**Title**: Elder Abuse and Allocation of Scarce Resources: A Reappraisal of Human Dignity with Respect to Older Persons.

**Abstract**

In considering the growing numbers of older persons in the world today and the global recognition of the healthcare needs of this segment of the population, this paper looks briefly at two aspects of care; elder abuse and the allocation of scarce resources. The paper explores how the dignity of the human person as an operating principle in both human rights law, and healthcare discourse, as well as in Catholic Social Teaching can lead health care professionals and other stakeholders to have a more holistic ethical outlook in contexts of elder care.

First the meaning of the dignity of the human person is discussed in the three fields of human rights, health care and Catholic Social Teaching.

Then its ethical importance in human rights, as this relates to the right to health care, is analyzed in the context of elder abuse and the allocation of scarce resources for older persons.

The paper next discusses the normative stance of both national and international law with respect to elder abuse and resource allocation pinpointing some inherent dilemmas.

Lastly, the principles of Catholic Social Teaching (CST) based as they are on a distinct social anthropology, are used to point the way forward for a revised ethic of care for the elderly.

Even though the treatment of the above parameters is not exhaustive, the paper is considered necessary on these two aspects of elder care, which, despite their global pervasiveness, insufficient reflection has been undertaken.

**Introduction**

The number of older persons in the world today is increasing and, the global recognition of the healthcare needs of this segment of the population led to this paper, which looks briefly at two aspects of care; elder abuse and the allocation of scarce resources (1). Elder abuse here does not refer to random acts of violence against old people that often appear in criminal justice reports. The paper explores how the dignity of the human person as an operating principle in both human rights law, and healthcare discourse, as well as in Catholic Social Teaching can lead health care professionals and other stakeholders to have a more holistic ethical outlook in contexts of caring for the elderly. After the meaning of dignity of the human person is discussed in these three fields its ethical importance in human rights, as this relates to the right to health care is analyzed in the context of elder abuse and the allocation of scarce resources for older persons. The paper next discusses the normative stance of both state and international law in these specific areas of care pinpointing some inherent dilemmas. Lastly, the principles of Catholic Social Teaching (CST) which recognize human beings as primarily social creatures and, which emphasize the role of solidarity and strong family and community protection, are used to augment the debate for a revised ethic of care for the elderly. While the paper does not attempt a definitive perspective on the topic, it is considered necessary to the debate on two areas of elder care on which insufficient reflection has been undertaken, despite their global pervasiveness.

**1 Human dignity in ethical discourse in three fields**

Human dignity has different meanings and has been used in a variety of senses. The major ones include “attributed dignity”, that dignity that people possess by virtue of their place in society; “intrinsic dignity”, that dignity which we ascribe to all human beings simply by virtue of being human and “inflorescent dignity”, that dignity which people possess to a greater or less extent inasmuch as they lack or possess, gain or lose special qualities, excellences or virtues (this is the kind of dignity we acknowledg by medals for bravery or awards for lifetime achievements (2). While intrinsic dignity or full inherent human dignity will be our special concern, the other uses of the term should be kept in mind during this argument. Even though the anthropological and philosophical foundations of the concept do have some dissenters what needs to be stated is that for most people, human dignity is also about acknowledgement of a person at the general level- that is giving to the other the respect and esteem that is each person’s due (3). It is for this reason that it must be acknowledged. Furthermore, this consensus does affect how care is practiced with the elderly in general and within the contexts of this paper.

In human rights the dignity of the person is enshrined in the documents of the United Nations, especially the Universal Declaration of Human Rights- UNDHR, of 1948 and the ICESCR, International Covenant on Economic, Social and Cultural Rights of 1966. While the former may have been main a reaction against the atrocities of the Nazis committed in World War II, the latter is critical for the realization of other crucial rights that affect all signatories. The preamble in the UDHR clearly states: ‘recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world’. So widespread is the acceptance of the term in international law that human dignity exists as a fundamental moral and legal value, appearing in the constitutions of 157 countries, comprising 81 per cent of the total number of sovereign states of the United Nations (4). As a result, it is not easy, nor desirable to simply remove human dignity from rights discourse or any other discipline for that matter, given the ongoing interpretations and overlapping consensus between legal systems as to the specific rights that are considered when one speaks of human rights (5). The ICESCR is highlighted for our purposes because in this treaty the economic, social and cultural rights of individuals and nations are often cited to include the welfare of older persons. And, although the UN Charter promotes universal respect for human rights and fundamental freedom for all, it stops short of expressly recognizing prohibited distinctions other than race, sex, language and religion. Age as a prohibited ground for discrimination is not stated. This fact this writer feels contributes to the lack of clarity in international legislation, at least up to 2015 when a specific regional document on older persons- The Inter-American Convention on Protecting the Human Rights of Older Persons came into International human rights law.

The question is which human rights promote human dignity and as a result operate as values in international law? As the literature shows, human rights are not just legal norms but include, sometimes explicitly, stated concepts of justice, dignity and autonomy. In most human rights texts therefore, the following rights are listed: the right to life, not to be tortured, not to be sold into slavery, not to be discriminated against, to have a private life, to freedom of conscience and religion, to marry, to be given a fair trial. This list is not exhaustive. For our purposes, the right to life is paramount in upholding the dignity of the human being. However, to uphold the dignity of the human person, the right holder is expected to be able to enjoy socio-economic rights broadly defined to include the right to food, water, work, shelter, health care, security and a sustainable environment (6). Both elder abuse and the allocation of scarce resources, especially medical services fall under the protection of socio economic rights. However, the protection of such rights often requires the empowerment of government to make these rights achievable. It is here that human rights discourse on human dignity becomes somewhat incoherent.

For instance, there is variance in the recognition of human dignity in significant ways when human rights is practiced in India or in Latin America, when compared to Canada or under the European Convention of Human Rights (7). The fact is, the rights discourse is not universal but as is agreed, deeply informed by a Western perspective. And, it is a perspective which impacts on our elderly population in both developing and developed countries since there is no central concept of interdependence. The reason for this is that the pervading philosophy of the western liberal society is based on Immanuel Kant’s individualistic conception of the human person, which concludes that although social relations are necessary, they are only conditionally good (8). The philosophical tradition thus neglects the importance of need or dependence as an aspect of human life (9). However, there does exist a more balanced philosophy not exclusively among Christian thinkers that understand the human situation as one of dignity and dependence: a dignity common to all human beings but equally a neediness that is common to all (10). Such thinking is more meaningful when dealing with our ageing population than an ethic where dignity is both something a person inherently has - but can lose it, and something which he or she seeks to gain.

With Catholic Social Teaching there are some commonalities in the recognition of human dignity with human rights law in general as stated above. For example, in the Encyclical *Pacem in Terris*, the Church not only accepts but embraces the human rights discourse (11). The Church fully endorses human rights which encompasses socio-economic rights as listed earlier and these are described as “the mean which are suitable for the proper development of life”. However, these economic rights or positive right to security is not left to chance or to the vagaries of the economy. The core understanding of human rights in so far as socio economic rights are concerned implies that the right to be free from economic deprivation takes precedence over some traditional autonomy rights as per private property and free commerce (12). In other words, such traditional rights are subordinated to the right of subsistence with dignity. The CST principle of ‘preferential option for the poor’ includes our ageing population and is thus applicable to all cultures. More importantly, in this context, human dignity is understood as existential- involving concrete, existing human beings rather than the conceptual understanding of status and value attributed to person

There is a distinct social anthropology that is foundational to our understanding of what it means to be a human person and that gives credence to the deeply objective value of common human dignity. Human beings are made in the image of God. The Imago Dei expresses a foundational relationship between God and man, with implications for properly appreciating basic human goods and human flourishing. The Imago Dei is the reason why CST principles of solidarity and the common good, participation and subsidiarity make sense when people and communities have to deal with each other, notwithstanding differences in race, social status, gender, age, rural or urban dwellers, or the health of persons. These in turn must have repercussions for appropriate medical decision-making where the dignity of the elderly is concerned. The communal dimension to CST principles is basically antithetical to a morality that insists on the value of ‘autonomy’ as the ground of the dignity found in persons i.e. rational human beings. Not all human beings will have the capacity to fulfill the characteristics associated with autonomy, due to age or disability.

**2. Health care and rights with abuse of elderly and the allocation of scarce resources.**

As stated earlier, the right to health is at base a right to life. It is in the recognition of the dignity of the human person, a living concrete person, that this right can be observed. However, the right to life does not mean that life must exist under all circumstances and we are reminded that ‘[i]t is not life, but the right to life which is protected by law’ (13). One can hardly equate self defense with the ability of an old person or caregiver to put an end to abusive behaviour but, there are some commonalities with torture found in abuse of the elderly. Apart from the obvious reasons in Christian thought why the right to life is to be respected, human rights discourse argues that the right to life has been identified as a ‘norm of *ius cogens*’, which may not be derogated from in any circumstances (14). No government may deny its existence. The duty of the state to protect the right to life has negative as well as positive applications. How can the state be effective when dealing with elder abuse?

Elder abuse or elder mistreatment is defied by the WHO as: “a single or repeated act, or lack of appropriate action, occurring in any relationship where there is an expectation of trust that causes harm or distress to the older person”. Types of elder abuse include psychological, physical, sexual and emotional abuse, neglect and financial exploitation, all of which are considered a violation of human rights. These abuses may occur at home or in institutions- hospitals, nursing homes, long-term care facilities and community settings. In a 2017 study based on 28 countries including 12 low and middle-income countries, the World Health Organization indicate that 15.7% of persons aged 60 and over were subjected to some form of abuse. The caveat on this data states that this may be an underestimation as only 1 in 24 cases of abuse is reported. Some states aware that it is a prevalent and damaging problem’ have instituted Elder Abuse Justice Acts which codify concern about the damaging effects on older persons and the prevention policies that may be adopted by caregivers (15). Such an initiative exemplifies the duty of the state to prevent unlawful deprivations or treatment. However, a close look at the available literature points to a dearth of information from developing countries. The state also uses positive applications to deal with elder abuse when in promoting the right to life or the right to health when it signs major UN treaties like the Convention on the Rights of Persons with Disabilities (16). Another example is the observance of World Elder Abuse Awareness Day begun by the United Nations in June 15, 2015. This global initiative has been observed ever since and its importance lies in the fact that elder abuse is no longer considered a private matter. More pertinent to our argument is the impetus given to developing countries after the signing of the 2003 Madrid International Plan of Ageing. It was after Madrid that many developing countries instituted national plans and policies of ageing. While specific legislation has been slow in some aspects of domestic law, there is some advance especially in one regional treaty (17). In my country, a recent government initiative to have all care homes registered has been welcomed, not only because of increasing anecdotal reports of elder abuse, but the fact that a major piece of legislation on oversight on Homes for the Aged from 2007 has not yet been passed into law (18).

With respect to the law on allocation of scarce resources like institutional homes, trained caregivers, access to basic medicines and primary care, the picture is not at all encouraging.

Many persons including health advocates do not typically see the law as a critical influence on health. They ignore the fact that Law does not mean only the statutes passed by a legislature, but that the “rule of law” is also a quality of the prevailing political culture. For this paper only two aspects of law will be dealt with. Within positive law it may be said that rationing and allocation of available resources are necessary and reasonable, and not only applicable to older persons. On the other hand, the return on investment economic culture of western liberal society impinges on older persons’ access to certain goods based what they have contributed to the state while they were working. In addition, preference is being given to younger persons who are considered important contributors to the society’s future (19). As one writer observes, “meaningful access to medicines is fundamentally a question of the right to life” (20). Notwithstanding the multiple treaties a state has signed on dignity of the person who is also old, the fact remains that the downturn in the economy since 2008 has affected the kind and depth of resources countries can give to providing for older persons. It is therefore obvious for public health law today that sustaining a growing older population is the responsibility of everyone- society, government, the family and the individuals themselves. In this respect, behavior change is not only for the poor but also for policy makers.

**3. The potential of using CST principles in elder abuse and allocation of scarce resources**.

The above discussion shows that public policy is being shaped largely by social and economic trends and the elderly, who are now the ‘new poor’ are subject to such initiatives. Catholic social teaching with its principles of the common good, the preferential option for the poor and marginalized, participation and solidarity are well placed to contribute positively to the role of an ethics of public health where the issues of elder abuse and the allocation of scarce resources are concerned. For our purposes, the principles of solidarity and subsidiarity are dealt with in some detail as these contribute to the suggestion of the re-recognition of the family in law, as well as having a more equitable distribution of resources. In so doing CST always maintains its theistic concept of the dignity of such persons. In almost all studies of risk factors, lack of community i.e. social isolation emerges as a significant one in elder abuse (21).

Recognizing the structure of the family in all its manifestations is clearly supportive to any initiative that a state can adopt in its public policy to deal with the abuse of its ageing populations. A sociological understanding of the family is a group defined by a shared identity, caring, economic cooperation (including financial support, domestic labour, childcare and elderly care) sometimes co –residence (22). It is from the family that a person learns the relational dimension of living, of the nature of self-giving and of a certain level of tolerance with other people. Psychologically, the contribution of family members to a sense of autonomous well-being of the elderly cannot be replaced by other caregivers, whether paid or voluntary. Indeed, some persons see the family as the only institution that can ensure recognition of every elderly person’s unique value (23). This is so regardless of the size of the family within which a person is born. Since economic indicators show that institutional arrangements are untenable to bear the exponential growth rate of older persons in most areas of the world, the idea of solidarity in the family and in the wider community as understood within Catholic social teaching can be of help. The natural inclination of solidarity – the love and mutual respect that is found in all families though eroded in many parts of the world, can be regained by intentional education at the community or parish level. Some countries have instituted intergenerational education in schools both primary and secondary as in Canada (24). This idea that should be emulated in both developing and developed countries as public policy as soon as possible. Such an initiative will perforce expand not just recognition of material needs and the kind of dependency that occurs with older people, but also widen the awareness and understanding that dignity of the older person is not limited to his or her status but goes beyond that to a transcendental reality- the person is made in the image of God. A reality in which not only the child and the older person share, but one that also extends to caregivers and community workers. With this understanding of a common destiny, solidarity will more readily show itself in the community by members willing to practice a collective commitment to sharing care, costs, and emotions with the old within their midst. The commitment will be seen also in the initiative to have more localized care homes rather than institutions; in the vocal lobbying for training for caregivers from within the family and community to be sanctioned by the state, the church, and by other interest groups. Such training will perforce be of international standards and be aware of cultural biases, and be more effective in spotting and reporting elder abuse, for instance. Solidarity training will result in greater numbers of volunteers in health care for our population. For one country, a retirees and adolescent partnership program as well as another in grandparents parenting in multigenerational families are suggestions for Intergenerational Solidarity initiative (25). In addition, because of awareness raising programmes, families and their communities will become alert to inequalities in the rationing of health goods for the old, and so demand an explanation from the state. In effect the common good of the society will be served. This kind of solidarity does not justify the stronger involvement of the state in public health as is practiced presently, and is thus heavily political (26). This writer firmly believes that until the family is simultaneously valued by all the major players in healthcare and by the global health community, elder abuse will never be tackled successfully.

The question does arise how can Catholic Social Teaching influence state and international law to modify the care of which we speak. Two scenarios already exist. More recently in the bioethics and public health literature there is a call for an ethic that is focused on vulnerable groups rather than on vulnerable individuals unlike what obtains presently in clinical and research settings (27). In this respect, social support networks as advocated by the WHO as a determinant of health is most timely (28). The communal training which CST advocates will perforce lead to wider participation as well as solidarity with those at risk, from many ethicists and lobbyists who do not just stop at criticizing policy but, go on to engage with the experts as well as affected stake holders including, citizens, patient populations, communities and non-governmental organization-NGOs (29). By such means, one can look forward to a public policy in which community initiatives are the drivers of change rather than merely directives sanctioned by the state. The other scenario is the legal framework of Community Health Workers programmes in low and middle-income countries- the LMICs (30). This group of health workers whose remit can range from implementing biomedical interventions to acting as counsellors and as community agents of social change, are readily poised for inculcating CST principles of solidarity, participation and the common good in their work. When these principles are actively pursued even in least developed societies, situations of neglect and poverty no longer become daunting. In addition, the solidarity that sometimes exist among individual countries where care for the aged is concerned, will be propelled by 3c of the Sustainable Development Goals which vows to:

Substantially increase health financing and the recruitment, development , training and retention of the health workforce in developing countries, especially in least developed countries and small island developing states.

It is up to the present generation of older persons, the not so old, and the young to begin a sustainable process of change that will affect all of us and the world as we know it.

**4. Conclusion**

This paper sought to provoke reflection on the dignity of the human person who is old and subject to elder abuse or, at risk for elder abuse. The reflection was also on all older persons who fall victims to the rationing and allocation of health services and medicines because of illness due to age. Insofar as the dignity of the human person is concerned, we observed that for all its widespread use in legal documents there are variations in interpretation, but these do not radically affect how people and nation states care for older persons. An overlap in the norms of the UDHR and other regional documents like the Inter American Convention on protecting the Human Rights of Older Persons with that of health care was also identified. These norms refer both to respect for the human right to life and the prohibition of torture and degrading treatment, as well as the protection desired for the wellbeing of older persons within the family and community. There was also convergence with the norms of Catholic Social Teaching with the principles of human rights in the observance of human dignity in general and in health care. However, CST interprets socio economic rights as applicable to all cultures and insists on the practical implications- subsistence with dignity for how these rights are to be protected. In addition, CST remains unambiguous in its emphasis on the relational aspect of human existence as a prerequisite for human flourishing, with its recognition of the dignity of the other that is untouched by accidents of age or strength or gender or of race. Of continuing concern was the prevailing consequentialist perspective that informs the allocation of scarce resources in medicines and institutional care for older persons. The universal economic downturn being experienced by both developed and developing countries point to a continued absence of equity in services and medicines for this group. Mindful that ongoing ethical analysis cannot be eliminated from public policy, we welcome the relational turn observed in public health to date, and we believe that a wider adoption of CST principles can prevent the present dilemma facing nations where elder abuse and allocating scarce resources to the elderly are of concern.

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