

WHAT DOES A HUMAN RIGHT TO SOCIAL CARE LOOK LIKE?

A PERSPECTIVE FOR SCOTLAND IN 2021



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INTRODUCTION

In a previous paper[1] I argued that social care should be seen as a human right distinct from but complementary to the human right to health. This short paper seeks to describe what such a human right to social care could look like in practice. It is written at a time of real turmoil and debate about social care in general and specifically the future of adult social care in Scotland. In and around that debate much has been articulated about human rights and how they should relate to social care but some of this commentary, I would contend, has lacked a clear and robust understanding both of the complexity of human rights in application and of social care in practice. This paper is admittedly inevitably subjective, but it originates from a perspective which believes that human rights can add significant substance to the fulfilment of social care within individual life and wider community, and that social care supports and services when underpinned by a human rights-based approach have the potential to exemplify human community at its best. It is also written from a belief that the articulation and development of policy and potential future systems around social care must be consistent with and consonant to human rights law and practice, principles and ethics.

SO WHY HUMAN RIGHTS AND SOCIAL CARE?

To briefly re-visit my earlier assertions in *'The Human Right to Social Care.'* In that paper I argued that the right to health has long been recognised as a fundamental human right with the World Health Organisation stating health as an inalienable human right:

'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.' [2]

The human right to health finds its fullest articulation within the 1966 International Covenant on Economic, Social and Cultural Rights. (ESCR) where in Article 12 it states:

'1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.' [3]

This assertion has been further advanced through case law but more directly in 2000 when the United Nations' Committee on Economic, Social and Cultural Rights issued General Comment No. 14, robustly placing the right to health as critical and central to the realisation of other human rights:

'Health is a fundamental human right indispensable for the exercise of all other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity.' [4]

For social care there is a critical emphasis within the Comment on the role of the citizen in exercising choice, control and participation in matters relating to health and wellbeing:

'A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels.' [5]

The presentation of a wider 'social definition' of health and wellbeing is also seen in what the General Comment states at section 25 for older persons:

'With regard to the realization of the right to health of older persons, the Committee, in accordance with paragraphs 34 and 35 of general comment No. 6 (1995), reaffirms the importance of an integrated approach, combining elements of preventive, curative and rehabilitative health treatment. Such measures should be based on periodical check-ups for both sexes; physical as well as psychological rehabilitative measures aimed at maintaining the functionality and autonomy of older persons; and attention and care for chronically and terminally ill persons, sparing them avoidable pain and enabling them to die with dignity.' [6]

The paper goes on to argue that, far from being a recent phenomenon, the description and delineation of the right to health as something which is holistic and *more than* just a right to physical and physiological health has a long history within international law and practice. This *holistic right to health* includes the right to the fullest realisation of health and well-being. This right for many individuals who live with the requirement of support and care is evidenced in the use of the term 'social care', but which variously and internationally has been described as a right to 'social services' and 'long- term care.'

My initial paper contended that social care has to be seen as distinct from though complementary to the realisation of the human right to health. In what follows I want to build on what was described there by exploring some of the key characteristics and principles of what is meant by having a human right to social care and what that means in practice. In so doing I will select some themes appreciating that they are not likely to be in any sense exhaustive.



CORE PRINCIPLES FOR A HUMAN RIGHT TO SOCIAL CARE

A SOCIAL MODEL OF SOCIAL CARE

The Covid-19 pandemic has necessitated a significant health care response centred around the preservation of life through robust infection prevention and control. One of the challenges in this has been to ensure that the distinctive elements of social care have not been lost amidst this focus. I have argued elsewhere[7] that the development of a human rights-based approach to IPC is an urgent task. This is best exemplified in the extent to which the ability of an individual to live in a non-institutionalised setting has been compromised by some protective measures taken within care homes which are first and foremost an individual's place of residence – their home – rather than an institutionalised environment.

These recent occurrences are an example of what for decades has been described as the 'clinicalisation' of social care; illustrative of a deficit and medical model of disability rather than the 'social model of disability' with its focus on individual autonomy, personal choice and independence. The social model argues that people are disabled by barriers in society, not by their impairment or difference. For social care there is perhaps time to re-articulate a 'social model of social care' grounded in human rights principles which serves to advance the principles of individual autonomy, personal choice and independence. Legislation around the personalisation of supports and services in both Scotland and England was meant to address this misplaced focus on a clinical approach to both disability and social care but arguably there is a very real danger that in the name of protection from a virus such advances are undermined by the pandemic response.

Social care is distinctive from though may incorporate elements of clinical and health care. Scottish Care has defined social care as:

'The enabling of those who require support or care to achieve their full citizenship as independent and autonomous individuals. It involves the fostering of contribution, the achievement of potential, the nurturing of belonging to enable the individual person to flourish.'

In essence social care is about enabling the fullness of life for every citizen who needs support whether on the grounds of age, disability, infirmity or health. Social care and support are holistic in that it seeks to support the whole person and it is about attending to the individual's wellbeing rather than simply their physiological health. It is about removing the barriers that limit and hold back and the fostering of conditions so that individuality can grow, and the independent individual can flourish.

There are key elements of social care as a human right which advances what might usefully be termed a 'social model of social care', which are worth reflecting in more detail upon.

INDIVIDUAL AUTONOMY

The ability to exercise individual autonomy regardless of personal characteristic or impairment is intrinsic to social care. The essence of good care and support is enabling an individual to exercise the fullest possible personal autonomy. It is the realisation that regardless of any cognitive or physical impairments that every human individual has the right to exercise choice, control and autonomy to the best of their abilities and capacity. Good care and support are about removing or limiting the barriers that prevent human autonomy and control. It is about enabling an individual to be as independent as possible, it is about reducing dependency rather than fostering it. This is where the 'social' within the care and support is critical because it addresses not just the clinical reasons which prevent contribution, participation and the fulfilment of the rights of a citizen but all other factors which act as barriers to citizenship.

That is why social care legislation in Scotland has sought, most especially since the establishment of the Scottish Parliament to articulate a set of principles and ethical standards which embeds the individual right of autonomy in relation to others. Legislation such as the Adults with Incapacity Act, the Social Care (Self-directed Support) Act or the Mental Health Care and Treatment Act, all underline that whilst there are indeed some who may have limits on their mental capacity there can be no automatic presumption of incapacity; rather there is always a presumption of capacity. I have the right to make decisions about my own person, body and life unless under very strict criteria it is deemed I no longer possess the mental capacity to do so. But even then there is an awareness that capacity can fluctuate and be episodic so there is a duty on those who care for and support me to continually seek to enable me to exercise autonomy, choice and control.

Without a sense of autonomy, we would feel continually fall under the control and agency of others; we would not be able to make decisions about what matters to us in our lives. So, in social care the fostering of autonomy is central and critical.

As a whole society we have an obligation to respect the autonomy of other persons, which put simply is to respect the decisions made by other people concerning their own lives. This is what lies at the heart of human dignity, the ability to allow others to grow into the fullest expression of their own humanity and individuality, without us forcing them to be someone they are not or to do something they do not want to do. All of which is boundaried by the laws and obligations of the whole community and society.

That last point is important because of course no one of us is wholly autonomous. We cannot just do what we want without appreciation that we live in relationship one with others in a society. But critically when we make decisions and act on those decisions, our decisions and actions are at least partly autonomous.

In social care and health care it has become one of the core ethical standards that an individual must be involved in decisions about their own health and wellbeing; must have ultimate control and voice in that decision-making and must have an ability to exercise informed choice.

Autonomy is regarded as a fundamental ethical principle in social care. Put simply it is the acknowledgment that individuals who have decision-making capacity have the right to make decisions regarding their care, even when their decisions contradict their clinicians' or other professional recommendations.

Autonomy is the principle which underlies the requirement to seek the consent or informed agreement of an individual before any clinical investigation or treatment takes place.

I would contend that the principle of individual and personal autonomy and the ethical requirements which arise from that in practice are a key component part of the human right to social care. It is from this centre that principles of independent living, of individual choice and control over packages of care and support all orientate.

There is an established literature[8] detailing the relationship between human rights legislation and personal/individual autonomy not least in relation to health care. The same broad principles can, I believe, be extended to include social care.

'Autonomy constitutes a prerequisite for proper implementation of human rights. The stronger personal autonomy is, the more advanced and productive a human being may strive to become. An autonomous person is the best self-advisor on compliance to his/her expertise and lifestyle. Rights embedded in a legal document are not sufficient to guarantee and protect a modern individual. The international community and domestic institutions have to create a mechanism that would provide the individual the proper legal conditions to exercise his/her own rights in accordance with existing social values.' [9]

The autonomy of the individual has sometimes been described as 'sovereignty of the mind'. In human rights law it finds its ultimate and most precise defence in freedom of thought.

'To lose sovereignty over our minds is to lose our dignity, our democracy, and even our very selves. Such sovereignty is termed mental autonomy. This is "the specific ability to control one's own mental functions," which include attention, memory, planning, rational thought and decision making. Dignity, "the resumption that one is a person whose actions, thoughts and concerns are worthy of intrinsic respect, because they have been *chosen, organized and guided*" requires mental autonomy.'[10]

There are various levels at which human rights engages in the requirement and right for personal autonomy, perhaps most especially in Article 8 of the European Convention of Human Rights with its emphasis upon psychological and physical integrity. However, an area which has been less examined is the extent to which the human right of freedom of thought [11] is, engaged directly in social care. I believe, critically that freedom of thought is profoundly engaged in social care at both the inter-personal relationship level and at the level of structures and processes to establish, monitor and enable that care and support. Freedom of thought is not as clearly outlined and articulated in human rights law as it might be, and this has led to a marginalisation of the right into the debates about the right to free speech and comment but its relevance to personal autonomy and decision-making in the context of care and support is important. There can be no greater theatre for the exercising of the human right to freedom of thought than in relation to one's health and wellbeing, one's social care and support.

PERSONAL CHOICE AND PARTICIPATION

Personal choice is part of the DNA of social care. The individual person must be able to have voice and agency in not only the care and support which is undertaken for and with them but must be the primary actor in such conversations and decision-making processes. This is why in legislation such as the Scottish Self-directed Support Act choice is given such a prominent position. It is choice not solely on the part of the individual in a 'consumerist' model but choice which is informed and enabled, and choice which is real. That is why there are clear legislative requirements for there to be proactive steps on the part of public authorities and bodies – indeed legal duties - to ensure the existence of a sufficient market or 'care' diversity to enable choice to be as real and authentic as possible. An option of one provider of care in a monopolistic State led model is not enabling of individual choice even if it is contended that choice lies within the limited offer available.

To remind ourselves of a key element on the right to health which is extended into social care:

‘A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels.’ [12]

The fulfilment of the human right to personal and individual autonomy in part articulated through the right to freedom of thought and practice is evidenced in the extent to which an individual has the ability to make choice in their social care.

Choice is not simply about ensuring individuals feel as if they are engaged, consulted and involved, however important those elements of social care assessment, planning and service design are. Choice is critically important and is essential to ensure that the individual protected characteristics of a person are addressed and that there is an ability not to contravene the Article 14 (EHRC) rights to non-discrimination. On too many occasions there has been a failure of social care systems to meet the particular cultural, ethnic, religious, sexual and gender needs of individuals. The human right to social care embeds the necessity of shaping the care and support an individual needs to their particular identity characteristics in a manner which is proportionate and reasonable.[13]

Participation is intrinsic to the exercising of any human right to social care. It is a participation which enables the individual to be an equal citizen in their community, to not be limited by their status in society or any personal characteristic. A human rights-based approach to the design and delivery of social care services necessitates the full participation of the individual through the exercising of diverse choice and the enabling of personal independence. It is this which in part enables the autonomy and individuality of the person.

‘Everyone has the right to participate in decisions which affect their human rights. A human rights-based approach requires a high degree of participation of rights holders in the development of policy and practice, as well as the involvement of affected communities, civil society and others. According to the International Covenant on Civil and Political Rights (ICCPR, Article 25) people have a right to participate in decisions which affect the realisation of their human rights. The Convention on the Rights of Persons with Disabilities (CRPD) also contains several protections of the right to participate in decisions and access to support for participation and access to information.’[14]



PERSON-LED EMPOWERMENT

Perhaps the overarching concept for the exercising of such choice and participation in social care have been the concepts of 'personalisation' and 'person-centred' models and work. Much has already been written on the relationship of human rights to personalisation and I do not want to revisit that here other than to acknowledge the focus on the critical role of the right to participation and empowerment.[15]

Most social care legislation in both England and Scotland which has focused on personalisation found its energy and roots in the independent living movement of the learning and physical disabled communities in the 1970s. It is a journey which arguably has only been partly fulfilled. We will come to independent living below but one of the characteristics of early personalisation models was the degree to which they envisaged an 'empowerment' of the individual to be able to exercise the fulness of their rights and to participate in society, regardless of barriers or personal characteristics, whether that be through work and activity, or by any other means.

It is highly debateable that personalisation in both legislative and practice terms has enabled the empowerment of individuals to fulfil their citizenship within their communities or even within their own lives.

The way forward, I would contend, is that we need to change our focus from person-centred care and support to person-led care and support. The latter articulates well the human right to social care, enhances individual autonomy, fosters participation and roots the reality of choice in the care dynamic.

The literature on '*person-centred care*' is voluminous but there is a distinct sparseness of reflection on what *person-led care and support* would look like. This is not a semantic observation. The two are distinct and different. Person centred care and support still gives agency, authority and direction to the professional individual or agent delivering that care and support. Person-led care gives primary control and agency to the individual person who is being supported. It is the latter that has the potential to enable empowerment of the individual, to reduce the risk of fostering dependency in the care relationship, and to resource the person to achieve their potential, which for many is independence. It is the latter which is grounded on critical relational concepts and which reduces the risk of making the care relationship into one which is transactional and functional. It is the latter which arguably encapsulates a human rights approach to social care.

It might be argued that the very nature of care and support has been often perceived as one which limits the capacity and choice of an individual being cared for. Such a view perceives care as a transactional and uni-directional affair, where the individual is 'done to' and has no voice, role or agency in the exchange between carer and cared for. That might arguably have been an accusation which had validity in the past, but I would hope increasingly it has no place in modern day social care. Writers such as Tronto have argued that there is a very real potential that the care relationship can act as an agency of empowering autonomy and the fulfilment of individual potential within a supported individual. This I would suggest is what person-led care within a relational dynamic is all about. It is why we need to urgently change the narrative which assumes that social care is the enabling of care and support on passive individuals. At its best social care has the potential to enable an individual to realise their human rights.

In an extensive and thoughtful article based upon field research, Sarah Keyes et alia [16] have suggested that empowerment can be at the heart of social care and have argued for the necessity of moving from a person-centred to a person-led approach. In so doing they have sought to build on the work of Tronto [17] who argued that care and support has to be centred on relationships in order to facilitate individual empowerment by redrawing boundaries of independence and partnership between people accessing support, professionals and the organisations within which they operate: Keyes et alia conclude:

‘In challenging the societal oppression of people with impairments, the social model of disability has underpinned the development of approaches to support that lead to empowerment. Within this paradigm, “care” has been rejected as a one-way process that has the potential to disempower and re-enforce marginalization. Through exploring service contexts that are rooted in empowerment, we have demonstrated that processes of empowerment not only required but were greatly enhanced by an acknowledgement of the interdependent nature of interaction at all levels of services. Without care, as defined within an ethic of care, processes that were supposed to be empowering have the potential to become disempowering... this paper challenges this rejection of “care” by highlighting the crucial role of relational and actual autonomy in realising empowerment.’[18]

INDEPENDENT LIVING & SELF-DIRECTED SUPPORT

The United Nations Convention on the Rights of Persons with Disabilities Article 19 says:

‘States Parties to the present Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:

- a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;
- b) Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;
- c) Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.’[19]

The above rights are intrinsic to social care and the realisation of such as a human right. They go way beyond seeing social care and supports as a means to an end for they describe the potential that the gradual realisation of all the human rights an individual possesses can be achieved through effective social care support and services. Importantly the realisation of Article 19 is seen as being interdependent with other articles in the Convention, for example the right to health, work and employment and participation in public life amongst others.

I have written earlier[20] about the potential and promise of Scotland’s Self-directed Support Act as a vehicle for the achievement and realisation of the human right to social care, through its potential to enable personal autonomy through the exercising of individual participation, choice and control. This in part is evidenced in the core fundamental principles of this legislation which underline what we have said thus far about autonomy, choice and participation, and person-led empowerment:

Sections 1 and 2 of the Act specify the general principles that guide practice:

1. Involvement – this requires that the supported person must have as much involvement as they wish in both the assessment and in the provision of any support agreed on completion of their assessment.
2. Collaboration – practitioners and providers must collaborate with the supported person in the provision of any support identified and agreed on completion of their assessment in order for them to be supported to achieve the outcomes they have identified.

3. Informed Choice – the supported person must be provided with any assistance that is reasonable to assist them to express their own view about the support that is being provided or to make any changes to that support including the specific involvement of individual staff in their lives.’ [21]

The most cogent recent analysis and description of what is meant by ‘independent living’ in Scotland was presented in ‘Our Shared Vision for Independent Living in Scotland.’[22] The vision of the latter declared that independent living was about choice, control, freedom and dignity. The relational dimension is at the heart of achieving such independence which is about mutual reciprocity achieved through the facilitation of choice:

‘Effective, person-centred social care, determined and led by the individual in partnership with the relevant professional increases the choice for the supported person and provided them with the opportunity to take more control and manage their life’ [23]

Independent living is only achievable through directly addressing the holistic needs and aspirations of an individual citizen. Thus, and this in some senses makes the Scottish legislation, so significant, there is an appreciation that assessments undertaken and supports offered have to be able to empower and enhance an individual’s ability not just to live independently but to realise their full human rights. In practice this means that there needs to be as much emphasis placed upon the universal needs of an individual as much as attending to their basic needs. There is a clear distinction between addressing needs which keep you alive and healthy and those which are more holistic and relate to well-being. To remain in relationship, to maintain friendships and be connected up to the community, to be able to work, influence and decide, are as important requirements of support as being nourished, healthy and safe. This is the territory where the right to health is realised through the human right to social care supports and care:

‘Participation and dignity are core aspects of independent living whereby all supported people should expect to have the same freedom, choice, dignity and control as other citizens at home, at work and in the community. In some respects, the concept of independent living provides a modern interpretation of the social welfare duties provided in the 1968 [Social Work Scotland] Act.’ [24]

During the pandemic there has been much popular and media comment on residential long-term care and its institutional nature. This paper is not the location to comment on the response to the pandemic in these settings, but it would be difficult not to reflect on the extent to which group-living and residential living either limits or fosters the nature of personal independence and enables or otherwise the fulfilment of the human right to social care.

There is an argument which suggests that independence can only be achieved in one’s own home and not in settings which require group and shared living with others. Whilst I respect those contentions what they have at their heart is the potential limiting of choice and a presumption that independence is a narrow continuum. It is perfectly possible, I believe, to achieve personal fulfilment and exercise greater autonomy when living in community with others than on one’s own. Collective and shared living models throughout the world have much to teach us about the ability of the mutuality of shared living and supports to enhance personal identity and wellbeing. An effective aged care facility or care home should enable independence not foster dependency regardless of the physical or psychological needs of the resident.[25] A care home is first and foremost someone’s home and not an infectious control unit. Whilst there may be some weight in legally describing residential care homes as ‘institutionalised care’ they are for those who work and live in them all about becoming ‘home’ where care and support is offered to allow life to be lived to the full even at the end of life. A care home at best is the gathering together of individuals to live alongside others in a way that they can be supported and cared for, nurtured and loved. At its best it is a living out of being in community and togetherness with others.[i]

IMPLICATIONS OF A HUMAN RIGHT TO SOCIAL CARE

In this short paper I want to conclude by exploring several strands which illustrate the potential of a human right to social care and what the above principles may involve.

FINANCE & RESOURCES

At time of writing and in the midst of the ongoing challenges of a global pandemic it is clear that the realisation of the human right to social care will not be without challenge not only in Scotland but elsewhere. The characteristics of a relational based social care system which respects individual autonomy, gives place to personal choice and enables participation, personal empowerment and control, and fosters independence, will all require not just structural change and legislative focus, but significant fiscal expenditure.

What is clear from a human rights-based approach is that the choices around budgets and finance are not separate from but intrinsic too the legal obligations which a human right to health – and social care – involve and require.

There is a clear international human right set of obligations and duties to ensure that at both national and local governmental level that fiscal decisions are undertaken utilising human-rights based approaches.

One of the major issues facing the practice of social care is delivering that care and support in the face of fiscal restriction and in most recent times in Scotland in the light of austerity. A human rights-based approach to the setting and delivery of budgets both at national level but also at the local administrative level where decisions are made on the allocation of local resources would have a profound impact upon social care. There is little that can be achieved at local level and certainly at the point of a local social worker making fiscal decisions if there is already an inadequacy of resource to meet the rights of individuals. The Scottish Human Rights Commission has published an immeasurably helpful set of papers on the practicalities involved in establishing a human rights-based approach to budget setting and resource allocation.[26]

‘Human rights budgeting recognises that budgetary decisions can have materially different outcomes for different groups. Government budgets are not always sensitive to this. In particular, the contributions that households, individuals (especially women) and communities make to the economy —by caring for people for example—are not always recognised because they are not bought and sold through the market. For this reason, it is not uncommon for budgets to reinforce systematic inequalities between groups—in particular between men and women—and miss out on opportunities to use public financing to improve the position of disadvantaged and marginalised groups.’[27]

The realisation of the human right to social care is intimately connected to the necessity of undertaking robust equality and human rights impacts in budgetary and fiscal decisions. There is little point in social care legislation containing a right for an individual to have access and control over a budget for their care and support if that very budget is limited in its ability to resource the supports and services required to enable the fulfilment of the human rights we have discussed thus far.

It is hoped that Scotland will introduce legislation to enshrine not only the Convention on Disabled Persons and other similar Conventions but also the International Covenant on Economic, Social and Cultural Rights (ICESCR). As part of the United Kingdom, we have as a State already undertaken international legal obligations to ensure the protection of the social, economic and cultural rights, including the right to an adequate standard of living, the right to health and I would contend the right to social care. This means we are committed to:

‘take steps... to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures’. Article 2(1) ICESCR

This has profound implications for the human right to social care and it is to be hoped that future legislation to incorporate ICESCR and legislative changes for existing devolved responsibilities will ensure that the requirement to undertake a human rights budget and fiscal analysis, not least as it affects the right to health and social care, will be embedded in legislation. This will involve a root and branch review of resourcing and allocation, prioritisation and commissioning, to enable the individual in receipt of social care supports to be empowered and in control, to exercise choice and effective autonomy. Key to this will be the use of a human rights modelling to address issues of inequity in terms of social care charging policies.

TECHNOLOGY AND DATA

The role of technology and digital in the delivery of social care and in supporting those who access services has become much more prominent during the pandemic.

There are many diverse areas in which human rights are engaged in the use of technology and digital in social care, not least the extent to which private data which is gathered and used in the delivery of care and support is owned and managed by the citizen themselves. Our overarching principles of autonomy, personal choice and control, as key to a human right of social care are central in the consideration of technological and digital supports for any individual in social care. Even personal independence far from being assisted by the use of technology in their own home or ‘homely setting’, can lead to the removal or restriction, and diminution of basic human rights for an individual.

I have written elsewhere[28] about the necessity to embed a human rights-based model for social care which recognises technology as the enhancer of human presence, the tool to embed and foster relationship, and as a set of supports to further develop and support communication and connection for citizens. Technology has considerable potential to foster the realisation of the human right to social care, but it equally has within it the potential to limit that realisation.

Dr Tara French has further developed the relationship between human rights and technology in social care and has stated:

'It is essential that the developments of technology and digital in health and social care move away from a continued focus on the needs of the service and system. Defining, developing and designing the role and use of technology and digital in social care needs to be framed by the aspirations of the person, the care context and situation, and the intention, outcomes and appropriateness of the role of technology and digital before considering the functionality and form of the resulting technology/digital enabler or support.

Specifically, in the context of social care, we also call for more design and development that begins with social care at the outset, emerging from a process of understanding, identification and exploration to meet the needs, challenges and aspirations of the people and the sector, rather than be ported, modified or adapted from an initial health context, focus and perspective.'

WORKFORCE

What might a human right for social care mean for the care workforce? It would certainly potentially lead to ensuring that there was equity and fair work principles with regard to employment terms and condition, the establishment of clear national frameworks to ensure equal treatment and a potential ability to address the issues of gender segregation which have so afflicted social care for many years. More specifically if we reflect on our principles of autonomy, individual choice and control, and the establishment of person-led models of care and support, there is a real potential to challenge the functional, time and task-oriented nature of a great deal of commissioned social care work.

It has been asserted above that relational, rights-based care and support is critical to fulfilling a human right of social care. This necessitates empowering those who work in social care in a manner which values their professional competence and abilities. There are many ways in which this could be achieved including the development of self-managed teams, the allocation of flexible caseload working to home carers, and a greater emphasis on the training and qualification of those who undertake work in the sector. At its heart we need, I believe, to move towards a situation where more autonomy is given to frontline workers to enable them to maximise the potential of relationships with those they support, be directed and influenced primarily by that relationship rather than pre-determined contractual obligations around which they are evaluated and monitored.

An important related element to this is the necessity to re-consider the primary focus of commissioned social care. Arguably too much social care support is delivered too late in the life cycle.[30] As a result, there is a failure to tap the potential offered by the development of reciprocal relationship-based care by autonomous workers in terms of preventative care and support. We have in many societies failed to invest in preventative care and wellbeing and as a result have faced both personal and economic loss by intervening too late. If it is about anything social care is about ensuring that through relationship, encounter and connection, an individual is supported to remain as independent and autonomous as possible for as long as possible.

REGULATION AND IMPROVEMENT

A critical component of any human rights framework is the degree to which the processes of accountability, recourse and evaluation are achieved. All human rights-based approaches have to be enforceable. They are not simply about aspirations and positive emotions and platitudes. A human right of social care has to be progressively realised and there must be clear and independent evidence that this is being achieved. The decades of international scrutiny of Conventions and Charters give witness to the influence of accountability and its role in progressing rights.

Though Scotland has uniquely developed a human rights-based set of Standards for health and social care delivery[31] it is at least debateable as to whether or not the system of inspection and scrutiny is as independent, reciprocal and mutual as it might be. Much work needs to be undertaken to ensure that the dynamic relationship that should exist between scrutiny and inspection with improvement support and quality development of supports and services is as resourced and developed as it might be. There is little point in articulating a human right to social care if there is little ability to evaluate whether this is occurring in practice and an ability to challenge systems and practices which vitiate against the same.

There is a real opportunity as we move towards the development of a human right to social care that we develop a fully reciprocal system of scrutiny and improvement. This cannot be based upon non-independent, non-transparent models but to be in accord with the principles enunciated above, requires a reciprocity and shared collective ownership by inspector and provider, citizen and community alike.



CONCLUSION

This paper has sought to argue that the human right to social care is an intrinsic part of the right to health. It has further offered some core principles which should underpin the outworking of such a right in practice and has lastly offered a few brief areas where there requires to be a particular focus or emphasis.

At heart, however, the success or otherwise of whether or not social care supports and services achieve their aim for any individual requires robust and independent assessment.

In conclusion I would suggest that this necessitates the use of the international framework PANEL to interrogate any social care model or intervention whether on a national or personal level. In so doing it is a pre-requisite that we ask the three key human right questions of any system or intervention, namely the degree to which it supports or does not the realisation, however progressive, of any human right, namely:

1. Does it strengthen the capability of right holders to participate and to secure the outcomes to which they are entitled?
2. Does it improve the ability of 'duty bearers' to deliver?, and lastly
3. What does it say about implementation of a rights-based approach and the realisation of rights?

Participation. The embedding of a human rights-based approach to any scenario or situation requires participation and involvement of those most affected either by a practice or by decisions being made. Social care has at its core the requirement to involve, include and enhance participation which fosters autonomy and embeds real, meaningful informed choice and personal control. Does our current or any future model for social care delivery enable the fullest participation of individuals?

Accountability. The second element of PANEL details that in any human rights practice there must be clear lines of accountability and responsibility. At essence when there are restrictions, or any curtailment of rights are these proportionate and appropriate and does there exist a mechanism to ensure proportionate and reasonable application.

Non-discrimination and Equality. This PANEL principle states that all forms of discrimination must be prohibited, prevented and eliminated. It further states that people who face the biggest barriers to realising their rights should be prioritised. Social care has been a right which has been conditional on the basis of assessment and the establishment of criteria, not least of which are financial. Are these equitable and non-discriminatory?

Empowerment. At the heart of this is the sense that everyone should understand their human rights and be fully supported to take part in developing practices which affect their lives. We have reflected above about empowerment being intrinsic to social care. An important element of this is the extent to which individuals are suitably informed and aware of their rights and also the options and choices available to them, including information conveyed in formats which are appropriate for them.

Legality. Lastly a human rights-based approach requires the recognition of rights as legally enforceable entitlements and is linked in to national and international human rights law. If we are to advance social care as a realisable human right there must be opportunity for appropriate challenge and recourse where it is believed or attested that this right has not been achieved.

This paper continues a conversation started earlier and I hope the voices of others will add to what is presented here. There is much more that could be said but I am convinced not only that there is a valid basis in arguing that social care is a human right but also that social care has the potential of being enriched by being viewed through the prism of human rights. It is a journey whose realisation is no doubt some distance into the future, but it is also one which offers us the potential of shaping a future for social care which has at its heart the principles of personal autonomy, informed choice and participation, person-centred empowerment and independence. If we address the challenges which clearly exist and threaten then we are much more likely to achieve a desirable social model of social care and the realisation of the human right to health and wellbeing which social care can enshrine.



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