental impairment or illness

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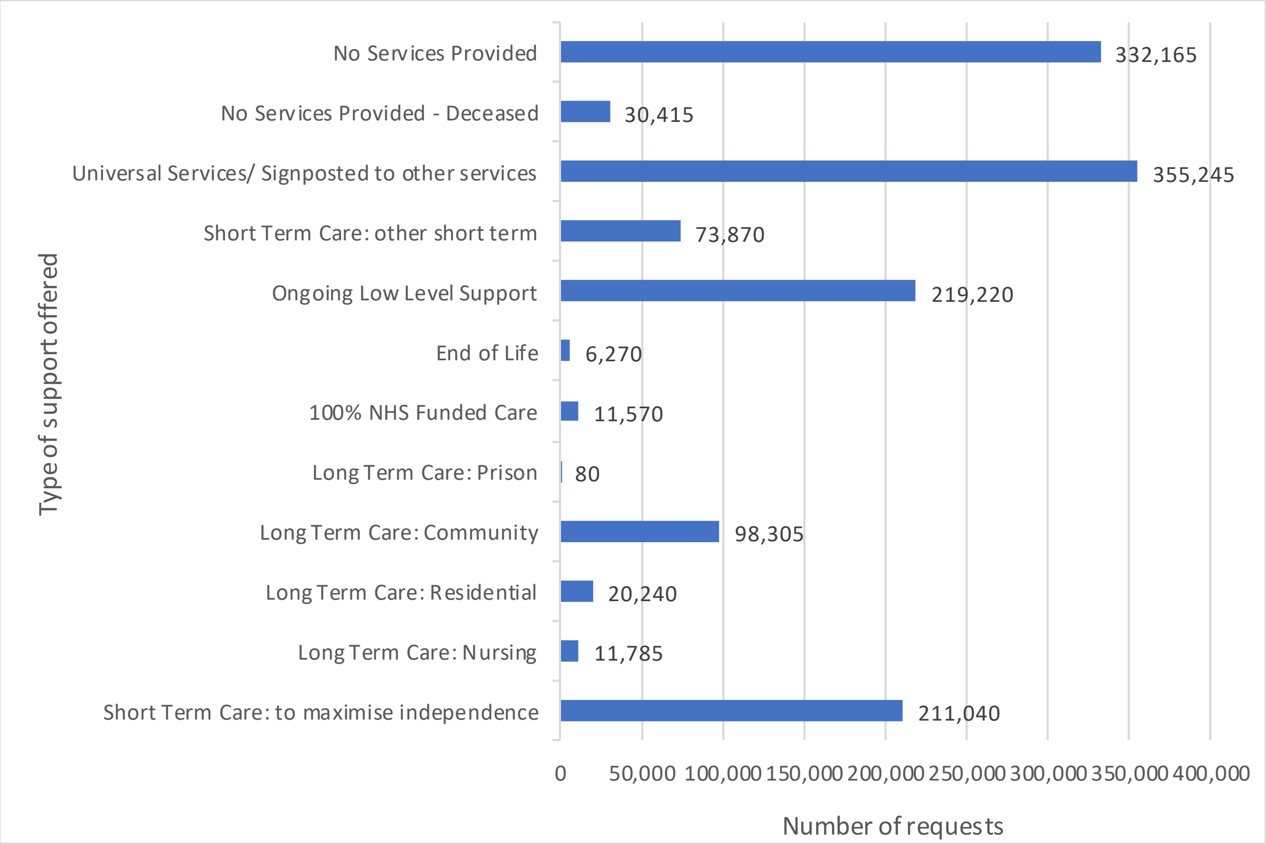
[38] Department of Health, *Direct Payments Guidance: Community Care, Services for Carers, and Children's Services (Direct Payments)* (2003).

(dementia) within the meaning of the Care Act 2014. Harry is not able to maintain his personal hygiene by showering, changing his clothes, or using the toilet unassisted, and he is starting to have falls. His son struggles to assist him with this because he cannot lift Harry safely. The local authority arranges some home care to help Harry and his son with household tasks and some respite care for the son (see 13.3.4 for the local authority's obligations towards carers). It directs them to a 'night owl' service it funds which is run by a local charity and staffed by volunteers who will help lift Harry if he falls or otherwise needs urgent help during the night.

In 2019/20 local authorities received 1,370,205 requests for support from those aged 65 or older. You can see what happens to these requests at Figure 13.2.

Figure 13.2 Types of support offered to those aged 65 or over in 2019/20



Source: NHS Digital, *Adult Social Care Activity and Finance Report, England 2019-20* reference data tables (2020).

13.3.4 Living in a care home

Residential accommodation may be part of the assessed needs and is therefore subject to a means test. Figure 13.3 sets out how the amount of capital that a person has affects what they have to pay towards their care. The state will pay all of the costs where someone has less than £14,250 in capital, although they may still have to contribute all of their income other than a personal expenses allowance, currently at least £24.90 per week. Above that, they will need to make a contribution. Where a person has capital in excess of £23,250 (£50,000 in Wales) they will be entirely self-funding: they will have to pay their own fees until they reduce it to a level where the state will meet all of the costs, although the person will still need to contribute potentially all of their income other than their personal expenses allowance. Given the costs of care, their capital may be used up very quickly, and it is possible that they may need to change care homes from somewhere privately funded to somewhere local authority funded (although most homes are a mix of privately funded and council-funded residents). The fact is that residential accommodation is very expensive. In 2020, the average cost of residential care was £34,944 per year without nursing care or £48,720 with nursing care.[39] Do not forget, though, that this is for 24-hour care, every day of the year, and for accommodation, laundry, entertainment/outings, food, and all the other things that go on in care homes.

Figure 13.3 Capital contribution to care costs

£0–£14,250	£14,205 – £23,250	Above £23,250
No capital contribution	Pays something towards care	Pays whole costs of care

The capital that a person has includes their share of the equity of their home, if they have own one.[40] There are exceptions to this, including where the home is occupied by a partner or minor child, or an older or disabled person, and local authorities must agree to defer payment until the person's death in some circumstances. The local authority must offer a deferred payment agreement to someone needing to live in a care home who has a legal or beneficial interest in

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[39] *Care Homes for Older People UK Market Report* (31st edn, LaingBuisson 2020).

[40] Cf where a person has needs which do not include residential care: in that situation the value of their only or main home is not taken into account. A good explanation of the rules is in B Sloan, '"Pension Freedoms", Social Care and Inheritance' in S Agnew, PS Davies and C Mitchell (eds), *Pensions: Law, Policy and Practice* (Hart 2020).

the property and has less than £23,250 in capital excluding the value of that person's share in the home. If a person gives away their assets (for example, to their children) they may still have to pay on the basis that they have deliberately deprived themselves of assets, although a life interest trust may be used to get around this.

Scenario 1

Illustration 1: Jean

Jean moves into a care home. She has capital assets (a home, a car, and some investments) totalling £300,000. This has been accumulated over a lifetime of work and raising children. She pays £34,000 per year to the care home (the national average for a non-council placement) for her care, accommodation, food, and living expenses. As her capital is above £23,250 no contribution is made by the local authority at all.

When she is down to her last £14,250 she keeps that money and the state pays the rest of her care. However, she gets £60 per week attendance allowance for a disability, and £177 per week state pension and she has to contribute all of this other than her personal allowance of £24.90. If she can live on that for her spending money, she will leave an inheritance of £14,250 to her children. It is however likely that she will need to use some or all of that money for things that make her life better.

The fact that the costs of care may require the older person to sell their home is controversial and something we discuss in section 13.5.

13.3.4 Elderly carers' needs

There are many people who care, 'unpaid, for a friend or family member who, due to a lifelong condition, illness, disability, serious injury, a mental health condition or an addiction, cannot cope without their support.'[41] These people are known as informal carers to distinguish them from those who are paid care workers.

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[41] HM Government, *Guidance for Those Who Provide Unpaid Care to Friends or Family* (23 August 2021). This definition is also used by the NHS and the Royal College of GPs.

The Care Act 2014 also covers the needs of informal carers, as long as they are providing someone with ‘necessary’ support and irrespective of whether the person being cared for is eligible to have their needs met under the legislation. Support is ‘necessary’ if the person being cared for requires support to carry out normal day-to-day activities.

A carer needs assessment will ask:

1. Does the carer's needs for support arise because they are providing necessary care to an adult?
2. As a result of their caring responsibilities, is it the case that:

   (a) the carer’s physical or mental health is, or is at risk of, deteriorating; or

   (b) the carer is unable to achieve any of the following outcomes:

      (i) carrying out any caring responsibilities the carer has for a child;

      (ii) providing care to other persons for whom the carer provides care;

      (iii) maintaining a habitable home environment in the carer’s home (whether or not this is also the home of the adult needing care);

      (iv) managing and maintaining nutrition;

      (v) developing and maintaining family or other personal relationships;

      (vi) engaging in work, training, education or volunteering;

      (vii) making use of necessary facilities or services in the local community, including recreational facilities or services; and

      (viii) engaging in recreational activities.[42]

3. As a consequence of being unable to achieve these outcomes, is there, or is there is likely to be, a significant impact on the carer’s wellbeing? (Being unable to achieve an outcome means that they are unable to achieve it without assistance; or are able to achieve it without assistance but doing so causes the carer significant pain, distress or anxiety; or they are able to achieve it without assistance but doing so endangers or is likely to endanger the health or safety of the carer, or of others.)

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[42] The Care and Support (Eligibility Criteria) Regulations 2015 (SI 2015/313).

If the answer to these questions is 'yes', the carer is eligible to have their needs met. These may include a range of different forms of support such as respite care, financial support, social/hobby groups, gym memberships, household help, training and counselling.

Identifying as a carer

Even when support is available, there are a number of reasons why carers may not seek out support. Carduff et al. found that some carers preferred simply to 'think of themselves as relatives or friends who were sharing the journey with the ill person'.[43] Hughes, Locock, and Ziebland found carers perceived their care 'as a normal part of the relationship' and identified themselves by their relationship - as husband, wife, partner, child etc, - rather than by their acts.[44] It was only when third parties, such as doctors, referred to them as carers that they began to think of themselves as that. The charity Carers UK found that 54% of carers took over a year to identify as a carer, while 24% took over five years and 9% took ten years.[45] In part, this may be because a caring role can be assumed gradually, but Carduff et al. also found that some carers actively resisted identifying as carers, because it involved an acknowledgment that their family member was ill or could not cope, or because they perceived the term as implying that they were suffering a burden. Some saw the title of carer as a 'bureaucratisation' of their relationship.[46] For some black and minority ethnic communities, caring was seen as a reciprocal relationship at odds with the implication of being someone's carer.[47]

Even when they did identify as carers, some did not have the time to seek assistance and others were resistant to external help, fearing that it might be intrusive or may 'divert resources to themselves at the expense of the cared-for person'. Some worried that external assistance would be expensive, or felt guilty that they were struggling. Some studies have identified that while male carers are in a minority, they are less likely to seek help than female carers, less likely to have confidence in external services, and more likely to feel that responsibility or duty towards the cared-for person prevents them from accessing help.[48] Not seeking help may have

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[43] E Carduff, A Finucane, M Kendall, A Jarvis, N Harrison, J Greenacre, and SA Murray, 'Understanding the Barriers to Identifying Carers of People with Advanced Illness in Primary Care: Triangulating Three Data Sources' (2014) 15 *BMC Family Practice* 48.

[44] N Hughes, L Locock, and S Ziebland, 'Personal Identity and the Role of "Carer" among Relatives and Friends of People with Multiple Sclerosis' (2013) 96 *Social Science & Medicine* 78.

[45] Carers UK, *Missing Out: The Identification Challenge* (November 2016).

[46] S Foster, Supporting Carers in Practice (book review) (2005) 13(4) *Health and Social Care in the Community* 396.

[47] G Netto, '"I forget myself": The Case for the Provision of Culturally Sensitive Respite Services for Minority Ethnic Carers of Older People (1998) 20(2) *Journal of Public Health Medicine* 221.

[48] N Greenwood and R Smith, 'Barriers and Facilitators for Male Carers in Accessing Formal and

serious consequences for the carer as well as the cared-for, impacting on employment (so that, for example, they do not apply for flexible working), finances, and their own well-being. Some have now argued that if you want to identify and support carers, the best way to do this is to avoid using the word 'carer' at all.[49]

Focus: Think Critically: Older Carers

While the carers' needs assessment applies to all adult carers, it is worth noting that many of those who care informally for older people - spouses, partners, friends – may also be older themselves. Even the children of the elderly may be drawing their own pensions. According to the Office for National Statistics, 23.9% of 60 to 69 year olds, 20.1% of 70 to 79 year olds, and 13.3% of those aged over 80 provide unpaid care to another person.[50] Many of them undertake continuous care for another person rather than ad hoc or intermittent care. The Princess Royal Trust for Carers found that 'the majority of older carers report caring for 60 or more hours a week – particularly those carers aged 70 or over.'[51] Some of these carers will also be jugging paid work alongside their caring role (see 13.4.1).

There is a significant literature on the effect of caring on carers. It can be emotionally and physically taxing. Two-thirds of older carers have long-term health problems themselves, and three-quarters of those aged 60 to 69 say that caring has worsened their mental health.[52] Research shows that offering carers support or respite breaks reduces the physical and mental strain on them.[53] Indeed, a significant proportion of older people with dementia move into residential care as a result of carers being unable to cope, meaning that greater support for carers could delay admission.[54] Caring may also prevent the carer from taking up opportunities,

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Informal Support: A Systematic Review' (2015) 82 *Maturitas* 162, discussing a number of other studies.

[49] V Molyneaux, S Butchard, J Simpson, and C Murray, 'Reconsidering the Term "Carer": A Critique of the Universal Adoption of the Term "Carer"' (2011) 31 *Ageing and Society* 422.

[50] Office for National Statistics, *Living Longer: Caring in Later Working Life* (15 March 2019).

[51] Princess Royal Trust for Carers, *Always on Call, Always Concerned: A Survey of the Experiences of Older Carers* (2011). See also Carers' Trust, *Caring about Older Carers: Providing Support for People Caring Later in Life* (2015) and University College London, *The Emotional Wellbeing of Older Carers* (UCL 2015), and R Dury, 'Older Carers in the UK: Who Cares?' (2014) 19(11) *British Journal of Community Nursing* 556.

[52] Princess Royal Trust for Carers, *Always on Call, Always Concerned: A Survey of the Experiences of Older Carers* (2011).

[53] N Singleton, *Mental Health of Carers* (Palgrave 2002).

[54] G Conochie, *Supporting Carers: The Case for Change* (The Princess Royal Trust for Carers and Crossroads Care 2011), citing A Bebbington, A Darton, and A Netten, *Care Homes for Older People: Volume 2. Admissions, Needs and Outcomes* (University of Kent 2001).

both economic (such as working full time) and aspirational (achieving life goals). One estimate is that a carer loses an average of £11,000 per year that they would otherwise be able to earn.[55]

Caring is a gender issue. It is, by and large, women rather than men who are carers. Men, where they care, are more likely to care for their spouses rather than other family members or friends (this could be because of stereotypes of caring as women's work, the greater number of older men remaining in full-time paid work, or the shorter life expectancy of men). Although carers come from all social classes, Arber and Ginn found that the majority of care in which the person being cared for lives with the carer (which is most likely where they are spouses) is undertaken by working class women.[56]

The value of this informal unpaid care was around £59.5 billion per year in 2016, the last available estimate. This is care for adults, not other forms of care that older people may undertake such as providing childcare. It represents the amount it would cost the state to replace that informal unpaid care with paid workers doing the same types of tasks.[57] It equates to 4 million social care workers providing individual care every week of the year. It does not take account of another benefit of caring, which is the well-evidenced ways in which informal care reduces or delays the need for hospital or residential care home admission with its accordant cost to the state.

This demand for unpaid care is projected to increase significantly between now and 2032, when it is estimated that over one million people aged over 65 will be disabled and receiving care from a child. Pickard estimates that 'the overwhelming majority of those providing intense care to parents in the early 20300s are still likely to be of "working age", and women are still projected to outnumber men by nearly two to one.'[58]

Although disabled people are eligible for certain state welfare benefits, and informal carers are eligible for carers allowance of (currently £67.50 for at least 35 hours per week of care), the existence of this huge number of informal carers represents an enormous financial saving to the state. Moreover, for many older people, being cared for by one's family, in the comfort of one's home is preferable to institutionalised care, although this is by no means a universal

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[55] House of Commons Work and Pensions Committee, Valuing and Supporting Carers (Fourth Report of Session 2007–08, HC 485-1) at para [102], cited by B Sloan, *Informal Carers and Private Law* (Hart 2012) 16.

[56] S Arber and J Ginn, 'Class and Caring: A Forgotten Dimension' (1992) 26(4) *Sociology* 619.

[57] Office for National Statistics, *Household Satellite Account, UK: 2015 and 2016* (2 October 2018).

[58] L Pickard, 'A Growing Care Gap? The Supply of Unpaid Care for Older People by Their Adult Children in England to 2032' (2015) 35(1) *Ageing and Society* 96.

preference.[59] Caring has a value to the individual and to society that is not reflected in pounds and pence, and that cost is borne by an army of unpaid carers.

13.3.5 The role of the NHS

You may be wondering what the role of the NHS is in relation to continuing care. The NHS National Framework guidance states that care of all kinds (including accommodation if needed) should be provided by the NHS where the individual's primary need is for healthcare rather than social care, and provides an assessment tool to decide this.[60] Where a person is not eligible for NHS continuing care but has medical needs that the local authority cannot meet, a jointly funded package of support may be offered.

There is not always a clear line between what is health care to be provided by the NHS, and what falls to the local authority. The distinction is important, because NHS care is free, whereas, as we have seen, local authority help is means tested.

13.4 The financial position of older people

In this section, we look at the financial position of the older population, the sources of income that they may have, and the number who live in relative poverty. At 13.5, in light of this discussion, we consider the social, moral, and legal implications: just who should care for older people in our society?

We will start by considering the types of income older people may have.

13.4.1 Earnings from employment

In the introduction to this chapter, we noted that 11% of those aged 65 and over are still in paid work. In part this is because the Employment Equality (Repeal of Retirement Age Provisions) Regulations 2011 brought an end to employers' right to forcibly retire employees who reached the age of 65, so that those who want to continue working can do so. Those who have an earned income can defer receiving their state pension, meaning that the pension will be higher once they do finally draw it. Many of those still working after 65 will not be employees, but rather self-employed and working part-time, which means that they have the flexibility to undertake caring for others.[61] Transitioning to self-employment and part-time work is common as people

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[59] F McGlone, *Disability and Dependency* (Family Policy Studies Centre 1992).
[60] Department of Health and Social Care, *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care* (October 2018).
[61] Office for National Statistics, *Five Facts about Older People at Work* (1 October 2016).

approach or pass pensionable age.[62] Although this may be something that they want, they may also experience discrimination in the jobs market and turn to self-employment out of necessity.

13.4.2 Savings and investments

The median amount of savings and investments held by someone aged 65 to 75 is between £25,000 and £50,000.[63] The median means that half of people have more than this and half have less than this. It varies significantly by geographic area. If you are reading this as a 'typical' student around the age of 20, you may well consider this to be a significant amount. However, remember that apart from any home this is the total of what has accrued over a person's whole working life and once a person stops working they may not be able to save anything more. The costs of care and other living costs not met by income will be met from this source.

13.4.3 State pensions

One of the most controversial political issues of recent years has been the increasing age at which people can draw their state pension. It is currently 66 for everyone, but from its introduction in the 1940s through to 2010 it was 60 for women and 65 for men. In the future, it will increase first to 67, then to 68. It is likely that the age will increase even further.

The criteria that a person must meet in order to be eligible for a state pension depends on when they were born. People can continue working beyond state retirement age and can choose to take their state pension or to delay taking it (in which case the payments they eventually receive will be a little higher).

Those who reached state pension age before 6 April 2010 will need forty-four years of qualifying national insurance contributions if they are men or thirty-nine if they are women in order to get the full pension. National insurance is usually paid by those who are in work, but national insurance credits are given to those who are unemployed but seeking work, ill/disabled, or who have taken time out as a parent or carer, among others. (For many years there were special reduced rates for married women.[64]) If you had fewer than eleven years of

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[62] R Crawford, J Cribb, H Karjalainen, and L O'Brien, *Changing Patterns of Work at Older Ages* (Institute for Fiscal Studies 17 June 2021).

[63] Office for National Statistics, *Total Wealth in Great Britain: April 2016 to March 2018* (5 December 2019). The median figure has been calculated from these statistics in an analysis at https://www.nimblefins.co.uk/savings-accounts/average-household-savings-uk Accessed 2 September 2021.

[64] The dire consequences of these can be seen in the speech by Steve Webb MP in *Hansard*: HC Deb 23 May 2000 vol 350 cc182-90WH. It is possible for divorcing women to adopt their husband's NI record, and this was

contributions (ten for a woman) then you would not get a pension at all, and if you were somewhere in between you would get a pro-rated amount. Those who do not have insurance contributions or credits may include very low earners or those who have lived abroad.

Focus: Know-How: What is national insurance?

National insurance is a form of tax paid by employers, employees, and self-employed people. In its current iteration, it is not paid by those of pensionable age, even if they are working, although this is set to change (see section 13.5.2). Payment of national insurance entitles people to certain welfare benefits and (if they pay over a long enough period) to a state pension.

You do not have to pay national insurance contributions on the first £9,568 of your income. You pay 12% on earnings between £9,568 and £50,270 and 2% on anything above that. From 2023, these figures will increase with the advent of the new health and social care levy discussed at 13.5.2. The rates are different for employers and the self-employed. It is sometimes possible to make voluntary contributions to become eligible for a state pension, if you have not made sufficient contributions in the past due to low earnings, time out of the UK, or a career break such as to raise children.

Those who reached pensionable age on or after 6 April 2010 but before 6 April 2016, whether men or women, needed to have paid national insurance contributions for a minimum of one and a maximum of thirty years. The full pension would only be received by those with a full thirty years' contribution; those with fewer contributions would get a proportionate reduction, or could make voluntary additional contributions to top up. Claimants would also receive an additional state pension (SERPS) which was linked to their earnings, unless they had contracted out, as many people did. Contracting out effectively redirected some of what would have been paid as national insurance contributions into an occupational or personal pension scheme.

Those who reached pensionable age on or after 6 April 2016 must have a higher number of years' contribution (ten) and a claimant will not receive the full amount unless they have made thirty-five years' payments. The full pension under the new system is £179.60 per week for

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something that the writer routinely advised her clients to look into. See https://www.gov.uk/state-pension-through-partner/y/divorced/female_gender Accessed 12 September 2021.

2021/22, which equates to £9,339.20 per year. As with the old systems, the amount is pro-rated for those with a lesser number of years. This is a simpler system and is intended to be better for women, as those with lower average earnings or whose careers have been interrupted by parenting responsibilities.

However, the new system has caused controversy for some women. The consequence of equalising the pensionable age between men and women gradually over a period of time has been that different women have retirement ages anywhere between 60 and 66 depending on when they were born. Unfortunately, while the government had a timetable for this which enabled people to know what their state pension age would be, in 2011 and 2014 the government decided to suddenly expedite the timetable, making women born between October 1953 and 1960 work longer than they had been told with very little notice, and sometimes pushing their retirement date back more than once, or by as much as five years.[65] The Institute for Fiscal Studies found that this caused a 'sharp' 6.4% increase in income poverty among women in their 60s even though more of them had continued to work and thus earn a wage.[66]

Note that while receipt even of a full state pension will yield an income below the income tax threshold, if you have a source of income on top of your state pension (such as a private or occupational pension or earnings) you may find that you exceed your personal tax-free allowance, currently £12,570 in 2021/22, and have to pay tax on anything above that. You will not, however, have to pay national insurance.

13.4.4 Private/occupational pensions

There are two kinds of non-state pension: occupational pensions and private pensions. Occupational pensions are arranged by the employer. The employee pays into the pension scheme from their earnings and the employer usually also makes a contribution. Private pensions can be arranged by people themselves. Pension funds are invested in the stock market and other investments such as bonds and gilts.

Once the pension holder reaches a specified age, he or she is entitled to draw the pension. In a defined contribution occupational schemes and private pensions, this is linked to the fund

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[65] D Thurley and R McInnes, *State Pension Age Increases for Women Born in the 1950s*, Briefing paper CBP-7405 (House of Commons Library 18 September 2020).

[66] Institute for Fiscal Studies, *'Can't Wait to Get My Pension': The Effect of Raising the Female Pension Age on Income, Poverty and Deprivation*, Working Paper W17/10 (2 August 2017). For some case studies, see K Peachey, 'Women Lose State Pension Age Appeal against Government' (*BBC News* 15 September 2020).

value. The pension holder will commonly use the fund to purchase an annuity: a policy that guarantees to pay a certain amount per year for however long the pensioner lives and which may or may not increase with inflation. Some schemes also allow the pension holder to draw all of their pension in instalments rather than by annuity; or as a single lump sum although there are serious tax penalties for this, and it is often not a sensible thing to do (and a Sloan points out it may affect your care fees liability).[67] In a defined benefit occupational scheme, the amount paid as pension will be a proportion of the pensioner's final salary or career average salary, multiplied by the length of service with the employer.

Approximately half of all adults contribute to a non-state pension, but there is a gender gap.[68] Men are more likely to have more valuable pensions than women, although the average pension fund at retirement has been estimated as £61,000, which would only buy an annuity income of a few thousand pounds per year.[69] Put simply, people are not saving enough for retirement.

13.4.5 State social security benefits

Elderly people may also be eligible for a range of state benefits to boost their income. Not everyone will be eligible for everything as some of these benefits are means-tested and some apply only to people living in certain places such as their own homes rather than care homes.

These benefits may include:

- Pension credit. There are two elements. There is a guarantee element which tops up a person's weekly income to a minimum level (currently £177.10 for single people and £270.30 between a couple). There is a savings element which is only available to those who reached pension age before 6 April 2016 and this is for those with savings or whose income is above the guaranteed level. It is worth just under £15 per week.

  Receipt of pension credit can act as a gateway to other benefits. For example, those aged 75 or older do not have to buy a television licence if they or their partner living at the same address receives pension credit. (Most care homes will have a group television

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[67] B Sloan, '"Pension Freedoms", Social Care and Inheritance' in S Agnew, PS Davies and C Mitchell (eds), *Pensions: Law, Policy and Practice* (Hart 2020).

[68] Office for National Statistics, *Pension Wealth in Great Britain: April 2016 to March 2018* (5 December 2019). No more recent statistics are available.

[69] See 'What Is a Good Pension Pot?' (*The Telegraph* 3 June 2021). For a figure of £50,000 in 2017 see 'Do You Have £50k Saved for Old Age? Average Pension Pot Swells 72% in Just Two Years - But Men Have THREE Times More Than Women' (*Daily Mail* 5 April 2017). The accuracy of either statistic cannot be verified.

licence.) Pension credit recipients may also get help with paying council tax . They will receive free NHS dental treatment (unlike most adults who have to pay for dental treatment although it is heavily subsidised by the state). They may receive housing benefit if they live in rented accommodation or a loan to pay the interest part of a mortgage if they own a property. They will receive a one-off cold winter payment of £25 to help with fuel costs if the temperature hits freezing for more than one week.

- Winter fuel allowance, an annual lump sum to help with the cost of heating the home. This is automatic to those with state pensions. Some people who receive the guarantee element of pension credit will also get a warm home discount on their bills from participating energy companies.
- Prescriptions and sight tests are free to anyone aged over 60.
- Most elderly people will *not* be eligible for bereavement support payments. Although these are for those whose spouse or civil partner (or cohabitants with dependent children[70]) died in the last 21 months, the claimant must have been below state pension age at the time. Some elderly people will be entitled to war widow's/widower's pension if their spouse or civil partner died as a result of armed service, even if the armed service was some time previously.
- Those in receipt of a state pension will not receive carer's allowance (even though many elderly people are carers) but may be eligible to receive extra housing benefit or a 'carer premium or 'carer addition' to pension credit instead.
- Personal independence payments for a person with a disability (or disability living allowance in the case of a person born before 8 April 1948) are only made to those over state pension if they started to receive them before they reached that age. Those over state pension age who need help with personal care may receive attendance allowance instead.
- Universal credit is not available for those over state pension age unless part of a couple in which one person is below state pension age. Other benefits linked to work or

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[70] Department for Work and Pensions, 'Press Release: Cohabiting Couples to Benefit from Changes to Bereavement Benefit Rules' (15 July 2021).

working age, such as employment and support allowance, usually stop when a person reaches state retirement age.

Focus: Think Critically: The cost of the elderly

The state pension and those welfare benefits that relate particularly to the elderly cost the state a great deal each year - about £118.4 billion, or about the same as the total for all universal credit and its predecessor benefits, all child benefit, and all disability related benefits added together. Most of this cost relates to the cost of providing a state pension. The state pension is forecast to cost £105.3 billion in 2021/22.[71]

The cost of the state pension is met by current taxpayers: there is no enormous savings fund used by the government to pay pensions. Each generation of earners pays the pension bill of the generation above it. When pensions were introduced, only a minority would ever reach pensionable age. Now, a person who has just reached state pension age can (on average) expect to draw that pension for around one-third of their total life, although there is around a decade's difference in life expectancy between those living in the most and least deprived areas of the UK.[72] This means that the cost of pensions has an upwards trend.

Another reason why pensions cost the state increasing amounts of money is because the amount each person receives increases each year by the greater of consumer price index growth (inflation), average earnings growth, or 2.5%. This is known as the 'triple lock'. The triple lock formed part of the current Conservative government policy to win votes at the last general election: pensioners are more likely to vote than younger people. It is therefore a political promise that is not part of the law. At the time of writing, the government has announced that it will break the triple lock, so that pensions will increase either by 2.5% or inflation, whichever is higher, in April 2022, rather than the calculation under the triple lock which would raise them by a significant 8%.[73]

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[71] Office for Budget Responsibility, *Welfare Trends Report March 2021* (23 March 2021) at table 1.1 and para 1.10.

[72] V Raleigh, *What Is Happening to Life Expectancy in England?* (The King's Fund 15 April 2021). See also C Jethwa, *Longevity Inequality, PPI Briefing Note Number 125* (Pensions Policy Institute December 2020).

[73] H Stewart, 'Pensions Triple Lock to Be Suspended Next Year, Government Say' (*The Guardian* 7 September 2021). See C Duffield, 'What Is the Triple Lock? Why State Pension 'Could Increase 8%' Next Year – What the System Means (*i News* 8 July 2021) and S Sandhu, 'State Pension: Older People Threaten to Withhold Support from Tories If Triple Lock Ends' (*i News* 24 August 2021) for a useful explainer.

In addition to the costs of pensions and associated benefits (£6.1 billion per year for pensioner housing benefit, £5 billion for pension credit, and £2 billion for winter fuel payments), there is also the cost of social care for the elderly, and hospital/medical treatment.

Many people, however, would consider that meeting these costs is a core function of the welfare state, and that people are entitled to be supported by the state at the end of many decades of hard work and contribution, or simply because they are in need. The welfare state is part of a social contract: contribute to the extent that you can while you can, and the state will look after you in your old age.

In section 13.4.5, we look at what proportion of the older population live in poverty, and at 13.5 we consider whether there should be an obligation on family members to financially support their older relations.

13.4.6 Poverty and older people

Although the cost to the state of an ageing population is significant, that does not mean that there is no poverty among older people. According to the Organisation for Economic Cooperation and Development (OECD), 12.1 % of those aged 66 to 75 and 19.7 % of those aged 75 or over live in relative income poverty in the UK. This is defined has having an income that is below half the national median household disposable income in that country.[74] The government looks at 'relative low income' which it defines as below 60% of the median. It calculates that 18% of pensioners are in relative low income after housing costs have been deducted.[75] To put this in context, the level is 25% for working age parents and 18% for working age people without dependent children.

More older people own their own home than do younger people. Around 75% of pensioners live in homes that they own outright, i.e., without a mortgage, compared to 20% or so of people who are of working age.[76] They may have bought their first house at a time when houses were more affordable for the average earner than they are now. This means that they do not have

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[74] Organisation for Economic Cooperation and Development, *Pensions at a Glance 2019: OECD and G20 Indicators* (2019). The median means that half of people have an income above that level and half an income below that level.

[75] B Francis-Devine, *Poverty in the UK: Statistics* (HC Library Briefing Paper 7096, 31 March 2021). This is a good overview. For a discussion of how different studies define old age poverty, see C Kwan and CA Walsh, 'Old Age Poverty: A Scoping Review of the Literature' (2018) 4(1) *Cogent Social Sciences* 1478479.

[76] Department for Work and Pensions, *Households below Average Income: An Analysis of the Income Distribution FYE 1995 to FYE 2020* (25 March 2021).

rent or a mortgage to pay. Pensioners are more likely to live in poverty if they rent rather than own. This is not only because they will have to pay rent, which can be a significant proportion of their income, but also because people who live in rented accommodation are more likely to have lower levels of private income, such as private pensions.[77]

Women pensioners are more likely to have relative low income than male pensioners, because they are more likely to live longer and because more of them than men have less valuable or no private pensions.[78] People of colour are also more likely to live in poverty, particularly if they are of Indian, Pakistani, or Bangladeshi heritage.[79]

Another measure of poverty is to look at how much disposable income a person has (adjusting for household size and composition), and thus what level of goods and services they can afford. On this measure, we can see that 27% of single female pensioners, 23% of single male pensioners, and 13% of couples live on less than 60% of the median national income.[80] Research by Dominy and Kempson found that many pensioners lived frugally and cut back on items such as clothing, leisure, and holidays, kept old cars and white goods running rather than replace them, and bought cheaper food rather than less food, in order to prioritise utility bills and healthcare costs.[81] Most of them did not consider themselves to be living in poverty even if, relative to others, they were.

The %age of relative low-income pensioners has fallen significantly since the mid-1990s. In general, income poverty among those of pensionable age is reducing relative to the working population, probably because of the pension 'triple lock', albeit that it is still much higher than in the 1960s or 1970s. However, even a minority of pensioners living in relative income poverty equates to over 2 million people, and older people are less likely to be able to take steps to improve their financial positions than some of those who are of working age. If they are living at the limit of their income, they cannot save for any unexpected items.

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[77] Joseph Rowntree Foundation, 'Pensioner Poverty by Ethnicity'. Available at https://www.jrf.org.uk/data/pensioner-poverty Accessed 2 September 2021.

[78] D Price, 'Pension Accumulation and Gendered Household Structures' in J Miles and R Probert (eds), *Sharing Lives, Dividing Assets: An Interdisciplinary Study* (Hart 2009).

[79] Department for Work and Pensions, *Households below Average Income, 1994/95-2019/20* (2021); see analysis 'Pensioner Poverty by Ethnicity' by the Joseph Rowntree Foundation at https://www.jrf.org.uk/data/pensioner-poverty Accessed 2 September 2021.

[80] Department for Work and Pensions, *Households below Average Income: An Analysis of the Income Distribution FYE 1995 to FYE 2020* (25 March 2021).

[81] N Dominy and E Kempson, *Understanding Older People's Experiences of Poverty and Material Deprivation* (Department for Work and Pensions Research Report 363, 2006).

We now turn to consider whose role it is to care for older people.

13.5 Who should care?

In 2019/20, adult social care cost local authorities £23.3 billion[82] or around 40% of their total expenditure.[83] Just under half of this sum is spent on those who are older, i.e., of pensionable age. This is a great deal of money, although when we adjust for inflation it is not keeping up with the increase in demand. This means that we are approaching a crisis in the funding of adult social care, and as a society we need to think about what should be funded, and for whom, and how.[84]

13.5.1 Meeting the costs of care

In the days before the advent of the welfare state, care for the elderly was effected through a combination of family care and the workhouses set up by the Elizabethan and Victorian Poor Laws. Many of them were grim institutions with harsh regimes reflective of their intention of discouraging reliance on state support. By the early twentieth century workhouses 'increasingly accommodated the sick or frail over sixties… [they] had become a long-stay hospital accommodating older patients.'[85] In 1908 the first old age pensions were introduced, albeit limited to those who were aged 70 or over, of low income, and who were not drunkards, not guilty of habitual failure to work, not former prisoners, and who did not receive poor relief under the Poor Laws. The pension was paid from general taxation.

The Poor Laws imposed a legal obligation to support one's children, parents and grandparents, although this obligation did not extend to married women. The Poor Laws, and thus this obligation, were eventually repealed in 1948 by the National Assistance Act, which imposed duties on local authorities to care for and accommodate those in need, including the elderly. Obligations to support relatives were ended by s42, with the exception of support for minor children and spouses. The Act was part of a number of Acts which together created the welfare state, providing a safety net of support from the cradle to the grave. The establishment of the NHS by the National Health Service Act 1946 gave people the right to seek hospital treatment without paying. The National Insurance Act of the same year introduced universal state pensions dependent on contribution. With less home ownership than there is now, residential

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[82] The King's Fund, *Key Facts and Figures about Adult Social Care* (2 July 2021).
[83] Association of Directors of Adult Social Services, *Budget Survey 2018* (2018).
[84] The King's Fund, *Key Facts and Figures about Adult Social Care* (2 July 2021).
[85] M Gorsky, 'Creating the Poor Law Legacy: Institutional Care for Older People Before the Welfare State' (2012) 26(4) *Contemporary British History* 441.

care costs were mostly funded by the state.[86] A mandatory retirement age took older people out of the jobs market.

As living conditions improved over subsequent decades, so did life expectancy. At the same time, social changes led to the separation of older family members from younger. As Oldham writes:

> Increased geographic mobility resulted in the physical distancing of different generations of many families. Even where there is no geographic separation, the changing role of women in the wider economy means that they are often either unwilling or unable to fulfil their historically traditional function of extended family 'carers'. … The intergenerational support obligation between adults has shifted from the 'private' realm of the family to the 'public' sphere of the state.[87]

This is not to say that there are no family carers. In 13.3.4, we note the tremendous contribution they make. Yet financial responsibility for those who cannot support themselves has largely moved to the state and the costs of that been borne by taxation. This has led to a belief that the state should not deprive people of all their resources, and that the quid pro quo for paying tax is that the state will provide and that some of the person's assets will be available to be left to the next generation. As Walker has written, 'the welfare state has operated as a system of intergenerational as well as intragenerational transfers and, therefore, has institutionalised and encouraged the expectation of reciprocity'.[88] The Dilnot Commission of 2011 was tasked with addressing this issue.

The Dilnot Commission report, *Fairer Care Funding*, proposed that individuals' contributions towards their social care should be capped at £35,000 over their lifetime.[89] Once someone had spent this sum, they should not have to pay any more towards their care and the state would pick up the remaining cost. This model would help preserve people's own assets, reduce the need for people to sell their houses to meet their care costs, and would enable more people to leave an inheritance to their children. Rather than having to make a full contribution if they had

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[86] K Bilton, Care Arrangements: Who Cares? Who Pays?' (2014) 1(1*) Bulletin of the Social Work History Network* 14.

[87] M Oldham, 'Financial Obligations within the Family: Aspects of Intergenerational Maintenance and Succession in England and France' (2001) 60(1) *Cambridge Law Journal* 128, 135-136.

[88] A Walker, 'Introduction: A New Generational Contract', in A Walker (ed.), *The New Generational Contract* (UCL Press 1996).

[89] A Dilnot, *Fairer Care Funding: The Report of the Commission on Funding of Care and Support ('the Dilnot Report')* (2011).

more than £23,250 of assets, they would not have to make a full contribution unless they had assets of more than £100,000. However, the individual would have to pay towards their living costs from their pension, up to £10,000 per year. The Dilnot report therefore shifted more of the costs of adult social care that currently lie with the person being assisted onto the state – some £1.7 billion in fact, rising to £3.6bn by 2025.[90] For this reason, the government did not immediately implement the Commission's recommendations.

In 2017, the Competitions and Markets Authority (CMA) confirmed that additional public funding was essential because otherwise the current model or services would become financially unsustainable. In particular, it found that local authorities are not paying enough to enable those care homes that take mostly local authority-paid residents survive. Most care homes take some privately paying residents and some paid for by the local authority. The problem is that the local authority pays much less. The CMA found that

> the average fee for a self-funder in 2016 was £846 per week, which is nearly £44,000 per year. This varies substantially between regions, with average weekly self-funder fees of £670 in the North East of England and £1,060 in the South-East. In contrast, [local authorities] on average paid £621 per week.[91]

This means that local authorities are paying up to 10% below the cost of running the homes, equivalent to a £200 to £300 million shortfall across the UK. This places a number of care homes at risk of closure. It also means, of course, that privately paying residents – those above the means-testing threshold - are effectively subsidising others' care through the much higher fees they pay, which the CMS found were in some cases all that enabled the care home to survive. In spring 2017 the government made an additional £2 billion available to support adult social care and there have been further smaller funds in subsequent years.

Local authorities cannot raise money from increasing council tax to the level they need, as the government places limits on this. However, from 2017/18 the government has allowed local authorities to charge an additional 3% to specifically support adult social care, dropping to 2% in 2020/21 and returning to 3% in 2021/22%. Although students do not have to pay council tax

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[90] D Brindle and N Watt, 'Government Questions Andrew Dilnot's £1.7bn Long-Term Care Plan' (*The Guardian* 4 July 2011).

[91] Competition and Markets Authority, *Care Homes Market Study Final Report* (2017) para 38ff.

if they live in an all-student household, you can see this precept on council tax bills. It is money that is ringfenced only to be used to meet adult social care costs. However, there is still a funding gap between what is needed and what is available. The Association of Directors of Adult Social Services' 2018 survey found that, projecting forward, no directors were fully confident that in 2021/22 they could meet their statutory obligations.[92] The Directors anticipated trying to address the shortfall between what they needed and what they had in a number of ways, principally by emphasising self or community help and increasing preventative services (to try to reduce the need for more expensive services later). However, some were looking at reducing personal budgets or the number of people provided with care: 'if a reduction in numbers of people in receipt of care is an outcome of a strategy of developing asset-based[93] and preventive approaches then this is a positive aspiration, whilst if it is about gatekeeping resources then there is a risk that people in need will be left without services which would be unlawful and financially risky', wrote the Association.[94]

13.5.2 New proposals for social care funding

There are two options for addressing the costs of adult social care. Either we reduce the services provided by the state (or the people that are eligible for them) so that those who cannot afford to meet their needs themselves have unmet needs or another source of funding, such as charity; or money has to be found to address the funding gap.

At the time of writing, September 2021, this is yet again a 'live' political issue. The government has announced its intention to increase national insurance payments to fund social care.[95] Both employers and employees will pay an extra 1.25% on top of their existing contributions, and this will be known as the Health and Social Care Levy. Most of the money would go towards the NHS, but about £2 billion would go towards social care.[96] Under the government proposals, from 2023 an older person requiring care would pay nothing towards that care from their capital if they had less than £20,000 of assets, and only those with more than £100,000 of assets would pay the whole cost of their care. This is obviously significantly higher than the current figure of £23,250 beyond which a person pays for their care. At the same time, the costs of lifetime

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[92] Association of Directors of Adult Social Services, *Budget Survey 2018* (2018).

[93] Asset-based approaches are described here https://www.scie.org.uk/future-of-care/asset-based-places/introduction Accessed 6 September 2021.

[94] Association of Directors of Adult Social Services, *Budget Survey 2018* (2018) at p16.

[95] HM Government, *Building Back Better: Our Plan for Health and Social Care* (CP506, 2021).

[96] Note, however, that not all of this will go towards direct care or subsidising care.

care would be capped at £86,000 per person. Once someone had spent that amount, subsequent costs would be met by their local authority.

However, it appears that this cap is for the costs of *personal care* only. Whether the older person is living at home, in supported accommodation, or in residential care, they will still have to pay their other living costs including food and accommodation. These may be substantial. (To give you some idea, estimates of this element vary from one-third to about half of the total fees[97] and in 2015, the government had proposed a cap on these at the level of £12,000 per year.[98]) Moreover, even though there would be a lifetime cap on care costs, a person may only be able to raise the maximum £86,000 over their lifetime by selling their home. The government has said that people will be able to use deferred payment plans to avoid the need to sell to do this.

Scenario 1

Illustration 2: Jean

Would Jean be better off if she had moved into a care home after these rules come into effect in 2023?[99]

Jean will still have to pay towards her care as she is still above the £100,000 level, but the state will pick up some of the costs once she falls below that level of capital.

The cap only relates to the care element of her care home fees, and not to the accommodation, food, laundry, entertainment, heating, cleaning, etc. services that they provide, often known as the 'hotel element'. This means that in order to reach the cap of £86,000 on the personal care element, Jean may actually spend double that.

If Jean requires nursing care, as opposed to general personal care, her fees for the care home will be even higher.

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[97] Cf guesstimates given in 'Care Cap Will Help Fewer Than One in 20: Boris Johnson's Social Care Plan Will Help Just 5% Of Elderly Patients, Economists Warn… and It Could Take Them Three Years to Reach Limit' (*Mail Online* 8 September 2021) and R Vaughan, 'Social Care: the Major Holes in Boris Johnson's Plan to Fix the System' (*i News* 8 September 2021).

[98] Department of Health, *The Care Act 2014: Consultation on Draft Regulations and Guidance to Implement the Cap on Care Costs and Policy Proposals for a New Appeals System for Care and Support* (2015) Ch 7.

[99] The government has said that nothing paid prior to the change coming into force in October 2023 would count towards the cap.

Of course, it all depends on how long Jean lives for. As a woman aged 75-79, her average life expectancy once she moves to a care home is 5 years.[100]

Reaction to these proposals has been mixed. Most people accept that social care is chronically underfunded and that this is going to get worse as life expectancy increases. The increased national insurance will also be paid by those over pensionable age who are still working, who currently do not pay national insurance at all. They will now pay the full rate of national insurance above earnings of £9,568 like those below pensionable age. This, combined with the temporary suspension of the state pension triple lock (see the focus box *Think Critically: The Cost of the Elderly* at 13.4.5), has led to criticism from a number of older people.[101]

Moreover, while those who earn below this sum, of any age, do not pay national insurance at all, there are many people of working age who earn more than this who still live in relative poverty and will find themselves, under these proposals, effectively subsidising the care of wealthier people, in order that the latter can preserve assets for their children's inheritance. The effect of the triple lock has been to decrease relative income poverty among pensioners, so it is lower than that of working age families with children. If you are reading this as a student of around 19 or 20 years old, you may well be acutely conscious of the difficulties that you are likely to have getting on the housing ladder, high rental fees, less valuable pension schemes, student debt, and cuts to state welfare benefits for the very poorest.

But in contrast to earlier generations, the consequence of the 'high homeownership rates of those born between 1930 and 1960, in combination with the long-term increase in house prices, is that younger cohorts are more likely to expect to inherit than their predecessors, and expect to inherit more on average'.[102] The national insurance rise therefore takes from your earnings, but in the expectation that it enables your parents to leave you something when they die.

Focus: Think Critically: Vulnerability Theory and Older People

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[100] Office for National Statistics, *Life Expectancy in Care Homes, England and Wales: 2011 to 2012* (2021).

[101] For some examples of the criticisms, and the point that the NI increase also contributes to the care of adults with disabilities and is therefore not all about pensioners, see the *Guardian* letters page on 6 September 2021 and those of other newspapers around the same period.

[102] Institute for Fiscal Studies, *The Economic Circumstances of Different Generations: The Latest Picture* (IFS Briefing Note BN187, 2016).

The influential American academic Martha Fineman has suggested that rather than considering certain categories of people, such as women or older people, we should seek to acknowledge and address our shared vulnerabilities.[103] She argues that vulnerability is inherent in humans, and a part of humans' universal experience: 'The idea of the vulnerable subject is anchored in the fact that we all are born, live, and die within a fragile materiality that renders all of us constantly susceptible to destructive external forces and internal disintegration.'[104] It is simply that at certain times, this vulnerability will become more visible, such as when we are children or very old, or due to illness, our economic situation, or as a victim of crime. Nina A. Kohn has referred to old age as the 'paradigmatic example of a human condition associated with vulnerability'.[105]

Fineman argues that it is vulnerability to which the state should respond, and that justifies a state's support for its citizens and individuals' support for one another. Rather than thinking about the different generations of families and populations as separate and distinct, and potentially competing with one another for access to resources, by considering vulnerability 'it becomes possible to reconsider how society should realistically and fairly apportion responsibility for human vulnerability and dependency across the life-course among the individual, the family, and the state and its institutions.'[106] We may each be resilient to a different extent, or vulnerable for a different reason, but what we have in common is that at some point we are all vulnerable and, perhaps, dependent on others. By refocusing our attentions on understanding how the state can ameliorate the effects of vulnerability, substantive equality can be achieved.

It might be understandable to think that the solution to vulnerability is paternalistic protection, so that awareness of vulnerability increases the risk of that state response.[107] In fact, Fineman

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[103] MA Fineman, 'The Vulnerable Subject: Anchoring Equality in the Human Condition' (2008) 20 *Yale Law Journal of Law and Feminism* 1.

[104] MA Fineman, 'Elderly as Vulnerable: Rethinking the Nature of Individual and Societal Responsibility' (2012) 20 *Elder Law Journal* 71, 89.

[105] Nina A Kohn, 'Vulnerability Theory and the Role of Government' (2014) 26(1) *Yale Journal of Law and Feminism* 1.

[106] MA Fineman, 'Elderly as Vulnerable: Rethinking the Nature of Individual and Societal Responsibility' (2012) 20 *Elder Law Journal* 71, 111.

[107] There is a good discussion of criticism of vulnerability theory in J Herring, *Vulnerable Adults and the Law* (OUP 2016).

herself suggests what have been called 'radically paternalistic legal approaches'.[108] To her, autonomy cannot be meaningfully exercised unless the person also has safety and security.[109]

But, Fineman argues, a state that is conscious of vulnerability would be able to analyse its role, and the role of its institutions, by reference to its effect on people. It may find that institutions or mechanisms or support are not equally accessible to all, and address that. It will see how the state reflects and creates privilege and disadvantage. Acknowledging our shared vulnerability also means that we cannot think of those who are vulnerable as being different to us, or somehow weaker or a burden, which is perhaps part of how we consider older people in our society. Kohn argues that despite the apparent paternalism of Fineman's own suggested approaches to old age, if society 'were to acknowledge the vulnerability of the human condition more broadly as Fineman urges, it could actually encourage the adoption of less paternalistic laws and policies.' Kohn gives the example of the disability rights movement, which 'has helped shift the provision of long-term care toward home and community-based care and away from the paternalistic, institutional care model that has historically characterized long-term care policy'.

Vulnerability theory therefore provides us with a lens through which we can consider the state's role towards older people, but it is not without its faults.

13.5.3 Filial responsibility laws

If the prospect of a distant inheritance, subject to the vicissitudes of your own and your parents' life between now and then, seems a high price to pay for tax rises now, consider that England and Wales are unusual in not obliging you to provide financial support to your parents or other relatives if they are in need.

In this jurisdiction, the only obligation is to support one's spouse and minor children through the laws discussed in Chapters 4 and 6.[110] Yet in many countries, laws exist that require a person to financially support certain other categories of relation. France, Germany, Hungary, Romania, Bulgaria, Republic of Georgia, Lithuania, Taiwan, and Singapore all have such laws, for example, as do around half of all US states. In some cases, the obligation is to support one's

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[108] Nina A Kohn, 'Vulnerability Theory and the Role of Government' (2014) 26(1) *Yale Journal of Law and Feminism* 1.

[109] MA Fineman, 'Elderly as Vulnerable: Rethinking the Nature of Individual and Societal Responsibility' (2012) 20 *Elder Law Journal* 71, 92.

[110] There is limited support for adult children under Sch1 Children Act 1989, principally those whose parents are separated and who are disabled or in education. For an unsuccessful claim by a 41-year-old man against his parents, see *FS v RS and JS* and [2020] EWFC 63.

parents but in other cases it can extend to all direct descendants and ascendants including in-laws. Sometimes, as in France, Bulgaria, and Romania, this is a reciprocal obligation: just as you must support your father so must he support you, if it is you in need instead.[111] In other places, the support is one-directional. In the Netherlands, parents may be called on to support their adult children, but children cannot be called on to support their parents. In Russia, the reverse is true: adult children are responsible for their parents, but not vice versa.[112] In France, the obligation to support one's ascendants is matched by mandatory succession laws: 'correlative succession rights that effectively ensure that the bulk of any estate is distributed among specific categories of relative', albeit not precisely the same categories as are obliged to offer support.[113] In contrast, in England and Wales the absence of filial responsibility is matched by considerable testamentary freedom.[114]

These differences may be attributable to different cultural and moral beliefs, different legal histories (including the legacy of the Napoleonic civil code), or different levels of state welfare provision.

Oldham argues that 'despite the differences in the particulars of the familial support laws, what these jurisdictions have in common, in contrast to England, is the establishment of a much more highly developed sense of family responsibility than exists in English law.'[115] In the Republic of Georgia, 99.8% of people agree that children should have their parents to live with them if the parents cannot look after themselves.[116] In the UK, increased geographic mobility/migration, changes in family forms, lower birth rates, smaller nuclear families, later parenthood, increasing levels of education, family breakdown, and the number of women in the workforce correlate with fewer carers/funders, and reduced levels of contact between parents and adult children, and although intergenerational cohabiting exists it is less common

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[111] M Oldham, 'Financial Obligations within the Family: Aspects of Intergenerational maintenance and Succession in England and France' (2001) 60(1) *Cambridge Law Journal* 128 describes the French law in detail.

[112] See K Herlofson, G Hagestad, B Slagsvold, and A-M Sørensen, *Intergenerational Family Responsibility and Solidarity in Europe* (Norwegian Institute for Social Research 2011).

[113] M Oldham, 'Financial Obligations within the Family: Aspects of Intergenerational maintenance and Succession in England and France' (2001) 60(1) *Cambridge Law Journal* 128, 150.

[114] See Chapter 5.

[115] M Oldham, 'Maintenance of the Elderly' in F Ebtehaj, B Lindley, and M Richards (eds), *Kinship Matters* (Hart 2006) 225.

[116] C Mureşan and P-T Hărăguş, 'Norms of Filial Obligation and Actual support to Parents in Central and Eastern Europe' (2015) 9(2) *Romanian Journal of Population Studies* 49.

than in some states.[117] This may mean, as Oldham says, that we have a reduced sense of family obligation. But that is not the only explanation.

As with a number of other countries, we have a system of general taxation to fund social care. Individuals in need are not reliant on the capacity of their family to help them. Instead, the financial burden of caring for those in need is born by the whole of society and support is distributed among claimants in accordance with their needs. That does not necessarily mean we and similar countries lack a sense of family obligation. We may simply have a greater sense of community obligation. Moreover, even though a developed social care system exists, a great deal of unpaid informal care is being provided by family members and friends. Walker has noted that 'the intergenerational caring relationship remains the main source of care for older people in Western welfare state societies' even though it is not the only source.[118]

In the UK, as social care institutions were developed, individual responsibility obligations were brought to an end. In this jurisdiction, the Poor Law requirement to support parents and grandparents was replaced by the help provided to the elderly under the National Assistance Act 1948. Similarly, some US states abolished filial obligations when state or federally-funded benefits were introduced.[119] Alternatively, it could be that in countries with filial support obligations there is a strong feeling that the community should not have to bear the costs of others' failure to obtain sufficient resources to see them through old age, and that people should look first to their own families.

It could be that some filial responsibility states have less developed state provision (for historic, ideological, and/or financial reasons) which places the burden on the family for lack of alternatives. Mureşan and Hărăguş put Bulgaria, Poland, and Lithuania into this category, and their research finds that in countries where publicly funded services are not available, people are much more likely to believe that they must support older family members who are in need, and that they are more likely to offer personal care support.[120] But it is difficult to untangle

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[117] E Grundy and M Murphy, 'Kin Availability, Contact and Support Exchanges between Adult Children and Their Parents in Great Britain', in in F Ebtehaj, B Lindley, and M Richards (eds), *Kinship Matters* (Hart 2006).
[118] A Walker, 'Introduction: A New Generational Contract', in A Walker (ed.), *The New Generational Contract* (UCL Press 1996), 3.
[119] John Walters, 'Pay Unto Others as They Have Paid Unto You: An Economic Analysis of the Adult Child's Duty to Support an Indigent Parent' (2000/2001) 11 *Journal of Contemporary Legal Issues* 376.
[120] C Mureşan and P-T Hărăguş, 'Norms of Filial Obligation and Actual support to Parents in Central and Eastern Europe' (2015) 9(2) *Romanian Journal of Population Studies* 49.

cause and effect. Are people caring because that is the cultural norm, or because of necessity? Or has one arisen from the other?

Filial responsibility laws send a strong message about the importance and centrality of the older generation within the family. The 'existence of the obligation creates a legal tie that, in terms of signalling, locates the older generation firmly within the family'.[121] This may be particularly important now that many people do not live close to their parents.

What would happen if we reintroduced filial responsibility laws in the UK? There are many precedents for the privatisation of public interest. But would this be practical? Oldham argues that while most people would be compliant, the costs of setting up and enforcing such a scheme would render it financially pointless. (One only has to look at the history of the Child Support Agency and its successors to see the issues). Walters disagrees, pointing out the deterrent effect of vigorous enforcement: people would not claim but reach agreement without state involvement, thereby reducing administration costs.[122] But Ruth Deech has argued that in this country:

> the possibility of switching support of indigenous adults away from the state to their children and grandchildren is not possible now. It would be seen as an attempt to cut state expenditure; it would give rise to arguments within families about the sharing of help and resources; it might deprive older people of state benefits now available to them; and it would certainly become a burden on the women in the family, whose independence and career progression would take a setback.[123] Many parents are in fact cared for by their children and others might feel it humiliating to have to seek a court order to that end. Broken marriages and geographical mobility mean that there are many parents who are not nearly as close to their children as they might be in better circumstances, indeed are estranged. There will be children without resources, or who have chosen careers that paid little and were not careers that their parents urged them to choose. Moreover, now that higher education equates with debt, the reality is that

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[121] M Oldham, 'Maintenance of the Elderly' in F Ebtehaj, B Lindley, and M Richards (eds), *Kinship Matters* (Hart 2006) 225.

[122] John Walters, 'Pay Unto Others as They Have Paid Unto You: An Economic Analysis of the Adult Child's Duty to Support an Indigent Parent' (2000/2001) 11 *Journal of Contemporary Legal Issues* 376.

[123] Interestingly, shortly after selecting this quote from Ruth Deech, and shortly after its announcement about reform of social care funding, the health secretary Sajid David, told the Conservative Party conference that 'Health - and social care - begins at home. Family first, then community, then the state' (B Riley-Smith and E Gatten, '"Turn to Family First – Not the State – for Social Care Support", Says Sajid Javid', *The Telegraph* 5 October 2021). The columnist Rhiannon Coslett responded on twitter: 'He means women should do it'.

> parents will be supporting children well into their own adulthood, and possibly taking responsibility for the debts of the children, rather than the other way round.[124]

It could therefore be that it is not possible to reintroduce filial responsibility laws once they have been removed, because society will have changed irreversibly. Of course, many people do provide financial or other support to members of their family, even though the law does not require them to do so. Grandparents often provide childcare; in Chapter 12 we noted the number of grandparents providing substitute care in child protection cases.[125] Many adult children provide assistance to older parents such as practical support with household tasks or errands, gifts of useful items, and payments of expenses.[126] Less tangible gifts such as love and affection and emotional support are also exchanged. But even where the relationship between parent and child is poor, a sense of obligation may compel one to support the other.

In the next section, we consider why.

13.5.4 Do children owe moral duties to their parents?

A number of philosophers have argued that children owe their parents various duties. However, they do not all agree on what duties these are, or why children may owe them. You may well consider that you owe your parents something. Some students hear this explicitly from their parents – and they are not necessarily talking about money, but about keeping in touch, studying hard, having a certain career, or behaving in a certain way. You may take the view that you did not ask to be born, and therefore owe your family nothing! But many of you will in fact feel love, affection, or gratitude towards your parents (although of course this is not everyone's experience). But does love and gratitude equate to a moral duty to your parents? If so, what kind of duty? How should that duty be fulfilled? And should a moral duty to one's parents – or other family members – be embodied in law?

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[124] Baroness R Deech Deech, 'Sisters, Sisters – and Other Family Members'. Gresham College lecture 2 February 2010. Available at https://www.gresham.ac.uk/lecture/transcript/download/sisters-sisters-there-were-never-such-devoted-sisters/ Accessed 12 December 2010.. There's a good discussion of the family changes that have affected the availability of family care by L Clarke, 'Family Care and Changing Family Structure: Bad News for the Elderly', in I Allen and E Perkins (eds), *The Future of Family Care for Older People* (HMSO 1995), although be aware that the data is now superseded.

[125] See also J Nolan and J Scott, 'Gender and Kinship in Contemporary Britain' in in F Ebtehaj, B Lindley, and M Richards (eds), *Kinship Matters* (Hart 2006).

[126] N Dominy and E Kempson, *Understanding Older People's Experiences of Poverty and Material Deprivation* (Department for Work and Pensions Research Report 363, 2006).

Simon Keller has argued that some of the existing theories that have been put forward to try to explain what duties children owe their parents, and why, are insufficient.[127]

One theory is that a sense of obligation arises because our parents have made a number of different kinds of sacrifices, possibly considerable, for our benefit. These sacrifices give rise to filial obligations. Others in our lives do not generally make the same level of sacrifice for us, and in this way the duties we owe our parents are greater than those we owe to other adults. Most of us could identify something that our parents had given up in order to raise us, and this may engender a sense of obligation. Conversely, if our parents have not been good parents, have not sacrificed for us but put their own interests first, it is unlikely that we would feel as strong a sense of obligation to them. Should it matter if the parents were legally or morally obliged to make such sacrifices? Is a parent owed anything for doing their duty? Some people do argue that a duty to one's parents should arise from the fact of child-raising. Just as the parents maintained the child, so the child must in future maintain the parents: the obligation is reciprocal. It is a bargain: 'I raised you; you help me in old age.' Teitelbaum argues that 'The adult children are franchisees, who have reaped the benefit of their parents' educational and other investment in them, and who now actively operate their own family units with the name, the reputation, and possibly the fortune of their parents at risk.'[128] In some countries, the child's obligation to a parent depends upon the parent having fulfilled their obligations to the child, so that parents who have seriously failed to meet their obligations do not incur a reciprocal right of support. But, of course, the child did not choose to be born and has not freely opted into that obligation. It is a debt that has been imposed on him by virtue of his parents' choice to have a child.

Some argue that children should help their parents out of gratitude, and that doing so is an expression of that gratitude. While it may not be akin to repaying a debt (cf the reciprocity theory), the extent of our duty of gratitude may depend upon the level of sacrifices made by our parents. But, as Blustein asks, 'Can children have duties to compensate their rearers or show gratitude to them for benefits they (the children) did not voluntarily accept?'[129] Would it depend on whether the benefit had been voluntarily provided by the parent, or would the duty

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[127] S Keller, 'Four Theories of Filial Duty' (2006) 56(223) *The Philosophical Quarterly* 254.

[128] LE Teitelbaum, 'Intergenerational Responsibility and Family Obligation: On Sharing' [1992] *Utah Law Review* 765, 776.

[129] J Blustein, 'Child Rearing and Family Interests' in O O'Neill and W Ruddick (eds), *Having Children: Philosophical and Legal Reflections on Parenthood* (OUP 1979).

to be grateful arise even where the parent was acting out of a legal obligation to provide for their own children? We can be grateful for favours that we have not requested, such as the parenting involved in raising us.[130] But duties of gratitude are vague, and any token of gratitude depends upon the effort put into it rather than the quantity or value of the token.[131] It would be difficult to translate that into law. As Stuifbergen and Van Delden write, 'The indeterminate nature of duties based on a broad interpretation of "debt" or on gratitude make it hard to define corresponding rights of parents to [receive] a certain kind of support from their children.'[132] Similarly, Wicclair points out, that 'There are countless ways in which adult children can demonstrate gratitude to impaired elderly parents, it may not be warranted to assume that the only appropriate way of showing gratitude to them is to help provide needed assistance.'[133]

Instead of reciprocity, sacrifice or gratitude, some philosophers have drawn an analogy with friendship: just as we would want to help a friend so we would want to help our parents (assuming that we have a good relationship with them). Indeed, we may feel that we *should* help them and that it would be wrong not to do so.[134] The friendship is likely to have arisen from the way in which the parents raised the child, but Jane English, who proposes this theory, argues that while children ought to do things for their parents, 'it is inappropriate and misleading to describe them as things "owed" … parents' voluntary sacrifices, rather than creating "debts" to be repaid, tend to create love or "friendship". The duties of grown children are those of friends and result from love…'[135] There is no quid pro quo in which what each person has done for the other is listed in a set of accounts: 'The duties of friendship do not require equal quantities of sacrifice', so that it is no argument at all to say that you should do *x* because I did *y*.[136] Moreover, the duty of friendship can exist only for as long as the friendship between parent and child endures. This means, therefore, that no duty arises where the child has no friendly feelings towards his parents, except that we may feel obligated out of respect for our former friendship, rather than the quality of our current one.[137] This might also be the

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[130] MC Stuifbergen and JJM Van Delden, 'Filial Obligations to Elderly Parents: A Duty to Care?' (2011) 14 *Medicine Health Care and Philosophy* 63.

[131] S Keller, 'Four Theories of Filial Duty' (2006) 56(223) *The Philosophical Quarterly* 254.

[132] MC Stuifbergen and JJM Van Delden, 'Filial Obligations to Elderly Parents: A Duty to Care?' (2011) 14 *Medicine Health Care and Philosophy* 63, 64.

[133] MR Wicclair, 'Caring for Fail Elderly Parents: Past Parental Sacrifices and the Obligations of Adult Children' (1990) 16 *Social Theory and* Practice 163, 176.

[134] N Dixon, 'The Friendship Model of Filial Obligations' (1995) 12(1) *Journal of Applied Philosophy* 77.

[135] J English, 'What Do Grown Children Owe Their Parents?' in O O'Neill and W Ruddick (eds), *Having Children: Philosophical and Legal Reflections on Parenthood* (OUP 1979).

[136] J English, 'What Do Grown Children Owe Their Parents?' in O O'Neill and W Ruddick (eds), *Having Children: Philosophical and Legal Reflections on Parenthood* (OUP 1979).

[137] N Dixon, 'The Friendship Model of Filial Obligations' (1995) 12(1) *Journal of Applied Philosophy* 77.

case where the parents have dementia and cannot recognise us. In such a situation, we would still feel love and a sense of duty towards them, even if they lacked the ability to reciprocate.

Does the friendship theory explain a sense of obligation to our parents? Simon Keller thinks not, arguing that 'you are stuck with your filial duties, in a way that you are not stuck with your duties of friendship', and while you may help out a friend, it is unlikely that you would ever do so because you think you owe a *duty* to them.

Perhaps, then, the friendship theory does not adequately explain why we may feel obligated to parents. Could it instead be about parental need? We may be particularly sensitive to the needs and vulnerabilities of our parents. This may explain why we feel an obligation to help our parents when we may not feel the same way about others, however great their need (with the probable exception of our children). Keller argues that the uniqueness of the parent-child relationship can best be explained by identifying the 'special goods' of parenting, namely that having children contributes something special to the parents' lives, and that being a child who has a strong relationship with his parents contributes something to the child's life, even when he is an adult. The things that parents and children have and do for one another are 'special goods': making significant sacrifices, providing long-term care, overseeing a child's development, sharing traits, having a special understanding of one another. It is hard to find these things in other relationships, to the same extent, or with the same meaning:

> When you make sure that you send presents for your parents' birthdays, make an effort to keep in touch, or do what is needed for them to get the care they need, you are almost certainly providing something for your parents that they will not get otherwise; you are providing your parents with something that no one but their child could (or is at all likely to) give them.[138]

There is something special about the parent-child relationship that is unique, and renders us uniquely placed to help one another. That doesn't mean that certain things, such as personal care, cannot be provided by someone else, it is just that it would not have the same meaning, and the provider may not feel the same sense of obligation.

It seems that none of these theories adequately explains the sense of obligation we may feel towards our parents. In fact, none of them adequately explain why a duty arises, if in fact it does, and what that duty looks like. Perhaps a better explanation is that all of the theories are

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[138] S Keller, 'Four Theories of Filial Duty' (2006) 56(223) *The Philosophical Quarterly* 254, 268.

true in part and that what we feel is a combination of friendship, reciprocation, gratitude, awareness of their need, and awareness of our unique place in meeting that need. Together, these create, for most people, a moral obligation to our parents. However, the nature and extent is unclear. Finch and Mason found that most people believe that a child has a greater responsibility towards their parents than do other family members, there was no agreement on what fulfilling that obligation involved.[139] Our responsibilities may be contingent on the precise circumstances and those could include our parents' need, our relationship with our parents (past and present), our ability to meet those needs alongside our other obligations, and indeed be 'tempered on both sides with a desire to retain mutual independence'.[140]

13.6 The abuse of older people

Elder abuse will always have existed in our society, but the sort of behaviour we would now consider abusive has not always been recognised as such. It has only been since the 1970s that elder abuse as a distinct concept has attracted attention,[141] and it was initially termed 'granny battering'[142] with a focus, therefore, on physical abuse within the family. An early letter to the *British Medical Journal* on the issue wondered 'how many of the elderly who "fall down frequently, doctor" do so because they are assaulted'.[143] As we now understand it, the abuse of older people may take a number of forms such as sexual, physical, financial, or emotional abuse, coercive and controlling behaviour, neglect, and so-called honour-based abuse, and it is certainly not exclusive to the family. It took until 1984 for the term 'elder abuse' to be coined.[144] Writing in 1999, Bridget Penhale referred to 'an increase in interest', so that 'the abuse of older people… is increasingly recognised', with the implication that it remained unrecognised in some areas or to some extent.[145]

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[139] J Finch and J Mason, 'Obligations of Kinship in Britain: Is there Normative Agreement?' (1991) 42(3) *British Journal of Sociology* 345.

[140] J Finch, 'Responsibilities, Obligations, and Commitment' in in I Allen and E Perkins (eds), *The Future of Family Care for Older People* (HMSO 1995).

[141] F Glendenning, 'What Is Elder Abuse and Neglect?' in P Decalmer and F Glendenning (eds), *The Mistreatment of Elderly People* (2nd edn., Sage 1997) describes the history of our growing understanding of the concept.

[142] A Baker, 'Granny Battering' (1975) 8 *Modern Geriatric* 20.

[143] GR Burston, 'Letter: Granny Battering' (1975) 3(5983) *British Medical Journal* 592 (6 September 1975).

[144] C McCreadie, 'From Granny Battering to Elder Abuse: A Critique of UK Writing, 1975-1992' (1993) 5(2) *Journal of Elder Abuse and Neglect* 7. See also S Biggs, 'A Family Concern: Elder Abuse in British Social Policy' (1996) 16 *Critical Social Policy* 63.

[145] B Penhale, 'Researching Elder Abuse: Lessons for Practice' in P Slater and M Eastman (eds), *Elder Abuse: Critical Issues in Policy and Practice* (Age Concern Books 1999).

One of the problems is that there is no commonly accepted definition of what is often called 'elder abuse'. This means that researchers and policy-makers may have different understandings of the nature and extent of the problem and therefore how best to address it. This 'has resulted in wide variations in reported prevalence rates'. However, one meta study by Yon et al. - a study of 52 other studies across 28 countries that seeks to iron out differences in definitions - found that in a given year 1 in 6 people aged 60 or over had experienced some form of abuse. The abuse was defined as 'a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person'. This distinguishes elder abuse as a concept from abuse by those in respect of whom there is no expectation of trust, such as a burglar, but incorporates family member, carers, and others with a role in providing care or services to an older person.

The prevalence of each form of abuse differ, and rates of abuse in institutional settings are higher than rates of abuse within the family – at least, the abuse that we know about. Psychological abuse was the most common in Yon's study, followed by financial, neglect, physical, and sexual, in that order. Older people may be particularly susceptible to certain forms of abuse because of physical or mental frailty, dependency, resources (or lack thereof), or location. Undue influence may arise where a person seeks to inherit from the older person either after their death or from transfer of property or use of the older person's assets or credit during the person's lifetime.[146] Control over medication, physical or chemical restraint, and neglect through malnutrition or inadequate personal care are all forms of abuse that may particularly torment older people. The reality is that without such protection it may be harder for them to leave or otherwise avoid interaction with their abuser. As Help the Aged has written:

> It is unrealistic to expect older people themselves to whistleblow and raise the alarm when they experience or witness an incident of abuse. Frequently the perpetrator of abuse will be in a position of power over the older person and so the consequences of complaining, as well as the fear of the consequences, are strong inhibitors for older people. Victims of abuse in their own homes may also be fear losing their home or their family by speaking up.[147]

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[146] See Ryan CW Hall, Richard CW Hall, and MJ Chapman, 'Exploitation of the Elderly: Undue Influence as a Form of Elder Abuse' (2005) 13(2) *Clinical Geriatrics* 28.

[147] Help the Aged, *Submission to the Parliamentary Select Committee on Health* (2003). Available at https://publications.parliament.uk/pa/cm200304/cmselect/cmhealth/111/3121103.htm Accessed 3 October 2021. This is a useful summary of the issue of elder abuse.

They may perceive the alternative – such as institutional care, loneliness, or poverty – to be worse.

The factors that increase the risk of abuse occurring include:

- Caregiver exhaustion and stress, such as over money (perhaps due to loss of earnings because of caring obligations) difficulties juggling caring with paid employment or child-raising; inadequate or insecure housing; or mental or physical illness (including depression and low self-esteem).
- The extent and nature of the care being required, which may include dealing with incontinence, physical falls, wandering off, personality changes, inappropriate undressing or sexualised behaviour, or aggressive and violent behaviour (common symptoms of dementia). This is the situational theory of abuse. Cognitive impairment is a particular risk factor.[148]
- Mutual financial and practical dependency and especially shared housing. The social exchange theory suggests that older people are more vulnerable and powerless, which increases the risk of abuse, and the caregiver may come to resent this, leading to abusive behaviour, particularly if the caregiver feels that they are not being sufficiently rewarded or are financially dependent on the older person.[149] Recent immigration by the older person to be closer to the younger can be a risk factor, as this can mean that the older person is less integrated (there may be language barriers, for example) and therefore more dependent on the caregiver.
- The psychology of the abuser and any substance abuse.
- A history of abuse, in which family members solve problems through physical violence or other forms of abuse (the social learning theory), or the caregiver has poor impulse control, or the parties had a poor relationship with one another during their earlier lives.
- Cultural or social pressures which may prevent the caregiver from seeking assistance or normalise mistreatment. ‘For example, in some cultures, sending elderly individuals to

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[148] JS Jones, C Holstege, and H Holstege, ‘Elder Abuse and Neglect: Understanding the Causes and Potential Risk Factors’ (1997) 15(6) *The American Journal of Emergency Medicine* 579.

[149] Y Abolfathi Momtaz, TA Hamid, and R Imbrahim, ‘Theories and Measures of Elder Abuse’ (2013) 13 *Psychogeriatrics* 82.

nursing homes is considered to be a form of abuse, whereas other cultures define it as a sign of caring.'[150]

- Lack of community support or resources, or social isolation.
- The caregiver being forced to provide care rather than choosing to do so.
- In the case of institutional caregivers, such as care home staff, poor pay and working conditions, lack of training, lack of supervision or oversight (by managers or by professional or family visitors), and high staff turnover can all increase the risk of abuse,[151] as can low job prestige, low satisfaction, and low caregiver educational attainment.[152] This is the stratification theory.

These factors do not automatically mean that abuse is present. They simply create the conditions in which it is more likely that abuse will occur. We can see some common themes, including dependency, caregiver stress, learned behaviours or caregiver pathology, and external factors. As with domestic abuse more generally, there are a number of theories about why abuse occurs, although no single theory adequately explains why it occurs in some families or institutional settings and not others.

13.6.1 Legal powers to address abuse

There is no specific criminal offence of abusing an older person. Depending on the nature of the abuse, a number of different offences could apply. These may be offences that could be committed against a person of any age (such as theft), in which case the vulnerability of the victim may be relevant to sentencing.[153] There are offences also which are specific to the relationship between abuser and victim or which apply to vulnerable victims only, irrespective of their age.

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[150] Y Abolfathi Momtaz, TA Hamid, and R Imbrahim, 'Theories and Measures of Elder Abuse' (2013) 13 *Psychogeriatrics* 82.

[151] JS Jones, C Holstege, and H Holstege, 'Elder Abuse and Neglect: Understanding the Causes and Potential Risk Factors' (1997) 15(6) *The American Journal of Emergency Medicine* 579.

[152] Y Abolfathi Momtaz, TA Hamid, and R Imbrahim, 'Theories and Measures of Elder Abuse' (2013) 13 *Psychogeriatrics* 82.

[153] Disability hostility is an aggravating feature in sentencing (s 146 Criminal Justice Act 2003), but even if that section does not apply the CPS notes' if there is evidence that the victim was deliberately targeted for their vulnerability, this will still make an offence more serious for sentencing purposes'. Crown Prosecution Service, *Prosecuting Crimes against Older People* (April 2020). Available at https://www.cps.gov.uk/legal-guidance/older-people-prosecuting-crimes-against Accessed 3 October 2021.

Section 44 Mental Capacity Act 2005 criminalises the ill treatment or wilful neglect of a person lacking mental capacity, and s127 of the Mental Health Act 1983 criminalises the ill treatment of a person with a mental disorder. Sections 20 and 21 of the Criminal Justice and Courts Act 2015 criminalises ill treatment of neglect by care workers or providers. Section 5 of the Domestic Violence, Crime and Victims Act 2004 criminalises causing or allowing a vulnerable adult to die or suffer serious physical harm. An adult is vulnerable if they are aged 16 or over and their ability to protect themselves from violence, abuse, or neglect is significantly impaired through physical or mental disability or illness, through old age or otherwise. There are also a number of offences relating to the administration of medication. Restraint or preventing the older person from leaving a place may also constitute assault or false imprisonment. Forced marriage or sexual activity is also a risk for older people.[154]

The statutory definition of domestic abuse introduced by the Domestic Abuse Act 2021 (see Chapter 7) is sufficiently wide to capture those forms of elder abuse that occur between those who are 'personally connected' within the meaning of the Act. It does not cover those who abuse the elderly within an institutional setting, or as non-family carers, or simply people who prey on elderly people with whom they have no connection. Nevertheless, if the victim and perpetrator are related, then they will fall within the provisions of the Family Law Act 1996 for occupation orders and non-molestation orders, or the 2021 Act's Domestic Abuse Protection Notices and Orders. The offence of controlling or coercive behaviour in an intimate or family relationship may also apply (s76 Serious Crime Act 2015).

Scenario 2

Illustration 3: Harry

Harry is aged 78 and has dementia. His son is his carer. While his risk of being abused is lower if he lives at home rather than in an institutional setting, there are a number of factors potentially raising the risk of abuse. If Harry was abused by his son, they would be personally connected within the meaning of the Domestic Abuse Act 2021 and 'associated' under the Family Law Act 1996, so that Harry could rely on some of the protections offered by these Acts. This would mean that his son was no longer permitted to care for him, and perhaps not even to contact him. The son may also have committed some criminal offences, although given Harry's dementia and vulnerability there may be difficulties in evidencing this. Indeed, it may be difficult to find

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[154] J Herring, *Vulnerable Adults and the Law* (OUP 2016) has a good chapter on the criminal law as it applies to the vulnerable.

evidence in relation to any abuse of vulnerable people precisely because they are vulnerable. Margaret Flynn, in her review of the abuse at Winterbourne View Hospital, a residential institution for those with learning difficulties, noted that 'patients were uniquely disadvantaged. Their concerns and allegations were dismissed as unreliable, the consequence of mental incapacity or their mental health status, or their desire to leave.'[155] Only when a journalist went undercover at the hospital and taped incidents of abuse for the BBC's ***Panorama*** programme were patients rescued.

How would any abuse of Harry be likely to come to the attention of the authorities? It could be that a friend or neighbour, doctor, or support worker raises their concerns. The local authority must, under the Care Act, make enquiries when they think an adult with care and support needs may be at risk of abuse or neglect. If Harry is being assessed for support, safeguarding questions may be asked routinely. Even if the assessment is of the son's needs as a carer, this should identify whether the son is under strain, strain being one of the risk factors in abuse. NHS staff also have safeguarding obligations,[156] and all agencies that assist vulnerable people should have a safeguarding policy in place that sets out the circumstances in which they must make reports to the police or local authority.

Each local authority will have a Safeguarding Adult Board, bringing together staff from the local authority, the local clinical commissioning groups (doctors) and the police, among others such as community groups. The board's role is to coordinate with agencies involved in safeguarding and publish a strategy for addressing risks to adults.

At section 13.2 of this chapter, we consider the role of the Court of Protection in protecting incapacitated people from harm. Sometimes, a person may be vulnerable without lacking in mental capacity. In *A Local Authority and others v DL*, the Court of Appeal dealt with a situation which appeared to involve multi-faceted abuse, in which the victims had capacity to decide whether or not to oust their son from their home, but were unwilling to do so. Although they had capacity, the Court held that the inherent jurisdiction nevertheless enabled it to take steps to protect them.

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[155] M Flynn, *Winterbourne View Hospital Serious Case Review* (South Gloucestershire Safeguarding Adults Board 2012.

[156] See, for example, the NHS England publication *Safeguarding Adults* and accompanying app.

Key Case: ***A Local Authority and others v DL*** **[2012] EWCA Civ 253**

DL was a man in his fifties. He lived with his parents (aged 85 and 90) in a house owned by his father. His mother was disabled and received daily care visits. The local authority became concerned that DL physically assaulted his parents, threatened them, controlled their movements in the house and stopped them from leaving, limited their access to visitors including health professionals and carers, and punished them by making them write lines. There were reports that he had been pressuring his father to transfer the house to him. The Mental Capacity Act 2005 did not apply, as the parents did not have 'an impairment of, or a disturbance in the functioning of, the mind or brain'. They did not want any steps taken against their son, but were influenced by DL to such an extent that they could not make free decisions. The Court of Appeal held that the passing of the 2005 Act did not limit the court's inherent jurisdiction in respect to those situations not covered by the 2005 Act. It therefore had the power to make injunctions to protect the parents.

The local Authority in this case had decided not to pursue the criminal law route, although a number of crimes were potentially involved, and this may have been due to evidential difficulties (the criminal standard of proof being higher than the civil standard) or the need for the parents to give evidence against their will. It demonstrates again the limitations of the criminal law in addressing issues of domestic abuse. How do we balance the autonomy of the victims and the need to empower rather than disempower them, against the risk that they are unable to exercise a free choice in relation to action against their abuser? In *A Local Authority and Others v DL*, the Court of Appeal's powers to protect the parents by making a decision to protect them from their son established a situation, free of their son, that enabled the parents to regain their autonomy. The Court expressed the view that this was entirely consistent with the parents' rights under Article 8 European Convention on Human Rights. However, undoubtedly there is a tension between the human rights of the parents – both to personal autonomy and to family life (both aspects of Article 8) and the state's obligations to protect its vulnerable citizens. Indeed, failure to protect the parents in this situation could also be a breach of their rights.

This brings us neatly to a discussion of the rights of older people.

13.7 The human rights of older people

If we want to protect older people, we need to recognise that they are rights-holders and that some of these rights should be reflected in the law. In this section, we look at the ways in which human rights instruments have been used by older people, and the direction of travel towards a possible convention on the rights of older people.

13.7.1 The European Convention on Human Rights

As we discuss in Chapter 9, the ECHR is a Convention of the Council of Europe, which is nothing to do with the European Union despite having members in common. The ECHR is incorporated into our domestic law by the Human Rights Act 1998. The Convention, and consequently the Human Rights Act 1998, applies to older people as it does to everyone, but, just as it is not designed for children, it does not contain articles that are specific to the needs of older people. However, some articles are used by or in respect of older persons more than others:

- Article 2 (the right to life)
- Article 3 (the right not to suffer torture or inhuman or degrading treatment)
- Article 8 (the right to respect for private and family life)
- Article 14 (non-discrimination): remember that this is a parasitic right, and means that there can be no discrimination in the application of the other rights. Age is not explicitly mentioned, but the category is not limited. The ECHR has considered age as an element of Article 14.[157]

In the present Covid-19 era, there are several aspects of the ECHR which are particularly relevant and have been the subject of some discussion: whether residents in care homes who are locked down and unable to have direct contact with family members are experiencing a breach of their Article 8 right to private and family life (most care home residents being there under local authority placement); and whether decisions made in respect of health care for older

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[157] E.g., *Schwizgebel v Switzerland* (Application no. 25762/07, decision 10 June 2010), which concerned a maximum age for adoption. The Court has a factsheet on its cases involving older people, which you can find at https://www.echr.coe.int/Documents/FS_Elderly_ENG.pdf Accessed 11 October 2021.

people during the pandemic constitute a breach of Article 2, the right to life.[158] Let us look at this more closely.

Focus: Think Critically: Human rights in the time of Covid

In an article in the *Journal of Adult Protection*, John Williams considers the human rights implications of the Coronavirus Act 2020.[159] The Act enabled local authorities to disapply the assessment of needs, financial assessments, duty to meet eligible needs and to review care and support plans contained in the Care Act 2014 and enabled the NHS to disapply its duty to provide continuing care. This meant that local authorities and the NHS were able to limit and prioritise access to social care and health care. 'Withdrawing social care from older people with disabilities is an interference in their right to private life, in particular dignity and autonomy', writes Williams. The Act therefore provided that local authorities continue to meet the needs of anyone where this was necessary to avoid breaching their human rights.[160] The problem with this, Williams, argues, is that without undertaking an assessment it will be impossible to determine what someone's needs are and therefore whether a failure to meet them would breach that person's human rights, under Article 8 or indeed, under Articles 2 or 3.

A second issue was the use of 'do not resuscitate' (DNR) decisions in some hospitals and care homes.[161] The Care Quality Commission found that between March 2020 (the first lockdown) and December of that year, the %age of residents in nursing homes with DNR decisions in place increased from 74% to 92%. The Essex Autonomy Project found that 28% of responding care workers reported that blanket DNR decisions were added to the file of every resident in their care home, and 24% said they were added to the files of every resident over a certain age.[162] Such a decision is only applicable to cardio pulmonary resuscitation, not other forms of medical treatment, and its use is a clinical decision: the treating doctor has determined that there is no realistic prospect of it being successful, in that it will not reverse the patient's

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[158] See also K Dzehtsiarou, 'Covid-19 and the European Convention on Human Rights' (Strasbourg Observers blog, 27 March 2020). Available at https://strasbourgobservers.com/2020/03/27/covid-19-and-the-europeanconvention-on-human-rights Accessed 10 October 2021.

[159] J Williams, '"Taking It on the Chin": Older People, Human Rights and Covid 19' (2021) 23(2) *Journal of Adult Protection* 86.

[160] Schedule 12 para 4(1).

[161] E.g., J Cooper, 'Surgery Asks Sickest Patients to Sign "Do Not Attempt CPR" Form if They Get COVID' (Wales Online 31 March 2020). Available at https://www.walesonline.co.uk/news/wales-news/coronavirus-covid-19-surgery-patients-18012444 Accessed 10 October 2021.

[162] M Kuylen, W Martin, A Wyllie, V Bhatt, and S Michaelowski, *Human Rights in Care Homes: A Survey Based Study Report* (Abridged) (v 2.1, Essex Autonomy Project 6 July 2021/October 2021).

underlying condition and may prolong or increase suffering.[163] For some, perhaps many, older people with severe covid, resuscitation is likely to fall into this category, and thus a 'do not resuscitate' decision may be appropriate. However, the medical guidance makes clear that blanket decisions aimed at a category of people, such as all those over a certain age or with a certain disability, are not permitted and they may breach the Equality Act 2010 and the ECHR. The Care Quality Commission concluded that 'some care home residents were wrongly subjected to decisions ruling out attempts at cardiopulmonary resuscitation (CPR) in the early stages of the covid-19 pandemic, leading to potentially avoidable deaths'.[164] The filing of DNR decisions without the correct process being followed, and on a blanket basis, would appear to breach the residents' Article 2 right to life, which is triggered not only by actual loss of life but by threatened loss of life too.

During various lockdown periods, there were serious limitations on the ability of older persons to leave the home or to be visited there by family and friends. In one survey of care home workers, 70% reported that their home allowed no family or friend visitors at certain periods during the pandemic. 84% reported that residents were not allowed to leave the facility. You can see in Figure 13.1 the drop in the number of applications being made to authorise a deprivation of liberty around the time of the first lockdown, which occurred towards the end of the first quarter of 2020. This was perhaps in part due to government guidance that suggested that most pandemic-induced restrictions would be covered by existing authorisations[165] and that the authority to detain residents arose from public health instructions and thus did not engage DOLS.[166] It was followed by a sharp surge in the number of applications after the Care Quality Commission expressed its concern.[167]

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[163] British Medical Association et al., *Decisions Relating to Cardiopulmonary Resuscitation: Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing* (3rd edition 1st revision, 2016).

[164] Care Quality Commission, *Review of Do Not Attempt Cardiopulmonary Resuscitation Decisions during the Covid-19 Pandemic: Interim Report* (2020). Available at www.cqc.org.uk/publications/themed-work/review-do-not-attempt-cardiopulmonary-resuscitation-decisions-during-covid. Accessed 10 October 2021.

[165] Department of Health and Social Care, *The Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (Dols) During the Coronavirus (COVID-19) Pandemic* (April 2021). Note that the drop seems to start pre-pandemic and a couple of reasons for this have been suggested, including that local authorities expected new legislation to change the law, and that local authorities were wrongly treating reporting DOLS applications as non-urgent: C Carter, 'Watchdog uncovers delays of up to six years in handling DoLS cases because of council triage system' (*Community Care* 16 February 2021).

[166] M Kuylen, W Martin, A Wyllie, V Bhatt, and S MIchaelowski, *Human Rights in Care Homes: A Survey Based Study Report* (Abridged) (v 2.1, Essex Autonomy Project 6 July 2021/October 2021).

[167] M Samuel, 'CQC warns of risk of unauthorised deprivation of liberty as DoLS reports drop on back of Covid' (*Community Care* 20 July 2020).

While many care homes are privately run, the majority of residents of care homes are funded by local authorities under the Care Act 2014. Local authorities are public bodies and they must therefore act in a way that is consistent with the human rights of those they fund.[168] Moreover, even in respect of those who are privately funded, the state has a positive duty to take appropriate steps to safeguard lives, even if no state actors are involved.[169] The strict approaches to access to or leaving care homes was intended to protect extremely vulnerable residents' lives: the interference with some people's Article 8 rights to private life in order to protect and promote the Article 2 right to life of others.

It is open to states to derogate from certain aspects of the ECHR in cases of national emergency, but what we have here is not a formal derogation but administrative practices, at state and local level, that potentially interfered with the human rights of the care home residents and potentially also those of their loved ones. There is no evidence about whether or not care homes weighed up of the rights and interests of those affected by these decisions against the wider state interest in controlling the pandemic and the need to protect the rights and interests of other residents. In fact, most care homes relied on government guidance,[170] which was silent on this issue. As a Parliamentary select committee noted, 'Since the start of the covid-19 pandemic, official guidance on care home visiting has prioritised the duty to protect residents' right to life (Article 2 ECHR), even where this has severely impacted the right to respect for private and family life (Article 8 ECHR).'[171] Only following criticism from a number of sources, including Parliament, was this approach modified.

13.7.2 The Social Charter

Alongside the ECHR, which deals with civil and political rights, sits the Council of Europe's Social Charter, a treaty addressing economic and social rights. It includes, among others, the right to be treated with dignity at work, collective bargaining, equality of opportunity, social

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[168] House of Commons/House of Lords Joint Committee on Human Rights, *Care Homes: Visiting Restrictions during the Covid-19 Pandemic* (Fifteenth Report of Session 2019–21) (May 2021) at para 11.

[169] European Court of Human Rights, *Guide on Article 2 European Convention on Human Rights: Right to Life* (2021).

[170] M Kuylen, W Martin, A Wyllie, V Bhatt, and S Michaelowski, *Human Rights in Care Homes: A Survey Based Study Report* (Abridged) (v 2.1, Essex Autonomy Project 6 July 2021/October 2021).

[171] House of Commons/House of Lords Joint Committee on Human Rights, *Care Homes: Visiting Restrictions during the Covid-19 Pandemic* (Fifteenth Report of Session 2019–21) (May 2021).

security benefits, medical assistance, and protections for the disabled and children.[172] Article 23 of the revised version deals with the rights of the elderly to social protection.

Statutory Extract: Article 23 Social Charter of the Council of Europe (revised version)

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 Care Act 2014 reflects a number the aspects of Article 23, placing an obligation on local authorities to provide information about services for older people, and including, as part of its definition of wellbeing, the individual's ability to participate in society. Nevertheless, the UK has not ratified the revised version of the Charter, and has only signed it. This means that is expresses support for its aims but has not yet agreed to be bound by the revised Charter's terms.

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[172] For information about the Charter, there are many links accessible from the Council of Europe webpage at https://www.coe.int/en/web/european-social-charter Accessed 9 October 2021.

The UK did ratify the original 1961 version of the Charter, but while this does refer to social welfare provision and support for the family, it makes no specific mention of older people at a distinct group.

The Council of Europe has also passed a Recommendation of the Committee of Ministers to Member States on the Promotion of Human Rights of Older Persons (2014).[173] This document sets out a range of recommendations covering areas such as non-discrimination, autonomy and participation in decision-making, protection from violence and abuse, social protections and employment, care, and the administration of justice. The (undated) UK report on its implementation highlights a number of initiatives, including the prohibition of most forms of age discrimination by virtue of the Equality Act 2010, the effect of the Mental Capacity Act 2005 and the creation of lasting powers of attorney, and the role of the Crown Prosecution Service in relation to crimes against older victims.[174] The UK does not appear to have submitted further, more recent, reports.[175]

13.7.3 United Nations Principles for Older Persons (1991)

The United Nations General Assembly adopted the Principles for Older Persons by resolution 46/91 of 16 December 1991.[176] The resolution 'encourages governments to incorporate the … principles into their national programmes whenever possible', so the resolution is not binding. The principles are as follows.

Statutory Extract: The UN Principles for Older Persons (1991)

Independence

1. Older persons should have access to adequate food, water, shelter, clothing and health care through the provision of income, family and community support and self-help.

2. Older persons should have the opportunity to work or to have access to other income-generating opportunities.

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[173] CMRec (2014)2. Adopted 19 February 2014 at the 1192nd meeting of the ministers' deputies.

[174] For the first compliance report, see https://www.coe.int/en/web/human-rights-intergovernmental-cooperation/work-completed/human-rights-older-persons Accessed 9 October 2021.

[175] For the most recent reports, see https://www.coe.int/en/web/human-rights-intergovernmental-cooperation/promotion-of-human-rights-of-older-persons Accessed 9 October 2021.

[176] See https://www.ohchr.org/en/professionalinterest/pages/olderpersons.aspx Accessed 11 October 2021.

3. Older persons should be able to participate in determining when and at what pace withdrawal from the labour force takes place.

4. Older persons should have access to appropriate educational and training programmes.

5. Older persons should be able to live in environments that are safe and adaptable to personal preferences and changing capacities.

6. Older persons should be able to reside at home for as long as possible.

Participation

7. Older persons should remain integrated in society, participate actively in the formulation and implementation of policies that directly affect their well-being and share their knowledge and skills with younger generations.

8. Older persons should be able to seek and develop opportunities for service to the community and to serve as volunteers in positions appropriate to their interests and capabilities.

9. Older persons should be able to form movements or associations of older persons.

Care

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

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

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

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

14. Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs,

needs and privacy and for the right to make decisions about their care and the quality of their lives.

Self-fulfilment

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

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

Dignity

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

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

13.7.4 United Nations Convention on the Rights of Persons with Disabilities (2006)

This United Nations Treaty was signed and ratified by the UK in 2009, as was a further Optional Protocol. State parties agree to eliminate all discrimination against those who are disabled. The Convention does not contain a binding definition of disability but explicitly states that ‘disability is an evolving concept’ and ‘results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others.’[177] This is the social model of disability. It recognises that people may have physical, mental, intellectual or sensory impairments, but it is the barriers that society places that renders them ‘disabled’. This may, of course, include a large number of older people.

The UN describes the role of the Convention as follows.

> While the Convention does not establish new human rights, it does set out with much greater clarity the obligations on States to promote, protect and ensure the rights of

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[177] Preamble.

> persons with disabilities. Thus, the Convention not only clarifies that States should not discriminate against persons with disabilities, it also sets out the many steps that States must take to create an enabling environment so that persons with disabilities can enjoy real equality in society. For example, the Convention requires States to take measures to ensure accessibility of the physical environment and information and communications technology. Similarly, States have obligations in relation to raising awareness, promoting access to justice, ensuring personal mobility, and collecting disaggregated data relevant to the Convention. In this way, the Convention goes into much greater depth than other human rights treaties in setting out the steps that States should take to prohibit discrimination and achieve equality for all.[178]

A committee on the rights of persons with disabilities and a conference of state parties monitor the states' implementation of the Convention. States report periodically to the UN with their progress. The initial report on the UK identified serious inconsistency with implementation.[179] The Optional Protocol enhances monitoring by creating a procedure that allows individuals who claim their rights have been breached to bring petitions to the committee, and enables the committee to undertake inquiries into grave or systematic violations of the Convention.[180]

13.7.5 Towards a Convention on the Rights of Older Persons?

The quick survey above demonstrates that while a number of instruments exist which affect the rights and interests of older people, the current international picture is far from perfect. As the ECHR is incorporated into our domestic law, it is possible for an individual to assert the rights contained therein in our domestic courts. The experience of the pandemic shows how easily these rights were disregarded in practice, although it would be fair to say that the pandemic was an exceptional situation. There is a lack of specific, enforceable rights in the other instruments. Let us take an example from the UN Principles: 'Older persons should be able to pursue opportunities for the full development of their potential'. How can this possibly be an enforceable right? It raises the same kinds of objections that we considered in Chapter 9

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[178] https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/frequently-asked-questions-regarding-the-convention-on-the-rights-of-persons-with-disabilities.html#iq1 Accessed 10 October 2021.

[179] You can read the documents at https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Countries.aspx Accessed 10 October 2021.

[180] You can read the applications concerning the UK at https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Countries.aspx (select the individual complaints, then the Convention then 'jurisprudence'). Accessed 10 October 2021.

when it came to children's opportunity rights. It is not specific enough for us to know what opportunities should be included and what role the state might have in enabling people to pursue those opportunities. There are no mechanisms for an individual to enforce the right to pursue an opportunity. They provide states with goals, and the state decides how and to what extent it may meet that goal, and if it does not there is no sanction. These are aspirations not obligations.

Some people have suggested that it is time for a new international convention to be drawn up that specifically addresses the rights of older people. It is reported that 400 organisations are working towards this.[181] In 2014 the UN's High Commissioner for Human Rights indicated her support for such a Convention.[182] Age Platform Europe, an umbrella group for EU citizens, has also indicated its support, pointing in particular to the urgency caused by the Covid-19 pandemic, with its serious impact on older people and their human rights.[183]

13.8 Conclusion

In this chapter, we have looked at areas of law and social policy that particularly affect older people, such as the Mental Capacity Act 2005, social care funding, and domestic or carer abuse, while also recognising that not all old people will be affected by these things, and some younger people will experience them. We have considered how society should meet the needs of older people, and the role that informal carers play. We have considered the current funding model and proposals to change this, as well as filial responsibility laws and whether we owe a duty to our parents, and if so what duty, and whether the law should reflect that duty. We have considered the ability of older people to pay for the care they need, and the state provision that exists. We have touched on the idea that the state should mitigate people's vulnerability over their life course. We have considered the human rights of older people, the instruments that protect those rights, and the difficulties of expressing them in such a way that enforcement is possible. Finally, we considered the effect of recent events, specifically the Covid-19 pandemic, on the human rights of older people.

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[181] https://www.helpage.org/what-we-do/un-convention/ Accessed 11 October 2021. See also their briefing paper *Strengthening Older People's Rights: Towards a UN Convention* (2010). Available at https://social.un.org/ageing-working-group/documents/Coalition%20to%20Strengthen%20the%20Rights%20of%20Older%20People.pdf Accessed 11 October 2021.

[182] 'UN Human Rights Chief Offers Her Support for a New Convention on the Rights of Older Persons' (UN High Commissioner for Human Rights press release 8 April 2014).

[183] Age Platform Europe, *Time for a UN Convention on the Rights of Older Persons - Discussion Paper* (August 2020).

Below, you will find some starting points for further research and reading. They are just that: starting points. As this chapter has included elements of economics, philosophy, law, history, medicine, social science, and politics, so too are there many further sources of research and writing on the lives of older people that are as varied as older people themselves.

Key points

- The Office for National Statistics tells us that 18.5 % of people in England and 21.1 % in Wales are aged 65 or over.

- The Court of Protection oversees matters relating to people who have lost mental capacity within the meaning of the Mental Capacity Act 2005. The court resolves disputes about the health/welfare and property/financial affairs of those without capacity. It will decide what is in a person's best interests. It has the power to authorise a person to be deprived of their liberty where this is in the person's best interests. A person will be deprived of their liberty where they are subject to continuous supervision and control and not free to leave (see Key Case *P v Cheshire West and Chester Council; P and Q v Surrey County Council* [2014] UKSC 19).

- Section 1 of the Care Act 2014 imposes a statutory duty on local authorities to promote the wellbeing of those people to whom the Act applies. This includes not only the person whose welfare is the concern, but also any carer that they have. Local authorities must assess and meet the needs of adult individuals in the local authority area whom the local authority has reason to believe need care and support, and their carers. They must also provide or commission services, facilities, or resources that can be offered that might reduce the need for support for individuals and their carers.
- Almost all older people will be entitled to a state pension and/or state benefits to supplement any private sources of income. Eligibility for certain forms of income depends upon the older person's national insurance history. Those state pension and welfare benefits that relate particularly to the elderly cost the state about £118.4 billion per year, which is about the same as the total for all universal credit and its predecessor benefits, all child benefit, and all disability related benefits added together. Despite this, 18% of pensioners are in relative low income poverty after housing costs have been deducted.

- In 2019/20, adult social care cost local authorities £23.3 billion or around 40% of their total expenditure, and just under half of this sum is spent on those who are of pensionable age. However, expenditure is not keeping up with demand. Either we reduce the services provided by the state (or the people that are eligible for them) so that those who cannot afford to meet their needs themselves have unmet needs or another source of funding, such as charity; or money has to be found to address the funding gap. The government has announced plans to increase taxes to fund social care, but to cap the cost an individual pays for their care (other than personal care).
- In many countries, laws exist that require a person to financially support certain other categories of relation. These laws do not exist, apart from in relation to spouses and minor children, in this jurisdiction. Such laws may reflect the capacity of that country's social welfare institutions. They may also reflect a different view on whether and to what extent children owe their parents duties. A number of theories of filial obligation have been suggested, but none adequately explains the sense of obligation we may feel towards our parents.
- Elder abuse will always have existed in our society, but the sort of behaviour we would now consider abusive has not always been recognised as such. There are a number of factors that increase the likelihood that abuse will occur, such as caregiver burnout, living in a care facility rather than with family, dependency, and cultural/social pressures. There is no specific criminal offence of abusing an older person. Depending on the nature of the abuse, a number of different offences could apply, some of them specific to vulnerable people.
- There are a number of human rights instruments protecting the rights and interests of older people, and there are calls for a new international convention. The Covid-19 pandemic has affected the rights and interests of older people, particularly those living in care homes.

Further reading: Some starting points

On the role and development of the Court of Protection, see J Weston, 'Managing Mental Incapacity in the 20th Century: A History of the Court of Protection of England & Wales' (2020) 68 *International Journal of Law and Psychiatry* 101524 and L Series, P Fennell, J Doughty, and A Mercer, *Welfare Cases in the Court of Protection: A Statistical Overview* (Cardiff University 2017). If you are interested in observing some cases, you may want to look online at the Open Court of Protection Project (https://openjusticecourtofprotection.org/) which tells you how to do that and what the restrictions are on reporting. Its blog also gives a good idea of the current work of the court. The relevant legislation is the Mental Capacity Act 2005 and the most important case relating to deprivation of liberty is *P v Cheshire West and Chester Council; P and Q v Surrey County Council* [2014] UKSC 19. You will be able to find a great many articles about the impact of this decision that a gilded cage is still a cage.

On informal care by family and friends, see G Conochie, *Supporting Carers: The Case for Change* (The Princess Royal Trust for Carers and Crossroads Care 2011), and B Sloan, *Informal Carers and Private Law* (Hart 2012). There are a number of other books about caring, including J Herring, *Caring and the Law* (Hart 2013) and L Gelsthorpe, P Mody, and B Sloan (eds), *Spaces of Care* (Hart 2020).

For the financial position of older people, start with some statistics. The Department for Work and Pensions, the Joseph Rowntree Foundation and the King's Fund all publish these. There is also a good Parliamentary briefing paper: B Francis-Devine, *Poverty in the UK: Statistics* (HC Library Briefing Paper 7096, 31 March 2021).

For filial obligations, both legal and moral, do refer to the articles cited in the footnotes to the chapter, such as those by Keller, Stuifbergen, and Mureşan respectively. There is a good discussion of the family changes that have affected the availability of family care by L Clarke, 'Family Care and Changing Family Structure: Bad News for the Elderly', in I Allen and E Perkins (eds), *The Future of Family Care for Older People* (HMSO 1995), although be aware that the data is now superseded.

For discussion of care funding, see A Dilnot, *Fairer Care Funding: The Report of the Commission on Funding of Care and Support ('the Dilnot Report')* (2011) and the recent HM Government, *Building Back Better: Our Plan for Health and Social Care* (CP506, 2021). The rules on funding can be found in the Care Act 2014 and the Care and Support (Eligibility Criteria) Regulations 2015 (SI 2015/313). A really clear summary of the financial difficulties of social care and the rising demand can be found at https://www.bbc.co.uk/news/health-50377846.

There is a helpful overview of elder abuse in Help the Aged's Submission to the Parliamentary Select Committee on Health (2003). This is available at https://publications.parliament.uk/pa/cm200304/cmselect/cmhealth/111/3121103.htm. F

Glendenning, 'What Is Elder Abuse and Neglect?' in P Decalmer and F Glendenning (eds), *The Mistreatment of Elderly People* (2nd edn., Sage 1997) describes the history of our growing understanding of the concept.