

Human Rights in an ageing society

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

The Netherlands has a strong social tradition in which varying political coalitions have legislated to provide an extensive social safety net, the two most noticeable features of which were a generally respected three-pillar pension system and a national insurance scheme to protect against incapacity for work.

The principles of non-discrimination and equal opportunities took root from the nineteen-sixties onwards. Initially, policies focussed on gender, later in the nineteen-nineties after fierce battle and lobby from a variety of interest groups the criteria were broadened to include ethnic background, handicap, age and sexual orientation.

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

The scope of the Law

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

Reconnaissance

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

Social protection

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

Productive ageing

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

From aftercare to prevention

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

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

From age segregation to integration

Respecting people in their right to participate means offering space, opportunities and freedom to everyone so that age diversity and the quality of human relationships become the norm within all organisations. This diversity should also be reflected in politics, culture and media where older people should be able to develop the characteristics of their generation. Diversity as a basic principle should have a counterpart in other areas. We could think about building 'Silver Cities' or large-scale communities just for older people. But is segregation the solution? It is argued that in mixed housing areas the different generations compensate each other's weaknesses with each other's strengths. The small-scale problems associated with being young or growing old can be dealt with within residential areas. This is also true for many ICT solutions in the fields of care, participation and ways to spend time and for policies that stimulates the transfer of culture between generations.

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

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

End of life issues

In the creation of an enabling and supportive environment for ageing people, we cannot ignore the particular difficulties of the final stage in life. The simultaneous occurrence of several chronic illnesses and sometimes the loss of mental faculties (dementia) in the last years of life requires the sensitive handling of issues involving life and death. These issues have been discussed for a long time in the Netherlands, resulting in an Act in 2002 to regulate the actions of physicians when terminating life in situations of “unbearable and hopeless suffering”. Such intervention is only permitted if the criteria are clearly met, including conditions of careful practice, and may only arise from a voluntary and carefully considered request from a patient who has been fully informed and has fully understood the course of his or her illness and the possibilities to treat it. Both the physician and the patient must be convinced that there is no other reasonable solution. A second, independent physician must also have visited the patient and confirmed in writing that the conditions of careful practice have been met. The actions to terminate life must be carried out with great medical care and the euthanasia must be reported afterwards to the local authority coroner and a regional review commission. If the acting physician has not fulfilled the requirements disciplinary proceedings can follow.

One of the aims of this legislation was to attempt to bring into the open the practice that already existed, thereby making it possible to deal with the wishes of patients concerning the end of their life in all openness and with due care. There has been much debate concerning the desire for the strong involvement of the medical profession in determining professional standards, quality requirements and the advancement of expertise. But contrary to what is often thought abroad, only few very old people actually make use of these provisions, perhaps because of the extensive investments that have been carried out in the development of palliative care. Good palliative care, after all, prevents the need to actively end life.

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