

Human Rights: A New Language for Aging Advocacy

Russell E. Morgan, Jr., Dr. PH,¹ and Sam David¹

Purpose: The purpose of this study was to consider how human rights concepts developed by the international human rights movement could contribute to advocacy efforts on behalf of the aging in an era of population aging.

Design and Methods: This study evaluated changes in popular perceptions of aging, the concomitant need for a reformulation of aging advocacy, and the role that human rights concepts could play in protecting older persons. It then considered human rights concepts as they are related to the issues of work, retirement security, health care, and long-term care. **Results:** Human rights apply to all aspects of the life spectrum and can be a powerful force in defending and protecting older persons by operating as a baseline for establishing the underlying values for aging policies and by linking older persons' concerns with the other segments of society. **Implications:** The study's conclusion suggests that seniors' groups should use human rights principles as a new foundation on which to develop new approaches to their public education and advocacy efforts.

Key Words: Older persons, Public policy, Equity, Entitlement, Principles, Values

Growing older should not be a disability in itself. But for many, it entails a struggle to maintain a decent standard of living.

The high costs of health care and the frequent bias against seniors in the workplace contribute to the difficulties of those approaching advanced age. As the United States experiences *population aging*—the steep rise in number of seniors, as well as their proportion of the total population—the problem may indeed worsen. Aging baby boomers, medical advances, and declining birth rates are swelling the number of seniors, thus increasing how many people will encounter these struggles.

Advocates for aging adults need a convincing argument that will establish broad political support for maintaining a high quality of life for all seniors throughout their lives. The platform for establishing these values, too much ignored thus far, is human rights (a concept that is understandable to those of all ages and for which they can also be passionate). Educating the general population about the universality of human rights concepts and their direct relevance to the most important policy issues impacting seniors can inspire public support for all segments of the population. Advocates could then use the newfound support and perhaps activism in lobbying for changes that would help the elderly population, while helping humanity in general.

Why Human Rights?

Like women or members of racial or ethnic minorities, the aging too are part of a unique minority, a minority that cuts across all other social divisions because we all eventually join it. And there are inherent difficulties that accompany the process of aging. The question becomes one of how to address the inevitable quality-of-life issues with concrete results.

Support for this project was provided by the SPRY Foundation, Washington, DC. Dr. Morgan is the President of the SPRY Foundation. He is also chair of the American Public Health Association's International Human Rights Committee. Sam David attends the University of Pennsylvania, School of Law, and is formerly a research assistant at Human Rights Watch and SPRY Foundation. We thank Amy Harshfield, SPRY Foundation, for her background research and contributions to the writing of this article.

Address correspondence to Russell E. Morgan, Jr., Dr. PH, SPRY Foundation, 10 G Street, NE, Suite 600, Washington, DC 20002-4215. E-mail: morganr@ncpssm.org

¹SPRY Foundation, Washington, DC.

Human rights principles, emerging into an international movement half a century ago, have evolved into a political force. Various treaties spell out standards and rights both for certain segments of the population and for everyone. But these documents are not well known by most of the U.S. population. For example, a 1997 poll commissioned by the National Center for Human Rights Education, in Atlanta, Georgia, showed that 92% of the American public has never heard of the Universal Declaration of Human Rights (UDHR), written in 1948 (National Center for Human Rights Education, 2001). Ironically, this was developed by a committee chaired by Eleanor Roosevelt and adopted by the United Nations on December 10th of that year. Although the human rights standards that the UDHR lays out, and which are enforced through the various human rights treaties, have not been fully recognized in the United States, they establish a basic foundation for supporting moral values for all societies.

Using human rights standards to advocate for seniors would characterize their needs within a framework that includes all other social and age groups. The right to health care, for example, applies to everyone, regardless of age or social status. Advocating for seniors' rights to accessible and universally affordable health care is thus an argument for good health care for all. If advocates for seniors depict the pursuit of health care for elders as a broader struggle (i.e., a struggle for our entire society, which is based on human rights and the fundamental values they establish), they would likely command wide, intergenerational support.

But convincing those who formulate aging-related policies to consciously recognize and respect the collective rights of seniors is crucial. And the means to that end lies in educating the general public about the rights of all citizens. If the majority of American people knew and understood that a healthy 80-year-old may be capable of working at the same level as his 40-year-old counterpart but won't earn as much, or that a 75-year-old's medicine for her age-related illness may cost her three times as much as her daughter's chronic illness drugs, then a typical policy maker might respond to the louder and more pervasive outcry for help. This education must include bringing about public awareness of the values incorporated in the UDHR (1948)—an understanding that will help Americans to digest the incontrovertible truth that all people are entitled to human rights, no matter who they are or where they live.

The concept of human rights has recently been catapulted into the forefront of American minds, as the events of September 11, 2001, and their aftermath keep the country saturated with media coverage of rights abuses. The horrors in various areas of the world have never gone away, but citizens are now more attuned to and informed of the realities that lie beyond their immediate vision. The inequities in the United States that result from national policies that treat young and old people differently create a significant issue of human rights as well and merit the attention of those of all ages. Why should a person lose the high quality of

health care received 30 years earlier, and why should anyone encounter obstacles upon trying to learn the new skills required for his or her career?

There is potential public support: In a poll sponsored by the National Center for Human Rights Education (2001), Peter Hart found that 54% of Americans believe elderly people need support through government programs to maintain a basic standard of living. The Center aptly states that "our compassion for those in need is greater than our understanding about how to use human rights to end their suffering" (p. 3). That lack of understanding must be remedied.

The Human Rights Framework

What are internationally recognized human rights and how do they pertain to seniors? Human rights standards are enshrined in a variety of international treaties and covenants, which are legally binding upon those nations that ratify them. Other documents and declarations also specify such rights, but are without the force of law behind them. They nevertheless represent a moral consensus of the international community.

Three documents comprise the International Bill of Rights: (a) UDHR (1948), (b) the International Covenant on Civil and Political Rights (ICCPR; 1966), and (c) the International Covenant on Economic, Social, and Cultural Rights (ICESCR; 1966).

The ICESCR (1966) enunciates rights to work (Article 6) and to just and favorable working conditions that provide workers with "a decent living for themselves and their families" (Article 7). Article 9 attests to a right to Social Security—essential for those in retirement and to those in need of long-term assistance. The right to "the enjoyment of the highest attainable standard of physical and mental health" is enunciated (Article 12), while recognizing limitations imposed by biological and socioeconomic preconditions and the government's available resources.

Three other human rights documents pertinent to seniors are (a) the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW; 1979), (b) the International Convention on the Elimination of All Forms of Racial Discrimination (CERD; 1993) and (c) the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT; 1984).

CEDAW (1979) and CERD (1993) make clear the obligation of governments to work toward abolishing all gender and race discrimination. They offer a sweeping definition of discrimination, clarifying that policies and practices that have an unjustifiably disparate gender- or race-based impact may constitute discrimination, even if the result was unintended. This understanding of discrimination is important for seniors, because gender and race are often relevant in examining the causes of preexisting inequalities in areas such as income and health care (Muller, 1999).

The ICCPR (1966), part of the International Bill of Rights, establishes a right to freedom from "cruel, inhuman, or degrading treatment or punishment" (Article 7). These injustices are understood in CAT

(1984) to be acts "committed by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity" (Article 16[1]). Although the meanings of these terms remain the subject of some debate, the prohibition against abusive treatment could be used to argue for more protection for seniors in nursing homes and facilities. As many of these homes are government funded, the residents—vulnerable because of a reliance on others for their care—could benefit from effective advocacy based on the stated prohibitions.

Seniors' advocates must also be aware of the United Nations (U.N.) Principles for Older Persons (1991). Although the guidelines therein do not have the legal force of the international human rights treaties, they are drawn directly from the principles established in the International Bill of Rights. Central to the U.N. Principles are the standards of independence, participation, care, self-fulfillment, and dignity for seniors, to be incorporated into government programs whenever possible.

The fundamental rights enunciated in the international treaties and their further exploration in the U.N. Principles for Older Persons (1991) provide the foundation for seniors' advocates to formulate their issues as society-wide human rights concerns. The United States, however, has not yet agreed to abide by all the treaties. It has signed and ratified the ICCPR (1966), CERD (1993), and CAT (1984), obliging the nation to meet those treaties' standards and to report on compliance with them to the relevant U.N. treaty bodies. But neither the ICESCR (1966) nor the CEDAW (1979) has been ratified by the United States. Unfounded congressional fears and arrogance may well play a part in this shameful disregard, but advocates must go beyond those politicians determined to keep the treaties off their senatorial desks. It must be articulated also to the public that there are core values shared by most Americans, and it is in the best interest of each citizen to stand up for the rights of others—strangers or not.

Thus, instead of focusing only on the unfortunate U.S. legal status of these two human rights accords, advocates should emphasize the accords' moral power and organizing potential. The ICESCR (1966) and CEDAW (1979) are the outcome of extensive consideration of economic, social, cultural, and gender-based issues, and represent wide agreement in the international community: 142 countries are a party to the ICESCR and 165 to CEDAW (United Nations, Office of the United Nations High Commissioner for Human Rights, 2000). Used carefully yet assertively by seniors' advocates, these agreements can become a mobilizing tool that enhances the movement to protect seniors—and all other members of society as well.

Applying Human Rights Standards to Seniors' Issues

Four key areas in the lives of seniors exemplify how the integration of human rights values could im-

prove the creation of public policies, federal and state, that address the needs of the growing senior population in communities across America: (a) work, (b) retirement security, (c) health care, and (d) long-term care.

The Workplace

Jeff is in his 60s and lost his high-level marketing job a decade ago. His difficulty finding a new job is typical for seniors: the years of experience didn't matter, once employers noticed his age. Some employers even admitted that his age led them not to hire him. He started his own business, earning a decent living although it was itself a demotion: he went from the upper \$80,000s to the upper \$30,000s. "I enjoy my work. I've stayed on the cutting edge of technology and computers and get a great deal of enjoyment from it; there is still software I would like to create and market," he says.

Jeff is entitled to the same just and favorable working conditions that are easily accepted and expected by those in other minority groups. But age-based discrimination is unfortunately not unusual.

Although mandatory retirement is less of a problem now than in previous years because of the Age Discrimination in Employment Act (1967), the issue of age discrimination in hiring and firing decisions has not improved to the same degree. The ability of seniors to realize equality in the workplace has been hurt by their limited access to training and employers' negative views of older workers. Stereotypes continue to convince many employers that older workers are inflexible and not easily adaptable to new technologies (Rix, 1999).

Although stereotypes cannot be changed by policies and laws, they can be gradually molded by education. The public can be made more aware, through effective advocacy efforts, that a person in Jeff's predicament is as entitled to and as capable of performing a good job as someone 20 years his junior. Not only might this new understanding mean that many employers would take older workers more seriously, but the workers themselves may stand up for their rights with more confidence and public support behind them.

Older women and minorities are particularly affected by these inequalities, as their training and income have been historically disproportionate to the rest of the senior population (Muller, 1999). Thus, they are especially vulnerable to the prospect of low-income jobs with limited benefits, exacerbating the preexisting problem.

Policy makers are pursuing reforms to encourage seniors to remain in the workforce longer. But some of the attempts to lengthen seniors' participation in the working world could result in jeopardizing their ability to secure just and favorable working conditions.

Employers' convincing seniors to keep working (e.g., by increasing eligibility ages for pensions or creating new incentives such as flexible schedules) does not expand their opportunities for decent employment. New training programs, however, would help to burst the myths that older workers (a) cannot learn

new procedures as well as younger workers, and (b) are not interested in the latest technologies and methods. As stated in the U.N. Principles for Older Persons (1991), "Older persons should have access to appropriate educational and training programmes" (p. 2).

By highlighting the fact that older workers are indeed entitled to the same opportunities and working conditions as members of other minorities, simply because both groups have the same rights, advocates can pressure policy makers to focus on finding solutions to the problem of age discrimination in hiring decisions—not on creating reforms that make it harder for aging workers to leave where they are.

Retirement Security

Susan, in her mid-70s, kept working until 2 years ago when she became ill. For three decades she has taken care of her mother, father-in-law, mother-in-law, and husband, who died in 1980. She is paying off her mortgage, has never had a job that provided a pension, and relies on Social Security as her lifeline. She spends about \$25 per week on groceries, and cannot afford to really become sick.

Susan's situation is not that different from many seniors who rely on Social Security benefits for the majority of their retirement income. Nearly 60% of older Americans rely on Social Security benefits for 50% or more of their income, and nearly one third rely on Social Security benefits for 80% or more of their income (Dauster, 1996). Population aging threatens this crucial source of retirement support.

As the 76 million baby boomers leave the workforce, fewer workers will support an increasing number of retirees through Social Security investments. In the short term, Social Security trust fund balances will grow, but these balances may reach their limit in 2022 (Meyers, 1999).

There is considerable dispute over the extent to which Social Security is imperiled. Several new economic and social policies have been proposed that may help counterbalance these effects of population aging. For example, people working beyond age 65 would contribute longer to Social Security; or, new government employees, at the state and local levels, could be included in the expanded pool of workers supporting Social Security. Thus valid questions have been raised about assumptions regarding the potential bankruptcy of Social Security and the degree to which the costs of providing it will rise (Meyers, 1999). But most analysts agree that there is a need for some modifications in order to maintain a financially healthy social insurance program that benefits all Americans.

One unacceptable alteration would be a dramatic reduction of Social Security benefits: This would result in clear discrimination against women and minorities. Two of the human rights documents, powerful in their morality, prohibit gender and race discrimination: CEDAW (1979) and the CERD (1993). As women and minorities are over-represented in the elderly poor

population, any harmful effects to that population in general are therefore disproportionately harmful to women and minorities. Seniors' advocates can invoke these documents to highlight how curtailments of Social Security would hurt women and minorities more than nonminorities. A successful explanation of this problem to politicians and citizens may illustrate the fundamental inequalities, and voters too may voice their concerns for a more equitable Social Security program.

Health Care

Sandra, covered by Medicare, pays for her prescription drugs out of her Social Security check, since neither Medicare nor her supplemental insurance covers them. She is finding that she can no longer afford the expense. Mary and her husband are \$8,000 in debt because they have been forced to pay for prescription drugs out of pocket.

Health care financing for seniors clearly needs to be changed. As the number of seniors rises, their main health insurance program—Medicare—will be increasingly challenged. Just as the integrity of Social Security is disputed, the extent to which Medicare is endangered is also debated.

Aside from population aging, other health care-related developments have contributed to the increased demands on Medicare (Binstock, 1999). The onset of new diseases, the increase in the number of people living into old age, and the costs of medicine and long-term care all put more demand on health insurance for elders. But according to government projections, the rapid rise in beneficiaries after the first baby boomers turn 65 is what will usher in Medicare's financial shortfall. (This shortfall refers to Medicare's Part A, which is a trust fund in much the same way as Social Security. In the 1999 annual report on the solvency of Medicare's Part A, the Hospital Insurance Trustees projected that the trust fund will remain solvent until 2015. In 1998 they projected solvency until 2008; see Caplan, Brangan, & Gross, 1999.) Measures under consideration to alleviate the problem include relying more heavily on health maintenance organizations (HMOs; a scenario under way for some years now), raising the eligibility age for Medicare, creating medical savings accounts, supplying health care vouchers, and rationing, or restricting, health care for seniors.

Examining these proposals through a human rights lens will demonstrate how such plans are inadequate and damaging for seniors. A human rights-based discussion could help close these gaps in access to health care. By focusing on everyone's right to the best possible health care, advocates for aging adults can point out to policy makers exactly how seniors are being left behind in this regard—seniors are not provided with the options or range of choices for adequate health care.

As access to health care is woefully insufficient for seniors, it may become even more problematic with the growth of population aging. Medicare does not

cover prescription drugs, nor does it require its participating HMOs to do so. Approximately one third of Medicare beneficiaries have no drug coverage whatsoever (Pear, 2000). The remaining two thirds receive some degree of drug coverage through medigap policies, Medicare HMOs, or employer retirement packages. But these plans do not preclude high out-of-pocket medicine expenses, nor do they protect against fluctuations in coverage due to policy profits and market trends. Some seniors are traveling to Canada, where pharmaceutical prices are lower because of the government's commitment to equity in aging.

Medicare does cover mental health costs, but copayments for mental health care remain significantly higher than those for physical health care. This is an ongoing obstacle to seniors' access to mental health treatment and increases the financial burden on their caregivers. HMOs fall short as well in providing adequate and consistent coverage for mental health care (Katz, 1999).

But for seniors, mental health care is indispensable. Mental health problems, especially depression, occur at high rates among the elderly population (National Institutes of Health, 1991). There are also clear links between depression and declining physical health, including malnutrition, worsening disabilities, and even increased mortality (U.S. Office of the Surgeon General, 1999).

The comorbidity factor often arises in seniors who suffer from depression; one disease may impede recovery from another. A stroke victim, for example, may not want to take the medication that is essential for his or her recovery if an underlying clinical depression is lurking. That depression, hidden or not, must then be treated in order for the patient to have a good chance at recovery from the stroke.

Advocates for aging adults also need to encourage medical researchers to be aware of special health concerns of seniors. Ethicists and legal professionals, as well as medical researchers, must watch for any bias against seniors in their case work and analysis and be vigilant in incorporating the health care challenges of seniors into any decisions and studies.

A rising problem in the senior population is one usually thought of as affecting only young adults: AIDS. But at least 10% of all cases are in patients aged older than 50. And a quarter of those are aged older than 60 (National Association on HIV Over Fifty, 2001). From 1991 to 1996, cases in those aged older than 50 increased by 22%—a much larger increase than the 9% that occurred in those aged 13–49 (Hirschhorn, 2001).

Health care providers and seniors themselves are not conditioned to be wary of the disease—they do not necessarily realize that this age group is at risk just as other age groups are. Educational campaigns about AIDS and HIV are not targeted at seniors: "How often does a wrinkled face appear on a prevention poster?" (National Association on HIV Over Fifty, 2001, p. 1). According to the National Association on HIV Over Fifty, the senior population has been, for the most part, omitted from research, clini-

cal drug trials, educational prevention programs, and intervention efforts. Thus outreach, education, and research on AIDS and HIV infection should be undertaken and encouraged by seniors' advocates, making it clear to both doctors and patients that thousands of people of a certain age are becoming infected each year. Facing that reality and taking steps to alleviate the problem will not only improve many lives in the older population, but save them.

The rights of seniors to good health care are mandated by human rights standards that apply to other segments of society—whether those standards concern equal opportunity in the workplace for women or access to public buildings for disabled people.

Long-Term Care

LaShawn, 84, was living in independent senior housing but became quite ill following an incorrect diagnosis of a medical problem. At 90 pounds, she moved in with her daughter, herself 65, who takes care of her. LaShawn's granddaughter also helps out, but worries that she could end up being the caregiver for both her mother and grandmother. LaShawn cannot be left alone, but day care costs and health expenses are high.

The problems of LaShawn and her family are common. The caregivers of frail seniors struggle to ensure that their loved ones receive the care they need in a supportive environment. Public funding for care is difficult to obtain: Medicare-funded home care, for example, is generally provided only for short, post-acute care needs and has restrictive rules for eligibility (Bergquist, 1999). Medicaid's requirements are less stringent, but not all services are provided.

Financially, the system is set for seniors to lose. To qualify for long-term care, one cannot have more than \$2,000 in assets, except for his or her home. A spouse's assets are considered as well, although a higher limit is set. A spend-down process often ensues, in which all assets are drained until eligibility is reached (Rein, 1996). The consequence is financial hardship and further dependency, both of which are socially and psychologically debilitating. Private insurance, if held, rarely covers long-term care: In 1995 it covered less than 6% of the national cost of nursing home and home care costs (Stone, 1999).

The demand for long-term assistance will dramatically increase with the rising number of seniors and with medical advances allowing people with chronic illnesses to live longer and with lower levels of pain (Stone, 1999). At the same time, other demographic factors may decrease the resources available for long-term care. For example, fewer children have been born to baby boomers than to those of previous generations, creating a shortage of people available to provide informal care and financial support for formal care to those entering old age in 25 years (Stone, 1999). Higher rates of divorce among baby boomers may further weaken the informal care networks. Women, the traditional providers of informal long-term care, now enter the labor force with higher frequency

and duration than in previous years, limiting their ability to care for older relatives (U.S. Bureau of Labor Statistics, 2000). Finally, the enormous geographic range of many contemporary families makes the provision of informal care and familial supervision of formal care more difficult (Barnes, 1995).

Thus, the necessity for high-quality formal care institutions is as high as it has ever been. Advocacy efforts based on human rights could have an impact on those who see no problem with limiting the number of students in a public school class—if a certain number of teachers is required by law for a given number of students, why is a nursing home allowed to be understaffed? A study by the Department of Health and Human Services reveals appalling conditions in many residential facilities, in part because of inadequate staffing levels (U.S. Department of Health and Human Services, 2000). People who are 85 years old have the same basic rights as the school children who are 8 years old.

The growing need for long-term care heightens the potential for elder abuse. Many seniors have a limited ability to voice real concerns regarding their care, depending on the extent of their physical or mental incapacitation. Some analysts estimate that 1.5 million seniors are the victims of elder abuse each year (Baron & Welty, 1999). Although elder abuse laws have been approved, the human rights education programs to prevent the abuse have been ignored. Thus abuse may be underreported because of dependency, lack of awareness of legal protection, or lack of competency, precluding the recognition of abuse. Both seniors and their caregivers must hear and digest the assertions of advocates who can explain why basic human rights are neglected in many of the policies that affect seniors.

New research into alternative long-term care options, increased support for families providing long-term care, and new monitoring mechanisms for private care facilities are important potential improvements in the lives of elderly people. Advocates should stress, through public-relations and educational efforts, that these issues are likely to affect almost everyone at some point.

An Action Agenda

Human rights standards can be a mighty long-term force in protecting the welfare of seniors in an era of population aging. In the crucial areas of work, retirement, health, and long-term care, these standards can be used to voice a principled defense of the rights of seniors, operating as a baseline for establishing the values that underlie new public policies. By framing seniors' issues as an integral component of a rights-based society, advocates could forge a broad consensus among all segments of society to support the improvement of living conditions for seniors.

The importance of seniors' issues must be emphasized not only to policy makers but to other human rights-based advocacy groups as well, whose positions would only be strengthened by incorporating these senior-related issues into their arguments. Human

rights are a life span issue, affecting each person for his or her entire life, from birth through death. Seniors' issues affect a significant portion of one's lifetime, just as children's issues are relevant for many years of one's life. If each advocacy group bases its arguments on the universality of human rights, a new network of partnerships can then be built, gaining strength from the sharing of a fundamental concept: Everyone has the same rights throughout life. Everyone will, at some point, be personally involved with human rights concerns—directly or indirectly.

Advocates for aging adults can take many steps to promote better conditions for seniors, in their communities and collectively at the national level, basing their efforts on a human rights-based approach:

1. Establish a clear statement of nonnegotiable values on which grassroots education and public marketing campaigns can be based.
2. Create formal human rights education programs for children and adults.
3. Promote national awareness of aging problems from the standpoint of human rights by identifying a set of fundamental principles to be communicated to all Americans. These principles would demonstrate that all seniors have the right to (a) adequate food, clothing, and shelter; (b) full benefits of social security, including long-term care; (c) just and favorable working conditions; (d) access to health care to maintain or regain an optimum level of physical, mental, and emotional well-being, and to prevent or delay the onset of illness; (e) live in dignity with respect to personal privacy; (f) freedom from exploitation and physical and mental abuse; (g) the pursuit of opportunities for the full development of their potential; and (h) remain integrated into society, and to participate actively in the formulation and implementation of policies that directly affect their well-being, sharing their knowledge and skills with younger generations.
4. Develop human rights education programs for caregivers and for seniors themselves, empowering them to be active on their own behalf and in cooperation with younger generations.
5. Form alliances with mainstream human rights and advocacy groups, encouraging specific review of issues relevant to seniors.
6. Form alliances with other social groups that focus on the common interest of fundamental human rights, such as civil rights groups, children's advocacy organizations, and public health groups that fight against inadequate health care coverage.
7. Publicize the standards outlined in the Universal Declaration of Human Rights (1948) and its related treaties and covenants, including the U.N. Principles for Older Persons (1991). Use them explicitly in both domestic and international education and advocacy efforts, while encouraging U.S. government ratification of all human rights documents.

By incorporating the powerful ideas behind the principle of human rights, advocates for aging adults can assist in fashioning a society that recognizes the dignity of all people, from the beginning of life until its end—a society, in the words of the United Nations, “for all ages” (United Nations Program on Aging, 2002).

References

- Age Discrimination in Employment Act. 29 U.S.C. §621 (1967).
- Barnes, A. (1995). The policy and politics of community-based long-term care. *Nova Law Review*, 19, 487–531.
- Baron, S., & Welry, A. (1999). Elder abuse. In L. A. Frolik (Ed.), *Aging and the law* (pp. 581–584). Philadelphia: Temple University Press.
- Bergquist, M. L. (1999). Home health care: What it is and who pays for it. In L. A. Frolik (Ed.), *Aging and the law* (pp. 410–414). Philadelphia: Temple University Press.
- Binstock, R. H. (1999). Older persons and health care costs. In R. N. Butler, L. K. Grossman, & M. R. Oberlink (Eds.), *Life in an older America* (pp. 75–96). New York: Century Foundation Press.
- Caplan, C., Brangan, N., & Gross, D. (1999). *The trustees' annual report on the status of Medicare hospital insurance (III) trust fund: 1999*. Washington, DC: Public Policy Institute, AARP. Retrieved November 26, 2000, from http://research.aarp.org/health/dd40_trustees_1.html
- Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted December 10, 1984, G.A. Res. 39/46, U.N. GAOR, 39th Sess., Supp. No. 51, at 197, U.N. Doc. A/39/51 (1984) (entered into force June 26, 1987), reprinted in 23 I.L.M. 1027 (1984), substantive changes noted in 24 I.L.M. 535 (1985).
- Convention on the Elimination of All Forms of Discrimination Against Women, G.A. Res. 34/180 December 18, 1979, Art. 1.
- Dauster, W. G. (1996, Summer). Protecting Social Security and Medicare. *Harvard Journal on Legislation*, 33, 461–509.
- Hirschhorn, L. (2001). HIV in the aging population: Partnerships in clinical care. Slide presentation from the 2001 National Association on HIV Over Fifty National Conference. Retrieved December 26, 2001, from <http://www.hivoverfifty.org/tip.html>
- International Covenant on Civil and Political Rights, December 16, 1966, 999 U.N.T.S. 171 (Art. 19(1); Art. 21).
- International Covenant on Civil and Political Rights, adopted 16 Dec. 1966, G.A. Res. 2200, U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (entered into force March 23, 1976).
- International Covenant on Economic, Social, and Cultural Rights, December 16, 1966, 993 U.N.T.S. 3 (Art. 11).
- International Convention on the Elimination of All Forms of Racial Discrimination, G.A. Res. 2106 (XX), December 21, 1965, Art. 1. See CERD, General Recommendation XIV(42) on Art. 1, Pt. 1, of the Convention, U.N. GAOR, 48th Sess., Supp. 18, at 176, U.N. Doc. A/48/18 (1993).
- Katz, I. R. (1999). Prepared statement before the Senate Special Committee on Aging. In L. A. Frolik (Ed.), *Aging and the law* (pp. 568–580). Philadelphia: Temple University Press.
- Meyers, R. J. (1999). Dispelling the myths about Social Security. In R. N. Butler, L. K. Grossman, & M. R. Oberlink (Eds.), *Life in an older America* (pp. 9–24). New York: Century Foundation Press.
- Muller, C. (1999). The distinctive needs of women and minorities. In R. N. Butler, L. K. Grossman, & M. R. Oberlink (Eds.), *Life in an older America* (pp. 97–120). New York: Century Foundation Press.
- National Association on HIV Over Fifty. (2001). *Educational tip sheet*. Retrieved December 26, 2001, from <http://www.hivoverfifty.org/tip.html>
- National Center for Human Rights Education. (2001). Bringing human rights home: Linking individual dignity with mutual destiny. 1996–2000 Report of Program Activities. Atlanta: Author.
- National Institutes of Health. (1991). *Consensus statement online* 9(3), 1–27. Retrieved November 26, 2000, from http://odp.od.nih.gov/consensus/cons/086/086_statement.htm#1_Introdu
- Pear, R. (2000, June 27). 17 percent increase in prescription drug costs hit elderly hardest, study finds. *New York Times*, p. A16.
- Rein, J. E. (1996, Spring). Misinformation and self-deception in recent long-term care policy trends. *Journal of Law and Politics*, 12, 195–340.
- Rix, S. E. (1999). The older worker in a graying America. In R. N. Butler, L. K. Grossman, & M. R. Oberlink (Eds.), *Life in an older America* (pp. 187–216). New York: Century Foundation Press.
- Stone, R. (1999). Long-term care: Coming of age in the twenty-first century. In R. N. Butler, L. K. Grossman, & M. R. Oberlink (Eds.), *Life in an older America* (pp. 49–74). New York: Century Foundation Press.
- United Nations, Office of the United Nations High Commissioner for Human Rights. *Status of ratifications of The Principal International Human Rights Treaties as of 15-May 00*. Available online at <http://www.untchcr.ch/pdf/report.pdf>
- United Nations Principles for Older Persons, A/RES/46/9, December 16, 1991, Annex.
- United Nations Program on Aging. (2002). *Mission statement*. Retrieved May 6, 2002, from <http://www.un.org/esa/socdev/ageing/>
- Universal Declaration of Human Rights, G.A. Res. 217 A (III), U.N. GAOR 3d Sess., Pt. 1, at 71, U.N. Doc. A/810 (1948).
- U.S. Bureau of Labor Statistics. (2000, February 16). Changes in women's labor force participation in the 20th century. *Monthly Labor Review: The Editor's Desk*. Retrieved November 25, 2000, from <http://stats.bls.gov/opub/ted/2000/Feb/wk3/art03.htm>
- U.S. Department of Health and Human Services. (2000). *Report to congress: Appropriateness of minimum nurse staffing ratios in nursing homes*. Retrieved November 25, 2000, from <http://hcfca.hhs.gov/medicaid/reports/rp700hmp.htm>
- United States, Office of the Surgeon General. (1999). Consequences of depression. In *Mental health: A report of the surgeon general* (Chap. 5). Washington, DC: Government Printing Office. Retrieved November 26, 2000, from <http://www.surgeongeneral.gov/library/mentalhealth/chapter5/sec3.html#consequence>

Received August 24, 2001

Accepted February 22, 2002

Decision Editor: Lawrence G. Branch, PhD