



## **EQUALITY COMMISSION FOR NORTHERN IRELAND**

### **Response to “*Who Cares? The Future of Adult Care and Support in Northern Ireland*” A Discussion Document**

**Department of Health, Social Services and Public Safety**

**March 2013**

#### **Introduction**

1. The Equality Commission for Northern Ireland (the Commission)<sup>1</sup> welcomes the opportunity to engage in the discussion on the future of adult health and social care services, set against the broad principles and analysis highlighted in the ‘*Who cares?*’ discussion document. (WCDD) published by the Department of Health, Social Services and Public Safety (the Department).
2. This response takes into account the consultation questionnaire provided. In making our response, the Commission provides feedback on equality aspects associated with:
  - the changing landscape of health and social care, the ‘future vision’ set forth in the discussion document;
  - maintaining health and social care service provision in the context of reconfiguration of resources; and
  - consideration of international human rights obligations such as the International Covenant for Economic, Social and Cultural Rights (ICESCR), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).

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<sup>1</sup> See Annex 1

3. This response draws on our work across a range of equality grounds as well as work being progressed in our role as 'independent mechanism' in Northern Ireland under the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)<sup>2</sup>.

### **Executive Summary**

4. A brief summary of our issues, concerns and recommendations is outlined below:
  - any new proposals regarding social care should take into account equality and human rights obligations;
  - the vision should be broadened to incorporate service user engagement at a strategic level as well as the engagement of service users within the various decision making structures associated with the design and delivery of the future model of social care;
  - consideration should be given to the exploration of all potential avenues for the future funding of our social care system;
  - consideration should be given to the merits of a legislative framework, similar to the approach adopted in England, to guarantee minimum support to service users and carers.

### **Context**

5. In setting out our recommendations with respect to the reconfiguration of adult health and social care we acknowledge the wide range of external pressures on the current system such as the changing demographics, the complexity of our current health and social care system and the sustainability and affordability of provision.
6. The Commission is also mindful of the current economic context within which this discussion is taking place, in particular Government's programme of financial austerity and its effect on welfare benefits and public services. We have previously

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<sup>2</sup> See Annex 1.

highlighted, in a wide range of public policy interventions concerning welfare reform, the likely adverse impact on a range of marginalised groups such as disabled people, older people and those with dependents<sup>3</sup>.

## Summary of Overall Comments and Recommendations

### Over-arching Comments

7. In relation to any future vision concerning the reconfiguration of adult health and social care, the consideration of equality of opportunity and human rights should be central. The Commission acknowledges the recognition given in the discussion document to these principles. In particular, we welcome the reference to the social model interpretation of the issues facing disabled people, and the recognition given to the UNCRPD as a tool that has both shaped and informed our changing expectations of health and social care.
8. Furthermore, the Commission endorses the key principles underlying the vision: **dignity and respect, independence, equity, equality and diversity, human rights and safeguarding the health and wellbeing of service users.**
9. However, we are concerned that the discussion document does not sufficiently emphasise an equality and human rights based approach. Much of the language within the document focuses on a needs based approach placing a greater emphasis on affordability and sustainability rather than equality of outcomes. For example, the reference to the sustainability and affordability principle as 'perhaps being the most important'<sup>4</sup>, rather than the principles of equity, equality and human rights.

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<sup>3</sup> See for example: Equality Commission for Northern Ireland (December 2011): *Response to the Department for Social Development's consultation on the Welfare Reform Bill (Northern Ireland) 2011 Equality Impact Assessment*. Available at:

<http://www.equalityni.org/archive/pdf/ECNIRresponseDSDWelfareReformBillEQIA141211.pdf>

<sup>4</sup> Department for Health, Social Services and Public Safety (2013): *Who Cares? The Future of Adult Care and Support in Northern Ireland, A discussion document*, page 20, paragraph 1. Available at <http://www.dhsspsni.gov.uk/who-cares-future-adult-care-support-ni-summary.pdf>

10. We strongly support the need for the development of advocacy services and the concept of 'self directed support' within the context of 'personalisation' of adult health and social care identified within the 'Who Cares?' and 'Transforming Your Care' proposals.
11. Furthermore, the Department's recognition that more needs to be done to ensure service users are viewed as equal partners directly involved in the design of their health and social care requirements, reflects both the social model interpretation of disability and the greater demand from all service users to have a greater say in how they receive health and social care services.
12. We acknowledge the principle that service users should have the opportunity to pay for their care support, having direct control over the delivery of services they require that best meet their personal circumstances. However, the issue of affordability **must not** in any way compromise the quality of health and care services for those service users not in a position to pay for **all or part** of their health and social care requirements.
13. It is important to note that the Social Security Agency recent discussion paper on a refreshed Benefits Take-Up Campaign, identified older people, disabled people, carers and their families as being most at risk of poverty<sup>5</sup>.
14. Further consideration of the most appropriate investment model for social care should take into account the need to avoid placing an undue financial burden on economically marginalised groups such as disabled people, people with dependents (carers) and older people, who have historically placed a greater demand on health and social care services.

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<sup>4</sup> Social Security Agency on Behalf of the Department for Social Development (December 2012): *Maximising Benefits and Outcomes – 'A Plan for the Improvement of the Up-take of Benefits'*. Discussion Document, page 12, paragraph 3. Available at: <http://www.dsdni.gov.uk/maximising-incomes-outcomes-consultation.pdf>

15. The Commission is aware that other developed countries such as Austria, Germany and Japan have adopted a more universal approach to the provision of social care funding, for example, through social care insurance schemes, promoting the realization of collective responsibility on the part of all citizens for the funding of health and social care.
16. The Joseph Rowntree Foundation has pointed out that *'It is entirely possible to combine universality – care that is available to non-poor and poor people alike – with principles of fairness, so that those who can afford to contribute to the costs of their care do so in proportion to their means. Progressive co-payments or charges contribute to the economic sustainability of social care funding arrangements and also to their political sustainability, in that they reduce arguments that those who can afford to pay are receiving free care'*<sup>6</sup>.

It is imperative that the debate on the future of social care explores all potential avenues for the future funding of our social care system.

17. The Commission would recommend that in considering the practice of Direct Payments and personalisation of social care that further consideration be given to an appropriate framework to protect the rights of both carers and service users. The Department for Health, Social Services and Public Safety and the Department for Social Development should take steps to ensure that both informal and paid carers receive appropriate support, including consideration of statutory provision of guaranteeing access to necessary resources, rights and entitlements etc.
18. Care needs to be taken to ensure that any changes to the resourcing arrangements for health and social care services do not result in diminishment of human rights and equality obligations noting, in particular, the obligation on State Parties

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<sup>6</sup> Glendinning, C. and Bell, D. (November 2008): *Rethinking social care and support: What can England learn from other countries?* in *Viewpoint*, page 7, Joseph Rowntree Foundation. Available at: <http://www.jrf.org.uk/sites/files/jrf/2335.pdf>

to progressively realise Convention rights articulated within the Article 2 (1) of the International Covenant for Economic Social and Cultural Rights (ICESCR)<sup>7</sup>.

19. The UN Committee on Economic, Social and Cultural Rights has stated that:

*“Any deliberate retrogressive measures ... would require the most careful consideration and would need to be fully justified by reference to the totality of the rights provided for in the Covenant and in the context of the full use of the maximum available resources”<sup>8</sup>.*

## **Specific Commentary**

### **The Vision**

20. The Commission endorses the overall thrust of the vision set out in the discussion paper - to empower people to take direct control of their health and care requirements, encompassing a transition from hospital based and institutional health and social care to supported living arrangements in the community.
21. However, we are of the view that the vision could be enhanced to reflect greater emphasis on the principles of equality and human rights alongside other considerations such as sustainability.

### **Equality and Human Rights Obligations**

#### **UN Convention on the Rights of Persons with Disabilities (UNCRPD)**

22. Whilst the Commission acknowledges that while some of the proposed measures correspond well with the delivery of

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<sup>7</sup> Available at: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>

<sup>8</sup> Committee on Economic, Social and Cultural Rights: *General Comment No. 3, The Nature of States Parties' Obligations* (Fifth session, 1990), U.N. Doc. E/1991/23, paragraph 9. Available at: <http://www.unhcr.org/refworld/pdfid/4538838e10.pdf>

Government's obligations under the UNCRPD, we believe that further consideration should be given to expanding the vision beyond personalisation of health and social care so that disabled people's views and the views of other groups such as carers and older people are incorporated at strategic policy decision making level.

23. **Article 19 of the CPRD, the right of disabled people to independent living**, set alongside other Articles such as the right to individual autonomy set out in Article 3(a), General Principles, encourages the practice of self directed support and the personalisation ethos upon which the Department's vision is based.
24. Article 19 sets out the right of persons with disabilities to equal access to mainstream services that are tailored to the individual service user requirements. Any new social care model must ensure that disabled people are free to choose the type of assistance they require to support a good quality of life and prevent isolation and economic hardship.

### **Personalisation of Social Care at a Strategic Level**

25. Proper consideration of any future social care model will require a great deal of planning and active involvement of the public in consultation, including those most affected by the proposed changes such as disabled people and older people (who are primary users of health and social care). This will require service users to be involved at the strategic and high level decision making in relation to any policy proposals regarding the future of social care.
26. The CPRD makes clear that disabled people's voices and experiences, reflecting both the aspirations of the individual disabled person and the collective experience of disabled people, are an essential ingredient for the effective implementation of the Convention.
27. **Article 3(a), General Principles**, of the CPRD requires consideration of the need for respect for inherent dignity,

individual autonomy, including the freedom to make one's own choices and the independence to enable that choice to be made. Further, **Article 3(c)** calls for the **full and effective participation** and inclusion in society of disabled people.

28. In terms of understanding the collective experience of disabled people and their situation, **Article 4(3), General Obligations**, requires the Department to closely consult and **actively involve disabled people, including disabled children**<sup>9</sup>, through their representative organisations, in the development and implementation of legislation and policies to implement the Convention and in decision making processes related to them.
29. The Commission acknowledges that the DHSSPS has, to date, closely engaged and/or involved key stakeholders, through a number of focus groups which have included older people and those with disabilities, in the debate examining the context, principles and aspirations associated with WCDD.
30. Disabled people in Northern Ireland have identified the right to participate in decision-making as a key priority<sup>10</sup>. The Department and others responsible for the delivery of adult health and social care, need to consider further how they can encourage the participation of disabled people in decision making processes in any new health and social care model. This could include, for example, incorporating the voice and experience of disabled people in the monitoring and evaluation reports on policies and strategies relating to the operation of direct payments. The development of models of stakeholder engagement in the structures associated with the new models of adult health and social care, such as the Integrated Health and Social Care Partnerships identified in the Transforming

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<sup>9</sup> See also: Equality Commission for Northern Ireland (2010): *Let's talk, let's Listen – Guidance for public authorities on Consulting and Involving Children and Young People*. Available at:

[http://www.equalityni.org/archive/LetsTalkLetsListen\(Final\).pdf](http://www.equalityni.org/archive/LetsTalkLetsListen(Final).pdf)

<sup>10</sup> Harper, C, McClenahan, S, Byrne, B. & Russell, H. (2012): *Disability programmes and policies: How does Northern Ireland measure up? – Monitoring implementation public policy and programmes of the United Nations Convention on the Rights of Persons with Disabilities in Northern Ireland* (Equality Commission for Northern Ireland: Belfast). Available at:

<http://www.equalityni.org/archive/pdf/UNCRPDFullReportFINAL260112.pdf>

Your Care Proposals would also help to fulfill CRPD commitments.

31. Furthermore, the Departments and Health and Social Care Trusts have an opportunity to engage with stakeholders utilising the mechanisms associated with the public sector equality duties with respect to Section 75 and the Disability Duties.
32. The Department should provide training for policy makers and service providers to ensure that they understand the value of user and carer involvement and have the necessary skills to support and work in partnership with them.

### **Personalisation of Health and Social Care Reconfiguration and Allocation of Resources**

33. The discussion document sets out an approach that many service users will have to pay for their health and social care, through the liquidation of personal assets, and through personal income including social security benefits.
34. Although the emphasis within the discussion document is on the responsibility of the individual to provide for their own social care needs, research by the Joseph Rowntree Foundation notes that in a number of other developed countries e.g. Austria, Germany and Japan, access to both health and social care is founded on the principles of universality, funded through social insurance schemes and taxation. The research points to the close alignment between health and economic inequalities and the likely greater demand on services from traditionally marginalised groups such as older people and disabled people who have greater care and support needs.
35. The Commission considers that the requirement to use savings to pay for personal health and social care should be applied fairly and consistently and not adversely impact on any particular group. This particular measure is likely to have an adverse impact on older people in need of residential care as opposed to domiciliary care.

36. The Rowntree research points out that an approach which shares the risk of social care across the whole population enables the burden of health and social care to be evenly distributed rather than increase the risk of poverty for already marginalised and excluded groups<sup>11</sup>. It is important that the debate on the future of social care explores all potential avenues for the future funding of our social care system.
37. The Commission notes the proposal that costs associated with health and personal care could be supplemented by an individual's income, including benefits such as Disability Living Allowance. However, we believe that the Department should adopt this approach only with respect to the care component. Benefits which have no relationship to health and social care e.g. those that relate to a mobility component should, in our view, be exempt from consideration.
38. Furthermore, although benefits such as Attendance Allowance do not contain a mobility component, people over 65 are likely to need financial support for their mobility requirements. Any means testing measure and threshold set regarding entitlement/payment for social care for this group should consider mobility and other requirements and rights beyond personal care e.g. the right to economic and social independence.
39. The Commission wishes to draw the attention of the Department to the requirement in Article 4 (2) of the CPRD with regard to economic, social and cultural rights, that the State Party *'take measures to the maximum of available resources with a view to achieving progressively the full realisation of these rights'*, (such as those enumerated in Articles 19, 25 and 28).
40. With respect to realisation of Articles 25, Health and 28, Adequate standard of living and social protection, the

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<sup>11</sup> Joseph Rowntree Foundation (November 2008): *Rethinking Social Care and Support, What can England learn from other countries?*, page 4, final 4 paragraphs. Available at: [www.jrf.org.uk](http://www.jrf.org.uk)

Department are required to ensure that disabled people are protected from any measure that would have the effect of diminishing the state's obligation to maintain these rights set out in the Convention.

41. Article 19, the right of disabled people to live independently, provides a choice to disabled people in determining how to live their own lives, particularly with respect to personal decisions regarding their living arrangements, including with respect to the personal care and support.
42. Article 19 also highlights the fact that disabled people have the right to have the opportunity to choose their place of residence, and where and with whom they live on an equal basis with others. It also identifies that disabled people should have access to a range of in-home, residential and other community support services, including the personal assistance necessary to support living and inclusion in the community, to prevent isolation, or segregation from the community.
43. Critically, consideration of Article 19 also requires that the Department ensures that the provision of services and facilities available to the general population are available on an equal basis to persons with disabilities and are responsive to their needs. Policies concerning welfare reform and the reconfiguration of health and social care must take account of this article, ensuring that any measures in the above areas do not denigrate in any way the right of disabled people to live independently.
44. The obligation to prevent retrogression of rights is also articulated within the International Covenant for Economic Social and Cultural Rights (ICESCR) and the United Nations Convention on the Rights of the Child (UNCRC)<sup>12</sup>.
45. The UN Committee on Economic, Social and Cultural Rights has stated that:

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<sup>12</sup> Committee on Economic, Social and Cultural Rights: *General Comment No. 3, The Nature of States Parties' Obligations* (Fifth session, 1990), U.N. Doc. E/1991/23, paragraph 9.

*‘Any deliberate retrogressive measures ... would require the most careful consideration and would need to be fully justified by reference to the totality of the rights provided for in the Covenant and in the context of the full use of the maximum available resources’<sup>13</sup>.*

- 46 This requirement means in practice that realignment of social security benefits or healthcare provision which directly or indirectly affects disabled people must not lead to retrogression of disabled person’s rights.
- 47 The Commission recognises that all of the rights set out in the Convention can be achieved progressively over a period of time. However, there is still a requirement that the Department consider their existing policies against Convention standards.
- 48 The concept of ‘progressive realisation’ appears in article 2.1 of ICESCR. The UN Committee on Economic, Social and Cultural Rights, in its General Comment No 3, highlighted that ‘progressive realisation’ requires at a minimum, that the State Party use foresight analysis and planning in the implementation of Convention rights.
- 49 Further, the Committee, in its General Comment No 5<sup>14</sup>, advises that in order to promote ‘progressive realisation’ of the relevant rights to the maximum of available resources, State Parties need to do more than merely abstain from taking measures which might have a negative impact on persons with disabilities. There is an obligation to take positive action to reduce structural disadvantage and deliver appropriate preferential treatment to people with disabilities to achieve the objectives of the relevant rights set out in the CRPD.

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<sup>13</sup> Available at: <http://www.unhcr.org/refworld/docid/4538838f0.html>

<sup>14</sup> UNISON (March 2010): *Who Cares Who Pays? A report on personalization in social care, prepared by Hilary Land, University of Bristol, Susan Himmelwelt, Open University*, page 29, paragraph 5. Available at: <http://www.unison.org.uk/acrobat/19020.pdf>

## Support for Carers

- 50 Within the general consideration of personalisation of health and social care, we note the reference made to the high costs of informal care provided by family and friends and that historically the issue of carers has not always received the attention from Government that it deserves.
- 51 Independent research funded by UNISON found that paying informal carers is cost-effective. First, they typically provide a greater range of services than they are paid for. This has long been acknowledged elsewhere in Europe. For example, in Norway, family carers, (and other personal assistants) had the same employment rights as other carers who were part of the municipal home help service in the 1970's and were regarded as very good value for money<sup>15</sup>.
- 52 At present carers in Northern Ireland have no legal entitlement to support and the health and social care framework for carers is governed by general good practice guidance.
- 53 We are aware that the Government is currently taking forward legislation in England to provide support to both service users and carers in relation to their rights and entitlements within the framework of social care.
- 54 The White Paper '*Caring for our Future: Reforming Care and Support*', outlines the Government's intention to provide legislative protection and resources for both service users and carers in England. The Department may wish to consider a similar approach protecting the rights of carers as well as service users in Northern Ireland<sup>16</sup>.
- 55 In our response to the Disability Strategy we recommended that the Strategy includes a strategic priority to address the

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<sup>15</sup> Department for Health (2012): *White Paper: Caring for our Future, reforming care and support*, page 35. Available at: <http://www.dh.gov.uk/health/files/2012/07/White-Paper-Caring-for-our-future-reforming-care-and-support-PDF-1580K.pdf>

challenges faced by carers in Northern Ireland. We specifically recommended that there be a statutory obligation to provide affordable childcare for children, a similar statutory obligation in relation to adults with high and complex support requirements should also be considered<sup>17</sup>.

- 56 Furthermore, we noted the reduced targets for respite provision to support informal carers to continue their role. The Bamford Action Plan set targets for increased respite provision of 200 learning disability packages and 2000 dementia packages per year. However, reductions in funding in 2010/11 resulted in these targets being reduced to 125 and 1200 respectively<sup>18</sup>.
- 57 The Commission understands that significant number of carers find they are not eligible for Carers Allowance due to strict rules over who can claim. Many carers have to rely on savings, pensions and critical illness insurance cover<sup>19</sup>.

### **Rural Equality Proofing**

- 58 The Commission recommends that the Department undertake a rural equality proofing exercise which takes into consideration the availability of infrastructure to deliver health and social care services to the rural community in order to reflect Article 25 (c) of the UNCRPD<sup>20</sup>.

### **Mixed Economy Model**

- 59 The Commission would seek assurances from the Department that the transition to community-based health and social care services and home based care using the mixed economy model of private and community/voluntary providers will not result in

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<sup>17</sup> Equality Commission for Northern Ireland (July 2012): *Response to OFMdFM Consultation on "A Strategy to Improve the Lives of Disabled People 2012-2015*.

<sup>18</sup> Carers Northern Ireland (June 2012): *In sickness and in Health Report – Summary of key findings*, page 1. Available at <http://www.carersuk.org/news-northern-ireland/item/2610-cw2012-research>

<sup>19</sup> DHSSPS Integrated Projects Unit (January 2012): *Evaluation of the Bamford Action Plan as at December 2011*, paragraph 5.4.5, page 29. Available at: <http://www.dhsspsni.gov.uk/bamford-evaluation-action-plan2009-2011.pdf>

<sup>20</sup> To 'provide... health services as close as possible to people's own communities, including in rural areas'.

diminution of health and social care services in particular for marginalised and excluded groups such as disabled people, older people and carers.

### **Welfare Reform Measures**

- 60 Future planning with regard to the reconfiguration of adult health and social care should also take into account changes to social security provision and any adverse impacts arising from the current welfare reform agenda which may lead to greater future demands on health and social care services.

### **Section 75 Outcomes and Impacts**

- 61 The Commission encourage authorities involved in the delivery of the eventual outcomes associated with the WCDD to consider equality of opportunity and good relations at all stages of policy development. Consultation, whether at the pre-screening, screening or EQIA stages, is a crucial element in this process.

- 62 The Commission recommends that any EQIA should consider:

- barriers to equality;
- the intended outcomes set out in the WCDD;
- relevant information and research programmes, including material gathered in the Department's audit of inequality;
- the potential impacts arising from WCDD e.g. transfer of services from the public sector to the community, voluntary and independent sector, including home based care;
- specific opportunities for alternative policies and positive or mitigating action, where potential adverse impacts are identified.

### **Monitoring and Review of Proposals Arising from WCDD**

- 63 The Commission recommends that equality considerations are integral to the development and implementation and review of legislation, policies, programmes arising from WCDD. Consideration should be given as to how the Section 75

mechanisms can best assist in the monitoring and review process likely to be used in the out workings of this debate<sup>21</sup>.

- 64 The Commission will continue to monitor compliance with Section 75 of the Northern Ireland Act as policies associated with ‘*Who Cares?*’ are developed and work with the relevant public authorities to ensure that the screening and EQIA of final WCDD options address potential equality impacts and human rights obligations.

### **Capacity Building**

- 65 The Commission recommends that the Department give consideration to capacity building as a measure to inform and support the involvement of health service users in the decision-making framework associated with WCDD.

### **Age Appropriate Delivery of Services**

- 66 As previously advised in our response to the consultation on public health, ‘*Fit and Well*’, the Department will be aware that there is a commitment in the Programme for Government 2011-2015<sup>22</sup> to consult on legislation prohibiting discrimination on the grounds of age in the provision of goods and services with the proposed introduction of the legislation in Northern Ireland during 2014-2015.
- 67 We recommend that an underpinning theme within WCDD should be the promotion of age equality within health and social care. The proposals should include a commitment to take appropriate actions, including an in-depth review of the degree to which age discrimination may exist within health and social care, prior to the introduction of legislation prohibiting discrimination on the grounds of age in the provision of goods and services.

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<sup>21</sup> Equality Commission for Northern Ireland (July 2007): *Monitoring Guidance for Use by Public Authorities*. Available at: <http://www.equalityni.org/archive/pdf/S75MonitoringGuidance0707.pdf>

<sup>22</sup>Northern Ireland Executive (2012): *Programme for Government 2011-15: Building a Better Future*. Available at: <http://www.northernireland.gov.uk/pfg-2011-2015-final-report.pdf>

68 Similar legislation came into effect in Great Britain on 1 October 2012. In advance, the National Health Service (NHS) had already taken preliminary steps aimed at avoiding discrimination claims. For example, the NHS Commissioning Board (NHSCB) published an equality analysis at the beginning of 2012. In addition, a wide-ranging review of age equality in health and social care was commissioned by the Department of Health in Great Britain in advance of the legislation taking effect. The review included a series of literature reviews commissioned by the Department of Health as well as, following the outcome of the review, the production of NHS Practice Guides on Achieving Age Equality in Health and Social Care<sup>23</sup> (this resource pack included an audit tool for achieving age equality and a social care practice guide).

## Summary and Conclusions

69 Whilst the discussion document identifies a number of the equality and good relations issues central to the review and future implementation of adult health and social care, further consideration needs to be given to equality and human rights issues relevant to the specific identity of a number of groups, such as women, disabled people and older people. This should aim to ensure that:

- current disadvantages experienced by equality constituencies are not compounded and new disadvantages are not created as a result of re-configuration of services from the public sector to the community/private sectors;
- enhancement of public participation in decision-making structures is encouraged alongside the development of personalisation of health and social care;
- mechanisms are put in place to deliver affordable and accessible health and social care to everyone;

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<sup>23</sup> NHS Southwest and the Department of Health (2010): *Achieving Age Equality in Health and Social Care*. Available at: <http://age-equality.southwest.nhs.uk/downloads/guides/age-equality-nhs-practice-guide-ALL-chapters.pdf>

- consideration is given to all options for the future funding of social care provision;
- give equal weight to the principles of equality and human rights alongside that of the sustainability of any future health and social care model;
- consideration is given to a legislative framework to provide guaranteed support and resources for service users and carers, similar to the approach adopted in England;
- consideration is given to the impact on health and social care services of the introduction of age anti-discrimination law.

**Legal Policy and Research Division  
March 2013**

## **Annex 1: The Equality Commission for Northern Ireland**

1. The Equality Commission for Northern Ireland (the Commission) is an independent public body established under the Northern Ireland Act 1998. The Commission is responsible for implementing the legislation on fair employment and treatment, sex discrimination and equal pay, race relations, sexual orientation, disability and age.
2. The Commission's remit also includes overseeing the statutory duties on the Department to promote equality of opportunity and good relations under Section 75 of the Northern Ireland Act 1998 (Section 75) and to promote positive attitudes towards disabled people and encourage participation by disabled people in public life under the Disability Discrimination Act 1995.
3. The Commission's general duties include:
  - working towards the elimination of discrimination;
  - promoting equality of opportunity and encouraging good practice;
  - promoting positive / affirmative action
  - promoting good relations between people of different racial groups;
  - overseeing the implementation and effectiveness of the statutory duty on relevant the Department;
  - keeping the legislation under review;
  - promoting good relations between people of different religious belief and / or political opinion.
4. The Equality Commission, together with the Northern Ireland Human Rights Commission, has been designated under the United Nations Convention on the rights of Persons with Disabilities (UNCRPD) as the independent mechanism tasked with promoting, protecting and monitoring implementation of the Convention in Northern Ireland.