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CONTENTS

JOURNAL OF AGING LAW & POLICY

VOLUME 12 SPRING 2021

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ADVOCACY AND THE RIGHTS OF THE VULNERABLE OLDER PERSON

Karen Williams & Sue Field[*]

Introduction

This Article highlights, within the Australian context, the contemporary issues surrounding advocacy and the rights of older, vulnerable persons to have someone advocate for them in various situations where they may have difficulty or cannot speak for themselves. In addressing this topic, this Article first examines the demographics of ageing and some of the factors that necessitate some people requiring the assistance of an advocate. Therefore, the focus of the Article is on both social and legal advocacy. It should be noted at the outset that Australia has a federal system of government comprised of six States and two Territories. Some legislation, as will be seen in the Article, is State- and/or Territory-based and the other is federal- or Commonwealth-based, which covers all States and Territories.

Depending upon where we live, what we do for a living, and how we perceive ourselves, we might – subjectively – observe that there appears to be a growing number of older people in Australian

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society. Objectively, this observation can be validated by statistics. According to the Australian Bureau of Statistics ("ABS") in 2020, 16% of Australia's population was 65 years of age or older.[1] In view of the fact that as of September 30, 2020 the estimated population in Australia is 25,764,115[2] our observations would appear to be correct. In line with most western countries, the proportion of older people in Australia's population is increasing.

However, reaching the age of 65 years does not automatically place a person in a homogenous group where they are "old," "frail," "incapacitated," or, indeed, "vulnerable" and a drain on the health and social security systems of the nation. Whilst, for many decades 65 was the age considered old, yet this was based on the fact that a person had to be 65 years of age to meet the age criteria to receive the Age Pension. This is no longer the case, as the Age Pension age has been steadily increasing by 6 months every 2 years and will continue to rise until July 1, 2023 when a person must be 67 years of age before they meet the age requirement.[3] It can be seen then that "old" is actually a more fluid concept.

Age alone is not the determining issue; however, as we age we are proportionally more prone to age-related physical and mental conditions.[4] In particular, there are people who are cognitively impaired, either as a result of age-related dementia or an acquired or traumatic brain injury.[5] However, despite not having a cognitive impairment or underlying conditions, many older people (and their

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[1] *Population by Age and Sex, Australia, States and Territories*, AUSTL. BUREAU OF STAT. (Dec. 20, 2018, 11:30 AM AEDT), https://www.abs.gov.au/AUSSTATS/abs@.nsf/Previousproducts/3101.0Feature%20Article1Jun%202018?opendocument&tabname=Summary&prodno=3101.0&issue=Jun%202018&num=&view=.

[2] *Population Clock,* AUSTL. BUREAU OF STAT. (Apr. 6, 2021 11:35 AM AEDT), https://www.abs.gov.au/ausstats/abs%40.nsf/94713ad445ff1425ca25682000192af2/1647509ef7e25faaca2568a900154b63?OpenDocument.

[3] *Who Can Get It*, AUSTL. GOV'T, https://www.servicesaustralia.gov.au/individuals/services/centrelink/age-pension/who-can-get-it (last updated Nov. 4, 2019).

[4] *Ageing and the Health System: Challenges Opportunities and Adaptations*, AUSTL. INST. OF HEALTH AND WELFARE, June 25, 2014, at 1, 1–2 (available at https://www.aihw.gov.au/getmedia/19dbc591-b1ef-4485-80ce-029ff66d6930/6_9-health-ageing.pdf.aspx).

[5] *See id.* at 2.

supporters) have difficulty understanding the complexities of their legal, health, and social situations and the systems of care that are available to them. These complexities can also be compounded by language differences and the provisions of information through electronic means when the older person may not be digitally literate.[6] These circumstances present their own vulnerabilities and may result in the older person requiring the assistance of an advocate to at least inform, but possibly represent them, and act in accordance with their will and preference. It is acknowledged that there is a fine line between a paternalistic and overly protective response that sees all older people as vulnerable.[7] To balance this view, a stronger human rights framework is required both generally and specifically for older people to preserve their own decision-making. While this has not occurred at a national level, there are some encouraging developments.[8]

Origins of Advocacy

Advocacy is not a modern phenomenon. The origins of advocacy can be traced back to practices engaged in by ancient Greeks and Romans.[9] In the case of the ancient Greeks, these

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[6] *See Older Australia at a Glance*, AUSTL. INST. OF HEALTH AND WELFARE, https://www.aihw.gov.au/reports/older-people/older-australia-at-a-glance/contents/diverse-groups-of-older-australians/culturally-linguistically-diverse-people (last updated Sept. 10, 2018) (discussing how not all older Australians speak English); Ben Hocking, *Older Australians Suffering from Digital Inclusion Gap*, YOURLIFECHOICES (Apr. 7, 2018), https://www.yourlifechoices.com.au/technology/addressing-the-digital-inclusion-gap/ (mentioning how only 51% of older Australians are internet users).

[7] *See* Karen Williams, Carolyn Sappideen, Michael Perkins & Sue Field, *Overview of Elder Law, in* ELDER LAW: A GUIDE TO WORKING WITH OLDER AUSTRALIANS 1, 9 (Karen Williams, Carolyn Sappideen & Sue Field eds. 2018) ("The lawyer needs to be prepared to respond to client demands that range between 'help me do it,' 'do it with me,' and 'do it for me,' requiring an ability to have a nuanced approach.")

[8] *See generally Human Rights Act 2019* (QLD) (Austl.).

[9] Stephanie A. Vaughn, *Experiential Learning: Moving Forward in Teaching Oral Advocacy Skills by Looking Back at the Origins of Rhetoric*, 59 S. TEX. L. REV. 121, 124 (2017).

practices were developed in relation to tribunals and courts where the person would explain their case or position to an orator who would then prepare an oration that the person would later present in court.[10] This system was further developed by the Romans where an "advocatus" would appear in a court or a tribunal to prosecute or defend the cause of their client.[11] The skills and attributes of successful advocates in ancient Rome were identified as educated and knowledgeable in law, upholders of the law, strong in oratory and debating skills, dedicated to an ethical approach, and dedicated to the interests of their clients.[12]

Building on these early times, advocacy in England can then be traced through feudal times to the clergy, who were considered highly educated citizens with knowledge of the law required to advocate for the citizens.[13] Thereafter, advocacy began developing into a profession and by the fourteenth century the beginnings of professional associations, such as Inns of Court (the early law schools), were established.[14] These professional bodies would then develop the qualifications required by those who sought to practice advocacy.[15]

Advocacy Practice

As clearly identified above, advocacy originated and developed in the legal profession. However, while understanding advocacy in the legal context may be helpful to our understanding of advocacy, it no longer provides a complete understanding of the practice of advocacy in a contemporary sense. Moreover, given its extensive development over centuries in a legal setting, reviewing the key elements of current legal advocacy along with the required and desired skills of a legal advocate gives a professional framework to view other types of advocacy.

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[10] E.W. Timberlake Jr., *Origin and Development of Advocacy as a Profession*, 9 VA. L. REV. 25, 25 (1922).
[11] *Id.* at 26.
[12] *Id.* at 27.
[13] *Id.* at 28–29.
[14] *Id.* at 30.
[15] *See id.* at 31, 34, 37–38.

Contemporary Legal Advocacy

The clear aim of contemporary legal advocacy is to persuade the decision maker, which is often the court or tribunal, to the arguments being presented.[16] While this is the primary aim of advocacy, there is much more to "arguing one's case" than fine oratory skills on the day of the trial.

A range of pre-trial activities are considered by most commentators on the subject as equally important keys to successful advocacy at the actual trial itself. Indeed, in a succinct outline of what is required for successful advocacy, being prepared has been suggested as one of the top three essential ingredients to advocacy.[17] Other critically important steps include neutrally or impartially assessing the evidence for and against your case before the trial begins, and if the evidence proves "poor" or limited in support of your client's case, advising clients of the need to negotiate the best possible outcome (advising not to go to trial).[18] Fundamental to the above is that such an approach be conducted courteously and truthfully in a manner that is not misleading to the decision maker, which is often the court, and, at all times, working within the professional rules and guidelines.[19]

Most descriptions of legal advocacy often lead to the qualities to be found in a good advocate. These qualities are often listed as being

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[16] Toni Lucev, *Advocacy - Some Essential Tips for Beginners*, FED. JUD. SCHOLARSHIP 1 (Dec. 11, 2012), http://www.austlii.edu.au/au/journals/FedJSchol/2012/17.html.

[17] Stafford Shepherd, *Ten Tips for Better Advocacy*, QUEENSLAND L. SOC'Y (Sept. 9, 2013), https://www.qls.com.au/Knowledge_centre/Ethics/Resources/Duty_to_the_court/Ten_tips_for_better_advocacy (this is a note based on observations of Magistrate Annette Hennessey, represented with permission by Ethics Centre).

[18] *See generally* Tigran W. Eldred, *Prescriptions for Ethical Blindness: Improving Advocacy for Indigent Defendants in Criminal Cases*, 65 RUTGERS L. REV. 333, 340–341 (2013) ("[A] lawyer who fails to seek information relevant to the case may fail to uncover evidence that can help . . . provide leverage in plea negotiations.").

[19] Shepherd, *supra* note 17, at 2; AUSTL. SOLS.' CONDUCT RULES § 4–5 (L. SOC'Y OF SOUTH AUSTL. 2011) (available at https://www.lawsocietysa.asn.au/pdf/AustralianSolicitorConductRules2015.pdf).

a good listener, honest, courteous, prompt, objective, frank, courageous, and industrious.[20]

However, while a detailed knowledge of skills required for trial advocacy is not necessary for the purposes of this Article, there are still some components of legal advocacy that are relevant to a broader discussion of advocacy and the vulnerable older person. Also, it is important to note that in recent times fewer legal disputes progress to trial.[21]

For some time, there has been a policy preference expressed by government toward mediation or alternative dispute resolution ("ADR"), which has resulted in fewer matters being fully litigated in court.[22] The main reason behind this transition from traditional civil court litigation to ADR has been that the civil court system has become out of reach of ordinary citizens and too slow to deliver justice.[23] Besides the barriers of cost and inefficiency, civil litigation has been characterised as inadequate to respond effectively to relational disputes.[24] Civil litigation has, arguably, been better placed to respond to disputes in relation to commercial transactions rather than disputes involving ongoing relationships such as parenting or family law, discrimination, social security, and workplace disputes.[25] The essential component of ADR is its move

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[20] *Top 25 Most Significant Skills and Abilities of Lawyers*, ASS'N ACCREDITED PUB. POL'Y ADVOCATES EUR. UNION, http://www.aalep.eu/top-25-most-significant-skills-and-abilities-lawyers (last visited Apr. 5, 2021).

[21] Margaret McMurdo, Former President of Court of Appeal of Supreme Court of Queensland, *Advocacy Inside and Outside the Courtroom*, at QUEENSLAND L. SOC'Y MODERN ADVOCATE LECTURE SERIES 2017, (May 11, 2017) (transcript available at https://www.qls.com.au/Knowledge_centre/Ethics/Modern_Advocate_Lecture_Series/Modern_Advocate_Lecture_Series_2017).

[22] *See* Thomas J. Stipanovich, *ADR and the "Vanishing Trial": The Growth and Impact of "Alternative Dispute Resolution"*, 1 J. EMPIRICAL LEGAL STUD. 843, 844 (2004) (noting how courts and government agencies promoted mediation and arbitration).

[23] Mary Anne Noone & Lola Akin Ojelabi, *Ensuring Access to Justice in Mediation Within the Civil Justice System*, 40 MONASH UNIV. L. REV. 528, 528–29 (2014).

[24] Sharon A. Williams, *Mediation of Family Law Cases*, OR. STATE BAR (June 2020), https://www.osbar.org/public/legalinfo/1218_MediationFamLaw.htm.

[25] Joe Harman, Judge of the Federal Circuit Court of Australia, From Alternate to Primary Dispute Resolution: The Pivotal Role of Mediation In (and In Avoiding) Litigation, Melbourne 2 (Sept. 9, 2014) (transcript available at http://www.federalcircuitcourt.gov.au/wps/wcm/connect/7783dc05-34c1-4297-a6cc-3dcd5fe01dc8/Speech-Harman-alternate-to-primary-dispute-resolution-

away from combative win-loss mode of litigation toward a collaborative or co-operative problem solving approach.[26] Over many years, the cost in relationship damage has been observed to be another detrimental aspect of the litigation process, and it has to be considered by the parties in progressing a litigated outcome.[27] Another benefit of the ADR process is that it is usually private, confidential, and aims to resolve disputes in a manner so that the parties can possibly continue in their relationship.[28] This can be beneficial and attractive to parties involved in relational disputes, in that the "dirty laundry" need not be aired in the public gaze.[29]

ADR may be used as a stand-alone process to resolve disputes. However, the micro-processes involved in ADR (or its key component parts), such as having an independent or impartial third party assist the parties to resolve a dispute, generate multiple options, or plan next steps in a complicated ongoing relationship, have also been utilised alongside the litigation pathway.[30] Mediation became extensively popular in Australia, at both the Federal (national) and State court level during the 1990s.[31] Family courts, in particular, set up their own ADR programs.[32] Within many courts, there is now a mandated mediation process that is necessary to complete before the parties can proceed to litigate their matter.[33] In

2014.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=7783dc05-34c1-4297-a6cc-3dcd5fe01dc8).

[26] *Id.* at 5 (quoting David Paratz, *The History of Mediation in Queensland*, 53 HEARSAY 1 (2011) (available at https://www.hearsay.org.au/the-history-of-mediation-in-queensland/)).

[27] Harman, *supra* note 25, at 13.

[28] *Id.* at 12–13 (quoting Patricia Bergin, *The Objectives, Scope and Focus of Mediation Legislation in Australia*, 2 J. CIV. LITIG. PRAC. 49 (2003)).

[29] *Id.* at 13.

[30] *Id.* at 4, 6 (quoting Leonard L. Riskin, *Understanding Mediators' Orientations, Strategies, and Techniques: A Grid for the Perplexed*, 1 HARV. NEGOT. L. REV. 7, 8 (1996)).

[31] *Id.* at 7.

[32] *Id.*

[33] *Id.* at 8.

fact, the use of ADR has become so extensive that it is now an integral component of the Australian justice system.[34]

Therefore, the advocacy skills of the lawyer are also utilized in this different ADR forum, and these skills include negotiation, mediation, identifying possible similar interests between the parties, problem solving, and co-operation.[35] These skills often require the advocate to listen carefully to what their clients are saying they want and/or need.[36] The advocate/lawyer must then act in their client's best interests to achieve some or all of the outcomes that they seek.[37] The benefits of a mediation-achieved compromise are that both parties are placed in better circumstances than those imposed by a court order.[38]

So, whether the advocate is in trial persuading the judge/tribunal or persuading the parties to identify their interests, identifying options to meet their interests, and co-operating with the other parties in order to reach an agreement, there are key characteristics of a successful advocate. A successful advocate is someone who can keep the information simple for the parties and, ultimately, the decision maker and has the ability to simplify complex concepts.[39] In the contemporary world, the high level of complexity of legislation, government policies, and the circumstances of many

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[34] *Id.* at 26 (quoting Patricia Bergin, former Chief Judge in Equity of the Supreme Court of New South Wales, The Objectives, Scope and Focus of Mediation Legislation in Australia, at the "Mediate First" Conference, Hong Kong Exhibition and Convention Centre, Hong Kong (May 11, 2012) (transcript available at https://www.supremecourt.justice.nsw.gov.au/Documents/Publications/Speeches/Pre-2015%20Speeches/Bergin/bergin_2012.05.11.pdf)).

[35] *See* Guy Bowe, *Skills and Values: Alternative Dispute Resolution: Negotiation, Mediation, Collaborative Law, and Arbitration*, 6 ARB. L. REV. 467, 470–471 (2014).

[36] *Id.* at 470 ("The lawyer must then divide the client's goals into essential, important, and desirable categories.").

[37] *Id.* at 478 ("The parties are trying to convince the mediator of the 'strength and sincerity of their position' so that the mediator will work their hardest to achieve the best possible outcome for their side.").

[38] *The Advantages of Mediation Cases over Traditional Lawsuits*, FINDLAW, https://www.findlaw.com/adr/mediation/the-advantages-of-mediation-cases-over-traditional-lawsuits.html (last updated June 20, 2016) ("For all the reasons above, parties generally report a better outcome as a result of mediation than they do from a lawsuit. Also, because there is no winner or loser, no admission of fault or guilt, and the settlement is mutually agreed upon, parties are typically more satisfied with mediation.").

[39] McMurdo, *supra* note 21, at 3.

individuals is conceivably understood as a "given" by most decision makers. Conveying the complexity is often insufficient to be persuasive. By communicating in a simplified and succinct style as well as showing the parameters of a dispute and the options available to a decision maker, the persuasive advocate is making the job of decision maker easier.[40]

Different Types of Advocacy

An advocate must be familiar with and prepared for a range of different types of advocacy. One of the simpler divisions is that advocacy can either be on a systemic (sector-wide) or individual level.[41] For example, in the latter situation, people can advocate for themselves, and this is termed self-advocacy (within court or tribunal legal advocacy, a "self-advocate" is termed a self-represented litigant).[42] Individual advocacy (non-legal or social advocacy) has largely arisen from the disability sector, where for decades people with a disability had the experience of their concerns not being heard and generally being invisible to the larger population due to services being provided for them within large institutions.[43]

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[40] *See* Meysa Maleki, *Leveraging Persuasion Skills for Effective Conflict Resolution*, THRIVE GLOBAL (July 2, 2020), https://thriveglobal.com/stories/leveraging-persuasion-skills-for-effective-conflict-resolution/.

[41] *Types of Advocacy*, W. VA. UNIV. CENTER FOR EXCELLENCE IN DISABILITIES, http://cedwvu.org/resources/types-of-advocacy/ (last visited Apr. 5, 2021).

[42] *Id.*; *What is Self-Representation?*, CAXTON LEGAL CENTRE INC, https://queenslandlawhandbook.org.au/the-queensland-law-handbook/the-australian-legal-system/self-representation/what-is-self-representation/ (last updated Mar. 1, 2019).

[43] *See generally* Jenny Pearson, *Research of the Models of Advocacy Funded under the National Disability Advocacy Program*, AUSTL. GOV'T DEP'T OF SOC. SERVICES 21–23 (Sept. 14, 2009), https://www.dss.gov.au/sites/default/files/documents/05_2012/rmaf_finalreport.pdf.

History of Disability Advocacy

On January 1, 1901, the proclamation was signed creating the Commonwealth of Australia.[44] Not long after, in 1908, the Invalid Pension was established enabling people with disabilities to be financially independent.[45] The impact of both World Wars resulted in an obvious increase of people with disabilities as veterans returned with combated-related permanent disabilities.[46] The Commonwealth Rehabilitation Service was established and institutions were expanded; however, not everyone was able to be accommodated in residential services, which resulted in the establishment of community services.[47]

From the late 1970s, there was a significant change. Up until then, the voices of people with disabilities were "filtered" through their service providers, health professionals, and family members.[48] Advocacy had been centred around a particular diagnosis or medical condition, such as issues affecting people with Downs Syndrome, Cerebral Palsy, or Vision Impairment.[49] When the United Nations declared the International Year of Disabled Persons ("IYDP") in 1981, the impetus was provided for people with disabilities to run their own conferences, work together across various disability types,

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[44] *Defining Moments: Federation*, NAT'L MUSEUM AUSTL., https://www.nma.gov.au/defining-moments/resources/federation (last updated Sept. 9, 2020).
[45] *Invalid and Old-Age Pensions Act* 1908 (Cth) (Austl.).
[46] *See* Janet Lynch, *The Families of World War I Veterans*, PUB. RECORD OFFICE VICTORIA, https://prov.vic.gov.au/explore-collection/provenance-journal/provenance-2015/families-world-war-i-veterans (last updated Mar. 27, 2020); Alex Cousley, Peter Siminski & Simon Ville, *The Effects of World War II Military Service: Evidence from Australia*, 77 J. ECON. HIST. 838, 842 (Sept. 2017) (available at https://www.cambridge.org/core/journals/journal-of-economic-history/article/effects-of-world-war-ii-military-service-evidence-from-australia/E67FB4FC53154CE831292BDF4AF69BE3).
[47] *History of Disability Rights Movement in Australia*, PEOPLE WITH DISABILITY AUSTL., https://pwd.org.au/about-us/our-history/history-of-disability-rights-movement-in-australia/ (last visited on Apr. 5, 2021).
[48] *Id.*
[49] *Id.*

advocate for themselves as individuals, and altogether push for collective social change to their circumstances.[50]

During the 1980s, the Commonwealth government was the first to grant funding for individual advocacy, and alongside this development various guardianship boards and Public Advocates or Public Guardians were established.[51] Because of the bulk style of decision-making that occurred in institutions was no longer appropriate for both community care and increased independent living, the movement for moving people out of institutionalised care began gathering pace as evidenced by the establishment of guardianship boards across Australia.[52] People with disabilities, including intellectual disabilities, were being geographically dispersed into smaller community houses.[53] Public advocates and public guardians were established to provide protection and safeguard the rights of people accessing greater freedom, which is what occurred in Victoria.[54] Following the implementation of guardianship systems for individualised decision-making, the international developments as marked by IYDP, and people with a disability seeking social change for themselves, the Federal

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[50] *Id.*

[51] *See Guardianship: Final Report* 24, VICTORIAN L. REFORM COMM'N 444, (Jan. 31, 2012), https://www.lawreform.vic.gov.au/sites/default/files/Guardianship_FinalReport_Full%20text.pdf ("The development of modern guardianship laws accompanied the deinstitutionalisation of services for people with cognitive disabilities in Victoria during the late 1970s and the 1980s.").

[52] *See id.* at 40 (explaining how the movement of persons with disabilities from large institutions to community-based institutions prevented a single institutional service from making their decisions); Louise Young & Adrian F. Ashman, *Deinstitutionalisation in Australia Part 1: Historical Perspective*, 50 BRIT. J. DEVELOPMENTAL DISABILITIES 21 (2004) (discussing Australia's history of deinstitutionalization).

[53] *Id.* at 21 (Australia's deinstitutionalisation "involved residential relocation of people with intellectual disability into geographically dispersed group houses with five or fewer residents serviced by community support staff.").

[54] *See generally Guardianship: Final Report*, *supra* note 51, at 24.

Disability Discrimination Act 1992 was enacted to provide relief for Australians from discrimination based on disability.[55]

Historically, people with a disability receiving care, including residential care, were predominantly subjected to a risk management paradigm.[56] The service providers and care workers managed risk through duty of care principles and standardised risk management procedures and protocols.[57] However, the increase for independence, self-determination, and autonomy is another key principle that conflicts with risk management.[58] This can be the "space" or tension whereby adults receiving care have their liberty impacted and advocacy can be required to ensure that more than risk management is occurring for the person.

Systemic Advocacy

Systemic advocacy has continued to develop via law reform initiatives, deliberate grassroots campaigns, and sector lobbying.[59] The United Nations Convention on the Rights of People with a Disability ("UNCRPD") has set clear standards for social inclusion as well providing legal recognition for people with a disability including the right to support regarding their decision-making.[60]

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[55] *DDA guide: What's it all about*, AUSTL. HUM. RTS. COMM'N, https://humanrights.gov.au/our-work/disability-rights/dda-guide-whats-it-all-about (last visited Apr. 5, 2021).

[56] Brian J. Taylor, *Risk Management Paradigms in Health and Social Services for Professional Decision Making on the Long-Term Care of Older People*, 36 BRIT. J. OF SOC. WORK 1411, 1412–13 (2006).

[57] *Id.*

[58] R. Hawkins, M. Redley & A.J. Holland, *Duty of Care and Autonomy: How Support Workers Managed the Tension between Protecting Service Users from Risk and Promoting Their Independence in a Specialist Group Home*, 55 J. INTELLECTUAL DISABILITY RES. 873, 879 (2011).

[59] Both the Queensland Law Reform Commission and Victorian Law Reform Commission have reviewed Guardianship Laws, and Every Australian Counts was a disability sector-wide campaign to encourage the federal government to introduce the National Disability Insurance Scheme.

[60] *Guiding Principles of the Convention*, U.N. DEP'T OF ECON. AND SOC. AFF., https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/guiding-principles-of-the-convention.html (last visited Apr. 5, 2021).

The UNCRPD's focus on legislation and policy frameworks has been a key recent development in improving human rights.[61]

In Australia, the Council on the Ageing ("COTA") is a long-established independent organisation that promotes systemic advocacy at both the State and Territory level.[62] One of COTA's key objectives is driving policy change based on the views of older Australians.[63] Some of its current key policy initiatives include mature age employment, digital inclusion, housing and homelessness, and health.[64]

The role of advocate (either individual or systemic) can be and has been prescribed within legislation. For example, the Office of the Public Advocate in Victoria has been assigned, through legislation, the following key duties:

- guardianship[65]
- promoting community involvement in decision-making[66]
- investigation of abuse, exploitation, and neglect[67]
- advising the Minister[68]
- general advocacy[69]

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[61] Queensland has currently upgraded its *Guardianship & Administration Act 2000* with the *Guardianship and Administration and Other Legislation Amendment Act 2019,* § 11B, which went into effect in late 2020.
[62] *Our Work*, COTA AUSTRL., https://www.cota.org.au/about/our-work/ (last visited Apr. 5, 2021).
[63] *Id.*
[64] *Id.*; *Digital Inclusion*, COTA AUSTRL., https://www.cota.org.au/policy/digital-inclusion/ (last visited Apr. 5, 2021).
[65] *Advocacy Services*, OFF. OF THE PUB. ADVOC., https://www.publicadvocate.vic.gov.au/our-services/advocacy-services (last visited Apr. 5, 2021).
[66] *Our Work*, OFF. OF THE PUB. ADVOC., https://www.publicadvocate.vic.gov.au/our-services/31-advocacy-and-research/supported-decision-making/38-supported-decision-making (last visited Apr. 5, 2021).
[67] *Advocacy Services*, *supra* note 65.
[68] *Our Work: Functions of the Public Advocate*, OFF. OF THE PUB. ADVOC., https://www.publicadvocate.vic.gov.au/our-services?path=&catid=0&id=55 (last visited Apr. 5, 2021).
[69] *Id.*

Social Advocacy

Social advocacy is strongly linked to concepts of equality, social justice, and the inclusion of marginalised people such as refugees, children, people with mental health concerns, people with disabilities, and older people.[70] Social advocacy has borrowed from concepts and ethics associated with legal advocacy such as advocating and negotiating for a client's best interests (often in a broad welfare sense) and acting independently, courageously, and without a conflict of interest.[71] Social advocacy ranges from informing people about the rights and options they have concerning social support programs to negotiating with a decision maker (such as a guardian) to facilitate access to the necessary multi-disciplinary or multi-agency services.[72] Social advocacy can include making complaints to relevant bodies, such as anti-discrimination agencies, human rights commissions, Public Guardian, or the Aged Care Quality and Safety Commission, when other more informal negotiations/meetings may have failed. In its recent report, Human Rights Watch ("HRW") details how families may utilise advocacy services in facilitating meetings with aged care facilities regarding concerns about care (or the administration of medications without the consent of the person or their decision maker).[73] One case study in the report details how, through a combination of meetings with medical and aged care staff, complaints to the relevant commission,

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[70] *What is Social Advocacy?*, DO GOODER, https://dogooder.co/why-dogooder/social-advocacy (last visited Apr. 5, 2021); *Social Advocacy*, LAWENTRANCE.COM, https://www.lawentrance.com/article/social-advocate.html (last visited Apr. 5, 2021).

[71] *See generally Legal Advocacy: What Advocacy Organizations Need to Know*, TCC GROUP, https://www.tccgrp.com/wp-content/uploads/2018/09/LegalAdvocacyHandout_AdvocacyOrganizations.pdf (last visited Apr. 5, 2021) (noting that legal advocacy can provide outcomes beyond legal conclusions, such as community empowerment, changing narratives, and pushing for regulatory change).

[72] PIERS GOODING, A NEW ERA FOR MENTAL HEALTH LAW AND POLICY: SUPPORTED DECISION-MAKING AND THE UN CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES 125 (2017).

[73] *See* HUMAN RIGHTS WATCH, "FADING AWAY": HOW AGED CARE FACILITIES IN AUSTRALIA CHEMICALLY RESTRAIN PEOPLE WITH DEMENTIA 7 (2019), (availalable at https://www.hrw.org/sites/default/files/report_pdf/australia1019_web.pdf.

and subsequent meetings with the new manager, "Mark" helped his father "David" have his chemical restraint medication eliminated.[74]

In order to understand advocacy, it is necessary to understand its functional components. The following list was formulated by the Australian Law Reform Commission regarding advocacy for children and young people. The list sets out the relevant key elements for this population, which also serves as a framework for advocacy for the older vulnerable person:

- "promoting the interests of children generally to ensure government and agency accountability"[75]
- "monitoring compliance with international obligations"[76]
- "scrutiny of legislation, programs and initiatives"[77]
- "conducting and/or co-ordinating research to promote best practice in relation to children"[78]
- "resolving complaints and conducting inquiries into individual concerns"[79]
- "supporting and assisting particular children to access services or obtain redress for complaints and problems"[80]
- "encouraging the development of structures to enable children and young people to be active participants in the decision-making processes affecting their lives."[81]

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[74] *Id.* at 39.
[75] *Advocacy: Functions and Options*, AUSTL. L. REFORM COMM'N (July 28, 2010), https://www.alrc.gov.au/publication/seen-and-heard-priority-for-children-in-the-legal-process-alrc-report-84/7-advocacy/advocacy-functions-and-options/.
[76] *Id.*
[77] *Id.*
[78] *Id.*
[79] *Id.*
[80] *Id.*
[81] *Id.*

Focus on Social Advocacy

As mentioned, this Article will focus on social advocacy along with references to legal advocacy. Self-advocacy is always an option for individuals to consider. Many agencies have developed self-advocacy tools to assist individuals to navigate complex care and complaints systems themselves.[82]

Where Does Advocacy Fit within the Human Rights Framework

A. Commonwealth

The Human Rights Framework is slow to evolve in Australia. Australia does not have a universal Commonwealth Charter of Rights and our constitution has only minimal implied rights.[83] Mostly, Australia relies on international instruments such as the UNCRPD.[84] In addition to the UNCRPD, Australia has the *National Disability Insurance Scheme Act 2013* ("NDIS Act"), which is applicable to each State and Territory as Commonwealth legislation.[85] The legislation came into effect to give people more choice and control over their lives by needs-based funding to pursue individual goals and aspirations.[86] The overarching disability framework, based on the UNCRPD and the NDIS Act, is the Australian National Disability Insurance Scheme ("NDIS") that

[82] *E.g.*, *Self-Advocacy*, ADA AUSTRL., https://adaaustralia.com.au/self-advocacy/ (last visited Apr. 5, 2021).
[83] George Williams, *The Federal Parliament and the Protection of Human Rights*, Parliament of Austl. (May 11, 1999), https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp9899/99rp20.
[84] *See* Michael Small, *The Convention on the Rights of Persons with Disabilities*, AUSTL. HUM. RTS. COMM'N (Oct. 10, 2007), https://humanrights.gov.au/about/news/speeches/convention-rights-persons-disabilities; *Guiding Principles of the Convention*, *supra* note 60.
[85] *National Disability Insurance Scheme Act 2013* (Cth) (Austl).
[86] *Id.* § 34.

provides assistance for people with a disability who are under 65 and meet the threshold level of disability.[87]

It is necessary to be under 65 to access the NDIS; however once an eligible person is over 65, they can elect to continue with the supports they receive through the NDIS or elect to access the Commonwealth Aged Care scheme.[88] The latter scheme, unlike the former, is means-tested and requires a co-contribution.[89] The ability to maintain disability supports when usually the only choice was to access Aged Care reflects the intended all of life approach of the UNCRPD, which has no age limit.[90] Access to the NDIS scheme has to occur before a person turns 65, which is problematic because when a person increases in age the more likely they are to acquire a disability.[91]

While we are witnessing the evolution of rights-based service frameworks relating to disability, we have yet to see the same consistent approach, in a consistent way, relating to guardianship and decision-making. Some Australian states and territories have implemented the suggested law reform initiatives that promote the UNCRPD.[92] For example, in late November 2020, Queensland

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[87] *See generally* Bill Madden, Janine McIlwraith & Ruanne Brell, *National Disability Insurance Scheme, in* ELDER LAW, *supra* note 7, at 110.

[88] *See The NDIS for People Aged 65 Years and Over*, NEW SOUTH WALES GOV'T, https://www.ideas.org.au/uploads/resources/993/Factsheet%20-%20The%20NDIS%20for%20people%20aged%2065%20and%20over%20-%20Easy%20English.pdf (last visited Apr. 5, 2021).

[89] *Aged Care Home Costs and Fees*, AUSTL. GOV'T, https://www.myagedcare.gov.au/aged-care-home-costs-and-fees (last visited Apr. 5, 2021).

[90] *Support for People Living with Disability*, AUSTL. GOV'T, https://www.myagedcare.gov.au/support-people-living-with-disability (last visited Apr. 5, 2021) (showing how Australia's Aged Care support is divided into categories of before and after the age of 65).

[91] Madden, McIlwraith & Bell, *supra* note 87, at 110, 113; *see* AUSTRALIAN INSTITUTE OF HEALTH AND WELFARE, DISABILITY AND AGEING: AUSTRALIAN POPULATION PATTERNS AND IMPLICATIONS (2000) (available at https://www.aihw.gov.au/getmedia/3e01a3dd-28d7-428c-a9b9-71133152b0ec/da.pdf.aspx?inline=true) (discussing prevalence of disabilities in ageing populations).

[92] *See generally Making Decisions for Others as a Guardian or Administrator*, QUEENSLAND GOV'T, https://www.qld.gov.au/law/legal-mediation-and-justice-of-the-

adopted a new set of more inclusive, supportive decision-making principles for formal or informal decision makers that align with the UNCRPD.[93]

Unfortunately, the development of international human rights instruments for older people has also been slow to develop. In 2010, an Open Ended Working Group ("OEWG") was established by the General Assembly of the United Nations to promote international collaboration on Human Rights for Older People.[94] Annual meetings are often held with particular themes for discussion such as rights for workers, access to employment, and access to justice.[95] The lack of a clear framework has ramifications for Australia, which has a history of adopting international instruments as highlighted by national developments with NDIS.

Both home-based and residential care for people aged 65 and over is provided through the *Aged Care Act 1997*.[96] This legislation regulates the funding arrangements for approved aged care providers that receive Commonwealth funds to subsidise care for older people.[97] Associated with the *Aged Care Act,* there is subordinate legislation that provides for the Charter of Rights, which was updated in 2019.[98] The relevant subordinate legislation is the *User Rights Principles 2014* and the *Records Principles 2014*.[99] The Charter of Rights is found in the *User Rights Principles* contains the following key principles:

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peace/power-of-attorney-and-making-decisions-for-others/making-decisions-for-others (last updated Nov. 30, 2020).

[93] *Id.*; *Guardianship and Administration and Other Legislation Amendment Act 2019* (QLD) (Austl.) came into legislative effect during 2020. *Id.*

[94] *Open-Ended Working Group on Ageing for the Purpose of Strengthening the Protection of the Human Rights of Older Persons*, U.N. HUM. RTS. OFF. OF THE HIGH COMM'R, https://social.un.org/ageing-working-group/ (last visited Apr. 5, 2021).

[95] *See generally Eleventh Session*, U.N. HUM. RTS. OFF. OF THE HIGH COMM'R, https://social.un.org/ageing-working-group/eleventhsession.shtml (last visited Apr. 5, 2021). Authors note the 2020 session was cancelled due to COVID-19. *Id.*

[96] *Aged Care Act* 1997 (Cth) (Austl).

[97] *Support for People Living with Disability*, *supra* note 90.

[98] *Charter of Aged Care Rights*, AUSTL. GOV'T, https://www.agedcarequality.gov.au/consumers/consumer-rights (last visited Apr. 5, 2021).

[99] *See generally User Rights Principles* 2014 (Cth) (Austl.); *Records Principles* 2014 (Cth) (Austl.).

I have the right to:

1. *Safe and high quality care and services;*
2. *be treated with dignity and respect;*
3. *have my identity, culture and diversity valued and supported;*
4. *live without abuse and neglect;*
5. *be informed about my care and services in a way I understand;*
6. *access all information about myself, including information about my rights, care and services;*
7. *have control over and make choices about my care, and personal and social life, including where the choices involve personal risk;*
8. *have control over, and make decisions about, the personal aspects of my daily life, financial affairs and possessions;*
9. *my independence;*
10. *be listened to and understood;*
11. *have a person of my choice, including an aged care advocate, support me or speak on my behalf;*
12. *complain free from reprisal, and to have my complaints dealt with fairly and promptly;*
13. *personal privacy and to have my personal information protected;*
14. *exercise my rights without it adversely affecting the way I am treated.*[100]

The relevant body that receives aged care complaints is the Aged Care Quality and Safety Commission ("the Commission").[101] The Commission derives its powers from the *Aged Care Quality and*

[100] *User Rights Principles* 2014 (Cth) Sched. 1 § 2 (Austl.)(emphasis added).
[102] *See generally Age Care Quality and Safety Commission*, AUSTL. GOV'T, https://www.agedcarequality.gov.au/ (last visited Apr. 5, 2021).

Safety Commission Act 2018.[102] Section 5 states that the object of the *Act* is to:

> *(1) . . . establish a regulatory framework that will:*
>
> *(a) protect and enhance the safety, health, well-being and quality of life of aged care consumers; and*
>
> *(b) promote aged care consumers' confidence and trust in the provision of aged care services and Commonwealth-funded aged care services; and*
>
> *(c) promote engagement with aged care consumers about the quality of care and services provided by:*
>
> *(i) approved providers of aged care services; and*
>
> *(ii) service providers of Commonwealth-funded aged care services.*[103]

Its authority for handling complaints is found within Part 2 of the Aged Care Quality and Safety Rules 2018.[104] Anyone can bring a complaint against a provider of a provider of an aged care service.[105] Once a complaint has been made, the Commissioner has a number of options available to her.[106] The Commission may:

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[102] *See generally Aged Care Quality and Safety Commission Act* 2018 (Cth) (Austl.).
[103] *Id.* § 5.
[104] *Aged Care Quality and Safety Commission Rules 2018* (Cth) pt. 2 (Austl.)
[105] *Id.* at pt. 2 div. 1.
[106] *Id.*

1. take no further action[107];
2. quickly resolve the issue, to the satisfaction of the complainant[108]; or
3. decide to undertake a resolution process in relation to the issue.[109]

Obviously, the second and third options are where care recipients may need the service and skills of an advocate.

The need for an advocate is recognised by the Commission, and its website contains details of advocacy services available to older people.[110] In particular, Older Persons Advocacy Network ("OPAN") is a Commonwealth-funded advocacy organisation that provides individual advocacy and supports older people, including their families and supporters, to raise complaints with both aged care service providers and, more formally, with the Commission.[111]

B. States & Territories

Disability and aged care services are funded by the Commonwealth through the previously-mentioned legislation. The six States and two Territories also provide key services relevant to vulnerable older persons. The key services relevant to the human

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[107] *Id.*
[108] *Id.*
[109] *Id.*
[110] *Services Available to Help You*, AUSTL. GOV'T, https://www.agedcarequality.gov.au/making-complaint/services-available-help-you (last updated Dec. 9, 2020) (stating that "an advocate can: support you in making decisions that affect your quality of life; provide you with information about your rights and responsibilities, and discuss your options for taking action; support you when you raise an issue with us or the service provider; support you at any stage of the complaints process. Advocates can stand beside you or work on your behalf, at your direction, in a way that represents your expressed wishes. An advocate will always seek your permission before taking action.").
[111] *Id.* ("OPAN is made up of nine state and territory based service delivery organisations. OPAN supports older persons and their representatives to effectively access and interact with Australian Government funded aged care services and have their rights protected. It is a free confidential service.").

rights of older people include provisions of health services, housing (including provision of public housing, regulation of retirement villages, boarding houses, etc.) and guardianship systems.[112]

The health services provision is relevant to older people as they age because they become more reliant on health services.[113] Currently, as Australia experiences outbreaks of COVID-19 and the heavy impact on Australia's Commonwealth-funded residential aged care sector, the varied response in older people being able to access the State or Territory based hospital system has become apparent.[114] Overall, the responsibility is placed with the aged care facility, with support from the Commonwealth and State agencies.[115]

More generally, health is the major issue of concern for most older Australians.[116] These concerns relate to affordability (for older people without health insurance), and waitlists for health care and

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[112] *See generally 'Caring for the Elderly' - an Overview of Aged Care Support and Services in Australia*, PARLIAMENT AUSTL. (Feb. 27, 2003), https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/Publications_Archive/archive/agedcare; *Aged Care Initiatives and Programs*, AUSTL. GOV'T, https://www.health.gov.au/health-topics/aged-care/aged-care-initiatives-and-programs (last updated Jan. 22, 2020); *Elder Care and Seniors Support*, MONEYSMART.GOV.AU, https://moneysmart.gov.au/elder-care-and-seniors-support (last visited Apr. 5, 2021).

[113] *About Aged Care*, AUSTL. GOV'T, https://www.health.gov.au/health-topics/aged-care/about-aged-care (last updated Feb. 1, 2021) ("Aged care is the support provided to older people who need help in their own home or who can no longer live at home. Government-funded aged care services are available to eligible people."); *see also* C. Dimity Pond & Catherine Regan, *Improving the Delivery of Primary Care for Older People*, MED. J. AUSTL. (July 15, 2019), https://www.mja.com.au/journal/2019/211/2/improving-delivery-primary-care-older-people (discussing continuity of care for the elderly in Australia).

[114] Bethany Brown & Nicole Tooby, *Covid-19's Devastating Impact on Older People in Australia*, HUM. RTS. WATCH (Aug. 6, 2020), https://www.hrw.org/news/2020/08/06/covid-19s-devastating-impact-older-people-australia.

[115] *See Corona Virus Disease 2019 (Covid-19) Outbreaks in Residential Care Facilities*, COMMUNICABLE DISEASES NETWORK AUSTL. (July 14, 2020), https://www.health.gov.au/sites/default/files/documents/2020/07/cdna-national-guidelines-for-the-prevention-control-and-public-health-management-of-covid-19-outbreaks-in-residential-care-facilities-in-australia.pdf.

[116] *Our Work*, *supra* note 62*; State of the (Older) Nation*, NEWGATE RESEARCH (Dec. 2018), https://www.cota.org.au/wp-content/uploads/2018/12/COTA-State-of-the-Older-Nation-Report-2018-FINAL-Online.pdf.

homecare services.[117] However, once people have received health or homecare services, they are generally satisfied with the care they receive.[118]

Public housing and housing affordability are also becoming key issues, particularly in relation to older women who may unexpectedly find themselves homeless. The causes underlying this issue are linked to unemployment, being single and isolated, economic disadvantage, and effects from domestic violence.[119]

Age-related cognitive conditions, such as dementia, are relevant to an increased need for advocacy, particularly in relation to decision-making for older people.[120] Making decisions is fundamental to personal identity, sense of self, or autonomy. When an older person has a cognitive impairment that impacts their ability to make their own decisions, it can lead to requiring extra informal support for decision-making, activation of the role of their attorney under an enduring power of attorney, or the appointment of a guardian or financial manager or administrator (often in a substitute decision-making arrangement by order of a State or Territory Tribunal or Board).[121] The activation of these supports, either

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[117] *Id.*

[118] *Id.*

[119] AUSTRALIAN HUMAN RIGHTS COMMISSION, OLDER WOMENS' RISK OF HOMELESSNESS: A BACKGROUND PAPER: EXPLORING A GROWING PROBLEM (2019) (available at https://humanrights.gov.au/sites/default/files/document/publication/ahrc_ow_homelessness2019.pdf).

[120] Williams, Sappideen, Perkins & Field *in* ELDER LAW, *supra* note 7, at 5 (discussing the increase in dementia among older Australians).

[121] *E.g., Guardianship & Older Adults: Myths & Facts*, VOLUNTEERS OF AM., https://www.voamnwi.org/pdf_files/guardianship-and-older-adults (last visited Apr. 5, 2021) ("Historically, guardianship has been viewed as a means of protecting an older adult who may have a diagnosis of Alzheimer's or related dementia or other cognitive impairment, or someone who may not be making the safest choices for themselves."); Donald Vanarelli, *Assessing the Need for Guardianship*, 2 AGING WELL 32, 32 (2009) (available at https://www.todaysgeriatricmedicine.com/archive/063009p32.shtml) ("A guardianship, which some states refer to as conservatorship or a similar term, is a formal legal action for substitute decision making. It confers on a designated individual (the guardian) the right to make decisions on behalf of another (the ward)."). *See Supported Decision Making: An Alternative to Guardianship*, INCLUDENYC,

informally or through a formal Board or Tribunal appointment, fall within the guardianship system.[122] It is recognised that the formal appointment of a guardian is necessarily intrusive and restricts a person's rights, particularly if the formally appointed decision maker excludes the older person in their decision-making.[123] An approach that lessens the impact on an individual's right to make their own decisions to the broadest extent possible is supported decision-making. Supported decision-making has grown alongside the development of the UNCRPD and encourages inclusiveness and participation of the person with a disability.[124]

Supported decision-making is generally defined as supporting another person to make their decision based on the facts and options available to them.[125] Although, by definition, the supporter is another person, the decision must be that of the person requiring the support.[126] If the supporting person was to make the actual decision this would no longer be supported decision-making but would move into the realm of the more restrictive model of substitute decision-making.[127]

Currently, various States and Territories are at differing stages of recognizing and implementing supported decision-making. This is evidenced by the different legislative and policy frameworks. For example, in New South Wales there is no legislative framework to address supported decision-making, notwithstanding that Australia is a signatory to the UNCRPD and has also ratified both the UNCRPD and the Optional Protocol.[128]

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https://www.includenyc.org/resources/tip-sheet/supported-decision-making-an-alternative-to-guardianship (last visited Apr. 5, 2021).

[122] Vanarelli, *supra* note 121.

[123] *Id.* ("A guardianship action is an involuntary proceeding and may be established over the opposition of the incapacitated person.").

[124] *Supported Decision Making: An Alternative to Guardianship*, *supra* note 121.

[125] *See id.*

[126] *Id.*

[127] *See generally* Jennifer Lansing Pilcher, Pamela Greenfield & Meghan Huber, *Substitute Decision Making Versus Supported Decision Making: What is the Difference?*, J. AGING LIFE CARE (2019), https://www.aginglifecarejournal.org/substitute-decision-making-versus-supported-decision-making-what-is-the-difference/.

[128] AUSTRALIAN LAW REFORM COMMISSION, EQUALITY, CAPACITY AND DISABILITY IN COMMONWEALTH LAWS 44 (available at https://www.alrc.gov.au/wp-content/uploads/2019/08/whole_ip_44.pdf).

However, in the state of Victoria, section 85 of the *Powers of Attorney Act 2014* makes the following provision in relation to supported decision-making:

> *(1) A person may appoint an eligible person to support the person in making and giving effect to decisions by exercising any of the powers set out in sections 87, 88 and 89*[129] *that are specified in the appointment in relation to any personal matters, financial matters or other matters (excluding matters concerning medical treatment and medical research procedures) specified in the appointment.*
>
> *(2) To avoid doubt, nothing in this Act or in an appointment under subsection (1) should be taken as providing for the making of a supported decision that is not a decision of the principal.*[130]

While there is a varied approach amongst the States and Territories toward supported decision-making, the Australian Law Reform Commission ("ALRC") has been a strong advocate of supported decision-making since 2014.[131] Besides its strong encouragement of supported decision-making, it also maintains that Tribunal- or Board-appointed substitute decision makers should be ordered as a last resort and that the will, preferences, and rights of persons should be the guiding factors in determining decisions.[132]

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[129] These sections refer to the powers in respect of matters relating to information power (§ 87), communication power (§ 88), and powers as to giving effect to decisions (§ 89).
[130] *Powers of Attorney Act 2014* (VIC) § 85 (Austl.).
[131] *See*, *e.g.*, *Towards Supported Decision-Making in Australia*, AUSTL. L. REFORM COMM'N (Sept. 18, 2014), https://www.alrc.gov.au/publication/equality-capacity-and-disability-in-commonwealth-laws-alrc-report-124/1-executive-summary-2/towards-supported-decision-making-in-australia/.
[132] John Chesterman, *Supported Decision-Making, in* ELDER LAW, *supra* note 7, at 96, 101.

When is Advocacy for the Older Person Required in Australia?

Advocacy is required on both the systemic and individual basis in Australia. The overall concerns of older people need to be represented both in the political and general community to ensure their policy preferences are considered on a sector-wide basis at both the national and State/Territory level. An example of this can be found in COTA Australia's *State of the (Older) Nation*, which collated the views on policy changes from a diverse range of older Australians.[133]

Individual advocacy is also required to assist people to navigate eligibility to services, raise issues of concern, and, if necessary, make formal complaints. Human Rights Watch ("HRW") has documented how people engaged advocacy services in relation to their concerns about the use of chemical restraint in residential aged care, particularly when individual family members were not achieving the outcomes they wanted.[134] While individual advocacy does not equate to a guaranteed outcome, it reduces the isolation of older people and their families as they seek positive changes in their circumstances.[135] Indeed, HRW noted that its report did not target the most vulnerable, as the most vulnerable (at least in the aged care setting) are those without visitors who may take on an informal advocacy role for the person they are visiting and older people who may have a disability that makes communication difficult.[136]

Another key issue that an older person, or their supporter, may seek advocacy support for is elder abuse. Elder abuse can occur in a number of settings ranging from the home of the older person to an aged care facility.[137] The range of settings, legal complexities, and proposed legal solutions to elder abuse have been investigated by the Australian Law Reform Commission, and its recommendations

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[133] *See State of the (Older) Nation*, *supra* note 116.
[134] *See "Fading Away": How Aged Care Facilities in Australia Chemically Restrain Older People with Dementia*, *supra* note 73.
[135] *See id.*
[136] *Id.*
[137] *Elder Abuse and Neglect*, HELPGUIDE, https://www.helpguide.org/articles/abuse/elder-abuse-and-neglect.htm (last updated Jan. 2021).

addressed social security, aged care, superannuation, banking and guardianship, and financial administration sectors.[138] Some of the recommendations suggested that the State and Territory Tribunals expand their jurisdiction to include granny flat disputes and recovery of monies lost to financial abuse.[139] Should these possible jurisdiction enhancements occur, then the demand for advocates (either legal or social) with expertise in these issues will grow.

Advocacy is currently required for people considered to have a cognitive impairment to the extent that their decision-making ability is affected because they are considered to lack capacity to make their own decisions.[140] The impact on someone's capacity can be either short or long term.[141] Regardless of whether a person has capacity or not, their ability to communicate can be enhanced or negatively influenced by their social supports.[142] Therefore, because of the above complexities surrounding an application for guardianship or financial administration, providing advocacy to assist the person

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[138] AUSTRALIAN LAW REFORM COMMISSION, ELDER ABUSE—A NATIONAL LEGAL RESPONSE 1–3 (2017) (available at https://www.alrc.gov.au/wp content/uploads/2019/08/elder_abuse_131_final_report_31_may_2017.pdf).

[139] *Id.*

[140] Peteris Darzins, *Assessment of Decision-Making Capacity, in* ELDER LAW, *supra* note 7, at 35, 47; Chesterman, *supra* note 7, at 107.

[141] *Lack of Capacity: Everything You Need to Know*, UPCOUNSEL, https://www.upcounsel.com/lack-of-capacity (last visited Apr. 5, 2021) (explaining that lack of capacity can be temporary or prolonged, giving examples of temporary mental conditions or medication side-effects for the former, and dementia, brain injuries, or learning disabilities for the latter).

[142] *See* Ann Marie White et al., *Social Support and Self-Reported Health Status of Older Adults in the United States*, 99 AM. J. PUB. HEALTH 1872 (2009) (available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2741527/pdf/1872.pdf) (explaining that positive social support can result in obtaining confidants with whom older people can confide in or receive feedback from to help set and accomplish goals); *compare with* AM. BAR ASS'N COMMISSION ON LAW AND AGING & AM. PSYCHOLOGICAL ASS'N, ASSESSMENT OF OLDER ADULTS WITH DIMINISHED CAPACITY 14, 114 (2008) (available at https://www.apa.org/pi/aging/programs/assessment/capacity-psychologist-handbook.pdf) (explaining that negative social influence can result in undue influence, such as when a caretaker or other person in the older person's social circle takes advantage of their position and assumes control over the older person's decision making, sometimes isolating them from others).

before a decision is made to formally appoint a decision maker is key to the maintenance of their own decision-making and autonomy.

At the time of writing this Article, the Royal Commission into Aged Care Quality and Safety ("Royal Commission") is taking its final submissions on the sector's response to COVID-19.[143] Depending on its recommendations concerning future changes required in both home-based and residential aged care, it is possible that this will also generate a greater role for advocacy. For example, in late 2019, the Royal Commission released its Interim Report.[144] The top three areas of concern were: (1) increasing the number of homecare packages, (2) decreasing use of chemical restraint, and (3) reducing the number of young persons with disabilities entering and residing in aged care.[145] Largely as a result of these initial urgent recommendations, OPAN has been recently funded to produce information in a range of formats to assist older people and their supporters to make informed choices around medication and, particularly, use of chemical restraint.[146]

What is Available in the Advocacy Arena?

There are a number of government funded advocacy programs targeted toward older Australians. Commonwealth programs include the National Aged Care Advocacy Program ("NACAP"),

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[143] *The Aged Care Royal Commission Will Provide a Final Report by February 26, 2021*, ROYAL COMM'N INTO AGED CARE QUALITY AND SAFETY, https://agedcare.royalcommission.gov.au/ (last visited Apr. 5, 2021). The authors want to note that general submissions closed on July 31, 2020.

[144] *Id.*; *About the Interim Report*, ROYAL COMM'N INTO AGED CARE QUALITY AND SAFETY (Oct. 31, 2019), https://agedcare.royalcommission.gov.au/sites/default/files/2019-12/about-the-interim-report.pdf.

[145] ROYAL COMM'N INTO AGED CARE QUALITY AND SAFETY, INTERIM REPORT: NEGLECT 10 (2019) (available at https://agedcare.royalcommission.gov.au/sites/default/files/2020-02/interim-report-volume-1.pdf).

[146] *See Medication: It's Your Choice. It's Your Right*, OLDER PERSONS ADVOC. NETWORK, https://opan.com.au/yourchoice/ (last visited Apr. 5, 2021) (providing a webinar series, a brochure, and other resources informing older people of their rights with respect to chemical restraint).

which is funded by the Commonwealth Department of Health.[147] This program, which is currently undertaken by OPAN, provides free, confidential, and independent advocacy for older people and their supporters who are accessing Commonwealth-funded aged care or considering applying for such care.[148] Besides providing individual advocacy, NACAP also emphasizes information on the aged care system and rights of older people receiving care along with the education of people providing aged care services.[149]

The key functions of NACAP advocacy include:

- "interacting with the aged care system"[150]
- "transitioning between aged care services"[151]
- "knowing and understanding your rights"[152]
- "making decisions about the care you receive"[153]
- "options for having your aged care needs better met"[154]
- "resolving concerns or complaints with your aged care provider about the services you receive"[155]
- "speaking with your service provider at your direction"[156]
- "increasing your skills and knowledge to advocate for yourself."[157]

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[147] *National Aged Care Advocacy Program (NACAP)*, AUSTL. GOV'T DEP'T OF HEALTH, https://www.health.gov.au/initiatives-and-programs/national-aged-care-advocacy-program-nacap (last updated Nov. 4, 2020).
[148] *Id.*
[149] *Id.*
[150] *Advocacy*, AUSTL. GOV'T, https://www.myagedcare.gov.au/advocacy (last visited Apr. 5, 2021).
[151] *Id.*
[152] *Id.*
[153] *Id.*
[154] *Id.*
[155] *Id.*
[156] *Id.*
[157] *Id.*

Community legal centres are available either on a local, State-wide, or Territory-wide basis and are usually funded by a combination of Commonwealth, State, and Territory funds.[158] A variety of services are funded under this program including local generalist community legal centres, Family Violence Prevention Legal Services, and Aboriginal and Torres Strait Islander Legal Services.[159] These services target a number of different sectors of the community including older people.[160] The overall aims of the community legal sector is to promote equity, social justice, and human rights.[161]

There are community legal services that specialise in legal advocacy for issues affecting older persons. These include:

- Caxton Legal Centre ("Caxton"), located in Queensland, has initiated a Seniors Legal and Support Service that incorporates social workers and lawyers who together assist older people and their supporters.[162]
    - Caxton also has a hospital-based health and justice partnership, which targets older people in health services who may be a victim of elder abuse or who may have wrongfully had their decision-making rights removed.[163]
- Seniors Rights Victoria ("SRV") provides "information, support, advice and education to help prevent elder abuse and safeguard the rights, dignity and independence of older people."[164]

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[158] *See* Commonwealth Attorney General, *The Justice Statement: Legal Aid*, AUSTRALASIAN LEGAL INFO. INST. http://www.austlii.edu.au/austlii/articles/scm/jchap6.html (last updated May 24, 1995).
[159] *About Us*, COMMUNITY LEGAL CENTRES AUSTL., https://clcs.org.au/about-us (last visited Apr. 5, 2021).
[160] *Id.*
[161] *Id.*
[162] How *SLASS Can Help Me?*, CAXTON LEGAL CENTRE INC., https://caxton.org.au/how-we-can-help/seniors-legal-and-support-service/ (last visited Apr. 5, 2021).
[163] *How Can OPALS Help Me?*, CAXTON LEGAL CENTRE INC., https://caxton.org.au/how-we-can-help/older-persons-advocacy-and-legal-service/ (last visited Apr. 5, 2021).
[164] *Elder Abuse*, SENIOR RTS. VICTORIA, https://seniorsrights.org.au/ (last visited Apr. 5, 2021).

- Seniors Rights Service is a New South Wales Community Legal and Advocacy service providing a range of legal help, OPAN advocacy, and education services for older people across New South Wales.[165]

The National Disability Advocacy Program ("NDAP") is another advocacy program which may be currently under-utilised by older people, but it is likely to grow in the future due to the possibility that people with a disability and receiving support under the NDIS can continue to receive services past the age of 65.[166] This program defines advocacy as:

- Communicating with minimal conflict of interest on behalf of a person or group of persons to promote their welfare, defend their rights, or assist them to access justice by being:
    - Only on their side[167]
    - Primarily concerned with fundamental needs[168]
    - Displaying active empathy[169]
    - Mindful of their duty of care.[170]

NDAP is a wide-ranging program that funds individual, systemic, family, citizen, legal, and self-advocacy.[171]

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[165] *About Us*, SENIOR RTS. SERVICES, https://seniorsrightsservice.org.au/about-us/about-us-overview/ (last visited Apr. 5, 2021).
[166] *See National Disability Insurance Scheme Act 2013* (Cth) § 29(1)(b) (Austl.) (providing that people receiving benefits over the age of 65 may lose those benefits only if they begin receiving permanent residential or community care).
[167] *National Disability Advocacy Program: Background*, AUSTL. GOV'T DEP'T OF SOC. SERVICES, https://www.dss.gov.au/our-responsibilities/disability-and-carers/program-services/for-people-with-disability/national-disability-advocacy-program-ndap (last updated Sept. 29, 2020).
[168] *Id.*
[169] *Id.*
[170] *Id.*
[171] *Id.*

What are the Eligibility Requirements?

The eligibility requirements depend on the requirements of the individual funding program. For example, for community legal centres, the requirement is that most clients are financially disadvantaged; for NACAP, the recipients of advocacy services are receiving or likely to receive aged care services; and for NDAP, the person has a disability.[172]

Rate of Uptake of Advocacy

OPAN reported in 2019 that over 1.3 million people received Commonwealth Aged Care services including both home care and residential care.[173] They further reported the following figures: over 13,000 older people and their supporters received advocacy or information in relation to their aged care services, over 2,000 received advocacy in relation to elder abuse, and over 1,500 education sessions were provided on aged care and/or elder abuse.[174]

It is of interest to note that Community Legal Centres Australia reported in 2019 that approximately 10% of community legal centre clients were aged 65 or over,[175] which is beneath the current population average of people aged 65 years or over (16%).[176]

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[172] *See Reconciliation Action Plan*, COMMUNITY LEGAL CENTRES AUSTL., https://clcs.org.au/reconciliation-action-plan (last visited Apr. 5, 2021); *National Aged Care Advocacy Framework*, AUSTL. GOV'T DEP'T OF HEALTH (Dec. 17, 2018), https://www.health.gov.au/sites/default/files/documents/2019/12/national-aged-care-advocacy-framework.pdf; *National Disability Advocacy Program: Background*, *supra* note 167.

[173] OLDER PERSONS ADVOCACY NETWORK, ANNUAL REPORT 2018–2019 4–5 (available at https://opan.com.au/wp-content/uploads/2020/01/OPAN_Annual-Report_2018-19_V6_HRes.pdf (last visited Apr. 5, 2021).

[174] *Id.*

[175] *Annual Report 2019-20*, COMMUNITY LEGAL CENTRES NSW (Nov. 26, 2020, 8:54), https://www.clcnsw.org.au/resource/annual-report-2019-20.

[176] *Population by Age and Sex, Australia, States and Territories*, *supra* note 1.

Skills and Qualifications of Legal Advocates

Professional legal advocates, who are also solicitors, are required to have completed a law degree along with practical legal training requirements.[177] Most solicitors are bound by the Australian Solicitors Conduct Rules, which importantly outlines required conduct.[178] Particularly relevant to legal advocacy for older people are the following key rules:

> *3. PARAMOUNT DUTY TO THE COURT AND THE ADMINISTRATION OF JUSTICE*
>
> *3.1 A solicitor's duty to the court and the administration of justice is paramount and prevails to the extent of inconsistency with any other duty.*
>
> *4. OTHER FUNDAMENTAL ETHICAL DUTIES*
>
> *4.1 A solicitor must also:*
>
> *4.1.1 act in the best interests of a client in any matter in which the solicitor represents the client;*
>
> *4.1.2 be honest and courteous in all dealings in the course of legal practice;*
>
> *4.1.3 deliver legal services competently, diligently and as promptly as reasonably possible;*
>
> *4.1.4 avoid any compromise to their integrity and professional independence; and*

[177] Katherine Lau, *A Comprehensive Guide to Practical Legal Training (PLT)*, GRADAUSTRALIA, https://gradaustralia.com.au/career-planning/a-comprehensive-guide-to-practical-legal-training-plt (last visited Apr. 5, 2021).

[178] LAW COUNCIL OF AUSTRALIA, REVIEW OF THE AUSTRALIAN SOLICITORS' CONDUCT RULES (2018) (available at https://www.lawcouncil.asn.au/docs/4dde1ab8-4606-e811-93fb-005056be13b5/2018%20Feb%20%2001%20ASCR%20Consultation%20Discussion%20Paper.pdf).

> *4.1.5 comply with these Rules and the law.*
>
> *5. DISHONEST AND DISREPUTABLE CONDUCT*
>
> *5.1 A solicitor must not engage in conduct, in the course of practice or otherwise, which demonstrates that the solicitor is not a fit and proper person to practise law, or which is likely to a material degree to:*
>
> *5.1.1 be prejudicial to, or diminish the public confidence in, the administration of justice; or*
>
> *5.1.2 bring the profession into disrepute . . .*
>
> *8.1 A solicitor must follow a client's lawful, proper and competent instructions.*[179]

This final point requires solicitors to work in close proximity with the medical and health professions to gain an understanding of their client's competency in relation to the particular matter that the client is seeking to retain the solicitor.

Social workers have also been employed as advocates in their own right and to work alongside lawyers. Their required skills and knowledge are regulated by the Australian Association of Social Workers ("AASW").[180] Advocacy is included in the Social Work ethical code as a core activity required to assist their clients to improve social justice and self-determination.[181] The ethical recommends independent advocacy be considered if social workers are required to act in a statutory or coercive way.[182] However, in social and systemic advocacy, there are no formal qualifications, knowledge, or skill sets required.

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[179] AUSTRALIA SOLICITORS CONDUCT RULES 6–7 (AUSTRAL. LEGAL COUNCIL 2015) (available at https://www.lawsocietysa.asn.au/PDF/rules_of_professional_conduct.pdf) (emphasis added).

[180] AUSTL. ASS'N OF SOC. WORKERS CODE OF ETHICS, AUSTRALIAN ASS'N OF SOC. WORKERS 5 (2020) (available at https://www.aasw.asn.au/document/item/1201).

[181] *Id.* at 6.

[182] *See id.* at 13.

Skills and Qualifications of Advocates

Given the wide-ranging sets of issues that advocates for older people will potentially be required to assist with, there is likely no one skill set or professional qualifications that would be able to cover the field. However, advocates will require knowledge on the following policy programs or systems:

- Aged Care
  - Disability Support
- Health
- Income Support
- Guardianship and Financial Administration
- Public & Community Housing

Advocates will also need practical knowledge on the impact of short-term and long-term cognitive impairment has on decision-making and utilising a supported decision-making framework. Advocates will also have to understand the complexities around elder abuse including family dynamics and possible neglect by service providers and health professionals.

Advocates will be required to work across a range of service settings. For example, solicitors practising in hospitals within a health-justice partnership or social workers working within a community legal service.

What is Offered in Respect of Training in Advocacy?

There appears to be little in terms of non-legal training in advocacy in Australia. There are some training materials developed for advocates such as ACT Aged Disability and Carer Advocacy

Service ("ADACAS") and development of supported decision-making materials including training materials for advocates.[183]

Also, relevant agencies such as the Australian Care Quality and Safety Commission ("ACQSC"), have developed training packages for providers of aged care, which are also useful for aged care advocates, to better understand role and powers of the ACQSC and the rights of older people.[184]

Many advocates acquire contemporary knowledge from attending a key range of conferences that are presented fairly regularly in Australia such as the National Elder Abuse Conference ("NEAC")[185] and the Australian Guardianship and Administration Council ("AGAC") Conference.[186] Currently, attendance at conferences is curtailed due to COVID-19.

Conclusion

It can be seen that there are a number of advocacy agencies and programs which are funded at both the Commonwealth, State, and Territory level. However, with the increasing proportion of older people in Australian society and the complexity of issues (including physical and mental health related concerns) they are facing, the current piecemeal approach is inadequate. Greater co-ordination is required linking advocacy with community legal, health, disability, and aged care services to improve responses for older people.

A more systematic and structured approach that deals with top key issues for older people needs to be developed so that advocates are better equipped to "cover the field." For example, what is needed

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[183] *Supported Decision Making*, ADACAS ADVOC., http://www.adacas.org.au/supported-decision-making/supported-decision-making/ (last visited Apr. 5, 2021).
[184] *Welcome to the Commission's Aged Care Learning Information Solution – Alis*, AUSTL. GOV'T AGED CARE QUALITY & SAFETY COMM'N, https://learning.agedcarequality.gov.au/ (last visited Apr. 5, 2021).
[185] *E.g.*, *National Elder Abuse Conference 22-23 July 2019*, ROCK THE BOAT, https://neac2019.com.au (last visited Apr. 5, 2021).
[186] *E.g.*, *2019 (March) National Conference – Canberra*, AUSTL. GUARDIANSHIP AND ADMIN. COUNCIL, https://agac.org.au/conferences-and-congresses/2019-march-national-conference-canberra (last visited Apr. 5, 2021).

is a "one-stop shop" advocacy program. At the minimum, Australia needs both better linkages and awareness across the various existing programs. This new approach will require funding for education and training to consolidate knowledge and skills to be effective across the diverse range of sectors and care programs to enable advocates to be better equipped to respond to the needs of older Australians.

DURABLE POWERS OF ATTORNEY: A TALE OF TWO CITIES

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TABLE OF CONTENTS

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ABSTRACT

Due to low birth rate and improved life expectancy, Hong Kong and Singapore are facing an imminent need to enhance the tools available for individuals to make plans for the management of their affairs when they no longer have the mental capacity to do so. One of these tools is the durable power, which has the advantages of being relatively informal and affordable. In Hong Kong, there is limited uptake of durable powers, which is due in great part to antiquated law and lack of public promotion. This contrasts sharply with Singapore, even though cultural practices and values in both places are similar. This Article examines durable power legislation and administration in Hong Kong and Singapore to identify the reasons for their dramatic differences. It argues that an adequate legal framework and rigorous public awareness campaign can significantly overcome the cultural inertia that surrounds durable power establishment. Although the focus is on Singapore and Hong Kong, this Article's observations are directly relevant to any jurisdiction that intends to promote the uptake of durable powers amongst its Chinese population and other ethnic groups with similar cultural values.

I. Introduction

Countries around the world are facing rapidly ageing societies, and Asian jurisdictions, such as Hong Kong and Singapore, are no exception.[1] Due to low birth rates[2] and improved

[1] U.N. DEP'T OF ECON. AND SOC. AFFAIRS, POPULATION DIV., WORLD POPULATION AGEING 2019: HIGHLIGHTS (2019) (https://www.un.org/en/development/desa/population/publications/pdf/ageing/WorldPopulationAgeing2019-Highlights.pdf).

[2] In 2018, the fertility rate in Hong Kong was 1.072 births per woman. *Fertility Rate, Total (Births per Woman) - Hong Kong SAR, China*, WORLD BANK, https://data.worldbank.org/indicator/sp.dyn.tfrt.in?locations=hk (last visited Sept. 27, 2020). The fertility rate in Singapore in 2018 was 1.14 births per woman. *Fertility Rate, Total (Births per Woman) - Singapore*, WORLD BANK, https://data.worldbank.org/indicator/sp.dyn.tfrt.in?locations=sg (last visited Sept. 25, 2020).

life expectancy,[3] both cities have witnessed significant increases in their elderly populations in recent decades.[4] As dementia incidence increases with age, a large elderly population suggests a high rate of people with impaired mental capacity who need assistance to manage their personal and property affairs.[5] In this connection, durable powers of attorney have increasingly become a critical and affordable tool for helping people to manage their affairs in later life.[6] By creating an agency arrangement that "endures" beyond the loss of capacity, such powers allow people to appoint, at a time when they are still lucid, someone of their own choosing to manage their affairs once they are no longer able to do so themselves.[7] In

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[3] *Life Expectancy at Birth, Total (Years) - Hong Kong SAR, China*, WORLD BANK, https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=HK (last visited Sept. 25, 2020). *Life Expectancy at Birth, Total (Years) - Singapore*, WORLD BANK, https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=SG (last visited Sept. 25, 2020).

[4] In 2018, people aged 65 or above accounted for 18% of the total population in Hong Kong, compared to 8% in 1988. KELVIN WONG & MATTHEW YEUNG, POPULATION AGEING TREND OF HONG KONG (2019) (https://www.hkeconomy.gov.hk/en/pdf/el/el-2019-02.pdf). The percentage of elderly in the population is projected to increase to 31% in 2036. CENSUS AND STATISTICS DEP'T, H.K. SPEC. ADMIN. REGION, HONG KONG POPULATION PROJECTIONS FOR 2017 TO 2066 (2017) (available at https://www.statistics.gov.hk/pub/B71710FA2017XXXXB0100.pdf). In 2019, people aged 65 or above accounted for 14% of Singapore's population, compared to only 6% in 1990. *M810611 - Key Indicators on the Elderly, Annual*, SING. DEP'T OF STATISTICS, https://www.tablebuilder.singstat.gov.sg/publicfacing/createDataTable.action?refId=14914 (last updated Sept. 9, 2020).

[5] LAW REFORM COMM'N OF H.K., SUBSTITUTE DECISION-MAKING AND ADVANCE DIRECTIVES IN RELATION TO MEDICAL TREATMENT ¶¶ 1.12, 6.44 (Rep. 2006) (available at https://www.hkreform.gov.hk/en/docs/rdecision-e.pdf).

[6] "Enduring power of attorney" is the term currently used in Hong Kong, although "continuing power of attorney" is used in the Continuing Powers of Attorney Bill. *Consultation Paper on the Continuing Powers of Attorney Bill*, GOVHK 1 (Dec. 2017), https://www.doj.gov.hk/en/community_engagement/press/pdf/cpa_consulte.pdf. Singapore uses the term "lasting power of attorney." *See* Rahimah Rashith, *Applying for Lasting Power of Attorney to be Faster, Easier*, STRAITS TIMES (July 21, 2019 5:00 AM SGT), https://www.straitstimes.com/singapore/applying-for-lasting-power-of-attorney-to-be-faster-easier. For ease of reference, the neutral term "durable power" is used in this Article.

[7] LAW REFORM COMM'N OF H.K., ENDURING POWERS OF ATTORNEY ¶ 1 (Rep. 2008) (available at https://www.hkreform.gov.hk/en/docs/repa_e.pdf).

performing this important function, durable powers extend autonomy—the protection of which is enshrined in the UN Convention on the Rights of People with Disabilities.[8] At the same time, however, the informal nature and light regulatory oversight of durable powers render them open to financial abuse.[9] Accordingly, balance needs to be struck between the conflicting goals of informality and donor protection.

This Article examines this balance in Hong Kong and Singapore. These two jurisdictions are particularly illustrative of the factors accounting for the successful implementation of a durable power regime in societies with a predominantly Chinese population, which tend to have cultural taboos about will-making and incapacity-planning.[10] The two jurisdictions are also broadly similar in terms of demography, culture, degree of economic development, and legal system. 92% of the Hong Kong population is ethnically Chinese,[11] whilst the percentage in Singapore is 74%.[12] However, the take-up rates of powers of attorney in the two cities are staggeringly different. In Hong Kong, an average of just 3.7 enduring powers of attorney were executed each year across the fifteen-year period beginning in 2001, the year in which the most recent amendment of

[8] Convention on the Rights of Persons with Disabilities arts. 3(a), 12(4), Dec. 13, 2006, 2515 U.N.T.S. 3. Singapore is a signatory of the Convention but has entered a reservation to article 12(4), which requires states to take *all* measures in relation to the exercise of capacity. Hong Kong (through China) is also bound by the Convention.

[9] *See* Kelly Purser, Tina Cockburn & Elizabeth Ulrick, *Examining Access to Formal Justice Mechanisms for Vulnerable Older People in the Context of Enduring Powers of Attorney*, 12 ELDER L. REV. 1, 2 (2020).

[10] *See* Sonia Kolesnikov-Jessop, *Asians Paying More Attention to Inheritance Planning*, N.Y. TIMES (July 16, 2010), https://www.nytimes.com/2010/07/16/business/global/16iht-nwasia.html.

[11] Census and Statistics Dep't, H.K. Spec. Admin. Region, *2016 Population By-Census: Main Results*, BY-CENSUS 2016 ¶ 3.18 (Nov. 2017), https://www.bycensus2016.gov.hk/data/16bc-main-results.pdf.

[12] Central Intelligence Agency, *Singapore*, WORLD FACTBOOK 2020, https://www.cia.gov/library/publications/the-world-factbook/attachments/summaries/SN-summary.pdf (last updated Aug. 2020).

durable power legislation took place.[13] Singapore, in contrast, has seen an average of 7,500 applications per year since 2010.[14] The stark contrast between these two broadly similar societies is intriguing and presents an interesting case study of the techniques used to overcome cultural taboos in establishing powers of attorney.

The main thesis of this Article is that an adequate legal framework and rigorous public awareness campaign can significantly overcome the cultural inertia that surrounds durable power establishment. Although the focus is on Singapore and Hong Kong, this Article's observations are directly relevant to any jurisdiction that intends to promote the uptake of durable powers amongst its Chinese population and other ethnic groups with similar cultural values.

In laying out its arguments in support of that thesis, the rest of the Article proceeds as follows: first, it critically evaluates the legal framework for durable powers in Hong Kong and Singapore to identify for their dramatically different receptions of such powers; second, it compares the public education campaigns and administrative systems for durable powers in the two jurisdictions to identify effective strategies for encouraging the uptake of such powers; and third, it examines judicial decisions dealing with financial abuse to identify the risk factors of this abuse and ways that it is perpetrated. The observations drawn from this examination are useful for evaluating the respective approaches in Hong Kong and Singapore. It will be seen that Hong Kong's approach is not only unduly restrictive but also woefully inadequate in preventing abuse. Finally, the Article concludes by proposing concrete safeguards that

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[13] According to the latest available official figures, a total of 438 enduring powers of attorneys were registered in Hong Kong from 2001 to 2016. Peter Wong, *The Law of Enduring Powers – A New Vista*, GUARDIANSHIP BOARD 9 (Feb. 18, 2017), https://web.archive.org/web/20200715103706/http://www.adultguardianship.org.hk/conf2017/4.%20Mr%20Peter%20WONG.pdf.

[14] Between passing the law in 2010 and the most recent statistic in June of 2019, about 67,000 lasting powers had been created in Singapore. Rashith, *supra* note 6.

can strike an appropriate balance between the goals of informality and donor protection.

II. Legislative Differences between Singapore and Hong Kong

A. Overview

Before focusing on the specific features of the durable power legislation in Hong Kong and Singapore, a brief overview of their respective legal frameworks is in order. As former British colonies, the two cities share the same legal lineage.[15] Local legislation often replicates its English counterpart even long after the end of colonial rule.[16] In Hong Kong, the Enduring Powers of Attorney Ordinance[17] was enacted just a few days before the end of British sovereignty in 1997[18] and is largely a word-for-word reproduction of the Enduring Powers of Attorney Act 1985 enacted in the United Kingdom,[19] which was repealed by the Mental Capacity Act 2005.[20] Singapore did not introduce a lasting power of attorney instrument until 2008 when it enacted the Mental Capacity Act.[21] As a latecomer to the durable power regime, Singapore was able to benefit from the root-and-branch reform that took place in the U.K. in 2005.[22] By contrast,

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[15] *See* Roy L. Sturgeon & Sergio D. Stone, *UPDATE: "One Country, Two Systems" of Legal Research: Finding the Law of China's Hong Kong Special Administrative Region*, GLOBALEX § 1.1 (Sept. 2018), https://www.nyulawglobal.org/globalex/Hong_Kong1.html; Tzi Yong Sam Sim & Chai Yee Xin, *UPDATE: A Guide to the Singapore Legal System and Legal Research*, GLOBALEX § 1 (Mar. 2017), https://www.nyulawglobal.org/globalex/Singapore1.html#.

[16] *See, e.g.*, Mental Capacity Act 2010, c. 177A, §§ 3–13, 15, 17–20, 22–25, 26–28, 31, 35–36, 37–41, Sch. 1–3 (Sing.) (implementing the exact language of the Mental Capacity Act 2005 (Eng.) into a similar act for Singapore).

[17] Enduring Powers of Attorney Ordinance, (1997) Cap. 501 (H.K.).

[18] *See* Sturgeon & Stone, *supra* note 15, § 1.1.

[19] Enduring Powers of Attorney Act 1985, c. 29 (Eng.), *repealed by* Mental Capacity Act 2005, c. 9 (Eng.).

[20] *See generally* Mental Capacity Act 2005, c. 9 (Eng.).

[21] Act 22/2008 (Sing.). Before the 2008 Act, a committee of estate needed to be appointed under the Mental Disorders and Treatment Act 1965, c. 178 (Sing.) to manage a person's welfare or property.

[22] *See* Constitutional Reform Act 2005, c. 4 (UK).

the Hong Kong Enduring Powers of Attorney Ordinance, which remains in force, has rendered the city's durable power regime extremely out of date.

Similar to its (long repealed) English model, the Hong Kong durable power system is adapted from traditional powers of attorney, which were developed from general principles of agency law in the private law context.[23] As with those traditional powers, donors can appoint an individual or trust corporation as their attorney for their financial affairs by executing an instrument in the form prescribed by the legislation in question.[24] The use of a legal tool developed primarily to serve commercial purposes in the informal family setting in which enduring powers are typically employed carries numerous limitations.[25] More than two decades after introducing a durable power system, Hong Kong is finally in the process of replacing it with a new continuing power of attorney regime.[26] If the new regime is to avoid the pitfalls of its predecessor, close analysis of those pitfalls, as well as the reasons for the aforementioned abysmal durable power take-up rate, is imperative.

By contrast, Singaporean durable power is grounded in the (relatively) modern philosophy captured by the English Mental Capacity Act[27] and is thus better designed for the needs of incapacity and an informal family setting. Singapore has also been proactive in reviewing and improving its Mental Capacity Act. For example, in 2016, the Act was amended to permit donors to appoint

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[23] M. JASMINE SWEATMAN, POWERS OF ATTORNEY AND CAPACITY: PRACTICE AND PROCEDURE 1 (2014); Catherine Seal, *Power of Attorney: Convenient Contract or Dangerous Document?*, 11 MARQUETTE ELDER'S ADVISOR 307, 309 (2010).

[24] Enduring Powers of Attorney Ordinance, (1997) Cap. 501, §§ 2(1), 3, 6, 8(1) (H.K.). For a critique, *see* Lusina Ho, *Financial Planning for Mental Incapacity: Antiquated Law in a Modern Financial Centre*, 44 H.K. L.J. 795 (2014).

[25] LAW REFORM COMM'N OF H.K., SUBSTITUTE DECISION-MAKING AND ADVANCE DIRECTIVES IN RELATION TO MEDICAL TREATMENT ¶ 7.195 (Rep. 2006) (available at https://www.hkreform.gov.hk/en/docs/rdecision-e.pdf).

[26] *See id.* ¶ 6.17.

[27] *See* Mental Capacity Act 2005, c. 9 (Eng.).

professional attorneys[28] and to broaden the power of the courts to revoke a lasting power of attorney.[29] Since the Act came into force in 2010, more than 67,000 durable powers have been created in Singapore.[30] The striking difference between the two cities in the reception of durable powers highlights the shortfalls of the Hong Kong regime.

B. Shortfalls of the Hong Kong Regime

A brief comparison of the two jurisdictions reveals at least six major features in their statutory regimes that may account for their differing degrees of success.

(i) Lack of Personal Care Powers of Attorney

Under the Hong Kong statute, durable powers authorize attorneys to make decisions only in relation to donors' property and financial affairs, not in relation to personal care matters.[31] While this limitation may stem from the historical origin of powers of attorney in the law of agency,[32] there is no reason in principle to prohibit attorneys from being appointed to deal with personal care. The restriction leaves statutory guardianship as the only option in Hong Kong for making substitutive personal care decisions on behalf of an individual with incapacity.[33] Unfortunately, the guardianship system in Hong Kong is a poor substitute for personal care powers.

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[28] Mental Capacity (Amendment) Act 2016, Act 10/2016, § 3(a)(ii)–(iii) (Sing.). *See Launch of Professional Deputies and Donees Scheme*, MINISTRY OF SOC. AND FAM. DEV., https://www.msf.gov.sg/media-room/pages/launch-of-professional-deputies-and-donees-scheme.aspx (last visited Sept. 27, 2020).

[29] Mental Capacity (Amendment) Act, §§ 17(3)(b)–(c), (5A). *See* Hang Wu Tang, *Financial Planning Mechanisms Available to Persons with Special Needs in Singapore*, *in* SPECIAL NEEDS FINANCIAL PLANNING: A COMPARATIVE PERSPECTIVE 218 (Lusina Ho & Rebecca Lee eds., 2019) (discussing these amendments).

[30] Rashith, *supra* note 6.

[31] Enduring Powers of Attorney Ordinance, (2013) Cap. 501, § 8(1) (H.K.); Enduring Powers of Attorney (Prescribed Form) Regulations, (2013) Cap. 501A, § 5 (H.K.).

[32] *See* SWEATMAN, *supra* note 23, at 1.

[33] Mental Health Ordinance, (1997) Cap. 136, pt. IV.B (H.K.).

Because guardians are appointed by the Guardianship Board,[34] rather than by the persons concerned while they are in good health, the system does not give effect to their autonomous choices in the way that personal care powers would. A guardian's financial power is also limited, with guardians authorized to utilize a set maximum monthly amount—which was HK $17,000 (about US $2,270) in the first quarter of 2020—for the sole benefit of the person concerned.[35] Accordingly, when the breadwinner and sole property owner in a family suffers a loss of capacity, the guardian cannot access those funds to cover the family's expenses, including school fees for any children.[36] The situation necessitates the appointment of a guardian in conjunction with a durable power, which significantly undermines the attractiveness of both legal tools.

The situation is very different in Singapore. Using a lasting power of attorney, a donor in Singapore can confer upon an attorney the authority to make decisions in relation to both his or her financial affairs and personal welfare,[37] although the attorney may exercise that authority only when the donor no longer has the capacity to make decisions concerning those affairs/welfare.[38] This arrangement affords greater scope for people to choose someone they trust to act on their behalf when they lose capacity. Restrictions are imposed on the attorney's powers only to avoid decisions that

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[34] *Id.* § 59(k).

[35] *Id.* pt. IV.B § 59R(3)(f). The amount is based on the median monthly employment earnings in Hong Kong, which is published on a quarterly basis by the Census and Statistics Department of the Hong Kong Government. *See Wages and Labour Earnings*, CENSUS AND STAT. DEP'T, https://www.censtatd.gov.hk/hkstat/sub/so210.jsp (last visited Oct. 12, 2020). *See HKD USD Historical Exchange Rate*, CURRENCY CONVERTER, https://www.currency-converter.org.uk/currency-rates/historical/table/HKD-USD.html (last visited Oct. 12, 2020) (noting that the exchange rate fluctuated from a single HKD being equal to 0.1283 to 0.129 USD during the first quarter of 2020).

[36] If the person concerned did not establish an enduring power before the onset of incapacity, it will not be necessary to apply for an order by the High Court under Part II of the Mental Health Ordinance to appoint a committee of estate to use his or her assets, a procedure that can take anywhere from a few months to a year. *See* SHERLYNN G. CHAN, A PRACTICAL GUIDE TO MENTAL HEALTH CARE LAW IN HONG KONG 38, 39 (2019).

[37] Mental Capacity Act 2010, c. 177A, § 11(1) (Sing.).

[38] *Id.* § 13(1).

may cause irreversible harm to or affect important interests of donors or to avoid irreversible harm to them, such as in the case of life-sustaining treatment being needed.[39] Similarly, an attorney may not engage in any act intended to restrain donors unless specified conditions are satisfied.[40] Finally, attorneys are not allowed to execute a will on behalf of donors and are subject to stringent limits on making gifts on their behalf.[41]

The Singaporean approach strikes a better balance between maximizing donors' scope of autonomy and preventing abuses of power by attorneys than the Hong Kong approach. Accordingly, Hong Kong is finally poised to permit the creation of "personal care" continuing powers subject to restrictions similar to those imposed in Singapore.[42] According to the Continuing Powers of Attorney Bill, a personal care power may be established on its own or in combination with a financial power.[43] In one respect, the proposed Hong Kong approach goes further than Singapore's: the draft Bill provides that a financial power takes effect upon execution unless the donor chooses otherwise.[44] This allows donors to combine a power of attorney with a continuing power in a single instrument, thereby providing a smoother transition to incapacity. In the event of such combined powers, the draft Bill further stipulates that the financial power must commence on or before the commencement of the personal care power.[45] Donors' funds will thus be available to provide for their care whenever incapacity intervenes.[46] If approved, these changes will bring Hong Kong into line with international

[39] *Id.* § 13(8).
[40] *Id.* § 13(2)–(5).
[41] *Id.* §§ 13(9)(a), 14.
[42] *Consultation Paper on the Continuing Powers of Attorney Bill*, *supra* note 6, Annex B §§ 3(1), 5, 6. The Bill excludes the delegation of powers over irreversible medical procedures such as organ removal or sterilisation.
[43] *Id.* § 3(1).
[44] *Id.* § 32. *Cf* UNIF. PROBATE CODE § 5B–104 (UNIF. LAW COMM'N 2019), UNIF. POWER OF ATTORNEY ACT § 104, 8B U.L.A. 32 (Supp. 2014).
[45] *Consultation Paper on the Continuing Powers of Attorney Bill*, *supra* note 6, Annex B §§ 32, 34.
[46] *Id.* § 34.

practice, like Singapore, although it will not make it the leader of the pack.[47]

(ii) Laborious Form-Filling

Although durable powers are legal instruments, they will be used widely and generally only if they are easy to establish and simple to understand. Balance, therefore, needs to be struck between prudence and convenience. Currently, the Hong Kong system is weighted too heavily in favor of security. For example, neither the Enduring Powers of Attorney Ordinance nor the prescribed registration form provides an option for donors to confer a general power over all of their properties upon the attorney concerned.[48] To do so, donors would need to laboriously check all of the items listed on the prescribed form as acts that the attorney is authorized to perform, as well as the range of properties they intend to place under the power.[49] Because the list on the prescribed form is comprehensive[50]—but not exhaustive—donors often need to customize it by supplementing it with acts or decisions that are not included. Such legal drafting goes well beyond what one might expect from a lay donor and deviates from the purported role of durable powers, that is, as an affordable self-help instrument of incapacity planning.[51] What is most astounding is that this restrictive approach is the result of an oversight by the drafters of the Hong Kong legislation. The approach was merely one of the options on which a consultation paper on the English Enduring

[47] The latest innovations introduce elements of supportive decision-making to durable powers. *See Powers of Attorney Act* 2014 (VIC) pt. 7; Assisted Decision-Making (Capacity) Act 2015 (Act No. 64/2015), pts. 3–4 (Ir.)

[48] Enduring Powers of Attorney Ordinance, (2013) Cap. 501A, § 8(1)(b) (H.K.); Enduring Powers of Attorney (Prescribed Form) Regulation (2013), Cap 501A, § 5 (H.K.).

[49] Enduring Powers of Attorney (Prescribed Form) Regulation, sch. 1 pt. A § 2, sch. 2 pt. A § 3.

[50] It includes the sale and mortgage of the concerned property and collection and disposal of capital and income. *Id.* sch. 1 pt. A § 2, sch. 2 pt. A § 3.

[51] Ho, *supra* note 24, at 795, 807.

Powers of Attorney Act sought comments.[52] It has never been recommended, let alone adopted.[53] It appears that the Hong Kong drafters adopted the option in question "in apparent ignorance of the fact that no such restriction had been adopted (or, indeed, recommended) in England and Wales."[54] The new continuing power regime in Hong Kong will remove these unnecessary impediments and permit the granting of general powers.[55] The hope is that the Hong Kong government will also simplify the prescribed form and provide guidance notes for the benefit of lay donors.

Donors in Singapore have a completely different experience when filling in the prescribed form. Two forms are available to establish a lasting power.[56] Form 1, the standard form, allows donors to grant a general power over all matters while opting to restrict the attorney's power to make gifts, consent to donors' treatment, and/or deal with their residential property without court approval.[57] These restrictions are set out in a list of options that donors can choose.[58] Form 2 provides greater flexibility by allowing donors to customize the lasting power and specify the decisions that the attorney is authorized to make on their behalf.[59] Donors are provided with clear guidelines when filling in the forms, and the Singaporean government is exploring steps to accommodate the online submission of applications.[60]

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[52] LAW REFORM COMM'N OF H.K., ENDURING POWERS OF ATTORNEY: PERSONAL CARE ¶ 4.4 (Rep. 2006) (available at https://www.hkreform.gov.hk/en/docs/repa2_e.pdf).
[53] *Id.*
[54] *Id.*
[55] *Id.*
[56] *The Lasting Power of Attorney (LPA)*, MINISTRY OF SOC. AND FAM. DEV., https://www.msf.gov.sg/ opg/Pages/The-LPA-The-Lasting-Power-of-Attorney.aspx (last updated Jan. 30, 2020).
[57] Off. of the Pub. Guardian, *Lasting Power of Attorney (LPA): Form 1 (2020)*, MINISTRY OF SOC. AND FAM. DEV. 6, https://www.msf.gov.sg/opg/AnalyticsReports/LPA_Form_1_2020.pdf (last visited Oct. 14, 2020) [hereinafter Form 1].
[58] *Id.*
[59] *The Lasting Power of Attorney (LPA)*, *supra* note 56, at 2.
[60] *See* Form 1, *supra* note 57, at 1.

(iii) Onerous Execution Requirements

The onerous requirements for executing a durable power in Hong Kong constitute another inhibiting factor for potential users. For a durable power to be valid, the donor must execute the instrument in the presence of *both* a registered medical practitioner, who must be satisfied that the donor has the necessary capacity, *and* a solicitor, who must be satisfied that the donor *appears* to have that capacity.[61] Previously, both the registered medical practitioner and solicitor had to be present at the same time and place, which posed significant challenges for prospective donors, as it was often difficult to arrange for the two professionals to be present together and significantly raised the cost of establishing a durable power.[62] This particularly stringent requirement was relaxed by the Enduring Powers of Attorney (Amendment) Ordinance 2011.[63] A durable power instrument can now be signed before a solicitor within twenty-eight days of its having been signed before a registered medical practitioner.[64] After the amendment took effect, the number of registrations increased from forty for the entire decade of 2001 to 2010 to 398 in the five-year period from 2011 to 2016.[65] Whilst the relaxation was a step in the right direction, the cost of requiring two professionals to certify a donor's capacity remains prohibitive for many prospective users.[66]

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[61] Enduring Powers of Attorney Ordinance, (2013) Cap. 501, § 5(2)(a)(i)–(ii) (H.K.).
[62] *See id.* § 5(2)(a)(i); LAW REFORM COMM'N OF H.K., ENDURING POWERS OF ATTORNEY ¶ 1.14 (Consultation Paper 2007) (available at https://www.gov.hk/en/residents/government/publication/consultation/docs/2007/epa.pdf) .
[63] Enduring Powers of Attorney Ordinance, (2013) Cap. 501, § 5(2)(a)(i)–(ii) (H.K.).
[64] *Id.* § 5(2)(a)(ii).
[65] Wong, *supra* note 13, at 9.
[66] *See* Enduring Powers of Attorney Ordinance, § 5(2)(a)(i); LAW REFORM COMM'N OF H.K., ENDURING POWERS OF ATTORNEY ¶ 1.13 (Consultation Paper 2007) (available at https://www.gov.hk/en/residents/government/publication/consultation/docs/2007/epa.pdf) .

Nonetheless, the draft of the Continuing Powers of Attorney Bill retains the double certification requirement.[67] In doing so, it goes both too far and not far enough. For example, the requirement is more stringent than the laws in England and Wales,[68] Australia,[69] Canada,[70] and Singapore,[71] which require certification only by someone qualified to assess the donor's capacity. In other ways, however, Hong Kong does not go far enough. In requiring both a doctor and lawyer to certify that the donor has or appears to have mental capacity, Hong Kong's legislation is unnecessarily duplicative while omitting any requirement to ensure that the

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[67] *Consultation Paper on the Continuing Powers of Attorney Bill*, *supra* note 6, Annex B §§ 28, 30.

[68] Mental Capacity Act 2005, c. 9, § 2(c) (Eng.); Off. of the Public Guardian, *LP12 Make and Register Your Lasting Power of Attorney: A Guide (Web Version)*, CROWN pt. A10, https://www.gov.uk/government/publications/make-a-lasting-power-of-attorney/lp12-make-and-register-your-lasting-power-of-attorney-a-guide-web-version (last updated Sept. 24, 2020) (allowing certification of capacity by someone with the professional skills to determine capacity or a friend, colleague, or anyone who has known the donor for over 2 years).

[69] *Powers of Attorney Act 2003* (NSW) § 19(2) (Austl.) (defining a prescribed witness as a legal practitioner, licensed conveyancer, employee of the NSW Trustee and Guardian, registrar, or employee of a trustee company and requiring certification that the instrument has been explained to a donor who appears to understand its effect); *Powers of Attorney Act 2014* (VIC) § 36 (Austl.) (permitting a medical practitioner or someone authorized to witness affidavits—such as a solicitor, registrar of probate or senior police officer—to certify the capacity and voluntariness of the donor); *Powers of Attorney and Agency Act 1984* (SA) § 6(2)(a) (Austl.); *Guardianship and Administration Act 1990* (WA) § 104A(2)(a) (Austl.) (allowing the witness to be a bank manager, an academic or a police officer who is authorized to take declarations); *Powers of Attorney Act 1998* (Qld) § 31(1) (Austl.) (dictating that the instrument must be signed by an eligible witness—a justice of the peace, commissioner for declaration, notary public or lawyer—who certifies that the donor appears to have capacity); *Advance Personal Planning Act 2013* (NT) § 10(2)–(3), (5) (Austl.) (requiring one permitted individual to verify the donor's identity, intent, and willingness to create this document); *Advance Personal Planning Regulations 2014* (NT) § (3)(1) (Austl.) (requiring a health practitioner, legal practitioner, or police officer to certify that the donor understands the instrument and is signing it voluntarily).

[70] *See* Power of Attorney Act, R.S.B.C. 1996, c. 370, § 16(1), (4) (Can.) (requiring two witnesses, but only one if the witness is a lawyer or a member of the Notaries Public in British Columbia); *Powers of Attorney Act*, R.S.A. 2000, c. P-20, § 2(1), (4) (Can.) (requiring only one witness over signatures in Alberta).

[71] Mental Capacity Act 2010, c. 177A, § 43(1)–(3) (Sing.) (requiring certification by a qualified psychiatrist, medical practitioner, or solicitor). *See also* Form 1, *supra* note 56, at 12.

donor's decision is not the result of fraud, coercion, or undue pressure. [72] For example, Hong Kong's position compares unfavorably to that of Ireland, which also requires double certification, but differentiates the role of the certifiers based on their expertise. [73] The medical practitioner certifies the donor's capacity, whereas the solicitor certifies that he or she understands the legal effect of the power of attorney and is not signing as a result of fraud, coercion, or undue pressure.[74]

Given the cost and effort involved in obtaining double professional certification, Hong Kong's approach provides little incentive for healthy individuals to establish a durable power. Accordingly, people generally wait until their health deteriorates to the point it becomes necessary to do so.[75] By that time, although they may still have the capacity to establish a durable power, they may be vulnerable to abuse and influence, risks that are not directly addressed by the execution requirements in Hong Kong.

(iv) Convoluted and Antiquated Definition of Mental Incapacity

To understand the shortfalls of the way in which mental incapacity is defined in the Hong Kong legislation, it is helpful to first consider the modern definition of incapacity in Singapore.

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[72] Enduring Powers of Attorney Ordinance, (2013) Cap. 501 (H.K.).
[73] Powers of Attorney Act 1996 (Act No. 12/1996) § 5(2)(d) (Ir.).
[74] *Id.*; Enduring Powers of Attorney Regulations 1996 (SI 196/1996) § 3 (Ir.); *see also* Assisted Decision-Making (Capacity) Act 2015 (Act No. 64/2015), § 60(1)(b)–(d) (Ir.) (requiring, when it comes into effect, a healthcare professional to certify the donor's capacity); *Powers of Attorney Act 2006* (ACT) §§ 19(2), 21–22 (Austl.) (requiring that one of the two witnesses must be a person authorized to witness the signing of a statutory declaration, such as a doctor, lawyer, nurse, accountant, or police officer and that the witnesses must certify both the donor's understanding and that the instrument is being signed voluntarily); *Powers of Attorney Act 2000* (TAS) § 9(1)(b)(i) (Austl.) (requiring two witnesses who are not close relatives of a party of the durable power to witness the signature, but requiring that they be a doctor or lawyer).
[75] *See* LAW REFORM COMM'N OF H.K., ENDURING POWERS OF ATTORNEY ¶ 1.12 (Rep. 2008) (available at https://www.hkreform.gov.hk/en/docs/repa_e.pdf).

Replicating the test in the English Mental Capacity Act, a person lacks capacity in Singapore "if at the material time he [or she] is unable to make a decision for himself or herself in relation to the matter [at hand] because of an impairment of, or a disturbance in the functioning of, the mind or brain."[76] The ability to make a decision encompasses the ability to understand, retain, and use information relevant to the decision and to communicate the decision.[77] The time- and decision-specific functional test used in the English and Singaporean legislation is widely accepted as a significant improvement on the diagnostic test that was once in vogue.[78]

The definition of mental incapacity in the Hong Kong legislation lags behind the English/Singaporean test in terms of both theory and technical simplicity. To analyze its inadequacy, the Hong Kong test needs to be set out in full. Section 2 of the Enduring Powers of Attorney Ordinance adopts the test of mental incapacity set forth in section 1A of the Powers of Attorney Ordinance, which provides that a person suffers from mental incapacity if:

> (a) he is suffering from mental disorder or mental handicap[79] and -
>
> (i) is unable to understand the effect of the power of attorney; or
>
> (ii) is unable by reason of his mental disorder or mental handicap to make a decision to grant a power of attorney; or

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[76] Mental Capacity Act 2005, c. 2(1) (Eng.); *see* BUV v. BUU [2019] S.G.H.C.F. 15 ¶ 29 (Sing.); *Re* BKR [2015] S.G.C.A. 26 ¶¶ 1, 12 (Sing.); Sarjit Singh Gill & Jamal Siddique, *Re BKR: Mental Capacity in Singapore*, IFL 30 (2016); *see also* Gary Chan, *Assessing Mental Capacity*, 32 SACLJ 287, 289 (2020); Allen Sng & Kah-Wai Tan, *The Deputyship Regime under Singapore's Mental Capacity Act: An Introduction*, 32 SING. ACAD. OF L.J. 167, 181–183 (2020).

[77] Mental Capacity Act, c. 9, § 1 (Eng.).

[78] Hui Min Lim, Lee Gan Goh & T. Thirumoorthy, *Legal Medicine: Assessing Mental Capacity and Writing Medical Reports for Deputy Applications*, 58 SING. MED. J. 18, 23 (2017).

[79] Mental disorder refers to mental illness or a disability of the mind that is not a mental handicap, whereas mental handicap refers to sub-average intellectual ability. Mental Health Ordinance, (2019) Cap. 136 § 2 (H.K.)

> (b) he is unable to communicate to any other person who has made a reasonable effort to understand him, any intention or wish to grant a power of attorney.[80]

In respect of section 2(a)(i), Hoffmann J. (later Lord Hoffmann), in *Re K; Re F*, clarified that donors need only have the capacity to understand the nature and effect of the power, not the capacity to manage their own property affairs.[81] Further, donors are considered to understand the nature and effect of the power if they understand that the attorney will assume complete authority over their affairs; that the attorney will be able to do anything with their property that they themselves could have done; and that the attorney's authority will continue without confirmation by the court when they become mentally incapable.[82] Although not stipulated in the Enduring Powers of Attorney Ordinance, recent case law has confirmed that the common law presumption of capacity applies to the establishment of a durable power.[83]

This test is lacking in several respects. First, in singling out mental disorder and mental handicap, it resonates with the antiquated concept of mental incapacity as referring to "lunatics" and "idiots."[84] Second, whilst one's inability to make a decision

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[80] Enduring Powers of Attorney Ordinance, (2018) Cap. 501 § 1A (H.K.) *adopted in* Enduring Powers of Attorney Ordinance, (2013) Cap. 501, § 2 (H.K.); *See* Victor WC Lui, Charles CY Chiu, Rachel SF Ko & Linda CW Lam, *The Principle of Assessing Mental Capacity for Enduring Power of Attorney*, 20 H.K. MED. J. 59, 61 (2014); Daisy Cheung, *Mental Health Law in Hong Kong: The Civil Context*, 48 H.K. L.J. 461, 479–80 (2018).

[81] [1988] 1 Ch 310, 315 (Eng.); *See also* To Lee Wah Samuel v. Yum Huin Ming, [2019] H.K.C.F.I. 1441, [140] (C.F.I.) (H.K.).

[82] *Re K* [1998] 1 Ch at 316.

[83] *Id.* at 310; *See To Lee Wah Samuel* [2019] H.K.C.F.I. 1441 ¶¶ 11, 15. The presumption is given statutory force in the Mental Capacity Act 2010, c. 177A, § 3(2) (Sing.).

[84] *See* MARGARET MCGLYNN, THE KING AND THE LAW: *PREROGATIVA REGIS* IN EARLY TUDOR ENGLAND 36 n.45 (1998); Chantal Stebbings, *Protecting the Property of the Mentally Ill: The Judicial Solution in Nineteenth Century Lunacy Law*, 71 CAMBRIDGE L.J. 384, 385 (2012); T.C.S. Keely, *One Hundred Years of Lunacy Administration*, 8

must be caused by mental disorder or mental handicap, no such causal link is needed in relation to one's inability to understand the effect of the power of attorney. Accordingly, a person who suffers from these medical conditions and fails to understand the effect of the power owing to a lack of linguistic competence or even poor eyesight will be denied capacity. Third, the causal link is also dispensed with in relation to an inability to communicate one's decision to others. Read literally, the over-inclusive wording in sub-section 2(b) would define as incapacitated someone who seeks to communicate in an environment so noisy that he or she cannot be easily heard.[85]

That the causal link is dispensed with in relation to an inability to understand the effect of a power of attorney and to communicate one's decision was unequivocally confirmed in *Samuel To*, a recent first instance decision.[86] The court did not consider the startling implications of the aforementioned definition. Should the courts have an opportunity to do so in the future, they are likely to construe the provisions in a way that avoids those implications. That being said, the current definition of incapacity in the Enduring Powers of Attorney Ordinance constitutes a botched attempt to follow English law and has in any event been rendered out of date by the Mental Capacity Act of 2005. The current definition in the Hong Kong legislation is based on the recommendation made by the UK Law Commission in 1995.[87] According to that recommendation, a person with mental incapacity is (1) unable by reason of mental disability to make a decision on the matter in question or (2) unable to communicate a decision on that matter because he or she is

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CAMBRIDGE L.J. 195, 195 (1943); F.W. Maitland, *The 'Praerogativa Regis'*, 6 ENG. HIST. REV. 367, 369–70 (1891).

[85] *See generally* Enduring Powers of Attorney Ordinance, (1997) Cap. 501, § 1A (H.K.) *adopted in* Enduring Powers of Attorney Ordinance, (2013) Cap. 501, § 2 (H.K).

[86] *To Lee Wah Samuel*, [2019] H.K.C.F.I. 1441, [9].

[87] The Enduring Powers of Attorney Act 1985 stipulates that a person is incapable if he or she "is incapable by reason of mental disorder of managing and administering his [or her] property and affairs." Enduring Powers of Attorney Act 1985, c. 29, § 13 (Eng.).

unconscious or for some other reason.[88] The second part of the recommended definition with respect to an inability to communicate was intended to be a residual, fall-back category for dysfunctions that may not result from a mental disorder, such as a loss of consciousness, Guillain-Barré syndrome, or "locked-in syndrome."[89] Unfortunately, the Hong Kong legislation adopted the recommendation without limiting the generality of the second part[90] and was unable to take into account its subsequent rejection in English legislation.[91]

Hong Kong also missed an opportunity to improve the definition of capacity in the 2011 amendment of the Enduring Powers of Attorney Ordinance.[92] Nor does the Continuing Powers of Attorney Bill seek to rectify the error.[93] In fact, it may have inadvertently added a new one. The Bill purports to replicate the definition in the Enduring Powers of Attorney Ordinance, but, unlike that Ordinance, it defines being "mentally incapable" as "(a) being mentally incapable" and "(b) suffering mental incapacity within the meaning of section 1A of the Powers of Attorney Ordinance."[94] Confusingly, sub-clause (a) does not reference the Powers of Attorney Ordinance,[95] which raises the issue of whether the adjectival phrase

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[88] LAW COMM'N, MENTAL INCAPACITY, 1995, No. 231, ¶ 3.14 (UK) (available at https://s3-eu-west-2.amazonaws.com/lawcom-prod-storage-11jsxou24uy7q/uploads/2015/04/lc231.pdf).
[89] *Id.* ¶ 3.13.
[90] ATTORNEY GEN.'S CHAMBERS, H.K., ENDURING POWERS OF ATTORNEY BILL, POWERS OF ATTORNEY (AMENDMENT) BILL ¶ 14(a) (Leg. Council Br. 1996) (available at http://library.legco.gov.hk:1080/search~S10?/.b1129328/.b1129328/1,1,1,B/l962~b1129328&FF=&1,0,,0,0); LEG. COUNCIL, H.K., OFFICIAL RECORD OF PROCEEDINGS: WEDNESDAY, 8 JANUARY 1997, at 87 (Rep. 1997) (available at https://www.legco.gov.hk/yr96-97/english/lc_sitg/hansard/970129fe.doc).
[91] LEG. COUNCIL, H.K., OFFICIAL RECORD OF PROCEEDINGS: WEDNESDAY, 8 JANUARY 1997 at 90.
[92] Enduring Powers of Attorney (Amendment) Ordinance, (2011) Cap. 501 (H.K.).
[93] *Consultation Paper on the Continuing Powers of Attorney Bill*, *supra* note 6, Annex B § 2.
[94] *Id.*
[95] *Id.* § 2(a).

is intended to bear a different meaning from the noun phrase expressing what is essentially the same concept.

(v) Lack of an "Operation Manual" for Attorneys

Crucial to the effectiveness of a durable power as an informal legal tool is the availability of clear and accessible guidelines of conduct for the attorneys concerned, most of whom are lay family members of donors. Hong Kong's current powers of attorney legislation is drafted in legal terminology that is derived from agency law, with little adaptation or elaboration to make it more readily comprehensible to the general public. For example, section 12(1) stipulates that the attorney's duties are "of a fiduciary nature," a legal concept that may not be self-evident to lay attorneys.[96] Section 12(2) further stipulates that attorneys have a duty to exercise their powers honestly and diligently, keep proper accounts, and refrain from entering into transactions involving a conflict of interest and mixing the donor's property with other property.[97] For laypeople, it may not be obvious what a "proper" account involves or which specific transactions amount to a "conflict of interest."

By contrast, the Singaporean Mental Capacity Act offers clear and concrete instructions specifying what attorneys should and should not do. Section 3(5) stipulates that they must act in the best interests of the donor,[98] and sections 6(1)-6(3) elaborate on the procedural steps they must take in order to so act, namely, (1) avoid making a decision on the basis of the donor's age and appearance or an aspect of the donor that does not accurately reflect what is in his or her best interests, and (2) consider all relevant circumstances, including the donor's will, wishes, feelings, beliefs, and values.[99] The donor must also be supported so that he or she can participate in decision-making.[100] In relation to dispositions or settlement of the

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[96] Enduring Powers of Attorney Ordinance, (2013) Cap. 501, § 12(1) (H.K.).
[97] *Id.* § 12(2).
[98] Mental Capacity Act 2010, c. 177A, § 3(5) (Sing.).
[99] *Id.* § 6(1)–(3).
[100] *Id.* § 6(4).

donor's property, an attorney must ensure, as far as is reasonably practicable, that the donor's property is preserved for the donor's maintenance during his or her lifetime.[101] The Mental Capacity Act also allows donors to nominate individuals who are to be consulted by the attorney in the performance of his or her duties.[102] These statutory provisions are further supplemented by a detailed Code of Practice (written in simple, plain language with case scenarios and examples) to help donors and attorneys to understand their rights and duties.[103] Put simply, the Singaporean legislation and its supporting Code of Practice are drafted as if they were an operation manual, whereas the Hong Kong legislation represents conventional statements of legal principles in technical jargon.

The Continuing Powers of Attorney Bill recognizes the need for accessible stipulations as to the attorney's scope of duties and proposes changes accordingly. Whilst the attorney's duties are still characterized as being "of a fiduciary nature,"[104] the Bill explains those duties in the language of acting in the "best interests" of the donor.[105] It also expressly requires attorneys to pay regard, as far as is practicable, to the donor's wishes and feelings.[106] They must also consult persons named by the donor and/or those caring for or interested in the welfare of the donor.[107]

(vi) Inadequate Safeguards for Abuses

The mechanisms for detecting and enforcing breaches of duty in Hong Kong are also woefully inadequate. Little thought has been

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[101] *Id.* § 6(6).
[102] *Id.* § 6(8).
[103] Off. of the Pub. Guardian, *Code of Practice Mental Capacity Act (Chapter 177A)*, MINISTRY OF SOC. AND FAM. DEV. 5 (Oct. 2016), https://www.msf.gov.sg/opg/Documents/CSC.MSF.OPGWebsite/Documents/Code_of_Practice_Oct16_final.pdf.
[104] *Consultation Paper on the Continuing Powers of Attorney Bill*, *supra* note 6, Annex B § 18.
[105] *Id.* § 19(a).
[106] *Id.*
[107] *Id.* § 19(b).

given in the Enduring Powers of Attorney Ordinance to accommodating the informal family setting of durable powers. As with commercial powers of attorney, the legislation gives the courts sole jurisdiction to resolve disputes, require an account from the attorney, and revoke the durable power or remove an attorney.[108] All of these powers can be exercised only on the application of an interested party, as neither the court nor any governmental department has the authority to investigate suspected breaches of the legislation or initiate court proceedings.[109]

This legal framework for monitoring and giving relief to breaches gives rise to at least three problems. First, the court is not the most suitable institution for addressing disputes involving durable powers. Not only are court proceedings costly and lengthy, they are often shunned for fear of disrupting family harmony, a fear that is particularly prominent in Chinese culture.[110]

Second, there is no mechanism for *preventing* abuses by attorneys, only a mechanism for *redressing* breaches that have already taken place. For example, the registration of durable powers with the court is a purely administrative procedure; it does not involve any court scrutiny of the validity of those powers.[111] A donor may, but need not, nominate up to two persons to be notified by the attorney before the attorney registers the durable power.[112] The lack of mandatory notification constitutes a serious loophole, allowing the registration requirement to be circumvented when it may be needed the most. If a vulnerable donor has capacity but is manipulated to appoint someone as his or her attorney without nominating a person to be notified, the donor's family or friends are

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[108] Enduring Powers of Attorney Ordinance, (2013) Cap. 501, § 11 (H.K.).
[109] *Id.*
[110] This is summed up in the Chinese idiom *jiachou buke waiyang* [family ugliness should not be aired]. *See The Education of Detained Chinese Feminist Li Tingting*, CHINAFILE (Mar. 16, 2015), https://www.chinafile.com/library/excerpts/education-detained-chinese-feminist-li-tingting (discussing this idiom); Wei Pei, *Harmony, Law and Criminal Reconciliation in China: A Historical Perspective*, ERASMUS L. REV. 1, 21 (2016) (discussing the importance of maintaining family harmony).
[111] Enduring Powers of Attorney Ordinance, § 9(7).
[112] *Id.* § 18(3).

unlikely to avail themselves of the right to check the register before the donor's property has been misapplied, at which point it may be too late to do so.

Third, the legislation gives power solely to interested parties (typically family members or close friends) to initiate court action.[113] No public supervisory body is assigned any role in investigating abuses, initiating sanctions, or removing errant attorneys.[114] The result is that donors who do not have a family or social network to support them in monitoring attorneys are left unprotected. With Hong Kong's low birth rate and shrinking number of extended families, the problem is likely to worsen in the future. At present, for instance, it is estimated that about 80,000 households in Hong Kong comprise elderly couples without children.[115]

In contrast, the Singaporean system comprehensively addresses the aforementioned concerns. For example, the Office of the Public Guardian (OPG) is equipped with sufficient investigative and adjudication powers, including the power to appoint a visitor to visit the donees of lasting powers and submit a report on their well-being to the OPG.[116] It also has the power to deal with representations (including complaints) by *any person* about the way in which attorneys are exercising their powers and to investigate any contravention or alleged contravention of the Mental Capacity Act.[117] The OPG may also require attorneys to provide specified information when they are suspected of a breach.[118]

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[113] *Id.* § 11.
[114] *Id.*
[115] Jennifer Ngo, *Almost 80,000 Elderly Hong Kong People and Their Sole Carers at Risk, Say Social Workers*, S. CHINA MORNING POST (Aug. 3, 2015), https://www.scmp.com/news/hong-kong/health-environment/article/1846018/almost-80000-elderly-hong-kong-people-and-their.
[116] Mental Capacity Act 2010, c. 177A, § 31(1)(d) (Sing.); Mental Capacity Regulations 2010, SI 105/2010, § 36 (Sing.).
[117] Mental Capacity Act, §§ 31(1)(h), (j), 32.
[118] Mental Capacity Regulations, § 38.

Furthermore, Singapore's Mental Capacity Act contains a provision mandating the protection of whistle-blowers who report abuse. Anyone who knows or reasonably suspects that a person who lacks capacity is in need of care may notify the OPG without having their identity revealed in open court.[119] Such protection incentivizes people to bring suspected abuses to the attention of the OPG. It is also a criminal offense in Singapore for an attorney to ill-treat a donor or to facilitate his or her ill-treatment by others.[120] The penalty for such ill-treatment recently doubled to a maximum fine of S $40,000 (US $28,700) and fourteen years' imprisonment if it results in death.[121] In summary, these measures collectively serve to promote early detection, timely investigation and effectively deter abuses.

The Continuing Powers of Attorney Bill has demonstrated a commitment to recover lost ground in these respects. The Hong Kong Guardianship Board will finally be granted the power to review the operation and validity of a continuing power on the application of an interested party or on its own initiative under the proposed continuing power legislation or the Mental Health Ordinance.[122] The Board may also require written reports on donors from two registered medical practitioners and a social inquiry report from the Director of Social Welfare.[123] It may even make a guardianship order suspending the continuing power for a specified duration.[124] Whilst these safeguards do not go as far as those in Singapore—there is neither a whistle-blowing provision nor criminal liability for ill-treatment over and above general criminal law[125]—they represent a significant improvement in the monitoring

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[119] Mental Capacity Act, § 43.
[120] *Id.* § 42(6).
[121] Criminal Law Reform Act 2019, Act 15/2019, § 179 (Sing.).
[122] *Consultation Paper on the Continuing Powers of Attorney Bill*, *supra* note 6, Annex B § 57.
[123] *Id.* §§ 59–60.
[124] *Id.* § 61.
[125] *See generally* Criminal Law Reform Act (discussing criminal law reform in Hong Kong without mentioning whistle-blowing or criminal liability for ill-treatment over and above general criminal law).

of attorney performance. It remains to be seen whether the Guardianship Board will proactively and effectively avail itself of these new powers.

III. Supporting Measures

In addition to having modern durable power legislation, Singapore also surpasses Hong Kong with respect to its supporting measures for the use of durable powers. For example, Singapore has demonstrated greater commitment than Hong Kong in actively promoting durable powers to the general public and providing administrative and financial support for donors and attorneys.

A. Robust Public Awareness Campaigns

Hong Kong's efforts to promote its durable power system also pale in comparison to Singapore's, largely because of the absence of a dedicated administrative department in charge of durable powers.[126] The Enduring Powers of Attorney Ordinance was initiated by the Department of Justice, whose task was arguably accomplished upon the legislation's enactment.[127] Yet, as we have seen, Hong Kong's experience suggests that, unlike commercial powers of attorney, it is not enough to put in place durable power legislation without raising public awareness about it and facilitating the community to avail themselves of this legal instrument.

A study carried out in 2007, ten years after the introduction of durable powers, revealed widespread ignorance of the existence and scope of such powers, even within the legal profession.[128] In response to the study's findings, the Department of Justice began

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[126] *See generally* LAW REFORM COMM'N OF H.K., ENDURING POWERS OF ATTORNEY ¶ 1 (Rep. 2008) (available at https://www.hkreform.gov.hk/en/docs/repa_e.pdf) (discussing Hong Kong's enduring power of attorney regulations without discussing a dedicated administrative department in charge of durable powers).

[127] Enduring Powers of Attorney Ordinance, (1997) Cap. 501, § 3 (H.K.).

[128] LAW REFORM COMM'N OF H.K., ENDURING POWERS OF ATTORNEY ¶ 3.15.

devoting more effort to the promotion of durable powers.[129] For example, leaflets for legal and medical practitioners and the general public have been issued, and websites (including an accessible version for senior citizens) containing relevant information on durable powers have been created.[130] In addition, the Investor and Financial Education Council, a subsidiary of the Hong Kong Securities and Futures Commission tasked with improving local financial literacy, recently released explainer videos on durable powers in Hong Kong.[131] Whilst the uptake of such powers has marginally improved in recent years, it still lags significantly behind that in Singapore.[132]

It may be tempting to blame such powers' lackluster reception in Hong Kong on Chinese culture and the taboos surrounding incapacity planning or to believe that the elderly are already being adequately taken care of by their filial children. Whilst there is a grain of truth in these conjectures, cultural values alone cannot account for the dramatic difference in the uptake of durable powers between Hong Kong and Singapore. As noted, 92% of the Hong Kong population is ethnically Chinese.[133] In Singapore, the percentage is just 74.3%, but the remainder of the population is primarily made up of ethnic Malays and Indians, who share similar values to the Chinese, meaning that around 97% of the Singaporean

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[129] *Enduring Powers of Attorney*, DEP'T OF JUST. H.K., https://www.doj.gov.hk/eng/epa/index.html (last visited Sept. 21, 2020).

[130] *Enduring Powers of Attorney*, CMTY. LEGAL INFO. CENTER, https://www.clic.org.hk/en/topics/enduring_Powers_of_Attorney/ (last visited Sept. 21, 2020); *Power of Attorney*, SENIOR CLIC, https://s100.hk/en/topics/Health-and-care/Enduring-Power-of-Attorney/What-is-an-Enduring-Power-of-Attorney/ (last visited Sept. 21, 2020).

[131] *Enduring Power of Attorney*, INVESTOR AND FIN. EDUC. COUNCIL, https://www.ifec.org.hk/web/en/retirement/features/money-matters-life-death/enduring-power-of-attorney.page (last visited Sept. 21, 2020).

[132] From 2007 to 2016, there were only 420 enduring powers of attorney registrations in Hong Kong. Wong, *supra* note 13, at 9.

[133] *The Demographic: Ethnic Groups*, RACE RELATIONS UNIT, HOME AFF. DEP'T, H.K., https://www.had.gov.hk/rru/english/info/info_dem.html (last visited Sept. 21, 2020).

population has a similar cultural outlook.[134] The country's success in the durable power arena powerfully demonstrates that cultural inertia can be overcome by robust legislation supported by proactive administrative measures. A closer look at the promotional campaigns in Singapore offers valuable lessons to Hong Kong and other jurisdictions interested in increasing the uptake of durable powers amongst ethnic groups with similar cultural values.

In Singapore, as soon as the Mental Capacity Act came into effect, a Public Guardian Board[135] comprising members from a broad spectrum of the community was appointed by the government to provide strategic guidance to the OPG.[136] Within the first year of the OPG's operation, a public education plan was also put in place to raise awareness amongst the general public.[137] In addition to media publicity, the OPG also leveraged grassroots organizations, voluntary welfare organizations, and social intermediaries to give talks and hold free workshops on lasting powers of attorney.[138] These efforts proved to be more effective in reaching out to the elderly population than websites or information leaflets, as in Hong Kong.[139] The OPG also leveraged the customer networks of financial institutions.[140] For example, it collaborated with the Post Office Savings Bank, which has a customer base of 4 million, to raise awareness of durable power of attorney amongst its customers

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[134] *Population and Vital Statistics*, MINISTRY OF HEALTH SING., https://www.moh.gov.sg/resources-statistics/singapore-health-facts/population-and-vital-statistics (last visited Sept. 21, 2020).

[135] The Public Guardian Board ceased operations after five years as the OPG had become mature in its organizational ethos, principles, practices, and operations, meaning there was no need for the Board to continue. OFF. OF THE PUB. GUARDIAN, ANNUAL REPORT 2013 (2013) (available at http://karenandkaren.com/wp-content/uploads/2014/11/OPG-AR-2013.pdf).

[136] *Id.* at 7.

[137] *Id.* at 9.

[138] *Id.* at 11–12.

[139] *Compare Mental Capacity/Mental Health Queries*, MINISTRY OF SOC. AND FAM. DEV., https://www.msf.gov.sg/media-room/Pages/Mental-capacity-health-media-queries.aspx (last visited Sept. 21, 2020), *with Enduring Power of Attorney*, *supra* note 130.

[140] *Annual Report 2013*, *supra* note 135, at 9.

through online platforms, mailings, and the screening of a promotional video at all of the bank's branches.[141]

The Singaporean government also established a stakeholder consultation group called Pro-Active Community Engagement (PACE), which comprises "sector champions" from the legal, financial, healthcare, public relation, and business sectors, to provide regular advice to the government on the promotion of lasting powers, allowing the government to draw upon the networks and frontline experience of PACE members.[142] These outreach efforts have been crucial in raising awareness of lasting powers in Singapore's elderly community, which has in turn rendered the elderly readier to make legal arrangements for incapacity.

B. Institutional Support

Since raising awareness amongst the general public, the Singaporean government has employed extremely effective nudging techniques to incentivize people to establish lasting powers.[143] For example, since 2014, the OPG has periodically waived the application fee for such establishment for a specified period of time, thereby incentivizing Singaporeans to sign up while the waiver is in place.[144] The OPG has also secured the provision of a free mailing service for the submission of lasting power applications,[145] thereby alleviating the need for the elderly to make special trips to submit their application forms in person. Mobile clinics also visit different parts of the city to provide convenient attestation services.[146] These clinics are attended by OPG staff members authorized to receive

[141] *Id.* at 10.
[142] OFF. OF THE PUB. GUARDIAN, ANNUAL REPORT 2010 (2010) (on file with author).
[143] For a discussion of nudging, *see* RICHARD H. THALER & CASS R. SUNSTEIN, NUDGE 252 (2008).
[144] *Lasting Power of Attorney Application Fees Waived for Two More Years*, MINISTRY OF SOC. AND FAM. DEV., https://www.msf.gov.sg/media-room/Pages/Lasting-Power-of-Attorney-application-fees-waived-for-two-more-years-.aspx#:~:text=2 (last visited Sept. 21, 2020).
[145] Theresa Tan, *Fee Waiver for LPA Extended to 2020*, STRAITS TIMES (June 29, 2018), https://www.straitstimes.com/singapore/fee-waiver-for-lpa-extended-to-2020.
[146] ANNUAL REPORT 2013, *supra* note 135, at 5.

lasting power applications.[147] Put simply, the Singaporean government delivers a convenient one-stop-shop service to the doorsteps of potential users to help them to establish enduring powers.

Conversely, a potential donor in Hong Kong typically needs to make two consecutive visits, first to a solicitor and then to a doctor, to establish a durable power, after which the solicitor's office submits a physical application for registration at the court.[148] The costs of these professional services are borne by the donor with no financial assistance from the government. Because of the risk of potential disputes pertaining to durable powers, the legal fee for establishing such powers is higher than that for writing wills.[149] To date, the only financial assistance available is that offered by the Hong Kong Mortgage Corporation Ltd., which revised its reverse mortgage program to allow existing borrowers and new applicants to retrieve lump-sum payments to meet the expenses of executing a durable power.[150] This measure benefits only a small fraction of potential donors. For the overwhelming bulk of the Hong Kong population, therefore, durable powers are far from being an informal, self-help financial planning instrument.

Thus far, this Article has drawn upon a comparison between Singapore and Hong Kong to show that an adequate legal framework and rigorous supporting measures can overcome the cultural inertia hindering durable power establishment. The legal framework in Singapore makes durable power an attractive self-help instrument for incapacity planning owing to such key features as comprehensive coverage of health and financial matters, the accessibility and affordability of execution, a modern definition of

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[147] *Id.* at 16.

[148] Victor Lui et al., *The Principle of Assessing Mental Capacity for Enduring Power of Attorney*, 20 H.K. MED. J. 59 (2014).

[149] *See id.* at 60 (explaining the complexity of establishing durable powers and how it differs from writing wills).

[150] H.K. Monetary Authority, *Promoting the Use of Enduring Power of Attorney by Borrowers Under the Reverse Mortgage Programme*, MY GOVHK (July 29, 2013), https://www.info.gov.hk/gia/general/201307/29/P201307290530.htm.

mental incapacity, a clear and accessible delineation of attorneys' duties and guidelines for their conduct, and rigorous preventive and remedial measures for abuses of power. In addition to its superior legal framework, Singapore's robust outreach efforts to raise public awareness, waiver of application fees, and delivery of execution services to potential donors' doorstep are phenomenal by the standards of any jurisdiction.

While Singapore provides useful inspiration for increasing the uptake of durable powers, we must not lose sight of the ultimate aim of such powers: protecting the well-being of individuals with mental incapacity. A truly successful durable power system is not defined by popularity alone, but rather by its ability to strike an appropriate balance between convenience and protection. It also needs to provide adequate safeguards and remedies with respect to potential attorney abuses. Accordingly, we now turn our attention to an evaluation of the success of the two durable power systems in achieving such a balance.

IV. Safeguards against Abuses

There is a growing body of literature suggesting that durable powers are often misused to facilitate financial abuse.[151] One commentator even considers "property powers of attorney as licenses to steal."[152] Recently, Denzil Lush, former Senior Judge of the English Court of Protection, expressed a critical view of the

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[151] AUSTL. LAW REFORM COMM'N, ELDER ABUSE – A NATIONAL LEGAL RESPONSE, REP. NO. 131 ¶ 5.2 (2017); RAE KASPIEW ET AL., AUSTL. INST. OF FAM. STUD., ELDER ABUSE: UNDERSTANDING ISSUES, FRAMEWORKS AND RESPONSES, RESEARCH REP. NO. 35, at 11 (2016); MELANIE JOOSTEN ET AL., PROFILE OF ELDER ABUSE IN VICTORIA: ANALYSIS OF DATA ABOUT PEOPLE SEEKING HELP FROM SENIORS RIGHTS VICTORIA, (2015) (https://seniorsrights.org.au/wp-content/uploads/2014/03/Summary-Report_Profile-of-Elder-Abuse-in-Victoria_Final.pdf); Natalie Wuth, *Enduring Powers of Attorney with Limited Remedies – It's Time to Face the Facts!*, 7 ELDER L. REV. 1, 7 (2013); Loy Zhi Hao & Priscilla Soh Yu Xian, *Reforming the Law Protecting the Elderly in Singapore*, 31 SING. L. REV. 253, 265–68 (2013).

[152] Ralph F. Jones, *Power of Attorney Accountability Thwarts 'License to Steal'*, MCLANE MIDDLETON, https://www.mclane.com/thought-leadership/power-of-attorney-accountability-thwarts-license-to-steal (last visited Sept. 21, 2020)

inadequate safeguards included in the 2005 reform of durable powers in the UK.[153] In a comprehensive survey of court judgments in Australia, Purser et al. identified the key risk factors of abuse through the misuse of durable powers.[154] Drawing upon that survey, this part of the Article examines reported instances of such abuse in Singapore and Hong Kong. It follows two lines of inquiry. First, it considers whether those instances reveal any loopholes in the current durable power regimes that need to be closed. Second, it identifies the measures that are unduly impeding the creation of durable powers while failing to provide precise, targeted responses to misuses. These two lines of inquiry help to identify what is needed to fine-tune the oversight of durable powers and strike an appropriate balance between the conflicting goals of convenience and protection. The Article also proposes safeguards for achieving such a balance.

A. Prudential Measures of Execution

Professional certification performs an important gatekeeping function. Although it does not provide fool-proof protection against those intent on misusing durable powers, certification affords professionals a valuable opportunity to verify the voluntariness of a donor's decision. If initial scrutiny in the form of certification had been taken seriously in the past, then financial abuses such as those in some of the reported decisions considered here might have been detected if not prevented. For example, in *Law Society of Singapore v. Sum Chong Mun*, which involved a disciplinary proceeding against a lawyer, the mistress of a donor had procured her lawyer friend to certify the donor's execution of a lasting power that

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[153] DENZIL LUSH, *Foreword*, *in* CRETNEY & LUSH ON LASTING AND ENDURING POWERS OF ATTORNEY v (8th ed. 2017); DENZIL LUSH, *Adult Guardianship and Powers of Attorney in England and Wales*, *in* SPECIAL NEEDS FINANCIAL PLANNING: A COMPARATIVE PERSPECTIVE 117, 143–45 (Lusina Ho & Rebecca Lee eds., 2019).

[154] Purser, Cockburn & Ulrick, *supra* note 9, at 2.

appointed the mistress as his sole attorney.[155] Mr. Sum, the lawyer friend, did so without meeting the donor or personally witnessing his signature, which turned out to have been forged by the mistress.[156] Whilst the problem in this Singaporean case stemmed from non-observance of the certification requirement,[157] not the inadequacy of the requirement itself, the case accentuates the need for clear signalling of the potential adverse consequences of professional misconduct.

Equally important is the need to provide adequate training on the certification process to relevant professionals. In another case heard in Singapore, the most sensational of those reviewed for this inquiry, a tour guide befriended Madam Chung, a childless, 90-year-old widow with over S $40 million in assets, eventually gaining her trust and moving into her residence.[158] He procured Madam Chung to write a will that gave him her entire estate and to appoint him as the sole attorney over her welfare and financial affairs.[159] Within four years of living together, her cash savings had plummeted from S $2.7 million to S $10 thousand.[160] The tour guide's misconduct surfaced only when Madam Chung was diagnosed with dementia and her niece found out about the lasting power.[161] The Singaporean Family Court held that Madam Chung had sufficient mental capacity to revoke the lasting power.[162] Although much of the misappropriation had taken place without any misuse of the durable power, the fact that it had been certified despite the presence of

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[155] Law Society of Sing. v. Sum Chong Mun [2017] S.G.H.C. 80 (Sing.); Grace Leong, *Another LPA Storm Brews over a Rich Person's Assets*, ASIAONE (Oct. 10, 2014), https://www.asiaone.com/singapore/another-lpa-storm-brews-over-rich-persons-assets (discussing the facts of the case).

[156] *Law Society of Sing.* [2017] S.C.H.C. 80 ¶¶ 2, 16, 61.

[157] *Id.*

[158] Chung Kin Chun K v. Yang Yin [2015] S.G.H.C. 215 ¶¶ 20, 29, 30, 38, 39 (Sing.). A series of other judicial decisions arose from this saga, such as TDA v. TCZ [2016] S.G.H.C. 63 (Sing.) and Public Prosecutor v. Yang Yin [2015] S.G.H.C. 3 (Sing.).

[159] *Chung Kin Chun K* [2015] S.G.H.C 215 ¶ 20.

[160] *Id.*; Lee Min Kok, *Yang Yin Saga: A Recap of the Case*, STRAIT TIMES (Sept. 19, 2016), https://www.straitstimes.com/singapore/courts-crime/yang-yin-saga-a-full-recap-of-the-case (discussing the facts of the case).

[161] *Id.*

[162] *Chung Kin Chun K* [2015] S.G.H.C. 215 ¶ 39.

numerous risk factors, including Madam Chung's mental impairment, social isolation, and dependence on the tour guide, who had been a stranger to her until three years prior to the power's creation, reflects the need to devote more regulatory attention to high-risk cases.[163] Accordingly, the relevant legislation needs to be supplemented with clear guidelines for the certifying professionals on how to identify and fully investigate high-risk cases.

The situation in *BUV v BUU* offers a case in point.[164] It is focused on an elderly, illiterate woman with a dementia diagnosis who executed a lasting power of attorney in favor of her eldest son, with whom she resided, giving him unrestricted authority to make cash gifts.[165] Although the lawyer who certified the woman's capacity testified that she had appeared to understand his explanation of the content of the lasting power, the court held that she had lacked capacity, observing that the lawyer had not been informed of her dementia and was not medically trained in assessing mental capacity.[166] It also held that the presumption of undue influence by the son was not rebutted on the facts.[167]

It is tempting to assume that the problems in these cases could have been overcome by requiring two certifiers,[168] one from each of the legal and medical professions. However, that assumption misses the point that the problems stem from the quality, not the quantity, of certification. Singapore's Mental Capacity Act, for example, already requires the certifier to confirm that the donor understands the purpose of the durable power and the scope of the authority conferred upon the attorney, as well as that no fraud or undue

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[163] *Id. See* Purser, Cockburn & Ulrick, *supra* note 9, at 12 for a comprehensive list of the risk factors for financial abuse.
[164] BUV v. BUU [2019] S.G.H.C.F. 15 (Sing.).
[165] *Id.* ¶¶ 7, 8, 10, 16, 69.
[166] *Id.* ¶ 79.
[167] *Id.* ¶ 98. The court revoked the lasting power on the basis of undue pressure pursuant to Mental Capacity Act 2010, c. 177A, § 17(3)(a)(ii)) (Sing.) and lack of capacity. *Id.* [114].
[168] See the recommendation in AUSTL. LAW REFORM COMM'N, ELDER ABUSE – A NATIONAL LEGAL RESPONSE, REP. NO. 131 ¶¶ 5.24–5.35 (2017).

pressure has been used to induce the donor to create the lasting power.[169] If an independent certifier who is qualified to assess mental capacity conducts a thorough examination, then the confirmation should be reliable. Whilst requiring a second professional certifier would enhance the degree of scrutiny by providing a second examination, the benefit of such a requirement might be marginal and disproportionate to the impediment imposed. In this light, in the absence of concrete guidance or training for certifiers, the requirement in Hong Kong that both a solicitor and doctor certify the matter at hand, that is, that the donor has capacity, but not the absence of coercion or undue pressure, goes both too far and not far enough.

A more balanced approach would be to require certification by one qualified professional but to bolster the gatekeeping exercise through a series of prudential measures. First, the certification process should be enhanced by providing guidelines on and training in the concrete steps that need to be taken in the interview with the potential donor. For example, certifiers should not limit themselves to explaining the legal effect of the durable power document and to asking close-ended questions about the donor's understanding. They should also satisfy themselves that the donor's decision to establish the durable power is free from fraud, coercion, and undue influence. To do so, they need to meet the donor independently and make general inquiries about the aforementioned financial abuse risk factors. What is needed is a core set of issues about which certifiers need to satisfy themselves. Whilst certifiers from the medical profession need to appreciate the core legal effects of a durable power, those from the legal profession need to know what the core cognitive and deliberative skills that constitute mental capacity are. Ideally, durable powers should be certified only by relevant professionals who have obtained the training and qualifications necessary to assess mental capacity and voluntariness in decision-making.

[169] Mental Capacity Act, § 2(1)(e).

Second, once the core content of the certification process is clear, there is no reason in principle why a healthcare or social care worker who has the requisite training and qualifications cannot play the role of certifier. Expanding the scope of certifiers with prescribed qualifications would also help to reduce the cost of execution.[170]

Third, if non-medical certifiers have any doubts about a donor's capacity or the voluntariness of his or her decision, then they should request a comprehensive assessment by a doctor or psychiatrist. They should also urge donors to avail themselves of the option to require the attorneys they appoint to notify up to five nominated individuals upon the onset of incapacity so as to engage others in attorney monitoring. Donors at high risk of abuse can thus be afforded protection without raising the cost of execution for the wider population.

Finally, in recognition that certification is not a fool-proof safeguard, the mandatory registration of durable powers upon execution should be put in place, with the registry of such powers made reasonably accessible by anyone with sufficient interest in the donor's well-being, such as their family members, close friends and/or relatives or, where appropriate, institutional carers. This measure would encourage and empower a donor's social network to monitor the attorney rather than leaving that task to the regulatory agency alone. Basic information, such as the names of the donor and attorney, should be made available to interested individuals. The administrative cost for the regulatory body of maintaining such a registry in today's Internet age would be negligible relative to the enormous benefits. A registry would also enhance the continuous monitoring of durable powers without raising the cost of execution or infringing privacy. It would provide an important safety net in cases where donors choose not to nominate individuals for compulsory notification upon the onset of incapacity or where the

[170] See the recommendation in AUSTL. LAW REFORM COMM'N, ELDER ABUSE – A NATIONAL LEGAL RESPONSE, REP. NO. 131 ¶¶ 5.44–5.45.

relevant individuals have not been notified, whether as a result of the attorney's fault or not.

B. Precautionary Monitoring

A common method of financial abuse by attorneys is to misuse the durable power to hollow out the assets of the donor, often by treating the donor's bank account as if it were the attorney's own. In *Ko Siu Ying v. Cheung Hay Lee Hailey*, a daughter misled her mother into appointing her as an attorney[171] and, within months, transferred over HK $1.2 million (US $154,000) from her mother's bank account to her own.[172] Fortunately, the mother still had mental capacity and revoked the power before further payments could be made.[173]

Donors who have lost capacity, in contrast, are forced to rely on family members or friends to intervene on their behalf. *Wong Chi Ho Jimmy v. Wong Oi Lun* provides a stark illustration.[174] In this case, Madam Wong, an 80-year-old spinster who suffered from cognitive impairment, appointed her step-nephew as her attorney.[175] He misused the durable power to institute legal proceedings in their joint name against Madam Wong's step-brother.[176] By misusing the durable power he had been granted, the nephew funded the litigation entirely with Madam Wong's assets, even receiving on one occasion money for the ostensible purpose of paying legal costs without passing it on to the solicitor.[177] Madam Wong resided in the same (family-owned) building as her step-nephew and depended on him

[171] [2018] H.K.C.F.I. 1797 ¶ 2 (H.K.). *See* Lee Finance Ltd. v. Ng Fun Lung, [2019] H.K.D.C 68 (H.K.) (relating the use of an ordinary power of attorney by a son to charge two properties he jointly owned with his mother to secure a personal loan at an interest rate of 46.8% and then abscond upon the loan's default). *See also* R v. Barton (David) [2020] EWCA Crim 575 (Eng.) (holding the legal charge over the properties unenforceable against the mother).
[172] *Chueng Hay Lee Hailey* [2018] H.K.C.F.I. 1797 ¶ 8.
[173] *Id.*
[174] [2020] H.K.C.F.I. 1073 (H.K.).
[175] *Id.* ¶¶ 7, 9, 18, 25.
[176] *Id.* ¶ 16.
[177] *Id.* ¶¶ 45–51.

for food and daily care.[178] He was apparently negligent in both respects despite paying significant amounts to family members to provide food and care.[179] The court reiterated the fiduciary nature of an attorney's duties and ordered the step-nephew to produce an account.[180] Madam Wong's family only learned of the abuse when she attended a family Christmas gathering in a poor physical state, smelling of incontinence.[181] Crucially, it was possible to bring the matter to the court only because the donor's family had the financial means to do so. Madam Wong's predicament echoes that of Madam Chung in Singapore, whose fortune was drained by a gold-digger.[182] The latter's predicament was discovered only when her abusive attorney flaunted his wealth online, sold rare pieces of art owned by her at bargain prices online, and cut off her monthly remittances to her sister and niece.[183]

These types of stories are not uncommon in Western jurisdictions either. In *Cohen v. Cohen*, for example, a son who had been appointed his mother's attorney transferred property valued at AUD $200,000 (US $140,000) to himself for AUD $1, leaving her with no money to pay the fees of the care home in which she resided.[184] In *Brennan v The State of Western Australia*, a solicitor was appointed as attorney of a bachelor with deteriorating mental and physical health who lived by himself.[185] Over a long period of time, the solicitor misused the durable power to appropriate almost

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[178] *Id.* ¶ 8.
[179] *Id.* ¶ 18.
[180] *Id.* ¶ 30 *citing* Kwok Chi Yin v. Kwok Yau Ki Jesse [2019] H.K.C.F.I. 428 ¶¶ 31–33 (H.K.).
[181] *Id.*
[182] Chung Kin Chun K v. Yang Yin [2015] S.G.H.C. 215 (Sing.); *see* TDA v. TCZ [2016] S.G.H.C. 63 (Sing.); Public Prosecutor v. Yang Yin [2015] S.G.H.C. 3 (Sing).
[183] *Chung Kin Chun K* [2015] S.G.H.C. 215 ¶ 29.
[184] Cohen v. Cohen [2016] NSWSC 336 (Austl.); Anthony J. Cordato, *Attorneys Transferring the Principal's Home to Themselves Must be Careful*, LEXOLOGY (Apr. 18, 2016), https://www.lexology.com/library/detail.aspx?g=cfb80692-72a8-4fa9-bf40-78eb9a0a44b4 (discussing the facts of the case); *See also* Smith v. Glegg [2004] QSC 443 (Austl.); Gillian Fisher-Pollard by her Tutor Miles Fisher-Pollard v. Piers Fisher-Pollard [2018] NSWSC 500 (Austl.).
[185] Brennan v. State of Western Austl. [2010] WASCA 19 ¶¶ 2, 4 (Austl.).

AUD $1 million (US $699,000) from the donor's bank accounts.[186] Some of the funds were transferred after the donor had passed away, and hence after the durable power had been automatically revoked.[187] What was particularly concerning in this case was the delay in detecting the thefts, which came to light only after the donor's death and, coincidentally, as part of an investigation into the miscreant's conduct as a solicitor, not as an attorney.[188]

There are important lessons to draw from the foregoing cases. There is little doubt that when attorneys' misdeeds are discovered and considered by the courts, they will be subject to appropriate sanctions in civil and criminal law.[189] In practice, however, most abuses are detected too late, and the victim's family may not have the means to go to court. To overcome these practical constraints, rigorous prudential monitoring of attorneys needs to be put in place, and the dispute resolution process needs to be deformalized.

In relation to prudential monitoring, there is much to be said for requiring attorneys to submit basic annual accounts to the relevant regulatory agency (the OPG in Singapore or Guardianship Board in Hong Kong).[190] The regulatory agency may also conduct periodic spot checks of donors with a high-risk profile, such as those who have reached old age, have severe mental or physical incapacity, and/or are suspected of being abused. In Singapore, the OPG has the power to arrange for a member of its Board of Visitors to visit a donee and provide a report on the donee's well-being to the OPG.[191] In Hong Kong, the Continuing Powers of Attorney Bill achieves the same effect by granting the Guardianship Board the power, upon an

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[186] *Id.* ¶ 3.
[187] *Id.*
[188] *Id.* ¶¶ 4–5.
[189] *See Cohen* [2016] NSWSC 336 ¶¶ 64–65 (Austl.) (finding a breach of fiduciary duty); Ko Siu Ying v. Cheung Hay Lee Hailey [2018] H.K.C.F.I. 1797 (H.K.) (finding a breach of fiduciary duty); *Brennan* [2010] WASCA 19 ¶¶ 6–19 (Austl.) (convicting for 70 counts of stealing and one count of fraudulently attempting to gain a benefit); Public Prosecutor v. Yang Yin [2015] S.G.H.C. 3 (Sing.) (finding a criminal breach of trust).
[190] Mental Capacity Act 2010, c. 177A, § 18(3) (Sing.); Ann Stanyer, *Lasting Powers of Attorney - Are They Good Enough Protection Against Financial Abuse?*, 2017 ELDER L.J. 225, 229–30 (2017).
[191] Mental Capacity Act, §§ 31(1)(d), 32(4).

application by an interested party or on its own initiative, to require a medical or social inquiry report on a donee if doing so is in the best interests of the donor and in accordance with his or her will and preference.[192]

In relation to improving access to justice, structural and systematic changes are needed to devolve adjudicative powers over durable powers to informal forums of dispute resolution. For example, the courts in both Singapore and Hong Kong have the power to request further information when there is prima facie evidence of abuse.[193] Given the prohibitive costs involved in the court process, there is no reason why that power should not be devolved to a tribunal that is subject to court appeals. It is, therefore, encouraging that the Continuing Powers of Attorney Bill will affect root-and-branch changes in Hong Kong by requiring proceedings on continuing powers to be made to the Guardianship Board while giving power to the courts to hear appeals against Board decisions.[194] Henceforth, disputes will be channelled to the Guardianship Board as an initial forum, thereby improving access to justice.[195] Furthermore, the Guardianship Board and the courts share the power to review continuing powers and to make such decisions as ordering attorneys to provide records and accounts of transactions and submit financial management plans for approval,[196] revoking or suspending a durable power, and removing an attorney.[197] In this regard, Hong Kong is going further than

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[192] *Consultation Paper on the Continuing Powers of Attorney Bill*, *supra* note 6, Annex B §§ 57–60.
[193] Enduring Powers of Attorney Ordinance, (2013) Cap. 501, § 11(1)(a) (H.K.); *Ko Siu Ying* [2018] H.K.C.F.I. 1797 ¶ 30; Mental Capacity Act, §§ 31(1)(h), (j), 32.
[194] *Consultation Paper on the Continuing Powers of Attorney Bill*, *supra* note 6, Annex B §§ 62(1), 74.
[195] *See* Mental Capacity Act, § 17(3)(b)–(c), 17(4)(b)–(c), 17(5A).
[196] *Consultation Paper on the Continuing Powers of Attorney Bill*, *supra* note 6, Annex B § 73(d), (e).
[197] *Id.*

Singapore, which continues to vest equivalent powers in the courts.[198]

C. Safeguarding Partners

The donors being unable to supervise their attorneys is key to the vulnerability of durable powers. One strategy would be to enhance the supervision of attorneys in line with the supervision required of deputies or guardians.[199] However, durable powers are meant to be self-help instruments,[200] based on trust (typically within the family), and are thus envisaged as requiring minimal intervention by public authorities. Accordingly, it might be more appropriate to preserve the differing roles of guardianship and durable powers, and thus for donors with no access to reliable attorneys to resort to the more regulated guardianship regime.

A better, less interventionist strategy would be to engage safeguarding partners to help to protect vulnerable donors. The ideal partners would be donors' family members and social networks, as well as the professionals who interact with them in the delivery of healthcare, social care, and legal and financial services.[201] Donors' family and social network could be engaged by having certifiers remind donors of the importance of nominating persons to be notified upon the onset of incapacity. That being said, however, because it is not and should not be mandatory for autonomous

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[198] Mental Capacity Act, § 17(4)(b), 17(5) (giving courts the power to revoke a durable power created as the result of undue pressure); *id.* § 18(2)(a), 18(3)(a)–(b) (giving courts the power to direct an attorney and order reports and accounts). These powers have not been vested in the OPG but may apply to the courts for such orders to be made. *See id.* §§ 17–18, 38(1)(e).

[199] *See Adult Guardianship and Powers of Attorney in England and Wales*, *supra* note 153, at 146–48.

[200] *Id.*

[201] *See* Off. of the Pub. Guardian, U.K., *Safeguarding Strategy 2019–2025: Office of the Public Guardian*, CROWN, https://www.gov.uk/government/publications/safeguarding-strategy-2019-to-2025-office-of-the-public-guardian/safeguarding-strategy-2019-to-2025-office-of-the-public-guardian (last updated Apr. 29, 2019). The UK OPG refers to close collaboration with healthcare and social care professionals, but the scope of safeguarding partners need not be so limited. *See id.*

donors to make such nominations, the risk of donors failing to act in their own best interests by declining to make nominations would remain. The maintenance of a public register is thus crucial as a fall-back measure that would allow concerned family members and friends to discover the existence of durable powers and the identity of the attorneys concerned. In this connection, clarification is also needed concerning the locus standi of the parties who can access the register or seek further information.[202] Singapore goes even further by providing that *any person* who knows or has reason to suspect that a person who lacks capacity is in need of protection may notify the Public Guardian.[203] The Mental Capacity Act also protects such whistle-blowers by stipulating that their identity need not be disclosed should they appear as witnesses in any proceedings.[204]

The professionals who interact with donors may play an important role in scrutinizing the misuse of durable powers if not in whistle-blowing. Equipping them to fulfill that role requires the adoption of industry-specific codes of conduct[205] and training in

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[202] Wong Chi Ho Jimmy v. Wang Oi Lun [2020] H.K.C.F.I. 1073 (H.K.) (holding that a step-brother who was paying for the donor's medical expenses had *locus standi* to seek a court order for the attorney to produce accounts and records). An "interested person" is determined by taking into account a person's connection with and benefit to the donor and whether the benefit can be achieved in any way other than by applying for the court to exercise its powers under the legislation. *See* Mental Capacity Act, § 38(3) (Sing.); Mental Capacity Act 2005, c. 9, § 50(3) (Eng.). *See also Powers of Attorney Act 2003* (NSW) § 35(1) (defining "interested person" as, apart from specified individuals such as the donor's guardian, someone with genuine concern for the welfare of the donor); *Powers of Attorney Act 1998* (Qld) c. 6 pt. 2 § 110(3) (defining "interested person" as, apart from the donor's guardian and family members, someone with a sufficient and continuing interest in the donor); *Powers of Attorney Act 2014* (Vic) pt 8 div 3 § 122(1) (defining "interested person" as the Public Advocate, the nearest relative of the principal, or any other person who has a special interest in the affairs of the principal). The *Consultation Paper on the Continuing Powers of Attorney Bill*, *supra* note 6 does not define the term "interested person."

[203] Mental Capacity Act, § 43(1) (Sing.).

[204] *Id.* § 43(4).

[205] *See, e.g.*, *Banking Code of Practice*, AUSTL. BANKING ASS'N ch. 14 (Mar. 1, 2020), https://www.ausbanking.org.au/wp-content/uploads/2020/06/2020-Code-A4-Booklet-with-July-1-COVID-19-Special-Note-WEB.pdf; *Guidelines for Handling Customers*

how to detect and report abuses. Not only would such codes of conduct facilitate the early detection of abuse, but compliance with them would also grant professional service providers such as banks and lawyers greater confidence in dealing and transacting with attorneys. Ultimately, they would allow durable powers to be used both widely and safely.

V. Conclusion

Although the only certainty in life is death, incapacity in later years is becoming an increasingly realistic prospect for growing numbers of people. Durable powers of attorney have emerged as an invaluable tool for incapacity planning in recent years. Through close comparison of the durable power regimes in Hong Kong and Singapore, this Article argues that an adequate legal framework and rigorous supporting measures for raising public awareness and removing the practical and financial impediments to durable power creation can effectively overcome the cultural barriers to the use of this tool.

Whilst most of the shortfalls in Hong Kong's current legal framework will be addressed by the introduction of the new continuing power of attorney regime, critical challenges lay ahead. The Singaporean experience shows that a rigorous public awareness campaign and close partnership amongst the oversight agency, donors' social networks, and professional service providers are critical to the success of a durable power system.

Thus far, Hong Kong has focused only on introducing new legislation, the drafting of which is under the jurisdiction of the Department of Justice. The new legislation will give adjudicative powers to the Guardianship Board, which is also expected to

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Who Lack Mental Capacity, ASS'N OF BANKS IN SING., https://www.abs.org.sg/docs/library/mca-guidelines-17-oct-2019_revised.pdf (last revised Oct. 17, 2019); *Financial Abuse Code of Practice*, UK FINANCE 1 (Aug. 2018), https://www.ukfinance.org.uk/system/files/Financial-Abuse-Code-of-Practice.pdf; *Cf* The DTC Ass'n, *Code of Banking Practice*, H.K. ASS'N OF BANKS ¶ 2.5 (Feb. 2015), https://www.hkma.gov.hk/media/eng/doc/code_eng.pdf (having no specific rules on handling financial abuse).

maintain a register of durable powers. Whilst these are crucial steps forward, as of yet no executive agency has been tasked with ownership of the promotion and management of durable powers, work that would go well beyond the current ambits of the Department of Justice and Guardianship Board. The former's role will end upon the enactment of the new legislation, whereas the latter is a leanly staffed, quasi-judicial tribunal that conducts hearings on guardianship orders for incapacitated adults.

What Hong Kong needs now is not just legislative reform. It must also structurally and systemically transform the way in which it manages durable powers by maintaining effective oversight of such powers and working closely with safeguarding partners, including donors' social networks and professional service providers. Only then will Hong Kong's durable power system overcome its current unsatisfactory state.

SPIDER WEB AND I'M CAUGHT IN THE MIDDLE:[1] OLDER PERSONS, RESIDENTIAL CARE, AND THE FAMILY TRUST- A NEW ZEALAND PERSPECTIVE

Dee Holmes[2]

I. Introduction

This article serves as an introduction to the new Trusts Act 2019, which is the first change to trust law in New Zealand since 1956.[3] While it received royal assent on July 30, 2019,[4] there was an eighteen-month lead in period for trusts to ensure they meet the new compliance and duty obligations. This is no mean feat for the estimated 300,000 to 500,000 trusts in New Zealand.[5] One group which could be affected by these changes are the aging population of baby boomers[6] who have potentially divested themselves of an

[1] COLDPLAY, TROUBLE (Parlophone Records 2000).

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[3] *Everything You Need to Know About the Trusts Act 2019*, SHARP TUDHOPE LAWYERS, https://sharptudhope.co.nz/2019/09/everything-you-need-to-know-about-the-trusts-act-2019/ (last visited Apr. 21, 2021) (explaining that the new Act replaced the Trustees Act 1956 and the Perpetuities Act 1964).

[4] Trusts Act 2019, s 2 (N.Z.).

[5] New Zealand Ministry of Justice, *Trust Law Reform*, JUSTICE.GOVT.NZ, https://www.justice.govt.nz/justice-sector-policy/key-initiatives/trust-law-reform/ (last updated Dec. 7, 2020). There is no trust register in New Zealand so numbers cannot be confirmed. *Id.*

[6] Susan Edmunds, *Policies 'Hard-Code' Difference Between Baby Boomers and Younger Generations, Researcher Says*, STUFF (Nov. 12, 2009), https://www.stuff.co.nz/business/117339974/policies-hardcoded-differences-between-baby-boomers-and-younger-generations-researcher-says. Baby Boomers are between 55 and 74 years of age. *Id.*

asset when settling a family trust. The spider web of trust law and residential care regulations can see older persons caught in the middle. Residential care is expensive, even if a person qualifies for a full subsidy paid for by the government; there are additional costs which mount up.[7] There are also disclosure rules when gifting[8] and personal involvements in a trust[9] that must be disclosed to the Ministry of Social Development (MSD) who manages the application for residential care subsidies as a government agency. This position is further complicated by three different forms of discretion, trustee discretion,[10] judicial discretion,[11] and discretion vested in MSD.[12] This article serves a dual purpose; first to provide a base knowledge of the New Zealand legal framework and New Zealand family trusts for an international audience; and second to explore the new Trust Act and residential care provisions and analyze them through a series of common scenarios.

II. The New Zealand Legal Framework

The New Zealand legal framework is unique and not found in all other jurisdictions. To start, New Zealand does not have a written constitution- it is found in several sources including:[13]

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[7] *See infra* Part IV (explaining subsidies and private fees).
[8] *See infra* pp. 14–15 (explaining disclosure rules around gifting).
[9] Settlors, trustees, and beneficiaries are covered in section 9 of the Trusts Act 2019. Trusts Act 2019, s 9 (N.Z.).
[10] Erceg v. Erceg [2017] NZSC 28 at [14] (N.Z.).
[11] Graham Virgo, *Judicial Discretion in Private Law*, 14 OTAGO L. REV. 257, 259 (2016).
[12] RICHARD LANG, RESIDENTIAL CARE SUBSIDY – MSD POLICY AND LEGAL DEVELOPMENTS 41–42 (2014).
[13] *New Zealand's Constitution*, THE GOVERNOR GEN OF N.Z., https://gg.govt.nz/office-governor-general/roles-and-functions-governor-general/constitutional-role/constitution/constitution (last visited Apr. 21, 2021).

> The Constitution Act 1986 is a key formal statement of New Zealand's system of government [which sets out] the executive, legislature and judiciary. [It also] recognises the Queen as the Head of State of New Zealand and the Governor-General as her representative. Other laws that outline the powers and functions of the three branches of government in more detail include the State Sector Act 1988, the Electoral Act 1993, the Judicature Act 1908 and the Senior Courts Act 2016 and the District Court Act 2016. Other important legislation includes the Treaty of Waitangi Act 1975, Ombudsmen Act 1975, the Official

> Crucial pieces of legislation, several legal documents, common law derived from court decisions as well as established constitutional practices known as conventions. Increasingly, New Zealand's constitution reflects the Treaty of Waitangi[14] as a founding document of government in New Zealand.

New Zealand's Parliament is unicameral with the House of Representatives as the only chamber. While this has its benefits,[15] the mixed member proportional representation (MMP) voting system still trips up the public at times. Each voter has two votes– one for a local member of Parliament (electorate) and one for the preferred political party.[16] To get a seat, political parties must get at least five percent of the party vote or win an electorate seat. Candidates who win in their electorate get that seat; with remaining seats filled from those on the party list. The party decides where candidates are ranked on the list and the order, they would enter Parliament. It is rare that a party has the numbers to govern alone, so an agreement needs to be reached with other parties to form a majority and pass legislation.[17] As already noted in the introduction, this is how the new Trusts Act 2019 came into being—voted through by the majority, passed into legislation, and then as we are a

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> Information Act 1982, the Public Finance Act 1989, the New Zealand Bill of Rights Act 1990, [and] the Human Rights Act 1993.

Id.

[14] *The Treaty of Waitangi*, N. Z. HISTORY, https://nzhistory.govt.nz/files/documents/treaty-kawharu-footnotes.pdf (last visited on Apr. 21, 2021).

[15] *Central Government*, N.Z. IMMIGR., https://www.newzealandnow.govt.nz/living-in-nz/history-government/central-government (last updated Nov. 25, 2020). The country is governed by the same rules without the need for a Federal and State System. *Id.*

[16] *Our System of Government,* N.Z. PARLIAMENT (Jan. 20, 2016), https://www.parliament.nz/en/visit-and-learn/how-parliament-works/our-system-of-government/.

[17] *What is MMP?*, ELECTORAL COMM'N, https://elections.nz/democracy-in-nz/what-is-mmp/ (last visited on Apr. 21, 2021).

Commonwealth Country signed off by the Governor General as the Queen's representative.[18]

The purpose of the new Act is to reform the current Trustee Act 1956.[19] Law reform can be sparked from many sources including cabinets, government departments, lobby groups, members of parliament, private citizens, etc. While the bill can gain enough support to be directly considered by government, it can also be referred to the Law Commission to investigate. It is the Law Commission[20] that conducts extensive research into the law, consults with key stakeholders and then publishes reports for consideration. The public can also submit opinions on these issues before final recommendations are published and tabled with the House of Representatives. The government can respond by either accepting all or some of the recommendations with the bill drafted or rejecting them with no amendments[21] made to the law.[22] The Law Commission played a significant role in the work of the new Trusts Act which was not instantaneous—the project started in March 2009 and closed after the publication on the review in September 2013.[23]

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[18] *New Zealand's Constitutional System*, JUSTICE.GOVT.NZ, https://www.justice.govt.nz/courts/going-to-court/without-a-lawyer/representing-yourself-civil-high-court/new-zealands-constitutional/#parliamentary-sovereignty (last visited on Apr. 21, 2021).

[19] Henry Stokes, *The Trust Act 2019: Moving on from the 1950s*, N.Z. L. SOC'Y (Nov. 29, 2019), https://www.lawsociety.org.nz/news/lawtalk/lawtalk-issue-935/the-trusts-act-2019-moving-on-from-the-1950s/.

[20] *Introducing the Law Commission: Our Job is to Review the Law*, L. COMM'N OF N.Z., https://www.lawcom.govt.nz/sites/default/files/contentAttachments/Introducing%20the%20Law%20Commission_3.pdf (last visited Apr. 21, 2021).

[21] *Muted Government Response on Relationship Property Law Reform*, N.Z. L. SOC'Y (Nov. 28, 2019), https://www.lawsociety.org.nz/news/legal-news/mutued-government-response-on-relationship-property-law/.

[22] *The Law Reform Process*, L. COMM'N OF N.Z., https://www.lawcom.govt.nz/sites/default/files/have-your say/The%20law%20reform%20process.pdf (last visited Apr. 21, 2021).

[23] LAW COMMISSION, REVIEW OF TRUST LAW IN NEW ZEALAND: INTRODUCTORY ISSUES (2010) (available at https://www.lawcom.govt.nz/sites/default/files/projectAvailableFormats/NZLC%20IP19.pdf); LAW COMMISSION, SOME ISSUES WITH THE LAW OF TRUSTS IN NEW ZEALAND: REVIEW OF THE LAW OF TRUSTS SECOND ISSUES PAPER (2010) (available at http://www.austlii.edu.au/nz/other/lawreform/NZLCIP/2010/20.pdf); LAW COMMISSION, PERPETUITIES AND THE REVOCATION AND VARIATION OF TRUSTS: REVIEW OF THE LAW OF

The government responded by accepting the conclusion that a new act was needed but that this would have to be "balanced alongside other competing Government priorities."[24]

New Zealand is a common law jurisdiction where precedent can be set from the bench. It is more difficult to change laws from the same position due to parliamentary sovereignty.[25] The court structure in New Zealand is simple compared to other jurisdictions, but it is the interactions at New Zealand's highest Courts[26] which are of interest. One of the main differences between the Court of Appeals (CA) and Supreme Court(SC) is that they can have different approaches to the interpretation of law. The CA tends to run more conservative while the SC takes a more liberal approach.[27] The SC, despite being New Zealand's highest Court, does not have the power to create legislation. An example of this is the case of *Wood-Luxford v. Wood,*[28] where the eligibility of who could make a claim under the Family Protection Act 1955.[29] was bought into question. It was decided that while the courts have broad discretion to make provisions for those that are eligible, this could not be extended to

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TRUSTS THIRD ISSUES PAPER (2011) (available at https://www.lawcom.govt.nz/sites/default/files/projectAvailableFormats/NZLC%20IP22.pdf); LAW COMMISSION, THE DUTIES, OFFICE AND POWERS OF A TRUSTEE: REVIEW OF THE LAW OF TRUSTS (2011) (available at https://www.lawcom.govt.nz/sites/default/files/projectAvailableFormats/NZLC%20IP26.pdf); LAW COMMISSION, COURT JURISDICTION, TRADING TRUSTS AND OTHER ISSUES: REVIEW OF THE LAW OF TRUSTS FIFTH ISSUES PAPER (2011) (available at https://www.lawcom.govt.nz/sites/default/files/projectAvailableFormats/NZLC%20IP28.pdf).

[24] MINISTRY OF JUSTICE, GOVERNMENT RESPONSE TO LAW COMMISSION REPORT ON REVIEW OF THE LAW OF TRUSTS: A TRUSTS ACT FOR NEW ZEALAND 3, 5 (2013) (available at https://www.justice.govt.nz/assets/Documents/Publications/government-response-to-law-commission-report.pdf).

[25] *New Zealand's Constitutional System*, *supra* note 18. The Judiciary cannot interfere with decisions of Parliament, such as the decision to pass a law. *Id.*

[26] *Structure of the Court System*, COURTS OF N.Z., https://www.courtsofnz.govt.nz/about-the-judiciary/structure-of-the-court-system/ (last visited Apr. 21, 2021).

[27] An example of this is the case of *Dixon v. R* where the CA took an orthodox approach to determine that a digital file could not be held to be property; the SC used the natural interpretation of the law to determine that it could. Dixon v. R [2015] NZSC 147 at [24], [51] (N.Z.).

[28] Wood-Luxford v. Wood [2013] NZSC 153, [2014] 1 NZLR 451 at [1] (N.Z.)

[29] Which allows estate claims by family members. Family Protection Act 1955, s 3 (N.Z.).

adding new classes of beneficiaries. This was a legislative responsible with a statutory history of close legislative control.[30]

The courts can hold government to account by stating that they have a case to answer which can lead to very controversial law changes. This happened with the Foreshore and Seabed Act 2004[31] which was a direct response to the 2003 CA decision of *Ngati Apa v. Attorney-General*[32] on whether certain land below the mean hightide mark was Maori customary land.[33] There was a primary objection in the Maori Land Court from both the Attorney General and non-Maori parties that this application could not succeed as a matter of law.[34] It was held that the Maori Land Court did have the right to investigate and grant that property held as Maori customary land could include that below the high water mark.[35] Hence, a quick turnaround by the Government to have the full legal and beneficial ownership of the public foreshore and seabed vested in the Crown.[36]

The reality is that it is going to be some time before cases from the new Act filter to the courts. But there is an onus to hold trustees to account for their decision making which could have flow on affects in the elder law space. An example is from the case of *Unkovich v Clapham*[37] which involved a minor beneficiary who had her inheritance from her late grandfather held in trust until she turned twenty-one. There was a request to the trustee to have these funds released so that she could continue her education in Australia. She would then have a better chance at obtaining a scholarship to attend university by improving her national tennis ranking.[38] A dispute broke out between the parents and the trustee over whether this was an appropriate use of funds, which ended up in court. The

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[30] Wood-Luxford, [2014] 1 NZLR at [27–28].
[31] Which was repealed on 1 April 2011 by Section 5 of the Marine and Coastal Area (Takutai Moana) Act 2011. *See* Foreshore and Seabed Act 2004, (N.Z.); Marine and Coastal Area (Takutai Moana) Act 2011, s 5 (N.Z.).
[32] Ngati Apa v. Attorney-General [2003] NZCA 117, [2003] 3 NZLR 643 (N.Z.).
[33] *Id.* at [3].
[34] *Id.* at [4].
[35] *Id.* at [88].
[36] Foreshore and Seabed Act, s 4(a) (N.Z.).
[37] Unkovich v. Clapham [2020] NZHC 952 (N.Z.).
[38] *Id.* at [8].

trustee was found to be in breach of her duty as trustee[39] and was personally liable for court costs.[40] The decision to refuse advancement was overturned with the remaining funds to be transferred to the beneficiary's parents to assist in her education.[41]

It is likely that the High Court (HC),[42] as the first port of call for any trust disputes, could have the potential to go rogue[43] even though the Act does have purposes and principles to guide the judiciary.[44] This leaves the CA as the stabling force[45] and/or the SC ready if it is deemed that the matter is of general or public importance, general commercial significance, or persuaded that a substantive miscarriage of justice may have occurred.[46] The courts can utilize the Legislation Act 2019 in its consideration of legal issues between trustees and beneficiaries. The purpose of the Act is to promote high-quality legislation for New Zealand that is easy to "find, use, and understand."[47] To that end, and among other things, it states the principle and rules on the interpretation of legislation[48] and "supports effective parliamentary and public scrutiny of legislation."[49] The meaning of legislation must be ascertained from its text, purpose and context.[50] This applies even if the purpose is not stated[51] and "includes indications in the legislation."[52] The legislation can be applied to circumstances as they arise[53] while requiring that "all Courts and persons acting judicially must take

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[39] *Id.* at [91].
[40] *Id.* at [92].
[41] *Id.* at [93].
[42] *Structure of the Court System*, *supra* note 26.
[43] Make an error in the law by not following established common law precedent. Such as in the case of Henry v. Henry [2007] NZFLR 640 where the CA has to rein in the HC for its interpretation of the findings of a lower court using a judicial review approach.
[44] Trusts Act 2019, s 3 (N.Z.).
[45] Henry v. Henry [2007] NZFLR 640.
[46] Imms v Gunson 2 [NZLR] 11.
[47] Legislation Act 2019, s 3(1) (N.Z.).
[48] *Id.* s 3(2)(a).
[49] *Id.* s 3(2)(e).
[50] *Id.* s 10(1).
[51] *Id.* s 10(2).
[52] *Id.* s 10.
[53] *Id.* s 11.

notice of all legislation."[54] A more comprehensive analysis of the new Act is discussed further in the article.

III. Family Trusts in New Zealand

Before addressing the specific laws around residential care and trusts, there is the position that seems to be taking hold in New Zealand. This is not surprising considering the barriers that are being placed in the way of trustee decision-making and the personal liabilities they face if challenges are brought by beneficiaries.[55] It has been reported by two trustee companies in New Zealand[56] that they have seen a rise in trusts being wound up on the basis that they are too expensive to maintain, and compliance requirements outweigh the benefits of having them. For many the reason for setting up the trust was to avoid their assets being means tested by the Government for residential care purposes.[57] But winding up a trust and distributing assets are two different features which might not provide the safeguard that people think.

For now, "the magic of the trust lies in its proprietary characteristics." It is flexible and can modify the legal interest as phrased the "friction of the title split" (into legal and equitable parts). The trust can convert the rights of third parties (such as creditors or spouses) to "no rights" —something that a contract does not do.[58] For example, "a creditor's right to be paid from assets that apparently belong to a debtor- and which the debtor enjoys (like a home)—may be transformed into 'no rights' by the magic of a trust because the assets in trust no longer belong to the debtor."[59] But when the debtor is the Government and a beneficiary requires

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[54] *Id.* s 81.
[55] Unkovich v. Clapham [2020] NZHC 952 (N.Z.).
[56] Perpetual Guardian and Public Trust.
[57] Tamsyn Parker, *Love Affair Over: Families Move to Wind Up Trusts*, NZ HERALD (JULY 30, 2020), https://www.nzherald.co.nz/business/love-affair-over-families-move-to-wind-up-trusts/EP44CJ2DG52RVKN5WHZUKTI6XM/.
[58] Kent D. Schenkel, *Trust Law and the Title-Split: A Beneficial Perspective,* 78 UMKC L. REV. 181, 201 (2009).
[59] LAW COMMISSION, REVIEW OF TRUST LAW IN NEW ZEALAND 31 (2010) (available at https://www.lawcom.govt.nz/sites/default/files/projectAvailableFormats/NZLC%20IP19.pdf).

residential care, this separation becomes mucky. The ability to reach into the trust is a matter of discretion and there are instances where the focus of a claim is to claw assets out. This will continue to be tested in the courts for years to come.[60] The important element to this is that a family trust is only as good as its administration, but that they are not designed to be static. It is not in the best interests of anyone if the trust deed is put into a draw as soon as it is signed never to be seen again. Beneficiaries needs change during the passage of time and so a trust should be reviewed to make sure it meets this need. Part of the concern with the new Trust law is that beneficiaries will somehow have more rights, but the law is not changing what has already been created. The purpose of having a trust is that trustees are supposed to do what is in the best interests of the beneficiaries. Problems do arise when there are conflicting claims by beneficiaries and the pressure on trustees if they make the "wrong" decision this can have legal consequences. Considering the inherent pitfalls to the above, the Ministry of Justice recognizes not just how many trusts there are in New Zealand, but that "[t]rusts are an important part of New Zealand society and the economy."[61]

When the Trusts Bill was introduced the following was included in its explanatory notes:

> The Trusts Act 1956 is outdated and no longer reflects current trust practice. Many of the provisions are difficult to understand and need to be read alongside a considerable body of case law. One of the policy objectives of the Bill is to provide a clear, simple, and accessible trust law. The Bill sets out important principles of trust law that have been established through centuries of case law. Making trust law more accessible in this way, and thereby improving the understanding of

[60] An example of this is Clayton v. Clayton [2016] NZSC 29 where the administration of the Trust was called into question. Mr Clayton was the settlor; sole trustee; principal family member and had the power to appoint discretionary beneficiaries and trustees; and the power to change any provision relating to the management and administration of the Trust. *Id.*

[61] New Zealand Ministry of Justice, *supra* note 5.

> these principles, will help to ensure trusts are administered properly. The Bill will also assist with the enforcement of the terms of the trust against trustees where necessary.[62]

While the new Act provides a codification of some existing common law principles, there are some additions that are noteworthy. The first is that the age of majority for an express trust[63] is eighteen years old[64] which overrides the age of majority at large.[65] There is concern that these and other beneficiaries are going to have rights to ask for trust information.[66] This is different to the position if their parents or grandparents have assets in their own name. There is no obligation to disclose personal information, but if the benefits of the trust are sought then this is the compromise on the other side.

With this there are three pertinent classes of beneficiaries associated with trusts that need to be explained. The first is when there is a fixed trust where discretion cannot be applied. Income and capital distributions are fixed to those named in the trust deed. The second is final beneficiaries — the class of beneficiaries who have an entitlement to the proceeds of the trust wind up on the date of distribution. The third and the focus of this article is discretionary beneficiaries — they are in a discretionary class because income and capital is distributed from the trust at the discretion of the trustees.[67] It is possible to elevate a class of discretionary beneficiary above another which makes them more likely to be considered first. This will be discussed during the case studies. For discretionary family

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[62] *Id.*
[63] Trusts Act 2019, s 12 (N.Z.).
[64] *Id.* s 20(1).
[65] *Id.* s 20(3) (overriding s 4(11) of the Age of Majority Act 1970, (N.Z.)).
[66] Such as a copy of the Trust Deed or the financials.
[67] Trustees are those who have a fiduciary duty to administer the trust for the benefit of the beneficiaries. Private individuals can be trustees, along with private companies (such as lawyer and accountancy firms and trustee companies that are set up until statue such as the Public Trust Act 2001, (N.Z.); The New Zealand Guardian Trust Company Act 1982, (N.Z.); and AMP Perpetual Trustee Company Act 1988, (N.Z.).

trusts, there is usually a natural love and affection between the settlors and those beneficiaries in the trust.[68]

IV. Residential Care in New Zealand

There are plenty of failings in aged care that need to be addressed, but not one place to go to seek assistance.[69] There have been moves to establish a Commissioner for the Elderly with a recommendation by Parliament's Social Services Community Committee. But the Government has been slow to implement such a position — it was budgeted for but did not yet eventuate.[70] There is one undeniable factor with residential care; it is expensive and must be paid for from somewhere. Depending on the circumstances of the resident this can be either as a private payer or where a residential care subsidy application has been successful.

Without a residential care subsidy there is a maximum contribution for private paying residents which is set yearly by each territorial local authority region. The Director-General of Health is required to notify the maximum contribution that applies in each region for long-term aged residential care.[71] This is the maximum weekly amount (inclusive of GST) that a resident assessed as requiring long-term residential care is required to pay for contracted care services. This care is provided to them in the region in which their rest home or continuing care hospital is located. The maximum contribution is the same for all residents regardless of the type of contracted care services they receive. Examples include Auckland

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[68] Income Tax Act s EW 44 (2007) (acknowledging consideration where debt is forgiven for natural love and affection).

[69] Depending on the situation there is the Privacy Commissioner, the Health and Disability Commission and the Retirement Commissioner. The Retirement Villages Act (2003) does provide provision for a Statutory Supervisor, but this is related to residents who pay a capital sum for a Unit in a Retirement Village not to a Rest Home or Hospital Care Institution, section 6.

[70] *See* Natalie Akoorie, *Daughter of Rest Home Resident Found with Maggots Supports Elderly Commissioner Role*, NZHERALD (Aug. 12, 2020), https://www.nzherald.co.nz/nz/daughter-of-rest-home-resident-found-with-maggots-supports-elderly-commissioner role/2AGJEBCCIUCGV5MAM6XDFFG5SU/.

[71] Residential Care and Disability Support Services Act 2018, s 53 (N.Z.).

City which is $1,193.08 with Hamilton City set at $1,135.75.[72] It is also important to acknowledge what is covered by government funding and what is not covered.

As a contracted service covered by the subsidy (contracted services include):[73]

- Food services
- Laundry
- Nursing and other care
- General practitioner visits
- Prescribed medication
- Continence products
- All health care that is prescribed by a general practitioner
- Transport to health services.

The contract between district health boards and rest home and hospitals are tailored to meet the needs of each resident and they cannot charge subsidized residents for services covered in their contract. Services that are not contracted include:[74]

- Specialist visits (not publicly funded by the District Health Board (DHB) or the Accident Compensation Corporation (ACC)[75]
- Transport to other services outside social functions
- Toll calls (made by the resident)
- Private toiletries
- Recreational activities, where those are not part of the normal program

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[72] *Maximum Contribution Applying in Each Territorial Local Authority Region from 1 July 2020*, GAZETTE.GOVT.NZ (June 30, 2020), https://gazette.govt.nz/notice/id/2020-go2874.

[73] *Residential Care Questions and Answers*, MINISTRY OF HEALTH, https://www.health.govt.nz/our-work/life-stages/health-older-people/long-term-residential-care/residential-care-questions-and-answers (last updated July 1, 2020).

[74] *Id.*

[75] Accident Compensation Corporation under the Accident Compensation Act 2001, (N.Z.).

- Hairdresser
- Dietitian, podiatrist, or other services that have not been prescribed by a doctor or are not funded by the DHB.
- Spectacles, hearing aids and dental care.

Any extra services a person agrees to pay for must be set out in their admission agreement or private contract with the rest home or hospital. A person does have the right to refuse any or all of the extra services offered by a rest home or hospital (that are not required under the DHB contract). This should be noted in their admission agreement.[76]

Now the catch- the cost of premium rooms that apply regardless of whether you are on a subsidy or not (some exceptions are available, but these are few are far between). Premium rooms are defined as having "additional features of a permanent or fixed nature." Examples include rooms that have an ensuite, extra space, or garden access and these rooms do not receive public funding. Charges for these rooms are negotiated between are providers and residents but must be specified in the admission agreement.[77] Premium room services do not need to comply with clauses A 13.2(a)[78] and (b)[79] of the Age-Related Residential Care Services Agreement[80] and the Resident can be charged for those services provided that:[81]

a. on the date of admission of the Resident:
   (i) there is not a Standard Room or a Premium Room for which Premium Room Services are not charged

[76] *Residential Care Questions and Answers*, *supra* note 72.
[77] *Aged Residential Care (ARC)*, TAS, https://tas.health.nz/dhb-programmes-and-contracts/health-of-older-people-programme/aged-residential-care/#Service (last visited Apr. 21, 2021).
[78] You do not require, as a condition of admission to or residence in your Facility, that a Resident or a potential Resident agree to receive and pay for any additional services. Age-Related Residential Care Services Agreement 2020-2021, cl. A13.2(a) (N.Z.).
[79] The Resident has a choice whether or not to receive any individual additional services. *Id.* cl A13.2(b).
[80] *Id.*
[81] *Id.* cl. A13.3.

available to the Resident at your Facility from which the category of Services required by the Resident is able to be provided; and

(ii) the occupancy level of rooms at your Facility from which the category of Services required by the Resident is able to be provided is 90% or more; and

(iii) you have identified another facility that is located 10 kilometres or less from your Facility that has a Standard Room or Premium Room for which Premium Room Services are not charged available for the Resident from which the category of Services required by the Resident is able to be provided; and

(iv) the Resident decides not to be admitted to the room described in subclause (iii), and

b. if the Resident decides to be admitted to a Premium Room and pay for Premium Room Services at your Facility, the Admission Agreement with the Resident expressly records:

(i) that the Resident acknowledges that he or she has chosen not to accept a Standard Room or a Premium Room for which Premium Room Services are not charged at another facility, which must be identified in the Admission Agreement, and has agreed to receive and pay for Premium Room Services at your Facility; and

(ii) the Resident's rights and obligations in respect of the Premium Room Services, the charge for the Premium Room Services, including details of notice requires.

To find out if a resident qualifies for a residential care subsidy a needs and means assessment must be undertaken. For a needs assessment a qualifying person is a person who-[82]

(a) is aged 65 years or over; and

[82] Residential Care and Disability Support Services Act 2018, s 12 (N.Z.).

(b) is funding eligible; and
(c) has been positively needs assessed; and
(d) received contracted care services; and
(e) is entitled, under section 32, to apply for a means assessment.

A person is "funding eligible" if the person is eligible for publicly funded health and disability services under an eligibility direction issued under section 32.[83] A person has been "positively needs assessed" if the person has been assessed under section 28 as requiring long term residential care (LTR care) indefinitely.[84] The liability of qualifying person for cost of LTR contracted care has four basic rules:

Rule 1: no qualifying person to pay more than maximum contribution

(1) No qualifying person is liable to pay more than the maximum contribution towards the cost of the contracted care services provided to that person.
(2) The maximum contribution is the maximum amount that an individual may be required to pay towards the cost of LTR contacted care provided to the individual and that is set for the region under section 53.
(3) Subsection (1) applies irrespective of the person's assets or income.[85]

Rule 2: qualifying person whose assets are above asset threshold must contribute maximum contribution

A qualifying person whose assets are determined by a means assessment under section 34 are above the applicable asset threshold must contribute the maximum

[83] *Id.* s 13.
[84] *Id.* s 14.
[85] *Id.* s 15.

> contribution for as long as that person's assets are above the applicable asset threshold.[86]
>
> Rule 3: qualifying person whose assets are equal to or below asset threshold must pay contribution based on income
>
> A qualifying person whose assets are determined by a means assessment under section 34 are equal to or below the applicable asset threshold must pay a contribution, based on income determined by a means assessment under section 37, towards the cost of that person's LTR contracted care.[87]
>
> Rule 4: funder must pay difference between qualifying person's contribution and cost of LTR contracted care
>
> In relation to each qualifying person, the appropriate funder must pay the difference between-
>
> (a) The qualifying person's contribution (under section 16 or 17, whichever is applicable); and
> (b) The cost of the qualifying person's LTR contracted care.[88]

These are helpful rules that allow residents to be classed into different categories to determine what their individual contribution would be. This is particularly relevant to trusts as will be discussed as part of the case studies.

There is a liability of person who has not been means assessed[89]

[86] *Id.* s 16.
[87] *Id.* s 17.
[88] *Id.* s 18.
[89] *Id.* s 19.

(1) This section applies to a person (P) who is qualifying except that-

(a) P has not been means assessed; or
(b) If P has been assessed, the result of the means assessment is not yet known.

(2) P must pay the maximum contribution until P is means assessed.

There is also an exception to liability in that a contribution can be covered by a person's benefit.[90]

(1) An exempt person is liable to contribute to the cost of that person's LTR contracted care the amount of any benefit that P received, less the personal allowance, and a funder must pay the balance of the cost.
(2) Personal allowance, in this Act and Schedule 2, means an amount of benefit, specified in regulations made under section 74, that a person is not required to contribute to the cost of LTR contracted care provided to the person.

There are two types of means assessment which are as follows:[91]

(a) an asset assessment:
(b) if required, an income assessment.

Who can apply for a mean assessment are:[92]

(1) A person who has been positively needs assessed may apply to MSD for a means assessment.
(2) An application for a means assessment must be made on a form provided for the purpose by MSD and the applicant

[90] *Id.* s 24.
[91] *Id.* s 31.
[92] *Id.* s 32.

must supply any supporting evidence or information that is reasonably required by MSD to complete the assessment.

It is MSD who must arrange for mean assessment to be conducted as soon as practicable after receiving an application.[93]

i) Asset assessment[94]

(1) The first stage of a means assessment is an asset assessment.
(2) An asset assessment must be conducted in accordance with Part 2 of Schedule2.
(3) This section does not apply to a special case person (who, under section 22(1), 24(1), or 26, is not liable to contribute from that person's assets).

An assets assessment must assess the value of the non-exempt assets of a person as at the date of means assessment and must determine whether those assets are above, equal to, or below the applicable asset threshold.[95]

ii) Income assessment[96]

An income assessment is required if an assets assessment has determined that a person's assets are equal to or below the applicable asset threshold. An income assessment must be conducted in accordance with Part 3 of Schedule 2.[97]

The content of income assessment[98]

(1) An income assessment of a person (P) must-

[93] *Id.* s 33.
[94] *Id.* s 34.
[95] *Id.* s 35.
[96] *Id.* s 36.
[97] *Id.* s 37.
[98] *Id.* s 38.

(a) Assess as at the date of means assessment P's annual income; and
(b) Determine a weekly contribution, up to the maximum contribution, that P must pay from income towards the cost of contracted care services provided to P; and
(c) Determine if and when in the 90-day period P's assets fell below the applicable asset threshold.

(2) In subsection (1), 90-day period means the period of 90 days before the date of means assessment.
(3) This section is subject to sections 24(1) and 26.

The factors affecting means assessment in regard to deprivation of income or property are as if the deprivation had not occurred.[99]

(1) This section applies where MSD is satisfied that a person who has applied for a means assessment (P), or P's spouse or partner, has directly or indirectly deprived himself or herself of any income or property.
(2) In conducting P's means assessment, MSD may include the income or property as if the deprivation had not occurred.
(3) In this section, property does not include an exempt asset.

The deprivation of income and property can also be included in the review of the means assessment.[100]

(1) This section applies where MSD is satisfied that a person who has been means assessed (P), or P's spouse or partner, has directly or indirectly deprived himself or herself of any income or property.
(2) In conducting a review of P's means assessment, MSD may include the income or property as at the date of the means assessment as if the deprivation had not occurred.
(3) In this section, property does not include an exempt asset.

[99] *Id.* s 39.
[100] *Id.* s 40.

How this deprivation is viewed is a matter of MSD discretion which is evident from the two sections above. One is the means assessment and one if a review of that same assessment. At either point MSD can include the income or property as if the deprivation had not occurred. This is the same case as the point above,[101] where "may" is turns to discretion.

The legislation explains the qualification process for who is eligible, with means testing split between assets and income and levels for what is included or not covered. There are disclosure rules for Trusts around the deprivation of assets and the allocation of income. There are further gifting provisions for those who have private wealth; with current rates of private assets allowed to be retained while still qualifying for the residential care subsidy. The asset threshold for every qualifying person is $236,336 and applies to those that do not have a spouse or partner; or whose spouse or partner is also a qualified person; or whose spouse, or partner is not a qualifying person but elected to have this threshold apply. Otherwise the threshold is $129,423 and applies if the qualifying person has a spouse or partner that does not qualify.[102] The effect of making this election is that while the applicable asset threshold will increase, but the value of the house and car will be included in the calculation of the person's assets.[103] Any asset that the person and the person's spouse or partner has is capable of being realized and this includes gifting. Exempt assets include the residential home if this is the principal residence of the person's spouse or partner, the interest in a car for personal use of the spouse, and any pre-paid funeral account of the person or of the person's spouse or partner.[104] For the purposes of residential care the general definition of income is the money value (before income tax) of a thing that: (a) is money received, or an interest acquired, by the person; and (b) is not an interest in a capital received or acquired by the person.[105] There is a

[101] *Id.* s 24.
[102] *Id.* sch 2, pt 1.
[103] *Id.* sch 2, pt 3.
[104] *Id.* sch 2, pt 2 .
[105] Social Security Act 2018, sch 3, pt 2, s 3 (2021), as directed from the dictionary in Schedule 3.

slight variation to this in that income in every case is after the deduction of income tax and extends to any benefit received by the person.[106] There is small window to gain income form assets which is exempt but it is very small.[107]

The gifting thresholds are set around a five-year window to include treatment in the last five years that a subsidy is applied for to longer than five years. For gifting or assets sold in the last five years, $6,500 of assets will not be counted (from when the subsidy is applied for) bringing the total to $32,500 per person.[108] For gifting or sold assets longer than five years the maximum is $27,000 a year total between you and your partner (even if they've died).[109] This can be a trap for Trusts because gifting is the way to forgive a debt when an asset is settled into a Trust. The disclosure rules around Trusts does make these timeframes irrelevant. You need to disclose your involvement with a Trust no matter the timeframe. So, gifting to Trusts does not fit within these parameters.[110]

V. The New Trust Legislative Framework

One of the benefits of a Family Trust is that it does act as a long term succession vehicle for the transfer of intergenerational wealth.[111] This has been strengthened by the extension of the maximum duration of a Trust from 80 years[112] to 125 years.[113] This does not preclude a Trust from running for a specific or implied

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[106] *Id.* pt 3, cls 5(b)–(d) (allowing for 50% if income from a private superannuation scheme; or from an annuity of a life insurance policy).
[107] *Id.* $1,027 if the person is single; $2,054 if the person's spouse or partner is a resident assessed as requiring care; or $3,081 if the person's spouse or partner is not a resident assessed as requiring care. *Id.*
[108] *Id.* There are exemptions if this gifting has been in recognition of care. *Id.*
[109] Ministry of Social Development, *Residential Care Subsidy*, WORK AND INCOME, https://www.workandincome.govt.nz/products/a-z-benefits/residential-care-subsidy.html#null (last visited Apr. 24, 2021).
[110] *Id.* In the application for a subsidy, you need to disclose if you are a settlor, trustee or beneficiary of a Trust. *Id.*
[111] *See Family Trusts – Pros & Cons of Setting up a Trust*, LIVE SORTED, https://sorted.org.nz/guides/protecting-wealth/family-trusts/ (last visited Apr. 24, 2021).
[112] Perpetuities Act 1964, s 6(1) (N.Z.).
[113] Trusts Act 2019, s 16(1) (N.Z.).

shorter duration.[114] "The common law rule known as the rule against perpetuities is abolished."[115] A person is not going to live 125 years from the time that they settle the Trust so the abolishment of this common rule principle is expected. One of the benefits of the Trusts Act 2019 is the simplicity of its wording which is in keeping with the Legislation Act 2019.[116] The purposes and principles are clear and succinct while capturing the core of both the operation of law and its administration.

> The purpose of the Act is to restate and reform New Zealand trust law by— (a) setting out the core principles of the law relating to express trusts; and (b) providing for default administrative rules for express trusts; and (c) providing for mechanisms to resolve trust-relating disputes; and (d) making the law of trusts more accessible.[117]

The principles cover the administration of law and the trust by ensuring that:

> Every person or court performing a function or duty or exercising a power under this Act must have regard to the following principles: (a) a trust should be administered in a way that is consistent with its terms and objectives: (b) a trust should be administered in a way that avoids unnecessary cost and complexity.[118]

[114] *Id.* s 16(2). It is common to still see a clause where a Trust is to be wound up on the death of a specific person after 21 years has passed. *Id.*
[115] *Id.* s 16(5). To exert control over property by deed longer than the lives of those living when the instrument was written. *Id.*
[116] Legislation Act 2019, (N.Z.).
[117] *Id.* s 3.
[118] *Id.* s 4.

The Act also has its own interpretation section which is consistent with the above-stated purposes and principles. The Act:[119]

> (a) must be interpreted in a way that promotes its purpose its purpose and principles; and (b) is not subject to any rule that statutes in derogation of the common law should be strictly construed; but (c) may be interpreted having regard to the common law and equity, but only to the extent that the common law and equity are consistent with— (i) its provisions; and (ii) the promotion of its purpose and principles.

An express trust is set out with characteristics, compliance, and a mode for creation.

"For the purposes of this Act, an express trust means a trust that— (a) has each of the characteristics set out in section 13; and (b) complies with section 14; and (c) is created in accordance with section 15."[120]

> The characteristics of an express trust are as follows: (a) it is a fiduciary relationship in which a trustee holds or deals with trust property for the benefit of the beneficiaries or for a permitted purpose; and (b) the trustee is accountable for the way the trustee carries out the duties imposed on the trustee by law.[121]

The only compliance noted in the Act is that "[a] sole trustee of a trust must not be the sole beneficiary of the trust."[122] There need to be other classes of beneficiaries.

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[119] *Id.* s 7(1).
[120] *Id.* s 12 (emphasis omitted).
[121] *Id.* s 13.
[122] *Id.* s 14. This is to avoid a situation like in *Clayton v. Clayton (as trustee of the Vaughan Road Property Trust)*. NZSC 29 (2016).

> (1) An express trust may be created— (a) by or under an enactment; or (b) by a person (the settlor) who, clearly and with reasonable certainty (and subject to any formalities prescribed by any enactment),— (i) indicated an intention to create a trust; and (ii) identifies the beneficiaries (or classes of beneficiaries) of the permitted purpose of the trust; and (iii) identifies the trust property. (2) A trust created under subsection (1) commences when a trustee holds property of the trust.[123]

The main reason for the Trust review is to make sure that the mandatory provisions are adhered to and that default provisions can either been included in the Trust Deed or not. They can be left out and not applied, but if they are included then the Trustees must also adhere to them. This means that a Trust Deed can be customized to meet the needs of the beneficiaries. The operation of the following mandatory and default provisions will be worked through in the case studies but below is a breakdown of them. The guiding principle for Trustees in performing mandatory and default duties is that they "must have regard to the context and objectives of the trust."[124] The mandatory duties "must be performed by the trustee; and may not be modified or excluded by the terms of the trust."[125]

The mandatory duties are:

- "A trustee must know the terms of the trust."[126]
- "A trustee must act in accordance with the terms of the trust."[127]
- "A trustee must act honestly and in good faith."[128]

[123] Legislation Act 2019, s 15.
[124] *Id.* s 21.
[125] *Id.* s 22.
[126] *Id.* s 23.
[127] *Id.* s 24.
[128] *Id.* s 25.

- "A trustee must hold or deal with the trust property and otherwise act— (a) for the benefit of the beneficiaries, in accordance with the terms of the trust: (b) in the case of a trust for a permitted purpose, to further the permitted purpose of the trust, in accordance with the terms of the trust."[129]
- "A trustee must exercise the trustee's powers for a proper purpose."[130]

The Default duties provide more details as they are customizable to the individual trust deed:

> General duty of care[:] When administering a trust (other than when exercising a discretion to distribute trust property), a Trustee must exercise the care and skill that is reasonable in the circumstances, having regard, in particular,— (a) to any special knowledge or experience that the trustee has or that the trustee holds out as having; and (b) if the person acts as a trust in the course of a business or profession, to any special knowledge or experience that is reasonable to expect of a person acting in the course of that kind of business or profession.[131]
>
> Duty to invest prudently[:] When exercising any power to invest trust property, a trustee must exercise the care and skill that a prudent person of business would exercise in managing the affairs of others, having regard, in particular,— (a) to any special knowledge or experience that the trustee has or that the trust holds out as having; and (b) if the person acts as a trustee in the course of a business or profession, to any special knowledge or experience

[129] *Id.* s 26.
[130] *Id.* s 27.
[131] *Id.* s 29 (emphasis omitted).

> that is reasonable to expect of a person acting in the course of that kind of business or profession.[132]
>
> Duty to exercise power for own benefit[:] A trustee must not exercise a power of a trustee directly or indirectly for the trustee's own benefit.[133]
>
> Duty to consider exercise of power[:]A trustee must consider actively and regularly whether the trustee should be exercising 1 or more of the trustee's powers.[134]
>
> Duty not to bind or commit trustees to future exercise of discretion[:] A trustee must not bind or commit trustees to a future exercise or non-exercise of a discretion.[135]
>
> Duty to avoid conflict of interest[:] A trustee must avoid a conflict between the interests of the trustee and the interests of beneficiaries.[136]
>
> Duty of impartiality[:] (1) A trustee must act impartially in relation to the beneficiaries, and must not be unfairly partial to one beneficiary or group of beneficiaries to the determent of others. (2) This section does not require a trustee to treat all beneficiaries equally (but all beneficiaries must be treated in accordance with the terms of the trust).[137]
>
> Duty not to profit[:] A trustee must not make a profit from the trusteeship of the trust.[138]

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[132] *Id.* s 30 (emphasis omitted).
[133] *Id.* s 31 (emphasis omitted).
[134] *Id.* s 32 (emphasis omitted).
[135] *Id.* s 33 (emphasis omitted).
[136] *Id.* s 34 (emphasis omitted).
[137] *Id.* s 35 (emphasis omitted).
[138] *Id.* s 36 (emphasis omitted).

> Duty to act for no reward[:] A trustee must not take any reward for acting as a trustee, but this does not affect the right of a trustee to be reimbursed for the trustee's legitimate expenses and disbursements in acting as a trustee.[139]
>
> Duty to act unanimously[:] If there is more than 1 trustee, the trustees must act unanimously.[140]

The advice around modification and exclusion of these default duties is more important than ever. If a person is being paid to provide advice on a trust, prepare the terms of a trust, or recommendations to a settlor, then that advisor must alert them to these and take reasonable steps to ensure that the meaning and effect is understood. While this does not invalidate the modification,[141] it is good practice. This highlights the importance of a Trust review and for the allowance of the 18-month window for modifications and exclusions to take place now before the new Act comes into force.

VI. Forms of discretion

There have already been examples of discretion allowed within the interpretation of the law covered by the Residential Care and Disability Support Services Act 2018.[142] There is a prominent case in New Zealand where the principles of judicial discretion and trustee discretion converge. Judicial discretion allows the judge to secure what he or she considered to be the just result with reference to particular facts of the case and it is justified if referenced to recognized principles.[143] While the trustee has an obligation to do

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[139] *Id.* s 37 (emphasis omitted).
[140] *Id.* s 38 (emphasis omitted).
[141] *Id.* s 39(3).
[142] *See e.g.*, Erceg v. Erceg [2017] NZSC 28; Ministry of Social Development v. Broadbent [2019] NZCA 201.
[143] *Judicial Discretion in Private Law*, supra note 11, at 259–60.

what is in the best interests of the beneficiary, how does this work in practice? This relationship was discussed in the case of *Erceg v. Erceg*, where the correct position of the Court's jurisdiction was found to be an exercise of supervisory jurisdiction but "not limited to the grounds of review of a discretionary decision by the trustees."[144] The Court "must exercise its jurisdiction as a court of equity, exercising its own judgment" and if so, "to what extent and on what conditions."[145] "The supervisory jurisdiction is an inherent jurisdiction of the Court. It is complementary to the Court's statutory jurisdiction under the Trustee Act 1956."[146] When it comes to disclosure of information, the Court will review the exercise of discretion by applying a well-established governing review of the decision. The Court should not intervene unless satisfied the Trustee erred in law or principle, overlooked a relevant point, factored in an irrelevant point, or make a decision that is plainly wrong. The words 'plainly wrong' refer to a decision that was simply outside the permissible ambit of the trustee's discretion.[147]

The discretion around the deprivation of assets has already been established. MSD has indicated that where a couple has already made gifts to their Family Trust that in total exceeded the asset threshold, but where all that the trust holds is their former family home, it is likely that the discretion will be exercised in favor of granting a subsidy. This is an application of discretion, but no guarantees can be given.[148] The key message from MSD is that their focus is on Social Security law, not Trust law. From a social security perspective, it is those who have resources that should be required to use them to support themselves. The system is not there to support a mechanism for people to bolster their intergenerational wealth or to assist people to receive their inheritance early. While it may not seem fair that a Trust established some years ago can be looked

[144] *Erceg*, NZSC 28 para 18.
[145] *Id.* This case was centred on disclosure of trust information withheld by the trustees on request after a request from a beneficiary. *Id.*
[146] *Id.* para 19. The SC made the distinction that "[t]he present case relates only to the inherent jurisdiction and we do not express any view about the statutory jurisdiction under the Trustee Act 1956." *Id.* para 19 n. 12.
[147] *Id.* para 14.
[148] *See id.* para 14 n. 10.

behind from the other perspective, it is equally not fair that assets should be allowed to be diverted and then for assistance to be sought from the state.[149]

There is one case that has changed the direction of Trusts and Residential Care in New Zealand. In anticipation of the pending Court decision, the legislation was already amended by repealing Part 4 of the Social Security Act 1964,[150] covering long term residential care in hospitals and rest homes. This is when the Residential Care and Disability Support Services Act 2018 was enacted. In the case of *Ministry of Social Development v. Broadbent*,[151] a Trustee of the Family Trust was empowered to make a distribution of trust income to Mrs. Broadbent even though she was merely a discretionary beneficiary. She also had "a right to request payment from the Family Trust."[152] "In a closely held family trust with a history of payment to her, trust income must be assumed to be available unless there are particular circumstances that demonstrate it is not."[153] The legal issue that arose was the practical application of the MSD decision to gross up the value of the assets of the Family Trust by calculating a notional income from that value.

In practical terms MSD is not entitled to gross up the value of the assets of the Family Trust, calculate a notional income from that value, and treat that as if it were Mrs. Broadbent's income for the purposes of Section 147.[154] Nor can the MSD ignore the debt validly forgiven by Mrs. Broadbent (and her husband before he passed away) in order to adopt a notional and constant interest rate available to her on that debt. Rather, the MSD "must adopt a calculation methodology that recognizes Mrs. Broadbent's notional income from the debt that would have steadily reduced over time and then determine in light of that, what a reasonable current income figure should be taking into consideration the terms and purposes of the

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[149] *See id.* para 105.
[150] Social Security Act 1964, s 4 (N.Z.) (repealed 2018).
[151] Ministry of Social Development v. Broadbent [2019] NZCA 201.
[152] *Id.* para 84 (citing Blackledge v Social Security Commission [1992] HC Auckland CP81; Keenan v Director-General of Social Welfare [2000] HC Auckland AP24-SW00, (2000).
[153] *Id.* para 84.
[154] Social Security Act 1964, (N.Z.).

means testing regime."[155] There are two factors from this decision. First, the confinement of trustee decision by judicial discretion where income in this situation has to be allocated to those beneficiaries who are in residential care unless a competing beneficiary can show that their needs are greater. Second, that notional income is not a calculation that is at the discretion of the MSD, they need to apply what actual income there is from the trust—not what they think it should be generating.

VII. Case Studies

These case studies are inspired by real-life situations encountered in practice. They affirm some of the principles and practices that have already been discussed and show how this area of law has a real effect on people.

The first case involves a ninety-eight-year-old discretionary beneficiary of a trust that was settled by her husband's brother in the late 1960s. It was set up for the benefit of her, her husband, and their five children. Her husband died in the 1980s. She had just moved out from independent living to a Rest Home environment. She had very little assets in her own name, but the trust had over $1 million dollars in capital. Her son (on her behalf) approached the trust for assistance with her residential care subsidy application. With approximately $25,000 in her own name, she was under the threshold for assets but did disclose that she was a discretionary beneficiary of a trust. The first question that the MSD had was had she deprived herself of an asset by settling this into the trust. A tracing exercise back to 1964 did not uncover any of her individual assets being gifted to the trust (everything was settled by her husband). The trust was generating some income from the capital investments so the direction for the MSD was that this had to be allocated to her as part of the means test to help fund her care. She was also staying in a premium room at $1400 a fortnight which was not covered by the subsidy. When she died a year later, the trust was wound up, as she was no longer in need. As she had lived so long,

[155] *Broadbent*, NZCA 201 para 86.

her children were now in their late sixties/early seventies and did not want to wait another twenty-one years after their mother died for what they considered was their inheritance. They were named as final beneficiaries, and there was the prospect that if the trust did not wind up, there would be a generation skip deemed to be unfair. The distribution date was bought forward, and the funds distributed in equal shares to the final beneficiaries. This is an example of a trust administered for the benefit of all beneficiaries.

The second case is an example of the pitfalls of an early windup on the advice of the settlor's accountant. The easiest way for the administration of a trust to be questioned is when the same person is wearing multiple hats. It is common to have a settlor, trustee, and beneficiary as the same person (which is fine if you are not the sole trustee and sole beneficiary at the same time). This makes the separation of powers difficult, but not impossible, if you wear different hats at the appropriate times. In this case, the person who sought advice was all three. To avoid the pitfalls of trusts and residential care subsidies, the accountant advised that the trust should wind up with the assets distributed to the final beneficiaries who were the children of the settlor and trustee. The children were very happy with their early inheritance and proceeded to spend the money as they saw fit. What she did not anticipate was that she would end up in residential care and had to disclose this trust wind up. It came as a shock to her when she found out that she did not qualify for the subsidy. She had deprived herself of an asset which she could have tapped into as a discretionary beneficiary because the trust assets had been distributed. She was not able to claw back the funds from her children because the funds were spent. She then had to go and live with one of her children because she could not afford to go anywhere else. Winding up the trust was not the issue; it was where the funds were distributed to that was. If you make a capital distribution back to yourself if you settled property, then you have restored your position. The trust can then wind up because there is nothing left to distribute to final beneficiaries

The last case is a cautionary tale where a Trust review identified a future problem if not rectified in the present. A decision was made a long time before for the benefit of minor children without thinking

about the long-term disclosure rules. A middle-aged couple with minor children came into the office for a Trust review and it was identified that their elderly parents were named as discretionary beneficiaries of the Trust. The reason was based on security for their children if something happened to them. Their parents would share day-to-day care of their children who be able to have distributions made to them to help cover costs without having distributions made directly for the benefit of the minor grandchildren. They were unaware of changes to disclosure rules where their parents would have to disclose their family trust to the MSD if they needed to apply for residential care. As the children were getting older the reason for having them named in the trust was no longer a valid consideration and they could be removed as discretionary beneficiaries. They have never received a benefit from the Trust and there were no issues moving forward. It was a matter of timing and being proactive while thinking about the current needs of the beneficiaries.

VIII. Conclusion

This article had a dual purpose; first to provide a base knowledge of the New Zealand legal framework and Family Trusts; and second to explore the new Trusts Act 2019 alongside the issues of residential care and analyze it through a series of case studies. What can be gathered from the case studies is that proper Trust administration can save problems in the long term. Winding up Trusts and distributing assets (especially to final beneficiaries) prematurely can cause deprivation of assets that has more impact than settling assets into a Trust. where assets are still available for use at a later date. If MSD deems that a residential care subsidy is not granted, then assets are still available from the Trust to fund residential care. There are likely to be many more challenges to the Court holding both Trustees and MSD to account for their decision making. The law may have been simplified to make it easy to understand for those who are involved with Trusts, but the complexity of beneficiaries needs and the use of Trustee discretion, MSD discretion, and judicial discretion, will create plenty of arguments for many years to come.

MEDICARE FOR ALL VS. MEDICARE AS IS: EIGHT KEY DIFFERENCES

Richard L. Kaplan[*]

Introduction

In the United States, one of the most significant components of "Aging Law" is Medicare, the national government's health care program for Americans age 65 and over.[1] This program was enacted in 1965 and is the closest iteration of universal health care that the United States provides for persons who have not served in the military.[2] Indeed, one measure of its success and general popularity is the nascent effort to expand this program to cover virtually all Americans regardless of age, an effort that has been styled by its proponents as "Medicare-for-All."[3] Notwithstanding this moniker, Medicare-for-All bears only a passing resemblance to the existing program from which it derives its name. Accordingly, this Article intends to set forth some of the major distinctions between Medicare-for-All as it has been proposed and the Medicare program as currently exists. This Article does not contend that its analysis extends to every difference of prominence, but it does provide an important starting point to disentangle some of the marketing spin that the label Medicare-for-All seeks to appropriate from the reality of the Medicare program presently in place.

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[1] *What's Medicare?*, MEDICARE.GOV, https://www.medicare.gov/what-medicare-covers/your-medicare coverage-choices/whats-medicare (last visited Sept. 15, 2020).

[2] Steve Anderson, *A Brief History of Medicare in America*, MEDICARERESOURCES.ORG (Sept. 1, 2019), https://www.medicareresources.org/basic-medicare-information/brief-history-of-medicare/.

[3] *See generally* Margot Sanger-Katz, *The Basics of 'Medicare for All'*, N.Y. TIMES (Feb. 25, 2020), https://www.nytimes.com/2020/02/25/upshot/medicare-for-all-basics-bernie-sanders.html.

I. Medicare is a Real Program

At the outset, it should be noted that the comparative enterprise being undertaken is inherently speculative because Medicare is a real program that has been in place for over half a century[4] while Medicare-for-All is merely a proposal. Furthermore, Medicare as it will be examined here is the program that is presently in force, reflecting a wide variety of legislative and administrative changes that have been enacted during its half-century of existence, and not as it was originally conceived. If that reality were not enough to make the attempted comparison somewhat imbalanced, the Medicare-for-All "plan" is at the very beginning of its gestation.

For purposes of this Article, Medicare-for-All is the actual legislation introduced by its most prominent proponent, Senator Bernie Sanders, Independent from Vermont, who made the very concept of Medicare-for-All a central tenet of his 2016 and 2020 campaigns for the Democratic nomination for President of the United States.[5] Specifically, this Article uses Senate Bill 1129 introduced by Senator Sanders on April 10, 2019, with 14 co-sponsors.[6] To say that this plan is still a work in progress is an almost comical understatement. Senate Bill 1129 has never received even a cursory examination in the United States Senate, no hearings have been held, no amendments have been offered, no Congressional debate has even been scheduled, and no alternative formulations have been offered by similarly inclined proponents. The legislative process with its competing compilations of necessary compromises has not even begun, let alone proceeded to a conference committee to reconcile those compilations. Thus, the Medicare-for-All plan this Article will examine is still at the very beginning of what would likely be a drawn-out process from which a very different piece of legislation is likely to emerge.

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[4] Anderson, *supra* note 2.

[5] *See Issues: Health Care as a Human Right – Medicare For All*, BERNIE, https://berniesanders.com/issues/medicare-for-all/ (last visited Sept. 15, 2020).

[6] *See generally* Medicare for All Act of 2019, S. 1129, 116th Cong. (2019).

The two-year gestation of the Patient Protection and Affordable Care Act,[7] popularly known as the Affordable Care Act or ACA and more colloquially as ObamaCare, is illustrative of this phenomenon. What was enacted on March 23, 2010, looks *very* different than the initial drafts of 2009, and legislation like Medicare-for-All, which purports to be even broader in scope than the ACA, would necessarily follow a similar course.

On the other hand, Senate Bill 1129 is not some mere placeholder and is 100 pages in its current iteration.[8] A similar proposal by Congresswoman Jayapal and 106 co-sponsors in the United States House of Representatives has similar heft,[9] but for purposes of this Article, the legislation introduced by Senator Sanders will be considered definitive since he is widely recognized as the initiative's primary sponsor and most passionate advocate. Nevertheless, the reality is that this Article must compare a real program—namely Medicare—with a proposal that is only at the very earliest stage of its development.

II. Medicare is Only Health Care Financing

Medicare does not purport to directly affect health care in the United States outside of the very important but nevertheless limited function of determining how such care should be financed.[10] That is, Medicare uses a combination of funding mechanisms to pay for health care for its beneficiaries but does not attempt to change how that health care itself is delivered. Those mechanisms include a payroll tax that is paid by all employees as a fixed percentage of their wages and salaries,[11] and this payroll tax is then matched in equal measure by those employees' employers.[12] Self-employed individuals effectively pay both portions of this payroll tax on their net earnings from self-employment[13] to derive a roughly

[7] Pub. L. No. 111-148, 124 Stat. 119 (2010).
[8] Medicare for All Act of 2019, S. 1129, 116th Cong. (2019).
[9] Medicare for All Act of 2019, H.R. 1384, 116th Cong. (2019).
[10] *See What's Medicare?*, *supra* note 1.
[11] I.R.C. § 3101(b)(1) (2018).
[12] *Id.* § 3111(b)(6).
[13] *Id.* § 1401(b)(1).

comparable contribution. Other Medicare financing mechanisms include monthly premiums paid by program enrollees and a bewildering array of annual and daily deductibles and copayments imposed on beneficiaries who receive covered health care services, as well as major funding provided by the federal government's general revenues, which come principally from the income tax on individuals and corporations.[14] But that is as far as Medicare purports to go. The actual *delivery* of health care is largely left to the vast network of private sector providers, including hospitals, nursing homes, home health care agencies, pharmacies, hospices, and doctors.

In contrast, Medicare-for-All seeks to go beyond the mere financing of health care and reform key aspects of how health care is delivered in the United States.[15] While such matters have generally been allocated to state governments under the U.S. system of federalism, even Medicare has sought to introduce new health care delivery arrangements such as Accountable Care Organizations, though largely as experiments authorized by the ACA.[16] Even then, these new arrangements are largely tied to cost-control efforts that are part of Medicare's historical focus on health care financing.

One prominent example of Medicare-for-All's ambitious reach is determining the proportion of the U.S. physician corps that is comprised of specialists as opposed to generalists or primary care providers.[17] As medical knowledge has become more extensive, a natural growth of specialists is not unexpected, but Medicare-for-All introduces some measures to shift the balance of new doctors away from the specialist component.[18] Even here, however, the purported reason for this intervention in how health care is delivered is that the increasing proportion of care delivered by medical

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[14] *Id.* §§ 1(a)–(d), 11(a).
[15] *See*, *e.g.*, Medicare for All Act of 2019, S. 1129, 116th Cong. § 502 (2019) (dealing with health care disparities "on the basis of race, ethnicity, gender, geography, or socioeconomic status.").
[16] David Blumenthal & Melinda Abrams, *The Affordable Care Act at 10 Years—Payment and Delivery System Reforms*, 382 NEW ENG. J. MED. 1057, 1058–59 (2020).
[17] *See* Medicare for All Act of 2019, S. 1129, 116th Cong. § 613(a)(1), (b).
[18] *Id.* § 613(a)(2)–(3).

specialists drives up the cost of health care generally, which is what Medicare-for-All is trying to reduce.

At the same time, Medicare-for-All makes no effort to address another health care cost-driver that pertains to the delivery of health care—namely, malpractice expenses and the related costs of so-called defensive medicine to ward off potential future claims.[19] While this issue has historically been left to state governments to address, a comprehensive effort to "reform" health care as opposed to reforming health care finance could hardly ignore this issue. Thus, although Medicare-for-All makes much more of an effort to reform health care in the United States, it is still more of a health care *financing* reform than a true health care reform proposal as such.

III. Medicare is an Earned Entitlement

Medicare as presently constituted enjoys considerable popular support, in large part because it is widely viewed as an earned entitlement.[20] Once a person begins working, whether as an employee or as a self-employed person, that person pays a payroll tax on their wages, salaries, or net earnings from self-employment. The tax rate is 1.45% for employees[21] and their employers,[22] and 2.9% for self-employed persons,[23] and the tax base is all their earnings[24]—unlike Social Security's annual cap on taxable earnings, which was $137,700 in 2020.[25] But the point is that Medicare benefits come after a working lifetime of paying for those benefits.

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[19] *See*, *e.g.*, *AMA Studies Show Continued Cost Burn of Medical Liability System*, AM. MED. ASS'N (AMA) (Jan. 24, 2018), https://www.ama-assn.org/press-center/press-releases/ama-studies-show-continued-cost-burden-medical-liability-system.
[20] *See* Patricia E. Dilley, *Breaking the Glass Slipper – Reflections on the Self-Employment Tax*, 54 TAX LAW. 65, 101 (2000).
[21] I.R.C. § 3101(b)(1).
[22] *Id.* § 3111(b).
[23] *Id.* § 1401(b)(1).
[24] *Id.* §§ 3101(b), 3111(b) (referencing I.R.C. § 3121(b) (2018)).
[25] *2020 Social Security Changes Fact Sheet*, SOC. SEC. ADMIN., https://www.ssa.gov/news/press/factsheets/colafacts2020.pdf (last visited Sept. 18, 2020).

To obtain those benefits, a person must generally satisfy two conditions: (1) be 65 years old,[26] and (2) have accumulated at least 40 "quarters of coverage" under the Social Security program.[27] There are exceptions to these requirements, but they remain the bedrock of Medicare eligibility. For example, a disabled person of any age qualifies for Medicare benefits once that person has received disability benefits under the Social Security program for 24 months,[28] but eligibility for such benefits is itself tied, in part, to working long enough to accumulate a specified number of "quarters of coverage." Those "quarters of coverage," in turn, require a person to have earned a stipulated amount in earnings subject to Social Security's payroll tax,[29] which is presently 6.2%,[30] matched by one's employer,[31] or 12.4% for self-employed persons.[32] That amount is adjusted annually for inflation and was $1,410 in 2020.[33] Although the phrase "quarters of coverage" seems to suggest a durational requirement, earning such quarters is actually based entirely on the amount of earnings achieved, up to a maximum of four "quarters of coverage," in any given year. Thus, if Megan works for a law firm in 2020 and earns $8,000 by working only during the month of June, she will be credited with the maximum of four "quarters of coverage" for that year ($8,000 divided by $1,410 = 5.67). In this manner, eligibility for Medicare requires that a person have had some non-trivial attachment to the U.S. workforce in at least ten calendar years.

Other people can qualify for Medicare derivatively. That is, a person can qualify for Medicare benefits if his or her spouse has accumulated the necessary 40 "quarters of coverage."[34] A divorced person can also qualify for Medicare benefits if that person's former spouse had accumulated the required 40 "quarters of coverage" and

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[26] 42 U.S.C. § 1395c (2018)
[27] *Id.* §§ 414(a)(2), 426(a)(2)(A), 1395c.
[28] *Id.* §§ 426(b)(2)(A)(i), 1395c.
[29] *Id.* § 413(d)(2).
[30] I.R.C. § 3101(a).
[31] *Id.* § 3111(a).
[32] *Id.* § 1401(a).
[33] *2020 Social Security Changes Fact Sheet*, *supra* note 25.
[34] 42 U.S.C. § 402(b)(1), (c)(1).

their marriage lasted at least ten years.[35] In either circumstance, the spouse seeking Medicare benefits through a current or former spouse must have reached age 65 in his or her own right.[36] In other words, the work requirement can be achieved derivatively but not the requisite-age requirement. This provision can be very important when a person's younger spouse seeks Medicare benefits. Thus, even though if Megan in the preceding example qualified for Medicare benefits when she reached age 65, her spouse Nick who is only 62 years old will not qualify until he reaches age 65.

If these conditions cannot be met, citizens and certain residents of the United States can enroll in Medicare, but they must pay a monthly charge in lieu of the payroll taxes that are otherwise required.[37] The monthly charge increases annually for inflation and was $458 in 2020.[38] For this purpose, residents must demonstrate that they have lived in this country during the preceding five years.[39]

Stripped to their essentials, these requirements generally mandate some serious financial involvement in the United States, either by working here themselves or through a spouse or former spouse, or by living here at least five years and paying a monthly charge. In contrast, Medicare-for-All would extend its benefits to anyone in the United States, regardless of whether they or any current or former spouse ever worked here and regardless of how long they have lived in this country.[40] No further requirements for eligibility are set forth in the current proposal, though it does authorize the Secretary of Health and Human Services to establish "criteria for determining . . . eligibility."[41] Even new immigrants who have entered the country illegally would qualify for benefits

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[35] *Id.* §§ 402(b)(1), (c)(1), 416(d).
[36] *What's Medicare?*, *supra* note 1.
[37] 42 U.S.C. § 1395i-2(a).
[38] *Medicare at a Glance Fact Sheet*, MEDICARE.GOV, https://www.medicare.gov/your-medicare-costs/medicare-costs-at-a-glance (last visited Sept. 19, 2020). If a person has earned 30–39 "quarters of coverage," the monthly premium to purchase Medicare Part A is $252. *Id*.
[39] 42 U.S.C. § 1395i-2(a)(3).
[40] Medicare for All Act of 2019, S. 1129, 116th Cong. § 102(a) (2019).
[41] *Id.*

under Medicare-for-All. The only limitation in the Medicare-for-All proposal would make ineligible any person who "travel[led] to the United States for the sole purpose of obtaining health care services."[42] Apart from raising serious questions of enforcement, this provision is the only limitation on receiving benefits under Medicare-for-All. One can certainly argue that such broad health care coverage might be appropriate on humanitarian or even contagion-containment grounds, but one cannot argue that such a program is Medicare.

IV. Medicare is Not a Simple Program

As noted previously, eligibility for Medicare is fairly simple, constituting only two readily determined components: chronological age of 65 and accumulation, either directly or derivatively, of 40 "quarters of coverage" under the Social Security program.[43] But the simplicity of Medicare ends there because Medicare has numerous options and required choices.

As I have explained elsewhere,[44] Medicare is not a single program but rather a composite of different constituent programs called "Parts," each of which has its own constellation of costs, benefits, and limitations.[45] Though largely a product of historical evolution, the path dependency of Medicare's development continues to define its scope to this day and even survived the most comprehensive health care legislation of the past half-century—namely, the Affordable Care Act.[46]

Be that as it may, new Medicare enrollees are often surprised by the range of mutually exclusive options and time-sensitive choices that they confront, especially when compared with more integrated health care plans sponsored by most employers for their current

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[42] *Id.* § 102(b)(2).

[43] *Who is Eligible for Medicare?*, HHS.GOV, https://www.hhs.gov/answers/medicare-and-medicaid/who-is-elibible-for-medicare/index.html#:~:text=Medicare%20has%20two%20parts%2C%20Part,for%20at%20least%2010%20years (last visited Sept. 25, 2020).

[44] Richard L. Kaplan, *Top Ten Myths of Medicare*, 20 ELDER L.J. 1 (2012).

[45] *Id.* at 4–7.

[46] Richard L. Kaplan, *Analyzing the Impact of the New Health Care Reform Legislation on Older Americans*, 18 ELDER L.J. 213, 244 (2011).

employees.[47] Without elaborating excessively, some of these choices include the following:

- If a person is not entitled to premium-free Medicare Part A to cover expenses incurred in hospital, certain nursing homes, home health care, and hospices, should that person enroll in this program and pay the required monthly charge? Note that if that person declines to enroll upon reaching age 65, there is a delayed enrollment penalty of 10% of the applicable premium—which was $458 in 2020[48]—that persists for two years for every 12-month period after age 65 during which that person did not enroll in Medicare Part A.[49]
- If that person enrolls in Medicare Part A, whether on a premium-free or monthly charge basis, does he or she want to purchase supplementary "Medigap" insurance coverage to cover the various deductibles and copayments that Medicare Part A imposes with no pre-set limitation on that person's out-of-pocket expenses?
- If that person decides to purchase such insurance, does he or she want to do so within the first six months of being eligible for Medicare Part B when that person cannot be declined by the private issuers of such policies on the basis of pre-existing medical conditions,[50] or should this person save the out-of-pocket premiums of such insurance and take a chance that such coverage will be unavailable or available only at increased expense in the future?
- If this person decides to purchase a Medigap policy presently, which type of Medigap insurance among the

[47] *See What Marketplace Health Plans Cover*, HEALTHCARE.GOV, https://www.healthcare.gov/coverage/what-marketplace-plans-cover/ (last visited Sept. 19, 2020) (describing the contents of plans offered on the insurance exchanges created by the ACA).
[48] *Medicare at a Glance Fact Sheet*, *supra* note 38.
[49] 42 U.S.C. § 1395i-2(c)(6).
[50] *Id.* § 1395ss(s)(2)(A).

ten available standardized "plans" should he or she choose to purchase,[51] each having its own monthly premium cost? Note that this decision can, and perhaps should, be revisited from time to time in the future.

- Does this person wish to purchase Medicare Part B to cover physicians' fees and ambulance charges, as well as durable medical equipment? Note that if he or she declines to enroll in this Part when they are first eligible, there is a delayed enrollment penalty of 10% of the monthly premium—which was $144.60 in 2020[52]—for each 12-month period after eligibility during which that person chose not to enroll in Medicare Part B.[53] Moreover, this penalty will increase the cost of this insurance *permanently* and will not diminish over time.
- Does this person wish to purchase Medicare Part D to cover the cost of prescription drugs? Note that if he or she declines to enroll in this Part when they are first eligible and does not have comparable coverage that meets the program's standard of "creditable coverage,"[54] there is a delayed enrollment penalty of 1% of the "national base beneficiary policy—which was $32.74 in 2020[55]—for each month during which this person did not have such coverage. Moreover, this penalty will increase the cost of this insurance *permanently* and will not diminish over time.
- If this person chooses to purchase a Medicare Part D plan, which one of the possibly 30 or more specific plans available in that person's state does he or she wish to

[51] *See Medicare & You 2021*, CENTERS FOR MEDICARE & MEDICAID SERVICES, DEP'T OF HEALTH & HUM. SERVICES 71 (Sept. 2020), https://www.medicare.gov/sites/default/files/2020-09/10050-Medicare-and-You_0.pdf (For persons who become newly eligible for Medicare after 2019, only eight different types of Medigap insurance are available).
[52] *Medicare at a Glance Fact Sheet*, *supra* note 38.
[53] 42 U.S.C. § 1395r(b).
[54] *Id.* § 1395w-113(b)(2). *See also id.* § 1395w-113(b)(5) (such coverage must meet or exceed the actuarial value of Medicare's Part D coverage).
[55] *Medicare at a Glance Fact Sheet*, *supra* note 38.

purchase, given each plan's coverage of particular pharmaceuticals, their dosage amounts, dosing frequency, and overall cost?[56] Note that this decision can, and perhaps should, be revisited from time to time in the future, especially since plan providers alter the composition of their plans regularly, often from plan year to plan year, such that a specific plan that worked well one year may no longer be appropriate. This circumstance is particularly likely if this person's drug regimen changes due to the diagnosis of new medical conditions and/or the development of new pharmaceutical interventions.

- As an alternative to this mélange of separate coverages, would this person prefer a managed care arrangement under Medicare Part C, currently styled "Medicare Advantage," that is similar to what he or she had through their employer before becoming eligible for Medicare? These arrangements currently account for 34% of all Medicare enrollees[57] and typically cover health care expenses regardless of particular category but impose major cost differentials if a specific health care provider is not in the plan's "network."
- If the person wants a Medicare managed care plan, which one of the possibly 30 or more specific plans available in that person's state does he or she wish to purchase?[58] This question, in turn, must consider each plan's current scope of in-network providers and which of the person's current medical specialists and other providers are within that network. Note that this decision can, and perhaps should, be revisited from time to time in the future,

[56] *See Find a Medicare Plan*, MEDICARE.GOV, https://www.medicare.gov/plan-compare/#/?lang=en (last visited Sept. 30, 2020).
[57] Gretchen Jacobson et al., *Medicare Advantage 2020 Spotlight: First Look*, KAISER FAM. FOUND. 1 (Oct. 2019), http://files.kff.org/attachment/Data-Note-Medicare-Advantage-2020-Spotlight-First-Look.
[58] *Id.*

> especially since plan providers alter the composition of their networks, adding new doctors and hospitals while dropping other previously covered providers.

In short, current Medicare imposes a fairly extensive array of required decision points and while it can provide exceptional breadth of coverage, there are significant limitations that must be considered. The current formulation of Medicare-for-All purports to cover virtually all providers, regardless of network affiliation or other limiting constraints.[59] While such a comprehensive and unlimited approach is certainly appealing, it bears little resemblance to the actual Medicare program that is its namesake. Many current enrollees in Medicare would regard Medicare-for-All's fully integrated program to be a major improvement, but it is not Medicare in any real sense of the word.

V. Medicare Has a Significant Co-Insurance Component

A major part of the appeal of Medicare-for-All is its apparent simplicity in locating the entirety of health care financing in a single entity—namely, the federal government. This very feature undoubtedly dooms the prospects for enactment of Medicare-for-All for some, perhaps many, Americans, as the underlying premise of Medicare-for-All is that you can trust your health care to the federal government.[60] For some, this premise is a punchline for a standup comedy routine, but for others, it represents frustration with the existing patchwork of health insurance companies and their penchant for deductibles, copayments, and surprise bills. Even the enactment of the ACA has not entirely ameliorated the dissatisfaction with current health insurance plans available to the pre-Medicare population. To be sure, the ACA eliminated pre-existing medical conditions as a barrier to securing health

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[59] *See Health Care as a Human Right - Medicare For All*, BERNIESANDERS.COM, https://berniesanders.com/issues/medicare-for-all/ (last visited Sept. 30, 2020) (One key point regarding Medicare-for-All is that it has "[n]o networks, no premiums, no deductibles, no copays, no surprise bills.").

[60] *See* Lee Rainie, Scott Keeter & Andrew Perrin, *Trust and Distrust in America*, PEW RES. CENTER (July 22, 2019), https://www.people-press.org/2019/07/22/trust-and-distrust-in-america/ (survey found that 75% distrust the federal government).

insurance.[61] But many of the policies available on the ACA's so-called "marketplace exchanges" sport large annual deductibles of $4,000 or more, confusing copayment obligations, and increasingly narrow networks of health care providers willing to accept such policies.[62] Ten years after the ACA's enactment, many people have said "Enough" and want Medicare instead, but Medicare is not without these annoyances either.

A. Deductibles

As noted previously, Medicare is not a single program and has individual Parts with their own restrictions and costs.[63] For example, Medicare Part A imposes a deductible per hospital admission that increases with inflation each year.[64] In 2020, this deductible was $1,408.[65] This amount is not trivial, but its true significance derives from the fact that it is imposed per each "spell of illness" in a hospital.[66] Such a "spell of illness" begins when a patient is admitted into a hospital and continues for 60 days after discharge from that hospital.[67] Thus, if Vileta enters a hospital on January 2 and leaves on January 14, her "spell of illness" lasts until March 15, which is 60 days after she was discharged. During this period, any subsequent hospitalization would not require a further deductible even if this hospitalization were for a condition unrelated to her initial hospital stay. But if she enters a hospital on April 1, then Vileta would owe another $1,408 even if this second hospitalization were related to the problem for which she was initially hospitalized. The per-admission deductible, in other words, is determined mechanically based on

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[61] *See* Katie Keith, *What It Means to Cover Preexisting Conditions,* HEALTH AFF. BLOG (Sept. 11, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200910.609967/full/.
[62] *See What Marketplace Health Plans Cover*, HEALTHCARE.GOV, https://www.healthcare.gov/coverage/what-marketplace-plans-cover/ (last visited Sept. 30, 2020) (describing the contents of plans offered on the insurance exchanges created by the ACA).
[63] Kaplan, *supra* note 44, at 4.
[64] 42 U.S.C. § 1395e(b)(1) (2018).
[65] *Medicare at a Glance Fact Sheet*, *supra* note 38.
[66] 42 U.S.C. § 1395x(a) (2018).
[67] *Id.*

days since discharge and not clinically based on the cause of a patient's hospitalization.

Furthermore, this example illustrates that Medicare Part A's deductible for hospital coverage is not a once-a-year matter and might be imposed two or even three times in a given calendar year. As a result, the actual cost exposure of a Medicare beneficiary from this deductible might be substantially higher than its amount might suggest.

Medicare has other deductibles as well. Hospital stays under this program are covered for 60 days within a "spell of illness."[68] If a patient requires time in a hospital beyond 60 days, Medicare will pay the cost of such care but imposes a per-*day* deductible of one-fourth of the per-admission deductible,[69] or $352 in 2020.[70] This arrangement can continue for as long as 30 days,[71] but any additional days within the same "spell of illness" imposes a per-day deductible of one-half of the per-admission deductible,[72] or $704 in 2020.[73] Those days after 90 hospital days within the same "spell or illness" are available for no more than 60 days tabulated on a cumulative lifetime basis.[74] So, if Vileta used 16 of her so-called "lifetime reserve" days in 2018, for example, she would have only 44 such "lifetime reserve" days available for the rest of her life. Any longer stay in a hospital would be entirely at her expense. This situation, though not common, is not unheard of either and shows that Medicare can impose very significant deductibles.

B. Copayments

Medicare Part B also has an annual deductible[75] but it is fairly modest—only $198 in 2020.[76] Its major financial imposition on

[68] *Id.* § 1395e(a)(1)(A).
[69] *Id.*
[70] *Medicare at a Glance Fact Sheet*, *supra* note 38.
[71] 42 U.S.C. § 1395e(a)(1)(A) (2018).
[72] *Id.* §§ 1395d(a)(1), 1395e(a)(1)(B).
[73] *Medicare at a Glance Fact Sheet*, *supra* note 38.
[74] 42 U.S.C. § 1395d(a)(1) (2018).
[75] *Id.* § 1395*l*(b).
[76] *Medicare at a Glance Fact Sheet*, *supra* note 38.

enrollees is a 20% copayment obligation on covered charges.[77] For example, if Vileta in the prior example had an appointment with her doctor after she satisfied her annual deductible, she would owe 20% of whatever amount Medicare approved for her doctor visit. So, if her doctor charged $200, Vileta would owe $40. This simple example, however, is subject to an important limitation – namely, that the 20% copayment is based on Medicare's "approved charge" and Vileta might owe some additional amount based on what Medicare is not willing to pay.[78]

Continuing with this example, assume that Medicare's "approved charge" for the services Vileta's doctor provided is $120. In that case, Vileta would be liable for $24 (20% of $120), and Medicare would pay her doctor $96 (approved charge of $120 minus $24). If Vileta's doctor is a "participating provider" in the Medicare program, this payment arrangement is the end of the matter as far as Vileta is concerned. It is not the end of the matter, however, for Vileta's doctor, because $80 of the doctor's charges ($200 minus $120) has not been paid. For that reason, Vileta's doctor may choose *not* to be a "participating provider" in the Medicare program. If that is the case, the doctor can charge Vileta a portion of the amount in excess of Medicare's "approved charge," but not more than 15% of that charge.[79] In this example, that excess can be as much as $18 (15% of the approved charge of $120), and Vileta's copayment obligation would therefore be $42 ($24 from 20% of the approved charge + $18 excess charge from a nonparticipating provider). Thus, Vileta is out of pocket for $42 on this single doctor visit, an amount that is higher than the copayment obligation of many health insurance plans.

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[77] 42 U.S.C. §§ 1395l(a)(1), 1395x(s)(1) (2018).

[78] *See generally id.* § 1395y (exclusions from coverage and Medicare as a secondary payer).

[79] LAWRENCE A. FROLIK & RICHARD L. KAPLAN, ELDER LAW IN A NUTSHELL 79–81 (7th ed. 2019).

C. Loss Limits

Medicare has deductibles beyond the ones explained above, but the more significant point is that Medicare lacks any annual cap or overall limit on how much an enrollee might owe for the sum of deductibles and copayments incurred during any given year. Certain low-income Medicare enrollees may be eligible for Medicaid coverage of these expenses if they qualify under the strict income and resource limits that program requires.[80] Otherwise, most Medicare enrollees obtain some sort of supplementary insurance, either through their former employers or from private insurers who offer so-called "Medigap" insurance.[81] These policies come in as many as ten versions that offer different benefits tied to specific Medicare deductibles and copayment obligations.[82] Premiums vary with more comprehensive policies requiring higher premium outlays, but they provide some protection against Medicare's otherwise unlimited cost exposure to affected beneficiaries. For almost a third of Medicare enrollees, a managed care plan under Medicare Part C provides this protection by covering most of the deductibles and copayments that Medicare generally imposes.[83] In any case, the absence of any annual limit on these co-insurance obligations is unique to Medicare.[84]

In contrast, Medicare-for-All promises to provide its services without any deductibles and copayments,[85] other than an annual deductible of $200 for prescription drugs for persons[86] with annual incomes of more than twice the federal poverty line.[87] The imposition of significant deductibles and copayments has long

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[80] *Id.* at 109–36.
[81] *See An Overview of Medicare*, KAISER FAM. FOUND. 3 (2019), files.kff.org/attachment/issue-brief-an-overview-of-medicare.
[82] *See Medicare & You 2021*, *supra* note 51, at 70–72 (For persons who become newly eligible for Medicare after 2019, only eight different types of Medigap insurance are available.).
[83] *See generally id.* at 57.
[84] *See* BEN G. BALDWIN, THE LAWYER'S GUIDE TO INSURANCE 67–68 (1999) (noting that private health insurance plans "typically have an annual stop loss provision").
[85] Medicare for All Act of 2019, S. 1129, 116th Cong. § 202(a) (2019).
[86] *Id.* § 202(b)(1)(C).
[87] *Id.* § 202(b)(1)(D).

characterized the U.S. approach to health insurance not just in Medicare but in health insurance generally.[88] The underlying premise is that insured individuals who have no "skin in the game" in terms of personal financial contribution would be profligate consumers of health care services. This fear of moral hazard in the health care context is less evidence-based than one might imagine. Many health care procedures are painful or at least inconvenient, and most people would rather not subject themselves to such procedures unless there was some genuine medical necessity.[89]

In an important study reported in *The New England Journal of Medicine*, Medicare patients in 18 plans that raised their copayments for doctors' visits were compared over a four-year period with Medicare patients in 18 other plans that did not raise their copayments for such visits.[90] As one might anticipate, the patients enrolled in the increased-copayment plans visited their doctors less frequently than did patients in the other plans.[91] But those patients were also hospitalized more often and for longer stays than the control group,[92] thereby incurring higher medical expenses overall as well as suffering poorer medical outcomes. The article noted that these results were consistent with similar research involving increases in copayments for prescription medications[93] and concluded that "increasing copayments for ambulatory care among elderly Medicare beneficiaries may be a particularly ill-advised cost-containment strategy."[94] Thus, moving to a system like Medicare-for-All with substantially reduced or even eliminated deductibles and copayments might ensure better health for affected Americans, as well as lower health care costs overall. But the point

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[88] Clark C. Havighurst & Barak D. Richman, *Distributive Injustice(s) in American Health Care*, 69 LAW & CONTEMP. PROBS. 7, 13–15 n.20 (2006).
[89] *See*, *e.g.*, Allison K. Hoffman, *Health Care's Market Bureaucracy*, 66 UCLA L. REV. 1926, 1973 (2019).
[90] Amal N. Trivedi, Husein Moloo & Vincent Mor, *Increased Ambulatory Care Copayments and Hospitalizations Among the Elderly*, 362 NEW ENG. J. MED. 320, 321 (2010).
[91] *Id.* at 324.
[92] *Id.*
[93] *Id*. at 327.
[94] *Id.*

here is simply that such a system—whatever its virtues—is not Medicare.

VI. Medicare's Coverage of Long-Term Care is Minimal

As I have noted elsewhere,[95] one of Medicare's most egregious coverage gaps is long-term care. Reflecting both general budgetary constraints and Medicare's origins in 1965-medicine, the program's coverage of long-term services and supports can only be described charitably as antiquated.[96] Despite the enormous changes in the medical field since Medicare was first conceived, it continues to limit its coverage of needed long-term care in ways that make no medical sense and constitute a major trap for the unwary.

Medicare's coverage of long-term care is predicated on several distinct requirements:

- The nursing facility must be Medicare-approved.[97] While most nursing facilities are part of the Medicare system, the persistent pattern of below-market reimbursement rates has resulted in most facilities sharply limiting the number of Medicare "beds" they designate as available to Medicare beneficiaries.[98] When that limit is reached, no Medicare patient is admitted.
- The patient must have been hospitalized within the 30 days preceding admission to the nursing home[99] for the same or a related, medical condition that was treated in the hospital.[100] Going directly to a nursing home from one's residence, in other words, will result in Medicare's not covering any part of the nursing home stay. For many older people, whose nursing home stay begins when

[95] Richard L. Kaplan, *Reflections on Medicare at 50: Breaking the Chains of Path Dependency for a New Era*, 23 ELDER L.J. 1, 35–36 (2015).
[96] *See* Richard L. Kaplan, *Cracking the Conundrum: Toward a Rational Financing of Long-Term Care*, 2004 U. ILL. L. REV. 47, 82–86 (2004).
[97] 42 U.S.C. § 1395i-3(a) (2018).
[98] *See generally* Anthony Szozygiel, *Long Term Care Coverage: The Role of Advocacy*, 44 U. KAN. L. REV. 721, 726 n.17–18 (1996).
[99] 42 U.S.C. § 1395x(i)(A) (2018).
[100] *Id*. § 1395f(a)(2)(B).

younger relatives ascertain—often during holiday visits—that they can no longer live alone, this requirement of an antecedent hospital stay becomes a major barrier to Medicare coverage.

- The hospital stay itself must last at least three days,[101] not counting the day of discharge.[102] As a result of various cost-cutting initiatives undertaken over the years, hospital stays have been shortened for many of the procedures that Medicare covers. That change notwithstanding, the three-day requirement for a qualifying hospital stay has never been modified and as a result, this requirement is now a more significant barrier to Medicare coverage of nursing home stays than was the case originally.
- Finally, the care provided in the nursing home must be characterized as "skilled nursing care" and must be provided every day the patient is in the facility.[103] This level of care requires the skills of a registered nurse, a licensed practical nurse, a physical therapist, or some similar professional,[104] and includes such services as catheters, gastronomy feedings, injections, and medical gas administration.[105] This level of care is *not* what is typically needed by many nursing home residents, especially those suffering from Alzheimer's Disease and other dementias.

Failure to satisfy any one of these requirements makes the nursing home stay not covered by Medicare. Incidentally, even if each element is met, Medicare's coverage of nursing homes is limited to 100 days per "spell of illness,"[106] and days after day 20 are subject to a per-day deductible that is one-eighth of Medicare's

[101] *Id.* § 1395x(i).
[102] 42 C.F.R. § 409.30(a)(1) (2020).
[103] 42 U.S.C. § 1395f(a)(2)(B) (2018).
[104] *Id.*; 42 C.F.R. § 409.31(a)(2) (2020).
[105] 42 C.F.R. § 409.33(a)–(c) (2020).
[106] 42 U.S.C. § 1395d(b)(2) (2018).

per-admission hospital deductible, adjusted annually for inflation.[107] In 2020, that per-day deductible for days 21–100 was $176.[108]

Medicare's coverage of nursing home care is one of its worst deficiencies and should be addressed. In the version proposed by Senator Sanders, Medicare-for-All addresses long-term care only by directing state governments to fashion coverage "plans" but provides almost no guidance for what such plans should cover.[109] The version of Medicare-for-All proposed by Representative Jayapal,[110] however, provides for coverage of "*any* long-term nursing services for the enrollee, whether provided in an institution or in a home and community-based setting."[111] Moreover, the need for such services is exceptionally broad, encompassing any "medically determinable condition, whether physical or mental, of health, injury, or age that (1) causes a functional limitation in performing *one* or more activities of daily living; or (2) requires a similar need of assistance in performing instrumental activities of daily living due to cognitive *or other* impairments."[112] A clearer contrast with the multiple preconditions that Medicare imposes would be difficult to imagine. Such broadened coverage of long-term care would appeal to many families of older people, especially if those older people have progressive neurological disorders like Alzheimer's Disease, but it's most certainly *not* Medicare.

VII. Medicare's Financing Relies on Non-Medicare Enrollees

As noted in connection with Medicare Part B's use of "approved charges" for physicians, Medicare does not pay whatever health care providers choose to charge.[113] This phenomenon is not limited to Medicare Part B or to physicians' fees, but rather pervades each and every cost component of the Medicare program. In an effort to limit the perennially deficit-ridden reality of Medicare's open-ended

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[107] *Id.* § 1395e(a)(3).
[108] *Medicare at a Glance Fact Sheet*, *supra* note 38.
[109] Medicare for All Act of 2019, S. 1129, 116th Cong. § 204 (2019).
[110] *See generally* Medicare for All Act of 2019, H.R. 1384, 116th Cong. (2019).
[111] *Id.* § 204(c)(2) (emphasis added).
[112] *Id.* § 204(a) (emphasis added).
[113] *See supra* Part V.B.

defined benefit design, Congress has turned to various cost-control mechanisms, beginning most notably with the Diagnosis Related Groups (DRG) in the Reagan Administration.[114] Under this initiative, the federal government devised a schedule of amounts it would pay for each authorized procedure a hospital might provide, and any excess incurred over that amount would not be paid by Medicare.[115]

This system of administratively dictated prices was tolerated by private health care providers for several reasons. First, Medicare has big sticks. That is, it covers health care expenses of older Americans, and this age cohort comprises the vast majority of patients in most U.S. hospitals.[116] Quite bluntly, hospitals cannot afford to alienate Medicare. Secondly, Medicare is a reliable payor. The program may not pay top dollar but it is backed by the full resources of the federal government, which is simply the most creditworthy payment source around. After all, no other insurance scheme is backed by the authority to issue the world's reserve currency. And third, many health care providers can "cost shift" some of revenues they lose from these set prices to other payment sources, especially employer-provided health insurance for employees under age 65.

This last consideration in particular raises various issues, including whether the federal government should be effectively subsidized by private payors or whether it should, in fact, pay its own way for the services it promises to cover. The differences involved are often difficult to determine and vary considerably across the panoply of health care providers. But some data have been compiled in the context of skilled nursing facilities. In a 2018 study prepared for the American Health Care Association, a similar

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[114] 42 U.S.C. § 1395ww(d)(2)(G) (2018). *See generally* RICHARD A. EPSTEIN, MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE? 159–61 (1997).

[115] *See generally* Elizabeth Davis, *How a DRG Determines How Much a Hospital Gets Paid*, VERYWELLHEALTH (Mar. 9, 2020), https://www.verywellhealth.com/how-does-a-drg-determine-how-much-a-hospital-gets-paid-1738874.

[116] *See* Ruirui Sun et al., *Trends in Hospital Inpatient Stays by Age and Payer, 2000-2015*, AHRQ (Jan. 2018), https://www.hcup-us.ahrq.gov/reports/statbriefs/sb235-Inpatient-Stays-Age-Payer-Trends.jsp ("Older age groups have higher rates of nonneonatal and nonmaternal inpatient rates.").

pattern of less-than-private payments was detected regarding "reimbursement rates" paid by Medicaid.[117] Although Medicaid is a jointly funded program of the federal and state governments, it follows a pattern similar to Medicare in dictating the rates it will pay and effectively forcing health care providers to recover some of the lost revenues from other payors.[118] In the context of nursing homes, the most common "other" payors are so-called private pay patients, i.e., individuals who pay their own nursing home expenses, and long-term care insurance companies who cover such costs for their insureds who require such care.[119]

The inescapable reality is that the only reason that Medicare can provide the services it does is that other payment sources exist to at least partially cover the deficiency.[120] Even then, this approach is insufficient in some circumstances. As a result, some physicians limit the number of Medicare patients they will accept or even decline to see Medicare patients altogether. The typical reason for instituting these practice limitations is the insufficiency of Medicare's payment schedules. Indeed, the latest survey on this subject revealed that nearly 8% of physicians limit the number of Medicare patients they will accept and that more than 14% have

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[117] *See* Hansen Hunter & Co., PC, *A Report on Shortfalls in Medicaid Funding of Nursing Center Care*, AM. HEALTHCARE ASSOC. (Nov. 2018), https://www.ahcancal.org/Reimbursement/Medicaid/Documents/2017%20Shortfall%20Methodology%20Summary.pdf#search=A%20REPORT%20ON%20SHORTFALLS%20IN%20MEDICAID%20FUNDING%20OF%20NURSING%20CENTER%20CARE.

[118] *See* Austin B. Frakt, *How Much Do Hospitals Cost Shift? A Review of the Evidence*, PMC (Mar. 2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3160596/ ("Public payments—from Medicare or Medicaid—go down . . . and as a consequence, private payments go up, taking health insurance premiums along with them."); *see also* Allan N. Johnson & David Aquilina, *The Cost Shifting Issue*, HEALTHAFFAIRS (Fall 1982), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.1.4.101 ("According to the Health Insurance Association of America (HIAA), Medicare and Medicaid underpaid hospitals and forced them to shift $3 billion in 1979 . . . . In 1981 the cost shift from Medicare and Medicaid reached an estimated $4.8 billion. As a result of this cost shifting, hospitals added an average of $41 extra per patient day to bills of commercial insurers and other charge payers in 1979 in order to recover revenues lost from Medicare and Medicaid discounts.").

[119] *Frakt*, *supra* note 118.

[120] *See* William Roberts, *Debating the Path Forward on Health Care Reform*, WASH. LAW., Jan./Feb. 2020, at 32, 34.

closed their practices to Medicare patients entirely.[121] While such limits are effectively impractical for certain medical specialties such as geriatrics and internal medicine, other specialties can and do impose such limitations. These limitations have a direct impact, it should be noted, on the Medicare patients themselves: if preferred providers will not accept Medicare, the resulting loss of access diminishes the value of having Medicare coverage.

But as long as there are significant non-Medicare sources of payment for health care providers, Medicare beneficiaries can obtain the services they want from providers they prefer. This situation could change rather dramatically, however, if non-Medicare sources of payment become fewer, which is essentially the environment that Medicare-for-All envisions. Medicare-for-All prohibits any private insurance that would duplicate coverage of the services that program covers.[122] Although Medicare-for-All allows providers to contract privately with individual patients,[123] any provider who does so is effectively barred from seeing patients who are covered by Medicare-for-All for one year.[124] How many health care providers would pursue that route is extremely unclear at this point, but it is certainly possible that even more doctors would stop seeing Medicare-for-All patients than is the case with Medicare presently. If that happens, current and future beneficiaries of the present Medicare program would be especially disadvantaged by the transition to Medicare-for-All.

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[121] THE PHYSICIANS FOUND., 2018 SURVEY OF AMERICA'S PHYSICIANS: PRACTICE PATTERNS & PERSPECTIVES 16 (2018) (available at https://physiciansfoundation.org/wp-content/uploads/2018/09/physicians-survey-results-final-2018.pdf).

[122] Medicare for All Act of 2019, S. 1129, 116th Cong. § 107(1) (2019). Employers would be similarly prohibited from providing duplicative coverage to their employees, former employees, or dependents of current or former employees. *Id.* § 107(2).

[123] *Id.* § 303(a).

[124] *Id.* § 303(c)(1), (2)(B).

VIII. Medicare Can Accommodate Expansion Without Major Disruption

The deficiencies of Medicare as delineated above suggest that the existing program could use some overall updating and reform,[125] but complete upheaval along the lines of Medicare-for-All is not required. History shows that significant programmatic improvements and extensions are possible within the existing framework of Medicare. For example, Medicare was extended in 1972 to disabled persons of any age once they have received disability income checks under the Social Security program for 24 months.[126] Similarly, the option for Medicare managed care was first enacted in 1982[127] and then substantially revised in 1997 as "Medicare + Choice"[128] and again in 2003 as "Medicare Advantage."[129] The addition of prescription drug coverage outside of Medicare managed care was relatively late in coming, but it became operational in 2006 following enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.[130] Other changes, such as lowering the age of eligibility to enable persons younger than age 65 to "buy in" to Medicare have also received serious attention in recent years.[131] Some of these changes are more significant than others, but their enactment or serious consideration demonstrates that shortcomings in Medicare can be remedied without wholesale disruption and chaos.

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[125] *See* Richard L. Kaplan, *Reflections on Medicare at 50: Breaking the Chains of Path Dependency for a New Era*, 23 ELDER L.J. 1, 31–37 (2015).
[126] Social Security Amendments of 1972, Pub. L. No. 92-603, § 201, 86 Stat. 1329, 1370–1374 (1972).
[127] Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 114, 96 Stat. 324, 341–53 (1982).
[128] Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4001**,** 111 Stat. 251, 275–327.
[129] Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 201(b), 117 Stat. 2066, 2176.
[130] *See generally Id.* § 101(a)(2), 117 Stat. 2066, 2071–2150.
[131] *See* Richard L. Kaplan, Nicholas J. Powers & Jordan Zucker, *Retirees at Risk: The Precarious Promise of Post-Employment Health Benefits*, 9 YALE J. HEALTH POL'Y L. & ETHICS 287, 342–54 (2009). *See generally* NAT'L ACAD. SOC. INS., EXAMINING APPROACHES TO EXPAND MEDICARE ELIGIBILITY: KEY DESIGN OPTIONS AND IMPLICATIONS (2020) (available at https://www.nasi.org/sites/default/files/NASI_Medicare%20Report_Final_Digital.pdf).

And one should be very clear: Medicare-for-All would be disruption on a major scale. The entire system of private health insurance for pre-Medicare enrollees would essentially be eliminated, perhaps after a brief "transition" period as the Medicare-for-All proposal provides. Nearly two million people work in that industry[132] and while some of those persons might migrate into the expanded public sector that Medicare-for-All would require, many others would find themselves unemployed. Labor unions that have negotiated health insurance programs that appeal to the specific concerns of their members would likewise see their years-long efforts dashed in favor of the new arrangements. Various other intermediaries, such as pharmacy benefit managers and health insurance consultants to business employers, would similarly be made obsolete.

For some, no doubt, this level of disruption might be a burden worth bearing for an improved health care financing environment, but the bottom line is that Medicare has been expanded and modernized over the years and is certainly capable of additional improvements made in the incremental manner that governmental programs tend to follow.

Conclusion

As this Article has shown, Medicare-for-All as proposed has very little in common with the actual Medicare program as it has been enacted and operated for the past half-century. If anything, the appellation Medicare-for-All should be seen for what it is – basically, a marketing slogan to sell essentially universal health care, a program that the United States has historically been unwilling to enact, based on a superficial and largely inaccurate resemblance to a popular governmental program to finance health care for an apparently "deserving" group of beneficiaries.

At the same time, opinion polls detect a willingness on the part of some Americans to break out of the path dependency that has

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[132] *See* Elisabeth Rosenthal, *'Medicare for All' Could Kill Two Million Jobs, and That's O.K.*, N.Y. TIMES (May 16, 2019), https://www.nytimes.com/2019/05/16/opinion/medicare-for-all-jobs.html.

characterized the wildly complex and uniquely U.S. approach to financing health care. A late-2019 *Wall Street Journal*/NBC News poll, for example, found that "two-thirds of registered voters support letting anyone buy into Medicare."[133] That same poll, however, found that "56% of registered voters oppose a Medicare for All plan that would replace private insurance" and that 62% opposed "providing government-sponsored health care to undocumented immigrants."[134] It is beyond the scope of this Article to assess the political viability of Medicare-for-All, but suffice it to say that a program that promises major revenue reductions for most important sectors of the health care industry (doctors, hospitals, nursing homes, pharmaceutical manufacturers, home health care agencies, pharmacies) and even mass unemployment to others (health insurance companies, pharmacy benefit managers) will encounter possibly insurmountable resistance. Health care reform is always difficult, because few issues affect people so personally and with so much emotion attached. Using Medicare as a rallying cry might help, but the differences between that program and Medicare-for-All are too significant to easily elide and may make the effort even less likely to succeed.

[133] *See* John McCormick, *Medicare Plan Finds Favor*, WALL ST. J., Sept. 22, 2019, at A4.
[134] *Id.*

ETHICAL ISSUES IN REPRESENTING A CLIENT WITH DIMINISHED CAPACITY*

*Howard S. Krooks**

I. Introduction

Attorneys often work with clients who have declined physically or mentally, which is known in legal parlance as diminished capacity.[1] Although Florida law assumes that every person has legal capacity unless a court has determined otherwise,[2] situations arise

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[1] *See* Charles P. Sabatino, *Representing a Client with Diminished Capacity: How Do You Know It And What Do You Do About It?*, 16 J. AM. ACAD. MATRIMONIAL L. 481, 482 (2000).

[2] FLA. STAT. § 744.102(12) (2021). "'Incapacitated person' means a person who has been judicially determined to lack the capacity to manage at least some of the property or to meet at least some of the essential health and safety requirements of the person." *Id.*

during a representation that present the attorney with difficult issues and often complex and challenging circumstances requiring resolution.

The American Bar Association (ABA) Model Rule of Professional Conduct 1.14(a) requires an attorney when representing a client with diminished capacity to maintain a normal client-lawyer relationship as long as possible.[3] Model Rule 1.14(a), while recognizing that the attorney's position is an "unavoidably difficult one,"[4] specifies that in a "normal" client relationship, the attorney should be able to fully communicate with the client, the attorney should protect the client's confidential communications and allow the client to make core decisions about the representation.[5]

Representing a client with diminished capacity puts the attorney in a predicament in procuring accurate information regarding the client's legal problem. To maintain a normal client-lawyer relationship, the attorney must implement a three-stage interview process with the client to determine the legal problem to represent the client effectively. This Article will explore the interview process further in Section XII. The process leads to one of four conclusions: from no evidence of diminished capacity to a lack of capacity and an inability to proceed with the representation.

This article also will examine the rules pertaining to representing a client with diminished capacity and the ethical issues in this circumstance. It will discuss the definitions and legal standards of capacity and the rules as contained in the American Bar Association's Model Rules of Professional Conduct. In addition, this Article will discuss the attorney's role in determining capacity and authority for referring a client for assessment of capacity. Furthermore, it will discuss the duty of communication and confidentiality between the attorney and client, when protective

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[3] MODEL RULES OF PROF'L CONDUCT r. 1.14(a) (AM. B. ASS'N 2021).
[4] *Id.* r. 1.14 cmt. 5.
[5] *Model Rules of Professional Conduct as Adopted by ABA House of Delegates, February 2002 - Center for Professional Responsibility*, AM. B. ASS'N, (Apr. 13, 2002), https://www.americanbar.org/groups/professional_responsibility/policy/ethics_2000_commission/e2k_redline/.

action can be brought by the attorney, and the importance of knowing a client's habitual behaviors and values, as they may be confused with incapacity. Additionally, the article will suggest some practical tips for ethically dealing with clients with diminished capacity.

II. What Is Capacity?

There is no universal definition of capacity.[6] While there is a difference between clinical capacity and legal capacity, there also are several different legal standards of diminished capacity, from testamentary capacity and donative capacity to contractual capacity.[7]

The phrase "being of sound mind" is commonly used in a last will and testament. The term "sound mind" is rather vague, but refers to a person knowing what's going on around him or her and being capable of making important decisions.[8] For example, if a person is lucid enough to sign and execute a will, he or she is said to have testamentary capacity.[9] The person might not be able to take care of all of his or her business or personal affairs or might even lack testamentary capacity before or after signing a will. There is no requirement that the person demonstrate capacity over a long period. The only requirement is that the person must have testamentary capacity when the will is executed.[10]

Donative capacity refers to the ability to make a gift of property or assets with the understanding of the nature and extent of the property to be donated.[11] Contractual capacity is the ability of the person to execute a contract and understand the ramifications of his or her actions.[12] For example, a person may have the capacity to

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[6] ABA COMM. ON L. & AGING & AM. PSYCHOLOGICAL ASS'N, ASSESSMENT OF OLDER ADULTS WITH DIMINISHED CAPACITY: A HANDBOOK FOR LAWYERS 5 (2005).
[7] *Id.* at 5–6.
[8] *Id.* at 5.
[9] *Id.*
[10] *Id.*
[11] *Id.* at 6.
[12] *Id.*

make decisions regarding certain simple matter but lack the capacity for other more complex affairs. This Article will discuss the legal standards of diminished capacity in greater detail in Section VII. Who determines capacity? Is it a doctor, a court, or someone else?

Some people believe it is inappropriate for attorneys to make capacity assessments. After all, they are not clinically trained in evaluating capacity. Yet, attorneys make capacity judgments daily, without formal training, including the initial determination of capacity as to whether clients can enter into the client-lawyer relationship.[13] Throughout the representation, when signs are present that capacity is questionable, the attorney must make deliberate efforts to assess capacity.[14] Subsequent assessments of capacity beyond the initial assessment may be needed as capacity is fluid. The bottom line is capacity assessments by lawyers are unavoidable.

When making an assessment, the attorney must always presume capacity.[15] The attorney may seek guidance from an appropriate diagnostician in determining the extent of a client's diminished capacity but should obtain client consent before any screening tests are performed.[16] If a person is unable to consent, a legally authorized surrogate could make this decision.[17] If necessary, an attorney can bring protective action if reasonably believed that a client has diminished capacity and is at risk of substantial physical, financial, or other harm, and in appropriate cases, seek the appointment of a guardian.[18] This Article will address how attorneys can bring protective action later on in Section X.

Working with clients who have declined physically or mentally is something attorneys face all the time. In the elder law world, this is known as diminished capacity.[19] However, there is a big

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[13] CAROLYN REINACH WOLF ET AL., HOW DO THESE DIAGNOSES/SYMPTOMS AFFECT CAPACITY AND/OR LEGAL REPRESENTATION, DISTINGUISHING DEMENTIA FROM MENTAL ILLNESS AND OTHER CAUSES OF DECLINE 24–25 (2017).
[14] MODEL RULES OF PROF'L CONDUCT r. 1.14(a) (AM. B. ASS'N 2021).
[15] FLA. STAT. § 744.3201 (2020).
[16] MODEL RULES OF PROF'L CONDUCT r. 1.14 cmt. 6.
[17] *Id.* r. 1.14 cmt. 5.
[18] *Id.*
[19] *See* Sabatino, *supra* note 1, at 482.

difference between the legal definition of diminished capacity and the clinical definition of diminished capacity.[20]

Much of the clinical testing done on people to determine if diminished capacity exists deals with their ability or inability to perform activities of daily living (ADLs).[21] ADLs are functional skills needed every day, such as eating, bathing, dressing, and walking.[22] A person's ability to perform ADLs is critical for living independently.[23] An assessment of a person's capacity for performing ADLs can determine a person's need and eligibility for state and federal assistance programs.[24] A person's decline in ability to perform ADLs can be caused by many different things, including acute illness or injury, decreased physical and cognitive functioning from normal aging, the side effects of medication, social isolation, and more severe cognitive impairment from different forms of dementia.[25]

Medically, a doctor may perform a mini mental state evaluation that tests if the person can count backward from twenty to one, if he or she can remember what year it is, or if he or she can identify who the president of the United States is; in addition, a doctor may test physical acuity, such as tying shoes, transitioning between sitting and standing or walking.[26] These quick tests screen for cognitive impairment, including short-term memory, orientation, and language function, but do not examine long-term memory or the reasons for the impairment.[27]

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[20] *See* ABA COMM. ON L. & AGING & AM. PSYCHOLOGICAL ASS'N, *supra* note 6, at 9–11.
[21] PETER F. EDEMEKONG ET AL., ACTIVITIES OF DAILY LIVING (2020) (available at https://www.ncbi.nlm.nih.gov/books/NBK470404/).
[22] *Id.*
[23] *Id.*
[24] *Id.* at 2.
[25] *Id.*
[26] *See* Hayley Willacy, *Mini Mental State Examination*, PATIENT (Feb. 6, 2017), https://patient.info/doctor/mini-mental-state-examination-mmse#:~:text=The%20mini%20mental%20state%20examination,or%20following%20a%20head%20injury.
[27] *See id.*

Nurses and other healthcare providers often assess a person's ability to perform ADLs before discharge from the hospital, as patients unable to perform ADLs might benefit from home assistance, rehabilitation, or placement in along-term care facility for further therapy.[28]

However, just because a person is determined to be of diminished capacity from a clinical perspective does not necessarily mean he or she is of diminished capacity from a legal perspective.

III. The Impact of Dementia on Diminished Capacity

When speaking about clinical diminished capacity, this not only refers to a client's physical inability to perform ADLs but also may include the client's mental inability to perform ADLs from the many different forms of dementia. It's important to note there is a difference between the cognitive decline that occurs with normal aging and dementia.[29]

According to the University of California San Francisco's Weill Institute for Neurosciences, our thinking ability appears to peak around age thirty and declines slowly from there.[30] Some of the more common signs of normal age-related decline include: "overall slowness in thinking and difficulties sustaining attention, multitasking, holding information in mind and word-finding," but some thinking abilities are not affected by normal aging, such as vocabulary, reading, and verbal reasoning; they may even improve as an individual ages.[31]

While the mild cognitive impairment that comes with normal aging does not prevent one from doing regular everyday tasks, physical and cognitive decline associated with abnormal aging and dementia can be severe and may interfere with everyday tasks. Some examples of the latter include: tripping and falling, tremors, memory issues, the inability to communicate or express oneself, and solving

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[28] EDEMEKONG ET AL., *supra* note 21.
[29] Weill Institute for Neurosciences, *Healthy Aging*, MEMORY AND AGING CENTER, https://memory.ucsf.edu/symptoms/healthy-aging (last visited Mar. 20, 2021).
[30] *Id.*
[31] *Id.*

common problems; physical and cognitive decline may also interfere with driving, cooking, or shopping.[32]

In addition, as a person ages, he or she is at an increased risk for having multiple chronic diseases, which could lead to functional impairment with ADLs.[33] Worsening memory issues or confusion is a form of cognitive impairment and could be a sign of the early stages of dementia.[34]

According to the Centers for Disease Control (CDC), "Dementia is not a specific disease but is rather a general term for the impaired ability to remember, think, or make decisions that interfere with doing everyday activities."[35] Alzheimer's disease, the most common form of dementia,[36] begins with mild memory loss and progressively worsens, leading to the loss of the ability to respond to one's environment.[37] Alzheimer's disease accounts for between sixty to eighty percent of dementia cases.[38]

More than five million Americans are living with Alzheimer's disease, and that number is expected to grow to fourteen million by 2060 in the United States.[39] It is the sixth leading cause of death of U.S. adults, according to the CDC.[40] The costs of treating Alzheimer's disease in the United States are staggering. They are expected to be between $379 billion to more than $500 billion per year by the year 2040.[41]

If one adds in the cost of long-term care, the costs are likely higher. The Alzheimer's Association believes the total national cost

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[32] *Id.* at 2.
[33] NAT'L ASS'N CHRONIC DISEASE DIRECTORS, CHRONIC DISEASES AND COGNITIVE DECLINE — A PUBLIC HEALTH ISSUE 2 (2020) (available at https://www.cdc.gov/aging/pdf/20-03-Chronic-Diseases-and-Cognitive-Decline-Pages-h.pdf).
[34] *Id.* at 2.
[35] *Alzheimer's Disease and Healthy Aging, What is Dementia?*, CDC, https://www.cdc.gov/aging/dementia/index.html (last updated Apr. 5, 2019).
[36] *Id.*
[37] *Id.*
[38] *Id.*
[39] *Alzheimer's Disease and Related Demantias*, CDC, https://www.cdc.gov/aging/aginginfo/alzheimers.htm#Who (last updated June 2, 2020).
[40] *Id.*
[41] *Id.*

of health care, long-term care, and hospice care for people with Alzheimer's disease will be in excess of $1 trillion by the year 2050.[42]

Attorneys will inevitably encounter clients with this devastating disease and other forms of physical and cognitive impairment, and must be prepared to work with them and their families, providing professional counsel in an empathetic and caring manner. They must understand and be sensitive to people who have dementia, the challenges they encounter daily, and the emotional toll dementia has taken on both the client and on the whole family. Additionally, attorneys must be able to assess a person's ability to maintain a normal client-lawyer relationship, notwithstanding a diagnosis of dementia or Alzheimer's disease.

IV. Executive Function Is Key to Capacity

What attorneys need to be concerned with most is not a specific diagnosis, such as dementia or Alzheimer's disease, but their client's executive function.[43] Is the client able to make decisions regarding his or her legal matters, estate planning, financial future, living arrangements, and the welfare of his or her spouse and family?

Consider this scenario:

An attorney meets with a client to discuss case strategy and notices the client repeats himself two or three times in the same conversation, forgets what he had for lunch that day but still fully understands who the attorney is, what the attorney is doing, and what the conversation is about. The client is fully capable of making

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[42] Mike Lynch, *New Alzheimer's Association Report Reveals Sharp Increases in Alzheimer's Prevalence, Deaths, Cost of Care*, ALZHEIMER'S ASS'N (May 30, 2018), https://www.alz.org/news/2018/new_alzheimer_s_association_report_reveals_sharp_i#:~:text=Total%20national%20cost%20of%20caring,other%20costs%20total%20%2430%20billion.

[43] Ester Heerema, *How Executive Functioning is Affected by Dementia*, VERYWELL HEALTH (Feb. 4, 2020), https://www.verywellhealth.com/executive-functioning-alzheimers-98596#:~:text=Other%20examples%20of%20impaired%20executive,choices%20affect%20those%20around%20them.

decisions about his legal representation. Now, fast forward six months, and the attorney is having a discussion with the client about changing the legal strategy, yet the client cannot understand what the attorney is talking about or make the same types of decisions. The client's decline is definitely noticeable, but he has not been declared legally incapacitated.

On the legal side, the law assumes that every person has legal capacity unless a court has determined that he or she lacks capacity.[44] Many people may lack capacity in both the clinical and legal sense, but they don't have guardians appointed for them simply because they haven't been brought to court. In the eyes of the law, these people are still assumed to have capacity, even if they really don't.[45]

From the attorney's perspective, one may very well be dealing with someone who lacks capacity but has not been adjudicated as incapacitated. So, what can be done about it?

V. Rules Pertaining to Lawyers Representing Clients with Diminished Capacity

As mentioned at the beginning of the article, the Model Rule of Professional Conduct 1.14(a) requires an attorney when representing a client with diminished capacity to maintain a normal client-lawyer relationship as long and as far as reasonably possible.[46] The rule recognizes that the attorney's position is an "unavoidably difficult one."[47] It specifies that in a normal client relationship, the attorney should be able to fully communicate with the client, the attorney should protect the client's confidential communications and should allow the client to make core decisions

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[44] *See* FLA. STAT. § 744.3201 (2020). An "[i]ncapacitated person means a person who has been judicially determined to lack the capacity to manage at least some of the property or to meet at least some of the essential health and safety requirements of the person." *Id.* § 744.102(12).

[45] *Id.* § 744.1012(3).

[46] MODEL RULES OF PROF'L CONDUCT r. 1.14 (AM. B. ASS'N 2021).

[47] *Id.* r. 1.14 cmt. 8.

about the representation.[48] Let's take a look at a couple of the duties as laid out in the Model Rules of Professional Conduct that pertain to representing clients with diminished capacity.

A. Rule 1.4: The Duty of Communications

The Duty of Communications rule requires an attorney to explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation and so the client can actively participate in his or her own representation.[49] The attorney must "promptly consult with and secure the client's consent prior to taking action," to " reasonably consult with the client about the means to be used to accomplish the client's objectives," and to comply promptly with a client's reasonable request.[50]

The rule recognizes that communications may be adjusted:

- to the representation;
- to the comprehension and needs of the client; and
- even allowing for delaying transmission of information if the delay is not "to serve the lawyer's own interest or convenience, or the interests or convenience of another person."[51]

B. Rule 1.6: The Duty of Confidentiality of Information

Confidentiality is a core value of the client-lawyer relationship.[52] All information relating to the representation is confidential, including any observations made by the attorney regarding a client's capacity.[53] Confidentiality remains vital even when the client has diminished capacity. An attorney must maintain

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[48] *Id.* r. 1.14 cmt. 1.
[49] *Id.* r. 1.4(b).
[50] *Id.* r. 1.4 cmts. 2–4.
[51] *Id.* r. 1.4 cmt. 7.
[52] *Id.* r. 1.6.
[53] *Id.* r. 1.6 cmt. 3.

client confidentiality even from concerned family members unless the client has consented to disclosure or if there is a need for protective action.[54]

According to the ABA's Model Rule of Professional Conduct 1.6, an attorney cannot reveal information related to the representation of a client unless the client gives informed consent, except:

- if the attorney believes it's reasonably necessary to prevent the client's "certain death or substantial bodily harm";
- "to prevent the client from committing a crime or fraud that is reasonably certain to result in substantial injury to the financial interests of another";
- "to secure legal advice about the compliance with these Rules";
- to respond to allegations in any proceeding concerning the representation of the client;
- to comply with a court order;
- to resolve conflicts of interest if the lawyer changes employment (the revealed information must not compromise the attorney-client privilege).[55]

The Duty of Confidentiality of Information further indicates that the attorney should "make reasonable efforts to prevent the inadvertent or unauthorized disclosure of, or unauthorized access to, information relating to the representation of a client."[56]

With this rule, a lawyer is authorized to reveal information about the client but only to the extent reasonably necessary to protect the client's interests.[57] Disclosing information about a client's diminished capacity can be a major risk and devastating to a client's interests. It could lead to serious consequences, including proceedings for involuntary commitment. Before consulting with a

[54] *Id.* r. 1.6(a).
[55] *Id.* r. 1.6(b).
[56] *Id.* r. 1.6(c).
[57] *Id.* r. 1.6(a).

diagnostician or family member about a client's condition, consider how that person may react and if their actions may be adverse to the client's interests.[58] Representing a client with diminished capacity puts the attorney in a predicament. Should the attorney say or do something to protect the client, or should the attorney keep the client's confidence? Because of the duties mentioned above, the attorney is compelled to try to communicate with the client and keep the client's condition confidential for as long as reasonably possible. So, how does the attorney effectively determine the client's objective and legal needs when the client appears to have diminished capacity?

VI. Attorney Assessment of Capacity

To maintain a normal client-lawyer relationship, the attorney must implement a three-stage interview process with the client to determine the legal problem to represent the client effectively.[59]

To make a thorough analysis of a client's capacity, the attorney should observe the client and interpret any signs of diminished capacity, evaluate and determine the specific legal elements of capacity for the transaction, and complete the analysis.[60]

The first step the attorney takes is called **Preliminary Problem Identification**, where the lawyer asks the client open-ended questions.[61] The attorney allows the client to relay the legal problem and the relief he or she seeks in a way that is most comfortable for the client.[62]

Next, the lawyer conducts a **Chronological Overview**, where the lawyer asks the client to relay the legal problem in a systematic successive manner, beginning when the legal problem first arose.[63]

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[58] *Id.* r. 1.14 cmt. 8.
[59] ABA COMM. ON L. & AGING & AM. PSYCHOLOGICAL ASS'N, *supra* note 6, at 13.
[60] *Id.*
[61] *Id.* at 17–18.
[62] *Id.* at 18.
[63] *Id.* at 14.

Finally, the attorney determines the possible causes of action or a planning strategy applicable to the client's case in the **Theory Development and Verification** step.[64]

The process of determining the legal problem to represent the client effectively leads to one of four conclusions:

1. There is minimal to no evidence of diminished capacity, in which case the representation can proceed.
2. There are some mild capacity concerns, but they are not substantial, in which case the representation can proceed.
3. Capacity concerns are more than mild or substantial, and professional consultation or formal assessment of capacity may be merited. In this case, only if the client is determined to have capacity by a professional may the representation proceed.
4. The capacity to proceed with the requested representation is lacking, in which case the representation may not proceed.[65]

VII. Legal Standards of Diminished Capacity

Previously, this Article referred to the difference between clinical capacity and legal capacity. A further analysis is required for legal capacity standards. According to the law, there are several legal standards of diminished capacity.[66]

One type of capacity is **Testamentary Capacity**.[67] This means at the time of executing a will, the testator (client) "must have the capacity to know the natural objects of his or her bounty."[68] In other words, the testator must "understand the nature and extent of his or her property and interrelate those elements sufficiently to make a disposition of property according to a rational plan."[69]

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[64] *Id.* at 20.
[65] *Id.* at 21.
[66] *Id.* at 5–6.
[67] *Id.* at 5.
[68] *Id.*
[69] *Id.*

This does not mean the testator must be capable of managing all of his or her day-to-day affairs.[70] The testator also does not have to have capacity consistently through time (i.e., the testator can sign his or her will at a lucid interval and lack capacity immediately before or after).[71] Testamentary capacity is considered the lowest level of capacity a person must have to execute a valid will.[72]

Another type of capacity is called **Donative Capacity**, where the donor (client) has the capacity to make gifts.[73] This requires an "understanding of the nature and purpose of the gift," including an "understanding of the [type] and extent of the property to be given, a knowledge of the natural objects of the donor's bounty, and an understanding of the nature and effect of the gift."[74] Some states require a higher standard for donative capacity than testamentary capacity.[75]

A third type of capacity is **Contractual Capacity**, where the courts assess the person's "ability to understand the nature and effect of the act and the business being transacted."[76] Contractual capacity requires a higher level of capacity than testamentary capacity.[77] If the transaction is highly complicated, an even higher level of understanding may be needed versus a simple transaction.[78] Minors, by definition, have no legal capacity to contract, and such contracts are generally voidable by the person who lacked capacity.[79]

Other standards of capacity include the capacity to convey real property or execute a deed, to execute a durable power of attorney, to mediate, and to make healthcare decisions.[80]

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[70] *Id.*
[71] *Id.*
[72] *See id.*
[73] *Id.* at 6.
[74] *Id.*
[75] *Id.*
[76] *Id.*
[77] *Compare id.*, *with id.* at 5 (explaining the standard for "testamentary capacity"); *id.* at 6 (explaining the standard for "contractual capacity").
[78] *Id.* at 6.
[79] Richard Stim, *Who Lacks the Capacity to Contract?*, NOLO, https://www.nolo.com/legal-encyclopedia/lack-capacity-to-contract-32647.html (last visited Mar. 20, 2021).
[80] ABA COMM. ON L. & AGING & AM. PSYCHOLOGICAL ASS'N, *supra* note 6, at 6.

For example, the capacity to make healthcare decisions is defined by the Uniform Health Care Decisions Act as the "individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health-care decision."[81] Health care capacity is related to the concept of informed consent.[82] In a clinical sense, informed consent means the patient not only decides to undergo the procedure or treatment but also *understands* the treatment and *voluntarily* agrees to undergo the treatment.[83] For attorneys, a client's capacity to make a healthcare decision may be needed to execute a Designation of Health Care Surrogate or other healthcare advance directives, similar to the capacity to contract.[84]

VIII. The Attorney's Role in Determining Capacity

Once an attorney understands the need to assess capacity as an integral part of his or her ability to render legal representation, what is the attorney looking for in determining if capacity exists? To answer that, we must explore the many possible signs indicating diminished capacity. Possible cognitive signs of diminished capacity, or in some cases, incapacity, include:

Short-Term Memory Loss

- Quickly forgetting information just discussed
- Repeating the same statements
- Asking the same questions multiple times
- Difficulty describing recent events
- Inability to discuss sports or weather ("small talk")

Communication Problems

- I brought my "thing" with the papers in it (i.e., notebook)

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[81] *Id.* (citing Uniform Health-Care Decisions Act § 1.3 (1993)).
[82] *Id.*
[83] *See id.*
[84] *Id.*

- Defers to others excessively ("My wife handles all my appointments; you'd have to ask her.")
- Difficulty staying on topic
- Difficulty finding words
- Comprehension problems
- Difficulty repeating back or paraphrasing simple concepts

Calculation Problems

- Difficulty with simple math
- Adding dollar amounts
- Inability to line up columns when adding
- Lack of awareness of financial assets

Disorientation

- Relative to time, space, or location
- Difficulty navigating the attorney's office building spatially
- Getting lost driving to the office
- Knowing what time it is
- Knowing what year it is

Significant Emotional Distress

- Client appears extremely anxious, tearful, or depressed.
- Emotional inappropriateness
- Experiencing a wide range of emotions (moving quickly from laughter to tears)
- Expressing feelings that seem highly inconsistent with what he or she is discussing (e.g., laughter when discussing death)

Delusions

- Belief that neighbor or government is spying on them
- Belief that food is poisoned (for assisted living facility or nursing home residents)
- Hallucinations
- Hearing voices nobody else can hear
- Having a conversation with another person who is not there

Poor Grooming and Hygiene

- No hair brushing
- No shaving
- No regular bathing or showering
- Wearing multiple layers of clothing[85]

Some suggest that it is inappropriate for an attorney to make a capacity assessment. Yet, the attorney makes capacity judgments daily, without formal training, including the initial determination of capacity as to whether the client can enter into the client-lawyer relationship.[86] Throughout the representation, when signs, such as those mentioned above, indicate that capacity is questionable, the attorney must make deliberate efforts to assess capacity.[87] Subsequent assessments of capacity beyond the initial assessment may be needed, as capacity is fluid.[88] The bottom line is that capacity assessments by lawyers are unavoidable.

If we accept the above premise, then the following questions will arise for the lawyer in assessing capacity:

1. When does a lawyer rely on his or her own instincts?
2. When should a lawyer refer the client to another professional for assessment?

IX. Does the Lawyer Have Authority to Refer a Client for Assessment?

First and foremost, the attorney must always presume capacity.[89] For an assessment to take place, the concerned parties must

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[85] *See id.* at 14–16.
[86] WOLF ET AL., *supra* note 13, at 25–26.
[87] *See* MODEL RULES OF PROF'L CONDUCT r. 1.14 (AM. B. ASS'N 2021).
[88] Laura J. Whipple, Comment, *Navigating Mental Capacity Assessment*, 29 TEMP. J. SCI. TECH. & ENVTL. L. 369, 370 (2010) ("[C]apacity is not a stagnant object . . . [and] can vary by mood, time of day, medication, physical condition of the individual, and the impact of any number of debilitating diseases.").
[89] FLA. STAT. § 744.102(12) (2020) ("'Incapacitated person' means a person who has been judicially determined to lack the capacity to manage at least some of the property or

overcome the presumption of capacity by a client exhibiting evidence of impaired decision-making.[90]

When the lawyer is not comfortable relying on his or her own instincts, he or she may wish to refer the client to a professional for formal assessment. Can the lawyer do this?

According to the ABA Model Rule of Professional Conduct 1.14, Comment 6, the "lawyer may seek guidance from an appropriate diagnostician" in determining the extent of the client's diminished capacity.[91]

The lawyer should obtain client consent for any assessments or screening tests performed or for referrals to other professionals for testing.[92] Client consent is crucial. Even clients with diminished capacity must still consent to being screened.[93] If a person is unable to consent, then consider whether there is a legally authorized surrogate who can make this decision, either someone named by the client as durable power of attorney or as a health care surrogate.[94] If there is no legally authorized person who can make a screening decision, and the lawyer does not believe the client is of sufficient capacity to provide that consent, protective action may be required (see Section X below).

The ABA's Restatement (Third) of the Law Governing Lawyers, Comment d. to Section 24, states "where practicable and reasonably available, independent professional evaluation of the client's capacity may be sought." [95] A referral to a physician for a medical exam can help rule out if the client is being overmedicated or taking a toxic combination of medications that could affect

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to meet at least some of the essential health and safety requirements of the person."); § 744.3201 ("Petition to determine incapacity.").

[90] *See* ABA COMM. ON L. & AGING & AM. PSYCHOLOGICAL ASS'N, *supra* note 6, at 31–36; Raphael J. Leo, *Competency and the Capacity to Make Treatment Decisions: A Primer for Primary Care Physicians*, 1(5) PRIMARY CARE COMPANION J. CLINICAL PSYCHIATRY 131, 132 (1999).

[91] MODEL RULES OF PROF'L CONDUCT r. 1.14 cmt. 6 (AM. B. ASS'N 2021).

[92] ABA COMM. ON L. & AGING & AM. PSYCHOLOGICAL ASS'N, *supra* note 6, at 34–35.

[93] *Id.*

[94] *See id.* at 40.

[95] RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 24 cmt. d (AM. B. ASS'N 2007).

capacity.[96] A medical exam can also uncover issues such as a poor diet, vitamin deficiencies, depression, infectious diseases, head trauma, poor eyesight, and other treatable conditions.[97]

Diagnosticians may include psychiatrists, psychologists, gerontologists, and other health professionals who can perform professional evaluations.[98] A doctor's letter detailing the capacity assessment can be very helpful, especially in potentially conflicted cases, in assisting the attorney to determine if a client has capacity.[99]

If an agent under a power of attorney or other legal representative has been appointed for the client, the attorney should look to the representative for decisions on behalf of the client, according to the ABA Model Rule of Professional Conduct 1.14, Comment 4.[100]

In addition, the attorney can consult with family members. According to Model Rule 1.14, Comment 3, "[t]he client may wish to have family members or other persons participate in discussions with the lawyer."[101]

If the attorney has strong concerns about a client's capacity or possible future litigation concerning the client's capacity,[102] and the conclusion is to seek a medical referral, clinical consultation, or evaluation from an "appropriate diagnostician,"[103] the attorney must know the basic steps of making a referral and how to select a clinician.[104]

In an initial conversation between the attorney and clinician to discuss concerns about a client, the attorney should not identify the client.[105] Sometimes, an attorney will seek a private consultation with a clinician to clarify capacity issues before deciding to

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[96] ABA COMM. ON L. & AGING & AM. PSYCHOLOGICAL ASS'N, *supra* note 6, at 17.
[97] *See id.* at 16–17.
[98] *See id.* at 32–33.
[99] *See id.* at 39.
[100] MODEL RULES OF PROF'L CONDUCT r. 1.14 cmt. 4 (AM. BAR ASS'N).
[101] *Id.* r. 1.14 cmt. 3.
[102] ABA COMM. ON L. & AGING & AM. PSYCHOLOGICAL ASS'N, *supra* note 6, at 31.
[103] "The lawyer may seek guidance from an appropriate diagnostician." MODEL RULES OF PROF'L CONDUCT r. 1.14 cmt. 6.
[104] ABA COMM. ON L. & AGING & AM. PSYCHOLOGICAL ASS'N, *supra* note 6, at 31–36.
[105] *Id.* at 34.

proceed.[106] Client consent is not required at this point. If the attorney does proceed with a formal referral, the attorney would need the client's consent, even if a written report is not completed.[107] The attorney should have a comprehensive discussion with the client and family members detailing the attorney's concerns before obtaining the client's consent.[108]

A formal evaluation/capacity report by an objective expert can be quite valuable in a case, as the opinions of the clinician can be used as evidence.[109] A drawback here is that a formal written assessment could be used against a client in civil litigation, even if covered under attorney-client or physician-patient privilege.[110] Many states and jurisdictions have exceptions and different interpretations of the law, so protection is not guaranteed.[111] However, a clinical evaluation does not have to be in writing.[112] The attorney can request that the clinician first call the attorney with preliminary conclusions before generating a written report.[113] After hearing the preliminary conclusions, the attorney can determine if the clinician should complete a written evaluation.[114]

To select an "appropriate diagnostician" or clinician, the best choice is an experienced medical or mental health professional in the area of expertise needed. For example, if a client is exhibiting signs of dementia, a neurologist with expertise in Alzheimer's disease would be appropriate,[115] whereas, if you think a client is suffering from a mental illness, such as schizophrenia, a psychiatrist is better suited to making an evaluation.[116]

Other clinicians an attorney can refer a client to include experienced geriatric physicians, geriatric psychiatrists, or gero-

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[106] *Id.* at 31.
[107] *Id.* at 31–36.
[108] *Id.* at 35–36.
[109] *Id.* at 31.
[110] *Id.* at 31–32.
[111] *Id.* at 32.
[112] *Id.*
[113] *Id.*
[114] *Id.*
[115] *Id.*
[116] *Id.*

psychologists who are specialists working with older adults.[117] Before selecting a clinician, an attorney should research the clinician's experience, as well as the tests performed and costs before making a referral.

X. Can the Lawyer Bring Protective Action?

The quick answer to this question is yes. According to the ABA Model Rule of Professional Conduct 1.14(b):

> When the lawyer reasonably believes that the client has diminished capacity, is at risk of substantial physical, financial or other harm unless action is taken, and cannot adequately act in the client's own interest, the lawyer may take reasonably necessary protective action, including consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a guardian ad litem, conservator, or guardian.[118]

For an attorney to bring protective action for a client, the requirements include:

- Existence of diminished capacity;
- A risk of substantial harm;
- An inability to act adequately in one's own interest.[119]

When taking protective action for a client, the lawyer is impliedly authorized to reveal information about the client, but only to the extent reasonably necessary to protect the client's interests (see Model Rule 1.14(c)).[120]

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[117] *Id.*
[118] MODEL RULES OF PROF'L CONDUCT r. 1.14(b) (AM. BAR ASS'N 2021).
[119] *Id.*
[120] *Id.* r. 1.14(c).

Taking protective action with a client is only done as a last resort when the normal client-attorney relationship cannot be maintained because the client lacks the capacity to communicate or make decisions about the representation.

Protective actions might include:

- Consulting with family members;
- Waiting for a certain period to permit clarification or to see if circumstances improve;
- Using decision-making tools like a Durable Power of Attorney; or
- Seeking professional services and protective agencies to protect the client.[121]

With any protective action, the attorney should take into account the wishes and values of the client, if known, and always act in the best interests of the client. The attorney should allow the client to maintain decision-making autonomy as much as possible.[122]

When necessary and in the appropriate circumstances, Model Rule 1.14 allows for the lawyer to seek guidance from a diagnostician.[123] Further, if the client does not have a legal representative appointed, the lawyer should consider if a guardian ad litem, conservator or guardian is necessary to protect the client's interests.[124] This step may not be necessary, as it represents a significant expense and can be quite traumatic to the client and family.[125] The ABA recommends the lawyer advocate for the least restrictive action on behalf of the client.[126]

A lawyer can take legal action on behalf of a person with diminished capacity in an emergency where the health, safety, or financial interests of the person is threatened.[127] However, the

[121] *Id.* r. 1.14 cmt. 5.
[122] *Id.*
[123] *Id.* r. 1.14 cmt. 6.
[124] *Id.* r. 1.14 cmt. 7.
[125] *Id.*
[126] *Id.*
[127] *Id.* r. 1.14 cmt. 9.

lawyer should only act if the client does not have another agent or representative, and then take legal action "only to the extent reasonably necessary to maintain the status quo or otherwise avoid imminent and irreparable harm."[128] The attorney must still maintain the client's confidences, disclosing information about the client to a family member, diagnostician or court only to the extent necessary to accomplish the protected action.[129]

XI. The Importance of Knowing a Person's Habitual Behavior, General Health and Values

A great danger in capacity assessment is that a client's eccentricities, aberrant character traits, health conditions, stress, hearing, and vision loss, or risk-taking will be confused with incapacity.[130]

Consider the following example of one client:

The doctors wondered, was she uncooperative, cantankerous, and obstinate because her memory and mental function were impaired, or was she a woman who had spent a long lifetime being uncooperative, cantankerous, and obstinate?

The woman's daughter was able to say that her mom had always been obstinate, but being uncooperative and cantankerous were new characteristics, more than likely associated with her recent injury. The main point of this is that a person does not lack capacity merely because he or she does things that other people find disagreeable or difficult to understand.[131]

Indeed, what may seem like incapacity to an outside observer, may be quite normal for that person and be more representative of a personality trait or behavioral pattern by the person rather than incapacity. For example, the person could be suffering from grief, stress, depression, hearing or vision loss, or a number of reversible health conditions.[132] In addition, an attorney should take into

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[128] *Id.*
[129] *Id.* r. 1.14 cmt. 10.
[130] ABA COMM. ON L. & AGING & AM. PSYCHOLOGICAL ASS'N, *supra* note 6, at 16–17.
[131] *Id.* at 17.
[132] *Id.* at 16.

account the client's educational, socio-economic, and cultural backgrounds.[133]

XII. The Assessment Interview

When assessing a client's capacity, the attorney should attempt to optimize capacity by taking a few reasonable steps before and during the assessment interview.[134]

The attorney should always attempt to interview the client alone.[135] However, sometimes family, friends or caretakers can play an important role in providing essential background information relevant to the work to be done.[136] Attorneys should adjust the interview environment to enhance communication. Impaired vision or hearing often produces non-responsive behaviors that may be wrongly interpreted as a sign of diminished capacity.[137]

Consider these steps to optimize the assessment interview:

- Speak slowly and conduct the interview in a quiet, well-lit area.
- Arrange the furniture in the room, so as to avoid glare from overhead lights or windows.
- Provide necessary audio or visual amplification to facilitate communication and functioning.
- Be patient. Some elder clients need extra time to process the information regarding decisions at hand.
- Meet with the client more than once to acquire a truer sense of the person's decision-making capacity.
- Inaccurate sessions due to fatigue may be avoided by scheduling shorter sessions at times when the client tends to be most alert.

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[133] *Id.* at 17.
[134] *See id.* at 27–30.
[135] *Id.* at 27.
[136] *Id.*
[137] *Id.* at 28.

- Home visits are especially conducive to optimal decision-making for many clients.[138]

Once the above steps have been performed, consider a standardized screening or mini-mental state evaluation where the client should respond to the following requests:

- Delayed recall of three items;
- Repeating a linguistically difficult phrase;
- Following a three-step command;
- Writing a sentence;
- Copying a two-dimensional figure;
- Performing serial threes or sevens, where the client counts backward by threes or sevens (e.g., 30, 27, 24, 21, 18, etc.);
- Spelling the word "world" backwards.[139]

The attorney should document his or her observations from the capacity assessment interview as well as any further analysis and summarize conclusions for the case file. The observations could be helpful if the decision is made to refer the client for further evaluation by a clinician or if further protective action is required.

Depending on the results of the attorney's assessment (from no signs of diminished capacity to mild or substantial concerns—see section VII above for more about this), the conclusion may be to have a private informal conversation seeking advice from a clinician on the findings. This informal conversation does not require client consent; if the attorney's assessment of the client indicates a referral for further assessment or formal evaluation by a clinician is warranted, the attorney must fully disclose his or her observed concerns to the client and obtain the client's consent to proceed..[140]

If a formal evaluation is the decided course of action, the attorney, after having in-depth conversations with the client and

[138] *Id.* at 28–29.
[139] *See id.* at 66.
[140] *Id.* at 31.

client's family members and receiving the client's consent, can refer the client to an "appropriate diagnostician,"[141] typically a physician (geriatrician/gerontologist or neurologist) or mental health professional that specializes in the health of seniors, brain function or cognitive impairment, and one that has experience in doing capacity assessments.[142] The diagnostician will confer with the attorney after making a clinical assessment and the determination will be made to either deliver a written report or not.[143] The attorney will take the formal evaluation's results into consideration upon determining legal capacity.[144] Ultimately, the attorney will make the call if there is sufficient capacity to continue the representation.

XIII. The Relevant Information Contained in an Assessment

What is typically contained in a capacity assessment report from a clinician and what should a lawyer do with that information? The basic elements of a capacity assessment report include:

- Demographic information about the patient/client (age, gender, race, marital status, etc.);
- A brief summary of the legal matter that prompted the assessment;
- A medical history of the patient/client and any current diagnoses, particularly if there are any neurological or psychological illnesses responsible for the patient/client's diminished capacity;
- The patient/client's psychosocial history, including information about the person's current living situation, occupation, and medical and psychiatric family history);
- Informed consent by the patient/client;
- Clinical observations of the person's speech, mood, behavior, etc.;

[141] MODEL RULES OF PROF'L CONDUCT r. 1.14 cmt. 6 (AM. B. ASS'N 2021).
[142] ABA COMM. ON L. & AGING & AM. PSYCHOLOGICAL ASS'N, *supra* note 6, at 32–33.
[143] *Id.* at 32–34.
[144] *Id.* at 33–34.

- A list of the tests administered and a summary of the results of the tests;
- The clinician's diagnosis and impressions from the test results;
- Recommended treatments or next steps.[145]

A key part of the report is a statement of validity by the clinician. This statement describes the effort the patient put forth during the assessment and whether the clinician finds the test results to be reliable and a valid indicator of the patient's level of cognitive health.[146] In the summary section, the clinician will summarize all the test results, clinical interviews and behaviors observed, and determine a diagnosis based on the integration of all of the information available, as well as a statement about the patient/client's capacity level.[147] The clinical opinion might state, for example, that the person's results are consistent with dementia and that he or she has the capacity to make simple decisions but not complex decisions.[148] The report might indicate, depending on the legal matter at hand, that while the person may have mild cognitive decline, the person is capable of signing a Durable Power of Attorney or Designation of Health Care Surrogate, or no capacity to sign the above.[149]

The attorney will review the report and follow up with the clinician as necessary to understand all the findings. The capacity assessment report can be used informally, simply as information about the client to be kept in a client's case file; in the case of a formal assessment for protective action or guardianship proceeding, the written report could be used as evidence in court.[150]

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[145] *Id.* at 37–39.
[146] *Id.* at 38.
[147] *Id.* at 39.
[148] *Id.*
[149] *See id.*
[150] *Id.* at 40.

The report and its findings should be used to support the least restrictive option for the client.[151] If the report is compelling in its findings of diminished capacity, the attorney may take "reasonably necessary protective action" as determined by Model Rule of Professional Conduct 1.14, such as speaking with the client's family members.[152] The overarching goal is to act in the client's best interests and to maximize capacity as much as possible.

XIV. Conclusion

America is rapidly aging, as baby boomers enter their late 50s to 70s, and life expectancy has increased to 78.6 years.[153] The number of Americans age 65 and older is projected to be 95 million in 2060, almost double what it was in 2018 (52 million).[154] While most older people do not suffer from dementia, more than 50 million people worldwide reportedly have Alzheimer's disease.[155] The demand for elder and long-term care will continue to increase dramatically as the number of people living with Alzheimer's increases.[156]

With this aging of our country, attorneys will undoubtedly encounter clients who may have diminished capacity, and they will be faced with having to assess or at least screen those clients for capacity. Attorneys may notice dramatic changes in their clients over time; however, it is quite difficult to be able to tell the difference between normal mild cognitive impairment as one ages compared to the early stages of dementia.[157] A key difference between the two is that someone with dementia will eventually not be able to function independently, while someone who is experiencing mild cognitive issues due to aging will be able to

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[151] *Id.*
[152] MODEL RULES OF PROF'L CONDUCT r. 1.14 (AM. BAR ASS'N 2021).
[153] *Fact Sheet: Aging in the United States*, POPULATION REFERENCE BUREAU (July 15, 2019), https://www.prb.org/aging-unitedstates-fact-sheet/.
[154] *Id.*
[155] *Alzheimer's and Dementia*, ALZHEIMER'S ASS'N, https://www.alz.org/alzheimer_s_dementia (last visited Mar. 20, 2021).
[156] *Fact Sheet: Aging in the United States*, *supra* note 153.
[157] ABA COMM. ON L. & AGING & AM. PSYCHOLOGICAL ASS'N, *supra* note 6, at 68.

maintain their independence.[158] Another sign of dementia is when a person's family is more concerned about a client's forgetfulness, while with normal aging, the client may be more concerned about his or her own memory issues.[159]

The ABA's Model Rule of Professional Conduct 1.14 triggers the need for an attorney to take reasonably necessary protective action if he or she believes that a client has diminished capacity and may not be able to act in his or her own interest.[160] This includes referring clients to and consulting with clinicians, and possibly seeking the appointment of a guardian or conservator. However, the rules also specify that the attorney must maintain a normal client-lawyer relationship as long as reasonably possible, which puts attorneys into an ethical bind when facing a question of capacity.[161] Attorneys naturally want to protect and preserve a client's autonomy and decision-making but they also must act in the client's best interests, which may be some form of protective action to keep that client safe.

Attorneys must know the legal standards of diminished capacity and be able to apply those standards in ethically assessing clients for capacity. They should know how to observe the signs of diminished capacity and know what to do if a client appears to show any of these red flags, from cognitive, emotional, and behavioral problems to memory loss, communication issues and other signs. Attorneys should strive to enhance a client's capacity whenever possible with various techniques, such as amplifying sound or eliminating distracting background noise, making sure the meeting room is well-lit, and practicing patience with clients who may take a little longer to express their thoughts.

If an attorney believes a client has "more than mild" incapacity issues, the attorney should seek an independent and objective opinion of an experienced clinician, while maintaining a client's anonymity. As with any normal client-attorney relationship, an

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[158] *Id.* at 68–69.
[159] *See id.* at 69.
[160] MODEL RULES OF PROF'L CONDUCT r. 1.14(b) (AM. BAR ASS'N 2021).
[161] *Id.* r. 1.14(a).

attorney is expected to maintain communication and confidentiality. A referral to a clinician for a capacity assessment requires a client's consent. This is not something that should be taken lightly, as it could be very traumatic for the client and for the attorney-client relationship.

Finally, the attorney needs to know how to review a capacity assessment report from a clinician, any recommendations for treatment for the client, and any other mitigating factors in making his or her judgment of capacity. As discussed previously, an attorney does not have to be a trained clinician to make a capacity judgment but the more familiar an attorney is with the standards and rules, the better the outcome for all involved.

APPENDIX A:

Practical Tips for Ethically Dealing with Clients with Diminished Capacity[162]

Practical Tip 1:

Capacity is ever changing. It can ebb and flow, so you have to go with the flow. An attorney must be willing to meet the client where and when she or he is most lucid.

Practical Tip 2:

Remember that sometimes a client's diminished capacity might be more of a reflection of our incompetency in adjusting to the emotional, physical, and physiological needs of the client. We have an ethical obligation to presume and enhance a client's capacity.

Practical Tip 3:

Be aware of distractions that may be around your office that would affect the client's capacity, such as outside noise, a view of the plaza/sidewalk outside your office or with people walking by, glare, and difficulty for the client to hear or see you.

Practical Tip 4:

Representing clients with diminished capacity requires more time to explain matters fully. A series of shorter, more focused meetings may be necessary.

Practical Tip 5:

Plan ahead for incapacity by asking permission and receiving consent to speak to others if the client's capacity comes into question.

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[162] Roberta K. Flowers, *Maintaining a "Normal Relationship" with Clients with Diminished Capacity*, 27 NAELA NEWS 19, 20 (2015).

Practical Tip 6:

Listen intently to the client and follow up before jumping to conclusions. The attorney must assume capacity, so if the client says something that seems to indicate incapacity, follow up with questions to clarify what the client meant. Do not jump to the conclusion that what they are saying is inappropriate or evidence that the client has become incapacitated.

Practical Tip 7:

Watch for indications from one meeting to the next that the client is declining. The attorney should always be observant of declining hygiene or physical deterioration.

Practical Tip 8:

The attorney should attempt to meet in private with the client. If the client wishes to have other people present, the attorney must talk directly to the client and not be distracted by the other people. Although it is sometimes a challenge, the attorney must insist that it is the client who speaks and not someone else speaking for the client.

Practical Tip 9:

The attorney should sit facing the client so that the client may be able to obtain visual clues as well as the words themselves.

Practical Tip 10:

Respect and dignity: These are key in working with clients with diminished capacity.

APPENDIX B:

American Bar Association's Model Rules of Professional Conduct Rule 1.14: Client with Diminished Capacity[163]

Client-Lawyer Relationship

(a) When a client's capacity to make adequately considered decisions in connection with a representation is diminished, whether because of minority, mental impairment or for some other reason, the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client.

(b) When the lawyer reasonably believes that the client has diminished capacity, is at risk of substantial physical, financial or other harm unless action is taken and cannot adequately act in the client's own interest, the lawyer may take reasonably necessary protective action, including consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a guardian ad litem, conservator or guardian.

(c) Information relating to the representation of a client with diminished capacity is protected by Rule 1.6. When taking protective action pursuant to paragraph (b), the lawyer is impliedly authorized under Rule 1.6(a) to reveal information about the client, but only to the extent reasonably necessary to protect the client's interests.

American Bar Association's Model Rules of Professional Conduct Rule 1.4: Communications[164]

Client-Lawyer Relationship

(a) A lawyer shall:

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[163] MODEL RULES OF PROF'L CONDUCT r. 1.14 (AM. BAR ASS'N 2021).
[164] *Id.* r. 1.4.

(1) promptly inform the client of any decision or circumstance with respect to which the client's informed consent, as defined in Rule 1.0(e), is required by these Rules;

(2) reasonably consult with the client about the means by which the client's objectives are to be accomplished;

(3) keep the client reasonably informed about the status of the matter;

(4) promptly comply with reasonable requests for information; and

(5) consult with the client about any relevant limitation on the lawyer's conduct when the lawyer knows that the client expects assistance not permitted by the Rules of Professional Conduct or other law.

(b) A lawyer shall explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation.

American Bar Association's Model Rules of Professional Conduct Rule 1.6: Confidentiality of Information[165]

Client-Lawyer Relationship

(a) A lawyer shall not reveal information relating to the representation of a client unless the client gives informed consent, the disclosure is impliedly authorized in order to carry out the representation or the disclosure is permitted by paragraph (b).

(b) A lawyer may reveal information relating to the representation of a client to the extent the lawyer reasonably believes necessary:

(1) to prevent reasonably certain death or substantial bodily harm;

(2) to prevent the client from committing a crime or fraud that is reasonably certain to result in substantial injury to the

[165] *Id.* r. 1.6.

financial interests or property of another and in furtherance of which the client has used or is using the lawyer's services;

(3) to prevent, mitigate or rectify substantial injury to the financial interests or property of another that is reasonably certain to result or has resulted from the client's commission of a crime or fraud in furtherance of which the client has used the lawyer's services;

(4) to secure legal advice about the lawyer's compliance with these Rules;

(5) to establish a claim or defense on behalf of the lawyer in a controversy between the lawyer and the client, to establish a defense to a criminal charge or civil claim against the lawyer based upon conduct in which the client was involved, or to respond to allegations in any proceeding concerning the lawyer's representation of the client;

(6) to comply with other law or a court order; or

(7) to detect and resolve conflicts of interest arising from the lawyer's change of employment or from changes in the composition or ownership of a firm, but only if the revealed information would not compromise the attorney-client privilege or otherwise prejudice the client.

(c) A lawyer shall make reasonable efforts to prevent the inadvertent or unauthorized disclosure of, or unauthorized access to, information relating to the representation of a client.

THE LAW IS THEIR AGEIS*

Peter Stanicz

Table of Contents

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I. Introduction

Every day we face myriads of situations where a decision has to be made. The autonomy to make decisions means power to articulate our priorities, values, and interests. Therefore, autonomy is not only a fundamental human right: it constitutes the essence of human personality. Personal autonomy is often taken for granted. However, this is hardly the case for persons living with mental disorders.

Most legal systems contain protective measures in order to help vulnerable groups of society such as the mentally disabled.[1] The basis of these measures is that people with mental disorders cannot properly understand and decide in their own best interests because they lack the mental capacity to foresee the possible outcomes of a decision.[2] Therefore, protection of vulnerable people requires empowerment of those people to make the right choices or to make the decisions on their behalf by a third party, resulting in the limitation of autonomy.

The case of Bernadette

Bernadette is thirty-eight years old, married, and the mother of a teenager. She is a high school literature teacher who is also completing her PhD. In her free time, she enjoys hiking and writing poems. She describes her life as complete, although she does believe that all good things will eventually come to an end.

Every day she helps her son get ready for school, then goes to work herself. The PhD work takes a toll on her sleep. During the day she spends her time with her husband and son, leaving the

[1] *See Your Legal Disability Rights*, USA.GOV, https://www.usa.gov/disability-rights (last updated June 3, 2020) (providing U.S. resources for people with disabilies); *EU Framework for the UN Convention on the Rights of Persons with Disabilities*, EUR. UNION AGENCY FOR FUNDAMENTAL HUM. RIGHTS, https://fra.europa.eu/en/cooperation/eu-partners/eu-crpd-framework (last visited Feb. 20, 2021) (explaining the EU's framework that was created and implemented to ensure compliance with the UN Convention on the Rights of Persons with Disabilities).

[2] *See* Convention on the Rights of Persons with Disabilties art. 1, Mar. 30, 2007, 2515 U.N.T.S. 3 (entered into force May 3, 2008) [hereinafter CRPD].

research for nighttime; a crucial deadline deprives her of sleeping hours.

Last spring she lost her grandmother; she grieved but did not feel broken. Their relationship was not flawless, but as we all know, conflicts and disagreements happen even despite the closest bonds of family. Shortly afterwards her neighbor passed away, but she had a long life full of adventures. Still, she remained positive. Then, her former friend and fellow poet decided to end his life by his own hands: a tragedy that shattered all that she previously felt was complete in her life.

One day she felt dizzy at school so she went home to rest. She took sedatives as she had been unable to sleep sufficiently for a long time and she finally wanted to rest. Although one pill would have sufficed, Bernadette instead took twleve, and left a suicide note on the night desk.

Bernadette convinced herself that it was a mere misunderstanding. All she wanted was to finally get some sleep. When she came to herself at the psychiatric ward, she immediately realized that something was wrong. She had been there before; the outpatient services are on the left side of the corridor. But this time, they turned right towards the psychiatric ward.

The diagnosis: bipolar affective disorder.[3]

Now that we know Bernadette, do we see her seemingly complete life in different light now? Is the lack of sleep still merely the result of overworking or do we now consider it to be the more disturbing insomnia caused by her mental disorder? Are we still able to believe her to be the loving mother that can provide for all the needs of her teenage son? Given her diagnosis, has the measure of her worth changed?

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[3] *See Bipolar Disorder*, NAT'L INST. OF MENTAL HEALTH, https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml (last updated Jan. 2020) (explaining that "[p]eople with bipolar disorder experience periods of unusually intense emotion, changes in sleep patterns and activity levels, and unusual behaviors . . . . These distinct periods are called 'mood episodes.' Mood episodes are [drastically] different from the moods and behaviors that are typical for the person." Extreme changes in energy, activity, and sleep go along with mood episodes).

This Article argues that diagnoses alone may not automatically justify a change of opinion. Bernadette is still the same knowledgeable and energetic woman, mother, wife, and teacher.

The symptoms of mental disabilities are extremely diverse.[4] Jurisprudential literature also takes notice of this character of mental disorders, as Szladits notes that "[t]he margins of insanity and imbecility are so vague that their distinction is more or less arbitrary, therefore unable to serve as solid justification for far reaching conclusions on various legal circumstances."[5] Even a mentally disabled person with a severe disorder is able to act in a societally conforming manner in numerous situations. Mild or moderate mental disability often means natural, average functioning in everyday situations. The mentally disabled include the schoolkid with mild learning difficulties and the murmuring schizophreniac, as well as the kind but often forgetful neighbouring lady or maybe even our own grandparents. Indeed, the rate of dementia in people ages 95 and up is at least 21% per year, jumping as high as 41% per year in people older than 100.[6] We meet mentally disabled people every single day as they live, work, shop, and run their families.

Since then Bernadette underwent urgent psychiatric care on multiple occasions, thus a Hungarian court put her under guardianship, restricting her legal capacity to decide on her place of residence or healthcare. These restrictions ought to serve Bernadette's best interests. In case her mental status declines, her husband— taking into consideration Bernadette's and the medical professionals' opinions—can make decisions on her behalf. If her mental disorder justifies, she may temporarily be put into a mental care home to help her recovery. The decision, however, is out of Bernadette's control. Her capacity to lead an autonomous, independent life has been jeopardized.

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[4] *Mental Disorders*, WORLD HEALTH ORG. (Nov. 28, 2019), https://www.who.int/news-room/fact-sheets/detail/mental-disorders.

[5] Szladits Károly (ed.): Magyar magánjog, Budapest, 1938, Grill Károly Könyvkiadó Vállalata, pp. 17–23.

[6] Szófia S. Bullain & María M. Corrada, *Dementia in the Oldest Old*, 19 CONTINUUM 457, 458 (2013).

Bernadette mentions that she is aware of her disorder and that she is glad for her husband's help, with whom as guardian, she discusses all the issues and they decide together. However, she also reveals feelings of insecurity and frustration when she is asked about her experiences so far. She holds herself less valuable since being virtually unable to make independent decisions. However, as Bernadette also understands that as a mentally disabled person, she might require assistance in her everyday functioning.

The restriction of individual autonomy through guardianship (and equivalent) measures is a Janus-faced approach. On one hand, a vulnerable person gets close to the institutionalized social care system and those without sufficient family ties are brought back into the sight of society. On the other hand, restriction of autonomy imposes severe boundaries on the person's everyday life. Guardianship in itself is a necessary compromise between respect for personal autonomy and the social obligation to protect vulnerable groups from deteriorating circumstances.

Autonomy grants us the independent nature of our lives; therefore, the ability to self-govern is core to our personality. Thus, its restriction goes beyond a mere restriction of rights, directly affecting our human nature. Mental disabilities show great diversity, but one thing they all have in common is their decision-shaping nature.[7] Accepting autonomy as a fundamental right requires respecting individual decisions even to the extent that they are distorted by mental disorders.

However, there are cases when a person's decision could be significantly harmful to themselves or others. There is a delicate balance between respecting personal autonomy and self-governance and also protecting the vulnerable person's best interests. This Article argues that there is no golden rule in defining when a decision threatens the person's best interests so much that it outweighs the value in protecting that person's autonomy. Instead, a carefully designed and tailor-made protective measure is necessary—one that can evaluate on a case-by-case basis whether

[7] *Mental Disorders*, *supra* note 4.

the threat of harm reaches the tipping-point and overrides the person's right to make a decision.

Cases similar to Bernadette's highlight the human rights implications of legal measures. Bernadette's story begs the question: are there essential universal fundamental rights' safeguards in the guardianship procedures that protect the individual's autonomy? Would it be possible to draw a system of fundamental rights' safeguards that States can implement into their legal systems according to their legal traditions, thus achieving a universally equal level of protection?

This Article additionally argues that procedural safeguards are the stepping stones of constituting the mentioned protective measure. First, to acquire a more complex and holistic understanding of restriction of autonomy, Part II of this Article will discuss nonlegal studies of philosophy, bioethics, psychology, and medicine. Part III will attempt to synthesize nonlegal and legal accounts of autonomy to reach an interdisciplinary concept of autonomy while also aiming to locate individual autonomy in human rights dogmatics. The interdisciplinarity will provide a vital starting point to identify shared values and similar patterns of the different guardianship procedures of various jurisdictions. Comparing existing safeguard systems, this Article aims to describe the currently functioning systems while searching for safeguards that are shared by a greater number of jurisdictions. The findings of the comparative method are then complemented by applying requirements set forth by fundamental human rights dogmatics to reflect on the very nature of the restriction. In Part IV, this Article describes three categories of the fundamental safeguards based on a human rights point of view revision of the existing standards. By providing forward-looking recommendations, this Article aims to emphasize the role of a human rights approach in a legal proceeding that can lead to severe interference with a person's autonomy.

The mentally disabled are a particularly vulnerable group, often lacking the ability to effectively stand for their own rights and interests. They have to rely on the legal system to protect them—to serve as their aegis. Therefore, implementing effective legal safeguards is an urgent and imperative obligation.

II. The right to autonomy

The first appearance of (individual) autonomy can be linked to the common law systems.[8] In *United Pacific Railway Co. v. Botsford*,[9] the U.S. Supreme Court stated that "[n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."[10]

Autonomy seems to have universal appeal as a beneficial quality,[11] however, there is seldom explicit reference to a "right to autonomy" in any of the leading human rights documents.[12] Therefore, different legal systems apply autonomy in different ways, as autonomy is often referred to and invoked in legal practice without being fit into a broader dogmatic framework.[13] The U.S. Supreme Court case, *Planned Parenthood v. Casey*,[14] explicitly

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[8] *See* David Vos, *Informed Consent, Patient Autonomy, and Causation: Competing Perspectives the United States, Ireland and Germany*, TRINITY C.L. REV. 147, 149–50 (2010).

[9] 141 U.S. 250, 251 (1891).

[10] *Id.*

[11] M.N.S. Sellers, *An Introduction to the Value of Autonomy in Law*, *in* AUTONOMY IN THE LAW 1 (2008).

[12] *See e.g.,* International Covenant on Civil and Political Rights, Dec. 16, 1966, 999 U.N.T.S. 172 (entered into force Mar. 23, 1976) [hereinafter ICCPR]; International Covenant on Economic, Social, and Cultural Rights, Dec. 16, 1966, 993 U.N.T.S. 3 (entered into force Jan. 3 1976) [hereinafter ICESCR]; Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, June 26, 1987, 1465 U.N.T.S. 85 [hereinafter CAT]; Convention on the Elimination of All Forms of Discrimination against Women, Dec. 18, 1979, 1249 U.N.T.S. 1 (entered into force Sept. 3, 1981) [hereinafter CEDAW]; Convention on the Rights of the Child, Nov. 20, 1989, 1577 U.N.T.S. 3 (entered into force Sept. 2, 1990) [hereinafter CRC]; European Convention on Human Rights, Nov. 4, 1950, E.T.S. No. 005 (entered into force Sept. 3 1953) [hereinafter ECtHR]; and the Universal Declaration of Human Rights contain no explicit reference to autonomy while the major legal instrument for the disabled, namely the Convention on the Rights of Persons with Disabilities, Dec. 13, 2006, 2515 U.N.T.S. 3 [hereinafter CRPD] refers to autonomy and individual autonomy two times each. Furthermore, even the CRPD does not elaborate on the substance of autonomy, it only refers to the freedom of choice aspect of personal autonomy.

[13] MARY DONNELLY, HEALTHCARE DECISION-MAKING AND THE LAW: AUTONOMY, CAPACITY AND THE LIMITS OF LIBERALISM 49 (2010).

[14] 505 U.S. 833, 851 (1992).

referenced the word "autonomy," taking a further step toward standardizing the legal interpretations and terminology of individual autonomy.

Superior courts of other common law jurisdictions also recognized that autonomy is a right to be protected. Autonomy was defined and safeguarded under the right to "life, liberty and security of the person" in Canada,[15] while Ireland defined autonomy as a personal right.[16]

Continental jurisprudence also recognized the legal character of autonomy. The European Court of Human Rights (ECtHR) first referred to a right to autonomy in the *Pretty v. United Kingdom*.[17] The Court stated that autonomy is to be understood under Article 8 of the ECtHR; a stance that was later reiterated in *Tysiac v. Poland*.[18] The main aspect of a "right to autonomy" was the principle of non-interference, which is a paradigm that "sits comfortably with the law"[19] as the necessary legal measures to enforce it are already present in different legal disciplines.[20] However, non-interference also simplifies morally and ethically difficult questions into mere legal questions of the legality of interference.

Autonomy in its most natural sense implies self-rule or self-governance, a right not to be interfered with by the state or by others, except if it is necessary and warranted by the common good of society as a whole.[21] However, autonomy solely as the paradigm of non-interference would fail to effectively safeguard the intrinsic value of autonomy. As it was developed by the ECtHR in *Tysiac*—in line with the fundamental rights approach of the Court—the

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[15] Canadian Charter of Rights and Freedoms § 7, Part I of the Constitution Act, 1982, *being* Schedule B to the Canada Act, 1982, c 11 (U.K.); *see also* Ciarlariello v. Schacter, [1993] 2 S.C.R.119, 135 (Can.).
[16] CONSTITUTION OF IRELAND 1937 art. 40; *In re* a Ward of Court, [1995] 2 IR 79, 93 (Ir.).
[17] 35 Eur. Ct. H.R 1, 35–36 (2002).
[18] 45 Eur. Ct. H.R. 23 (2007).
[19] DONNELLY, *supra* note 13, at 49.
[20] For instance, the law of property or possessions has already developed legal tools against illegal interference. For more information on how Property Law interacts with the right to non-interference, see generally S. Coval, J.C. Smith & Simon Coval, *The Foundations of Property and Property Law*, 45 CAMBRIDGE L.J. 457, 461–63 (1986).
[21] Sellers, *supra* note 11, at 1–2.

positive side of the right to autonomy imposes positive obligations for the states to promote and protect individual autonomy in a proactive manner.[22]

II.1 Autonomy as a fundamental right

Individual autonomy being invoked in legal discussions and disputes raises the question of the legal origin of autonomy. Observing the ECtHR's jurisdiction, in line with the principles of common law and the nonlegal development of autonomy, the fundamental rights character of autonomy crystallizes. However, a further question is where autonomy belongs in human rights instruments or whether it may be considered a sui generis (independent) fundamental right.

A. The right to self-determination[23]

The right to self-governance includes the right to express and unfold one's personality and generally safeguards the person from undue intervention through the principle of non-interference.[24] Independence is at the heart of autonomous living, therefore, subsuming autonomy under the right to self-governance can be approved. Further support of this approach is shown though the bioethical origins of autonomy that fundamentally define personal autonomy vis-à-vis informed consent and the right to refuse medical treatment.[25]

However, placing autonomy under self-governance may be challenged from a philosophical point of view. The right to self-governance primarily protects the individual from undue

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[22] *See Tysiac*, 45 Eur. Ct. H.R. at 15.
[23] *E.g.*, International Covenant on Civil and Political Rights art. 1.1, Dec. 16, 1966, 999 U.N.T.S. 172; International Covenant on Economic, Social, and Cultural Rights art. 1.1, Dec. 16, 1966, 993 U.N.T.S. 3. This Article intends to refer to the right of self-determination as the individual's right to lead a life without undue interference.
[24] Magyarország Alkotmánybírósága [Hungarian Constitutional Court] Apr. 23, 1990, MK.35/1990 (Hung.).
[25] ONORA O'NEILL, AUTONOMY AND TRUST IN BIOETHICS 2 (2002).

interference,[26] while the philosophical approach to autonomy emphasizes the need for sufficient availability of quality choices and alternatives when a person is to make a decision.[27] Thus the philosophical approach requires a significantly proactive stance of States. Under human rights' dogmas, availability of sufficient choice alternatives would mean an enforceable State obligation to promote individual autonomy to its fullest, which may exceed the general non-interference paradigm of the right to self-governance.

B. The right to dignity

There is no universal consensus whether human dignity is a principle of human rights law or an explicit fundamental human right. The Preamble of the Charter of the United Nations as well as the Universal Declaration of Human Rights both recognize human dignity as a value inseparably linked to all human persons.[28] Despite the lack of mention of an explicit right to dignity in international legal documents, this Article argues that dignity is a fundamental right because its inviolable nature appears unquestionable, and it is often mentioned in the same fashion as explicit rights. Additionally, human dignity as a constitutional right appears in—among others—the constitutions of Colombia, Germany, Hungary, Poland, Russia, Switzerland and South Africa while numerous other constitutions also name it as a value to be protected, thus enshrining it with legal protection under constitutional law.[29] Furthermore, reference to an

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[26] Jane Dryden, *Autonomy*, INTERNET ENCYCLOPEDIA OF PHIL., https://iep.utm.edu/autonomy/ (last visited Feb. 20, 2021).
[27] Yael Braudo-Bahat, *Towards a Relational Conceptualization of the Right to Personal Autonomy*, 25 AM. U. J. OF GENDER, SOC. POL'Y & L. 111, 118 (2017).
[28] United Nations, *Charter of the United Nations*, 24 October 1945, 1 UNTS XVI, available at: https://www.refworld.org/docid/3ae6b3930.html; G.A. Res. 217 (III) A, Universal Declaration of Human Rights (Dec. 10, 1948).
[29] CONSTITUCIÓN POLÍTICA DE COLUMBIA [C.P.] art. 1; GRUNDGESETZ [GG] [BASIC LAW] art. 1, *translation at* http://www.gesetze-im-internet.de/englisch_gg/index.html; MAGYARORSZÁG ALAPTÖRVÉNYE [THE FUNDAMENTAL LAW OF HUNGARY], ALAPTÖRVÉNY art. 2; KONSTYTUCJA RZECZYPOSPOLITEJ POLSKIEJ [CONSTITUTION OF THE REPUBLIC OF POLAND] art. 30; KONSTITUTSIIA ROSSIISKOI FEDERATSII [KONST. RF] [CONSTITUTION] art. 21 (Russ.); BUNDESVERFASSUNG [BV] [CONSTITUTION] Apr. 18, 1999, SR 101, art. 7 (Switz.); S. AFR. CONST., 1996, art. 10.

explicit right to dignity provides a more stable legal basis for other explicit rights that are directly derived from human dignity, such as the right to autonomy.

Psychological analysis of autonomy highlights that it is not an exclusively qualitative aspect of life. Asserting power over one's own life through decision-making that reflects the individual's values, will, and preferences constitutes the core of human personality; therefore, there is no personality without autonomy. Furthermore, since personality and individuality are the essence of human life,[30] there is no doubt that they are enshrined in the right to dignity. The right to dignity is the basis of autonomy and self-governance; it is a "general" fundamental right[31] that protects being human as a whole. Thus, the right to dignity provides basis for the protection of further explicit or implicit rights such as the right to privacy, freedom of thought, or sexual orientation.[32] Deriving individual autonomy from the right to dignity and associating it with human personality itself provides for a high level of protection. However, it must be pointed out that legal instruments of supported or substituted decision-making restrict autonomy in order to counter-balance the vulnerability of the person.[33] Therefore, if the conditions for the restrictive-supportive measures are drawn too narrowly, protection of dignity, and therefore autonomy, becomes

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[30] Francis Rogers describes personality and individuality as "the irreducible minimum of man, his immortal soul." Francis Rogers, *Personality and Individuality*, 214 N. AM. REV. 514, 514 (1921).

[31] AHARON BARAK, HUMAN DIGNITY: THE CONSTITUTIONAL VALUE AND THE CONSTITUTIONAL RIGHT 156–57 (Daniel Kayros trans., Cambridge University Press 2015).

[32] *See International Panel of Experts in International Human Rights Law and on Sexual Orientation and Gender Identity, Principles on the Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity [Yogyakarta Principle] (2006)*, U. MINN. HUM. RTS. LIBRARY, http://hrlibrary.umn.edu/instree/YogyakartaPrinciples.html (last visited Feb. 20, 2021).

[33] *Concepts of Legal Capacity and Approaches to Decision-Making: Promoting Autonomy and Allocating Legal Accountability*, LAW COMM'N OF ONT., https://www.lco-cdo.org/en/our-current-projects/legal-capacity-decision-making-and-guardianship/final-report/4-concepts-of-legal-capacity-and-approaches-to-decision-making-promoting-autonomy-and-allocating-legal-accountability/ (last visited Feb. 20, 2021) [hereinafter *Concepts of Legal Capacity and Approaches to Decision-Making*].

overly burdensome, overriding the best interests of the person and possibly excluding them from social help.

C. A sui generis right?

Recognising the right to autonomy as an independent fundamental right may be a pioneer approach. Producing an exhaustive catalogue of human rights involved and exercised during everyday functioning is hardly plausible. Even if it were possible, this Article argues that it would not be desirable.

An explicit fundamental right that centres around the person's everyday life and functioning—thus, autonomy—may have several key advantages. The right to autonomy could be a human right that safeguards personal autonomy in a holistic fashion. The negative side would guarantee the paradigm of non-interference, whereas the positive side implies obligations for the states to act proactively in developing less restrictive yet equally efficient measures to protect the mentally disabled. The essence of such right to autonomy would be its flexibility: to cover any possible aspect of everyday life based on the specific situation if the mentally disabled person requires assistance or protection. However, no other explicit human right can be invoked. Therefore, it could achieve the protection of individual autonomy in a holistic way that always reflects the individual circumstances.

The main criticism for making autonomy an independent fundamental right could be that it provides no novelty to a broad interpretation of the right to self-governance. It would be difficult to identify an aspect that cannot be subsumed under self-determination, thus its value for the legal practice is challenged. The right to self-determination and human dignity are too broad-scoped; therefore, bending their interpretations to include the diverse but relatively well definable group of the mentally disabled might not provide the attention necessary to induce an innovative and focused approach to their problems. However, I argue that recognition of autonomy as a sui generis human right focusing on the everyday functioning of the individual would raise awareness on the need for effective protection and support for the mentally disabled.

Most legal systems contain protective measures (most commonly substituted decision-making or assisted/supported decision-making) to help vulnerable groups of society, such as the mentally disabled.[34] The basis of these measures is that mentally disabled people cannot adequately foresee the consequences of their choices, thus cannot decide in their own best interests.[35]

The restriction of individual autonomy is a Janus-faced approach. On one hand, a vulnerable person gets close to the institutional social care system, while on the other hand, restriction of autonomy through limiting legal capacity places severe boundaries on everyday life. Despite these boundaries, restriction of legal capacity is often a necessary compromise that "reflects a balancing of two important, sometimes competing objectives: to enhance the patient's well-being and to respect the person as a self-determining individual."[36] In the following section, this Article discusses the currently existing approaches to restriction of legal capacity: the historic status and outcome based approaches; the functional approach of mental capacity; and the possible applications of two new approaches: the wills and preferences approach and the vulnerability principle.

II.2 Legal capacity

Legal capacity is the capacity to have one's decisions be recognized by law: to be able to make decisions with legal effect.[37] Article 12 of the CRPD guarantees that disabled people are

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[34] *Chapter Six: From Provisions to Practice: Implementing the Convention – Legal Capacity and Supported Decision-Making*, U.N. DEP'T ECON. & SOC. AFFAIRS, https://www.un.org/development/desa/disabilities/resources/handbook-for-parliamentarians-on-the-convention-on-the-rights-of-persons-with-disabilities/chapter-six-from-provisions-to-practice-implementing-the-convention-5.html (last visited Feb. 20, 2021).

[35] Nina A. Kohn et al., *Supported Decision Making: A Viable Alternative to Guardianship?*, 117 PENN. ST. L. REV. 1111, 1126–27 (2013).

[36] PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTHCARE DECISIONS: THE ETHICAL AND LEGAL IMPLICATIONS OF INFORMED CONSENT IN THE PATIENT-PRACTITIONER RELATIONSHIP 57 (1982).

[37] OLIVER LEWIS, LEGAL CAPACITY IN INTERNATIONAL HUMAN RIGHTS LAW 25 (2015).

recognized "as persons before the law,"[38] as well as the right to "legal capacity on an equal basis with others in all aspects of life."[39] However, the Convention does not give a clear definition of legal capacity, so a jurisprudential understanding and definition is vital.

Legal capacity is the legal reflection of decision-making autonomy; it is "a construct which enables law to recognize and validate the decisions and transactions that a person makes."[40] Lack of legal capacity means that a person's choices cannot have legal effect; indeed, they are often considered null and void. Without legal capacity, autonomous life and self-governance becomes a fiction—hence the label of "civil death" for restricted legal capacity.[41]

Today, the 'dominant approach to legal capacity forges a strong link between mental capacity and legal capacity.[42] The presumption is that if a person lacks the *mental* capacity necessary to foresee the consequences of their decisions, the State restricts or removes their *legal* capacity to protect them from the unforeseen—and presumably harmful—consequences. Then, the State appoints a substitute decision-maker to decide in their best interests on their behalf.[43]

II.3 Mental capacity approach

There are two historical approaches to restriction of legal capacity, both of which have been surpassed by jurisprudence as well as legal practice. The status-based approach relies solely on

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[38] Convention on the Rights of Persons with Disabilties art. 12.1, Mar. 30, 2007, 2515 U.N.T.S. 3.
[39] *Id.* art. 12.2.
[40] LEWIS, *supra* note 37, at 25.
[41] COMM'R FOR HUMAN RIGHTS, WHO GETS TO DECIDE? RIGHT TO LEGAL CAPACITY FOR PERSONS WITH INTELLECTUAL AND PSYCHOSOCIAL DISABILITIES 9 (2012); *Legal Capacity*, CTR. FOR PUB. REPRESENTATION, https://www.centerforpublicrep.org/issue/legal-capacity-supported-decision-marking-and-guardianship/ (last visited Feb. 20, 2021) (explaining that "[p]eople under guardianship experience a kind of 'civil death' because they have no right to make their own decisions about . . . health care, their finances, [marriage], with whom to associate, and other day-to-day decisions others take for granted.").
[42] Matthew Burch, *Autonomy, Respect, and the Rights of Persons with Disabilities in Crisis*, 34 J. APPLIED PHIL. 389, 389 (2017).
[43] *Id.*

medical evidence: medical diagnosis of a psychiatric or cognitive disorder served as the basis for restriction.[44] The outcome-based approach uses formal syllogism and assesses mental capacity based on the quality of the outcome of the decision-making process.[45] If the decision has undesirable consequences, this approach presumes that the person lacks mental capacity. As a result, the person's legal capacity has to be restricted in their best interests.[46]

The Council of Europe has moved on from the two historic approaches[47] and replaced them with the functional approach.[48] The functional approach "emphasizes the ability to make a specific decision or type of decision at a particular time, evaluating the abilities of the individual to understand, retain and evaluate information relevant to a decision."[49] Several mental disabilities (such as phasic mental disorders, degenerative disorders, temporary injuries or trauma, dementia, Alzheimer etc.) result in fluctuating mental states; therefore, decision-making ability has to be observed at the given time the decision is made. Additionally, different decisions require different sets of skills, so universal decision-making capacity (or mental capacity) is subjective and is affected by numerous factors.[50]

The difference between the functional approach (also known as functional test or mental capacity approach) and the historic approaches is that the functional approach does not label the individual as wholly competent or incompetent; it is no longer a binary black-or-white concept. The functional approach recognizes

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[44] *Concepts of Legal Capacity and Approaches to Decision-Making*, *supra* note 33.
[45] *Id.*
[46] *See id.*
[47] *See* Council of Europe, *Committee of Ministers of the Council of Europe Recommendation,* No. R(99)4, (1999).
[48] *Id.* (providing that "the legislative framework should . . . recognize that different degrees of incapacity may exist and that incapacity may vary from time to time," and that "a measure of protection should not result automatically in a complete removal of legal capacity.").
[49] *Concepts of Legal Capacity and Approaches to Decision-Making*, *supra* note 33.
[50] *Functional Approach to Capacity*, SAGE ADVOCACY, https://www.sageadvocacy.ie/resources/legal-rights/decision-making-capacity/functional-approach-to-capacity (last visited Feb. 20, 2021).

the need to establish safeguards to minimize interference, which could be described as the least restrictive measure doctrine.[51]

The functional approach provides for individualized assessment of mental capacity: it does not view mental capacity as the universal ability to make decisions, but instead focuses on the specific skills and capacity required to make certain decisions.[52] The functional approach successfully implements the findings of empirical research showing that in practice, many people who lack capacity in certain areas of life may still be able to make sound decisions for themselves in other areas.[53]

Therefore, the essence of the functional approach is that evaluation of a choice is limited to a particular decision taken at the respective time, providing a tailor-made individualized assessment of mental capacity—one that is applicable to any member of society. The functional test is supposed to be universal,[54] as anyone can fail regardless of their mental status if they lack the skills required to make a specific decision. At the same time, any person with mental disorder or disability could pass the test if they demonstrate certain capacities.

However, this Article argues that the functional approach is not as universally beneficial as it seems. In theory, the functional approach is universal in the sense that any person without the required decision-making capacities would fail such test.[55] However, in practice the application of such a test is arbitrary and discriminatory against the mentally disabled. First, no person without a history of mental disorders would ever be required to take a functional approach test because the presumption of mental and legal capacity is only challenged based on the presence of mental disabilities. Second, the functional approach reflects a reversed approach to mental capacity. Stating that "any disabled person can pass the test" suggests that they have no capacity unless proven

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[51] *Concepts of Legal Capacity and Approaches to Decision-Making*, *supra* note 33.
[52] *Id.*
[53] *See* Paul Appelbaum & Thomas Grisso, *The MacArthur Treatment Competence Study I: Mental Illness and Competence to Consent to Treatment*, 19 LAW & HUM. BEHAV. 105, 107 (1995).
[54] *See Functional Approach to Capacity*, *supra* note 50.
[55] Burch, *supra* note 42, at 390.

otherwise by the test itself, whereas the human right nature of autonomy would suggest that every person bears mental and legal capacity unless it must be necessarily restricted in the best interests of the person, there are no less restrictive or equally suitable measures to apply, and the restriction is proportional.

In the functional approach, lack of mental capacity results in lack of legal capacity by definition because mental capacity is the prerequisite for legal capacity.[56] Proponents of the functional approach argue that the approach is non-restrictive, as the legal consequence merely recognizes the absence of these capacities instead of actively restricting them.[57] However, legal capacity is an artificial legal concept in that all humans are presumed to have capacity unless proven otherwise; therefore, stating that the approach merely "recogni[zes] the factual absence of decision-making"[58] is misleading: the approach requires explicit legal action.

Legal mechanisms should require clear and precise standards for restriction of legal capacity. Mental capacity as such a standard is based on decision-making ability that is considered to be the prerequisite of autonomy. However, the definitive and inevitable connection between mental capacity as decision-making ability and personal autonomy lacks elaborate validation in legal literature.

A further question is to define what skills are required for decision-making that fulfil the criteria of mental capacity. "At a practical level, the greater the range of abilities required, the greater the number of people who will be found to lack capacity."[59]

The MacArthur Treatment Competence Study showed that the implications of this are especially significant for patients with mental illnesses. The study tested patients with mental illnesses (schizophrenia and depression) and physical illness (angina) in respect of understanding, reasoning ability and appreciation (which is essentially the ability to reach authentic or consistent decisions). When patients were tested for understanding only, approximately 28 per cent of patients with schizophrenia were found to lack capacity.

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[56] *Id.* at 389.
[57] *Id.* at 391.
[58] *Id.*
[59] DONNELLY, *supra* note 13, at 94.

However, when all three abilities were tested, approximately 50 per cent of patients with schizophrenia were found to lack capacity. This difference in impact was confirmed by the results obtained in respect of patients with depression. For patients with physical illness, the abilities tested had a less obvious impact . . . .[60]

II.4 Alternatives to mental capacity: the will and preferences approach and the vulnerability paradigm

A. Will and preferences

The will and preferences approach takes a further step away from the traditional approaches by linking legal capacity to having a will or preference instead of to cognitive abilities.[61] The will and preferences approach therefore lowers the minimum threshold for having a discernible will or preference. The person meets this threshold if they (or their substitute decision-maker) is able to make a decision that is in line with their "diachronic identity" (identity across-time), thus "replacing the rational abilities view of autonomous decision-making with a non-cognitivist mesh theory."[62] In this regard, having a will or preference means making a decision that is consistent with the diachronic identity or to have such a decision made on the individual's behalf.[63]

The will and preferences approach removes the cognitive aspect of autonomous decision-making and focuses on the consistency of one's life. However, identity and preferences might change over time—the individual is able to reflect on and adjust previous preferences in the light of new information, experience, or higher-order desires. Furthermore, a consistent diachronic identity may also be contradicted by phasic or episodic disorders, therefore,

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[60] *Id.* Further discussion on the required decision-making abilities and skills is addressed in Chapter III under the procedural safeguards of the assessment of mental capacity.
[61] Burch, *supra* note 42, at 394.
[62] *Id.* at 395. The expression 'mesh theory' used by Burch may be better understood if we view a person's life (diachronic identity) as a series of interlocked and intertwined decisions or actions. Therefore, in this concept, any new decision made has to fit into a pre-existing, coherent diachronic identity. *Id.*
[63] *Id.*

diachronic identity as the ultimate criterion is unclear and ambiguous. Additionally, having a diachronic narrative might not always be available: the will and preferences approach is based on the presumption that the person's previous life and path is known, whereas in the healthcare context many decisions have to be made urgently, when such information is often not available to the healthcare professionals.[64]

This Article criticizes the will and preferences approach as being too vulnerable to manipulation and interference. The main criticism is that it is often impossible to know if the person legitimately wills something or if an external factor (mental disorder, addiction, another person etc.) influences the person's will. However, the will and preferences approach is an important new approach in international disability law. Even if it can be criticized for lacking certainty due to the subjective nature of a person's wills, preferences, and previous choices in life, the will and preferences approach has great potential to shape legal practice on how the mentally disabled are treated.

B. The vulnerability paradigm

The approach taken by the courts has been to consider preemptive intervention to prevent the circumstances where an adult might not be able to exercise free choice at an ascertainable point in the future.[65] The vulnerability paradigm has two major components:

- the "vulnerable adult" is an inherently vulnerable person based on a set of fixed intrinsic human characteristics; and
- situational vulnerability is a vulnerable state based on the specific circumstances of the situation[66]

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[64] *See* Bryan Murray, *Informed Consent: What Must a Physician Disclose to a Patient?*, 14 AM. MED. ASS'N J. ETHICS 563, 565 (2012).
[65] *See id.* at 259; Michael C. Dunn, Isabel C.H. Clare & Anthony J. Holland, *To Empower or to Protect? Constructing the 'Vulnerable Adult' in English Law and Public Policy*, 28 J. SOC'Y L. SCHOLARS 234 (2010).
[66] Dunn, Clare & Holland, supra note 65, at 241.

The justification for intervention is no longer tied to a specific decision: personal autonomy need no longer be respected by the court if the person is deemed to be vulnerable.

The main advantage of focusing on vulnerability instead of mental capacity is that it precisely reflects the protective aim of the restriction of autonomy. Rather than being occupied with assessing the decision-making or cognitive skills of a person, the vulnerability approach focuses on how to prevent circumstances that would render the person coerced into decisions against his or her will and interests. However, this flexibility and proactivity is also the major risk of the concept. Overriding the decision of an admittedly autonomous person on the grounds of his "vulnerability" constitutes extreme interference with the right to self-governance and personal autonomy. This Article contends that restriction of autonomy based solely on the vulnerability paradigm overrides autonomous decisions based on unclear conditions and status-like circumstances; thus, it severely lacks sufficient safeguards. However, it must be noted that the vulnerability principle reflects the main protective aim of restriction of autonomy more accurately than the mental capacity approach.

II.5 Summary

Personal autonomy was first used in legal context by common law courts.[67] In the early stages, it was not referred to as an explicit right or concept; nevertheless, its legal and non-legal substance could be clearly observed in legal practice.[68] The continental legal practice and jurisprudence followed the common-law courts shortly after as the ECtHR pioneered the right to autonomy in *Pretty*.[69] Personal autonomy was first seen as the ultimate paradigm of non-

[67] Nigel Poole, *A Common Law Right to Autonomy of Treatment*, ROYAL COLL. OF SURGEONS OF ENG. (Nov. 10, 2016), https://www.rcseng.ac.uk/news-and-events/blog/the-right-to-autonomy-of-treatment-is-a-common-law-right/#:~:text=The%20Supreme%20Court%20held%20that,over%20the%20treatment%20they%20undergo.&text=This%20right%20of%20autonomy%20over%20treatment%20is%20a%20common%20law%20right.

[68] *See id.*

[69] Pretty v. United Kingdom, 35 Eur. Ct. H.R 1, 35–36 (2002).

interference; the positive state obligations arising from the protection of autonomy were recognized and stated in later court decisions, such as in *Tysiac*,[70] while explicit references to a right to autonomy became more and more common across the board.[71]

The right to individual autonomy was implemented into legal practice, but its legal origins remained unclear. Observing the common law courts and the developmental efforts of the ECtHR may suggest that a fundamental rights approach would go in line with legal practice while also reflecting the non-legal aspects of personal autonomy. The right to autonomy is yet to be precisely implemented into human rights dogmas because the exact place of the right is unclear. Autonomy could be subsumed under the protective regime of the right to self-governance or the right to dignity, while its unique recognition as a fundamental human right protecting the everyday functioning of persons may also be a possibility.

Substitute or supported decision-making are the most commonly used legal institutions in the protection of mentally disabled adults.[72] They are Janus-faced instruments aiming to find the appropriate trade-off between protecting the person's best interests while also respecting his personal autonomy to the highest possible extent.[73] These protective measures necessarily restrict personal autonomy which formulates as restriction of one's legal capacity.[74] The basis for restriction of legal capacity in most legal systems is a lack of mental capacity,[75] even though other approaches (such as the will and preferences approach or the vulnerability paradigm) also have

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[70] Tysiac v. Poland, 45 Eur. Ct. H.R. 969 (2007).

[71] *See* Niki Aloupi, *The Right to Non-Intervention and Non-Interference*, 4 CAMBRIDGE J. INT'L & COMP. L. 566, 566 (2015).

[72] *See* Antonio Martinez-Pujalte, *Legal Capacity and Supported Decision-Making: Lessons from Some Recent Legal Reforms*, 8 LAWS 1 (2019).

[73] *See Supported and Substitute Decision-Making*, AUSTRALIAN LAW REFORM COMM'N (Sept. 18, 2014), https://www.alrc.gov.au/publication/equality-capacity-and-disability-in-commonwealth-laws-alrc-report-124/2-conceptual-landscape-the-context-for-reform-2/supported-and-substitute-decision-making/.

[74] *Id.*

[75] Bernadette McSherry, *Decision-Making, Legal Capacity and Neuroscience: Implications for Mental Health Laws*, 4 LAWS 125, 128 (2015).

great potential to shape practice of how we treat persons with mental disabilities.

Persons with disabilities often experience denial of their legal capacity as a fundamental denial of recognition respect: "to give appropriate weight in . . . practical deliberations to the other person's moral worth."[76] Denial of recognition respect is experienced by a mentally disabled person as denial of their dignity as a person, causing significant distress and possibly stigmatizing an already socially vulnerable person.[77] Denial of equal worth and equal membership of society can erode the disabled person's feeling of self-worth and self-esteem while also enhancing a feeling of inferiority.

The harms of denial of recognition respect can at times be more harmful than the consequences of a possibly improper decision the person would make without State intervention. Even if intervention is necessary and inevitable, the person's preferences should be respected to the best possible extent in order to make them feel respected as equal human beings and equal members of the same society. Therefore, this Article argues that in defining the tipping point where the decision of a mentally disabled person has to be overridden in his or her best interests must reflect the trade-off between recognition respect and individual welfare.

III. Fundamental procedural safeguards

III.1 Towards a system of procedural safeguards

As described in greater detail in the previous chapters, current legal systems strive to achieve legal protection of mentally disabled

[76] Burch, *supra* note 42, at 398. Darwall uses the expression "recognition respect" to refer to respect that consists of giving appropriate consideration to the respected person; they are entitled to be taken seriously and the fact that they are indeed persons be weighed appropriately. *See id.* In other words, recognition respect means that any discussion about the mentally disabled should—as a moral obligation—adequately reflect that they are persons and not an abstract issue to be solved. *Id.*

[77] *Id.*

adults via interference with personal autonomy.[78] The aim of these measures is universal: to provide effective and sufficient protection of vulnerable persons through substituted or supported decision-making. Although de facto legal regimes of protection vary greatly, two core models can be identified that are complemented by a third—mostly hypothetical—model:

- Substituted decision-making: where the decision making capacity is removed from an individual and given to a substitute decision-maker that acts directly on behalf of the individual.[79] The rights and duties from legal actions affect the legal status of the individual directly.[80] Two subcategories of substituted decision-making can be distinguished based on the scope of the restriction:
    - Plenary guardianship means that all (or all but the most personal) decisions are made by the substitute decision-maker;[81]
    - Partial guardianship means that in certain—legally prescribed—areas the decision-making capacity is shifted whereas in other areas the individual retains capacity.[82]
- Supported decision-making: where the interference with personal autonomy occurs by designating a support person to the individual to provide the necessary assistance in decision-making.[83] The support person cannot make

[78] *Supported and Substitute Decision-Making*, *supra* note 73.
[79] *Part 2: Substitute Decision Makers*, SPEAK UP ONT., https://www.speakupontario.ca/resource-guide/part-2-substitute-decision-makers/ (last visited Feb. 20, 2021).
[80] *See id.*
[81] *Guardianship*, FLA. COURTS, https://www.flcourts.org/Resources-Services/Court-Improvement/Family-Courts/Guardianship (last visited Feb. 20, 2021).
[82] *Partial Guardian Law and Legal Definition*, USLEGAL, https://definitions.uslegal.com/p/partial-guardian/#:~:text=A%20partial%20guardian%20is%20a,conferred%20by%20a%20court%20order (last visited Feb. 20, 2021).
[83] *See* Zachary Allen & Dari Pogach, *More States Pass Supported Decision-Making Agreement*, AM. B. ASS'N (Oct. 01, 2019),

decisions on behalf of the individual.[84] Instead, the support person may provide legal representation, but can only pursue the person's direct will and orders, whereas a substitute decision-maker fundamentally decides for the individual.[85] Therefore, the individual retains their decision making capacity when they are assisted by supported decision-making.[86] However, even providing support influences the individual's decision-making, which interferes with personal autonomy.

- Ultimate respect for individual autonomy means that decision-making capacity is absolute and cannot be restricted or interfered with: under no circumstances can a decision be made on behalf of an individual, nor is the vulnerable person granted support in the decision-making.[87]

III.2 A Procedural Approach

The discussion on the most suitable protective regime is still unresolved; indeed, these regimes are diverse, as they are reflective

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https://www.americanbar.org/groups/law_aging/publications/bifocal/vol-41/volume-41-issue-1/where-states-stand-on-supported-decision-making/#:~:text=Supported%20decision%2Dmaking%20is%20often, members%2C%20professionals%2C%20and%20others.

[84] *Supported Decision-Making: Frequently Asked Questions*, ACLU, https://www.aclu.org/sites/default/files/field_document/faq_about_supported_decision_making.pdf (last visited Feb. 20, 2021),

[85] *Id.*

[86] *Supported Decision-Making*, TEX. COUNCIL DEVELOPMENTAL DISABILITIES, https://tcdd.texas.gov/resources/guardianship-alternatives/supported-decision-making/ (last visited Feb. 20. 2021).

[87] This article porposes a third, merely hypothetical, model on the grounds that it fails to respond to the vulnerability of the individual. It does not address the need for protection, nor does it reflect the circumstances of the person or provide any form of assistance or support. The reason to consider it a third model based on interference can be derived from the positive state obligation to promote personal autonomy and empower the mentally disabled. The state can fulfill the mentioned positive obligation by providing for either substitute or supported decision-making. Nonetheless, not complying with the obligation is a possibility even though it should be denied from a fundamental rights perspective.

of common law and continental legal systems, which vary between regions, countries, or states.[88] The positive obligation arising from human rights dogmas requires States to take proactive measures in providing efficient protection.[89] However, based on sovereignty, it is up to the State's discretion to decide on the most appropriate regime of legal protection.[90] International or regional multilateral treaties and documents as well as legal bodies or commissions may provide guidelines and even set out specific obligations; however, due to the lack of consensus, it would be too ambitious to deny State discretion in choosing the most appropriate regime.[91]

As a result, the status quo of substantive regulation is extremely diverse. Nevertheless, despite the divergence in substantive regulation, all legal systems prescribe a legal procedure that leads to the protective regime.[92] This legal procedure is—in almost all jurisdictions—based on the general procedural rules of civil or administrative procedure combined with certain specific provisions.[93] Without taking a stand in the discussion on the most suitable substantive regime (as it would exceed the thematical framework of the research), in the following sections this Article analyzes and compares the existing procedural safeguards that are designed to protect the fundamental rights of mentally disabled persons: procedures that can lead to restriction of legal capacity—a grave interference with one's autonomous life.

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[88] *See Mental Health, Human Rights & Legislation*, WORLD HEALTH ORG., https://www.who.int/mental_health/policy/legislation/en/ (last visited Feb. 20, 2021).

[89] *Id.*

[90] *See* Convention on the Rights of Persons with Disabilities art. 33, Dec. 13, 2006, 2515 U.N.T.S. 3.

[91] There are efforts from the CRPD Commission to converge the various regimes based on uniform core principles, but the resistance of the State Parties has effectively obstructed it so far.

[92] *See* E.C. Fistein et al., *A Comparison of Mental Health Legislation from Diverse Commonwealth Jurisdictions*, 32 INT'L J. L. & PSYCH 147, 147 (2009).

[93] *See id.* at 148. Their relationship is most often governed by the lex specialis derogat legi generali principle: the specific provisions governing the particular area of restriction of legal capacity take precedence over general provisions of procedural law. *Principle*, TRANS-LEX.ORG, https://www.trans-lex.org/910000/_/lex-specialis-principle/ (last visited Feb. 20, 2021). However, in areas not requiring special mental disability sensitive provisions, the general procedural rules apply.

First, this Article will the stage for analysis by discussing the special characteristics of procedures on restriction of legal capacity: the vulnerability of those involved and the unique difficulties of the procedure. Then the overarching principles of these legal proceedings will be examined, namely the outstanding importance of the right to a fair trial. After describing the core differences between a procedure on restriction of legal capacity and a general civil procedure under the umbrella of the ultimate fundamental rights safeguard of the right to a fair trial, this Article will discuss these procedures as a practical matter. The specific human rights procedural safeguards will be divided into three main categories (preliminary, strictly procedural, and follow-up safeguards) and individually described based on their universality (global, regional, national, or state-level) and why they are necessitated by human rights dogmas.

This comparative method is based mainly on analysis of the United States' and European legislation and caselaw complemented by international legal instruments and legislation of other Asian, South-American, or African countries.[94] Building on the findings of the comparative method, future legislative recommendations will be drawn in an attempt to describe the human rights safeguards that ensure that the procedure on assessment of the necessity of a protective-restrictive regime reflects the vulnerability of the mentally disabled and provides utmost respect for their human rights, while also maximizing the possibility of providing tailor-made protection that suits their very specific needs and circumstances.

III.3 Sanism

When studying the varying elements of mental disability law, the conclusion can be reached that

[94] This Article focuses on mainly European and American rules because of the availability of more transparent and extensive literature and case law in those regions.

> something goes on in the mental disability law process that cannot be explained by the usual modes of legal analysis that are typically used in doctrinal studies of, for example, tort law, contracts law, or securities regulation law. Something happens in mental disability law that distorts the litigation, the fact finding, and the appellate process. This 'something' negatively affects all participants: litigants, lawyers, lay and expert witnesses, trial and appellate judges, jurors, scholars, legislators, the media, and the public."[95]

Under a scenario where women are not allowed to choose their spouse or men their employment, or where the state designates the residence of ethnicities or minorities. However, when it comes to the mentally disabled, common practices that perpetuate discrimination are less clear and are criticized by significantly less people.

Despite the few lonely voices of practitioners, lawmakers, scholars, and judges which advocate for the rights of the mentally disabled, academy and practice are largely silent about sanism. "As a result, individuals with mental disabilities—'the voiceless' . . . are frequently marginalized to an even greater extent than are others who fit [regular minority groups]."[96]

This effect is difficult to grasp, yet it is often observed in legal practice. Perlin defines and labels this sui generis prejudice (an "-ism") as sanism.[97] Sanism reflects the supposed rule of the socially constructed concept of the sane mind. Perlin describes it as even more insidious than any other "-isms" as it is:

- "Largely invisible";
- "Socially acceptable";

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[95] MICHAEL L. PERLIN, THE HIDDEN PREJUDICE: MENTAL DISABILITY ON TRIAL 3 (2000). Perlin explains that this "something" is the inherent sanism that is built into humans due to our method of processing information: to simplify and narrow our vision of how the whold works to "explain all behaviour." *Id.*

[96] *Id.* at 23.

[97] *Id.* at 21–23.

- "Frequently practiced (consciously or unconsciously) by individuals who regularly take liberal or progressive positions decrying similar prejudices regarding sex, race, ethnicity, or sexual orientation."[98]

Sanism itself is based on irrational beliefs and assumptions that are striving to give us an explanation of who the mentally disabled are, and how and why are they different.[99]

Deep within, these assumptions intrinsically "reflect our fears and apprehensions about mental illnesses," people living with mental disabilities "and the possibility that we ourselves may become mentally disabled one day."[100] Sanism serves the purpose to fulfil our desire of clearly separating our "sane selves" from those "insane," and to distinguish "us" from "them."

Stereotypes are the "attribution of general psychological characteristics to large human groups."[101] The basis of sanism is categorisation based on generalisations.[102] Mental disorders constitute a lesser-known area for the public opinion. Thus, the fear of the unknown as well as our belief in our ultimate rationality drives us to search for an explanation to life. Stereotypes are capable of simplifying otherwise complex and ambiguous issues so that they are simplified to match the understanding capacity of our cognitive abilities.[103] The strong conviction that each of us are rational beings furthers the already developed stereotypical attitude and results in a belief that our worldview is ultimately correct. Any additional information we receive about mental disabilities is processed based on the stereotypical scheme; taking a more critical stance against information contradicting the scheme than towards those validating it, striving for stability jeopardises the deconstruction of the

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[98] *Id.* at 22.
[99] *See* PERLIN, *supra* note 95, at 23 (making the paradox of challenging the rationality of the mentally disabled based on our own irrational beliefs even more bizarre).
[100] PERLIN, *supra* note 95, at 23.
[101] Henri Tajfel, *Cognitive Aspects of Prejudice*, 25 J. SOC. ISSUES 79, 81–82 (1969).
[102] *See* PERLIN, *supra* note 95, at 21–23.
[103] *See id.* at 22.

stereotype.[104] It must be highlighted once more that these decision-shaping factors are subconscious; one is not aware of their working.

Prejudice based on mental capacity may affect all actors participating in procedures leading to restriction of legal capacity: legal representatives, judges, experts and witnesses.[105] Following Perlin's observation that judges represent the overall conventional morality of society, in which sanism is deeply rooted,[106] it can be concluded that the outcomes of judicial procedures may also be highly influenced by sanist thinking. Since judges are particularly vulnerable to heuristic thinking as it enables them to avoid ambiguous and morally or ethically demanding decisions by using over-simplifying schemes (heuristics, Ordinary Common Sense, or biased stereotypes).[107] Therefore, the question of whether the person's decision-making capacity and capability for autonomous living necessitates intervention—the main deciding factor according to the theoretical legitimacy of supported or substituted decision-making—is reduced to whether the person before sanist judges fits their assumed concept of "the mentally disabled person" by means of appearance and observable behaviour. Thus, the complex dilemma on the inevitability of restriction of legal capacity is reduced to the person fitting into an irrational stereotype based on sanism.

However, this Article differs from Perlin's account of an inevitably sanist judicial system and actors. Sanism is a subconscious decision shaping factor, therefore one is not fully aware when it affects a decision; conversely, one is also unaware whether a decision is intact from sanist thinking. Notwithstanding that sanism might be a key threat to a fair and just legal procedure involving the mentally disabled, this outcome is that it is a mere possibility, not an inevitable pitfall. Judges and other legal actors may or may not adopt a sanist stance in a legal case; it not only varies

[104] This further proves the previous paradox-argument. It can be observed that the same heuristical thinking is present in the way we think about the mentally disabled as their own heuristical thought process. In this paragraph the anchoring and status quo heuristics are particularly visible.
[105] PERLIN, *supra* note 95, at 3.
[106] *Id.* at 51.
[107] *Id.* at 22.

with each person, but the same person may be affected by sanism vis-a-vis a certain case and not when handling another. Nevertheless, as sanism might crucially alter legal procedures and decisions affecting the mentally disabled, this Article agrees with Perlin's claim that an adequate system of fundamental safeguards has to reflect the concerns posed by sanist thinking.

As a result, the core supportive aim of procedures assessing mental capacity (decision on the necessity of a restrictive-protective regime) may appear jeopardised. Efficient legal safeguards have to be implemented into the legal procedure to counterbalance the risks posed by the complex and debated nature of restricting legal capacity and a sanist judicial and social system. The overarching aim of such safeguards is to guarantee that a severe and broad-scoped restriction of human rights via legal restriction of personal autonomy fulfils the requirements of a fair trial. The right to a fair trial is the ultimate safeguard to ensure that the restriction of human rights is in line with human rights principles and is sufficiently validated.

III.4 The Outstanding Importance of the Right to a Fair Trial

Aegis was originally the shield of the ancient Greek god Zeus.[108] Given to Athena, the goddess of wisdom, the fearsome weapon—through disciplined awareness and wisdom—was turned into a protective force: it symbolises protection or patronage by a powerful, knowledgeable, or benevolent source.[109] Likewise, the law serves as an aegis for the mentally disabled, whose vulnerability it can effectively counterbalance. The mentally disabled are at a disadvantage to stand for their own rights and interests, thus ensuring their recognition as equals is an imperative duty of states as well as society. Protection through restriction of personal autonomy is a double-edged measure: it may achieve the effective

[108] *Aegis*, GREEK MYTHOLOGY, https://www.greekmythology.com/Myths/Elements/Aegis/aegis.html. (last visited Mar. 17, 2021).
[109] *Id.*; *Aegis*, NEW WORLD ENCLYOPEDIA, https://www.newworldencyclopedia.org/entry/Aegis (last visited Mar. 17, 2021).

protection of a vulnerable person; however, its price is paid in the loss of autonomy and freedom. As mythology holds, great wisdom and self-disciplined awareness are the keys to finding the delicate balance in the trade-off.

Procedures leading to the restriction of legal capacity (and thus, personal autonomy) via substituted or supported decision-making are based on the same paradigm: they aim to provide effective support to persons with mental disorders and to safeguard their best interests.[110] These procedures share the same goal: examination and assessment of the person's capacity and competence to make autonomous decisions in order to—without any doubt—underlie the necessity of the application of a protective regime.[111]

These procedures are prescribed and governed by law and, mostly, by legal professionals. However, various other disciplines are also necessarily involved (such as psychology and medicine: psychiatry and neurology) to reach a sufficiently broad-scoped outcome that accomplishes a harmonic synthesis of legal and non-legal fields. Without regards to the substantive aspects of the protective regime chosen by the state, it can be concluded that the general aims, subjects, and objectives of these procedures, are similar—the main difference being the nature of the outcome decision.[112] Therefore, the fundamental rights safeguard system ensuring a fair procedure affects them similarly. Thus, for the purposes of the following sections, legal procedures on restriction of legal capacity leading to substitute or supported decision-making are discussed jointly.

In restricting a person's autonomy and decision-making legal capacity the main aim is to reach (or at least to approximate as close as humanly possible) the discussed ideal compromise. A decision on the necessity (or lack of necessity) of legal intervention is inevitably the outcome of some sort of process or proceeding. This process in the vast majority of states lies within the authority of courts that

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[110] *See* Antonio Martinez-Pujalte, *Legal Capacity and Supported Decision-Making: Lessons from Some Recent Legal Reforms*, MDPI LAWS, Feb. 2019, at 1, 1–6.

[111] *See id.* at 7–11 (examining the regulations governing legal capacity in Argentina).

[112] The difference being the possibly applicable protective measures of supported and/or substituted decision-making.

assess the necessity of intervention through trial before delivering the final decision.

As for all trials, the fundamental human right to a fair trial applies to proceedings leading to restriction of legal capacity. The right to a fair trial is enshrined in several international documents, civil codes, and civil procedure codes.[113]

"The right to a fair trial is a norm of international human rights law designed to protect individuals from the unlawful and arbitrary curtailment or deprivation of other basic rights and freedoms."[114] In the narrow sense it guarantees an impartial and lawful decision.[115] A distinction has to be made between the fairness of a decision and that of a trial. However, the right to fair trial itself establishes the connection between the two: a decision manifesting as the outcome of a fair and just trial maximises the possibility of a just decision.[116]

An exhaustive list of the elements of the right to a fair trial cannot and should not be drawn. The circumstances and aspects of the particular proceeding have to be examined, as in many cases only by observing the procedure as a whole can it be concluded whether it fulfilled the requirements of a fair trial.[117] However, there are certain generally accepted and crystallized elements of a fair trial that are broadly applicable.

The European Court of Human Rights also emphasises the applicability and importance of having safeguards to ensure a fair trial in legal proceedings which can result in the restriction of an individual's legal capacity.[118] The general procedural fair trial requirements in legal capacity proceedings in its case law are

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[113] *See*, *e.g.*, International Covenant on Civil and Political Rights art. 14, Dec. 16, 1966, U.N.T.S. No. 14668 (entered into force Mar. 23, 1976); European Convention on Human Rights art. 6, June 1, 2010, C.E.T.S. No. 194; African Charter on Human and Peoples Rights arts. 3,7, 26, June 27, 1981, 21 I.L.M. 58, (entered into force Oct. 21, 1986); American Convention on Human Rights arts. 3, 8–10, Nov. 22, 1969, O.A.S. T.S. No. 17955.

[114] *What is a Fair Trial? A Basic Guide to Legal Standards and Practice*, TAVAANA 1 (Mar. 2000), https://tavaana.org/sites/default/files/fair_trial_0.pdf.

[115] *See id.*

[116] *See id.* at 12–14.

[117] *E.g.*, Magyarország Alkotmánybírósága [Hungarian Constitutional Court], MK.6/1998 at sec. II(5) (Hung.).

[118] *See* European Convention on Human Rights arts. 5–6, Nov. 4, 1950, E.T.S. No. 005.

derived from principles applicable to deprivation of liberty.[119] The first step in assessing whether there has been a fair trial is determining the lawfulness of the proceeding according to national law.[120] However, the Court points out that lawfulness under Article 5 para. 1. (e) of the ECtHR goes beyond national rules.[121] The "procedure prescribed by law" refers to a fair and appropriate procedure, requiring sufficient procedural safeguards against arbitrariness.[122]

III.5 The System of Safeguards from a Comparative Point of View

This article seeks to categorize the fundamental procedural safeguards in legal capacity proceedings based on which stage of the procedure they belong to:

- Preliminary safeguards come into effect before the actual procedure commences; this category contains all safeguards that apply prior to the individual case including when the procedure is set into action. Due to the preliminary nature of these safeguards, they inherently have an abstract quality.

- Strictly procedural fair trial safeguards apply throughout the entire legal procedure from the application until the final legally binding decision is made. These concrete and specific safeguards apply to particular elements of the procedure.

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[119] *Id.*
[120] *Id.*
[121] *Id.* art. 5(1)(e).
[122] *Id.* arts. 5–6. For the purposes of this section, a person serving as a substitute decision-maker or decision-making support person will be consistently referred to as "guardian" in order to avoid ambiguity in terminology as well as to help identify the common aspects of the various legal systems compared. Following the same logic, legal proceedings on restriction of legal capacity will be uniformly referred to as "guardianship" or "guardian procedures."

- Follow-up safeguards come into play after the final decision is made, their core aim is to monitor, review, and ensure that the restriction of legal capacity applies no longer than it is necessary. The nature of these safeguards can be abstract as well as concrete.

The three categories are separated in time; however, it has to be pointed out that a genuine fair trial can only be achieved if the groups of safeguards effectively build upon each other. Their applicability follows a set, linear order (nevertheless, a cyclical aspect can also be observed). The sequence does not necessarily conclude with the follow-up safeguards: in case of fluctuating mental capacity or significant improvement in the person's mental status initiating the procedure to annul or alter the restrictive decision invokes the preliminary safeguards once more, then to be followed by the strictly procedural safeguards during the procedure. Therefore, the described categories may repeatedly be invoked in a cyclical fashion.

A. Preliminary Safeguards

Right to Initiate, Petitioners

The guardianship proceeding begins either with the filing of a petition or application or in certain jurisdictions courts hold the power to initiate the procedure ex officio if (while dealing with other cases) they encounter an individual in need of guardianship.[123] Significant diversity can be observed in the list of potential petitioners among jurisdictions. While in line with the UGPPA almost all states of the United States allow the individual or any person interested in the individual's welfare (many of them implementing catch-all provisions such as "any person") to stand as

[123] *See*, *e.g.*, Winsor C. Schmidt, *Guardianship for Vulnerable Adults in North Dakota: Recommendations Regarding Unmet Needs, Statutory Efficacy, and Cost Effectiveness*, 89 N.D. L. REVIEW 77, 102 (2013).

petitioner.[124] Several other legal systems constitute a narrowly drawn list of potential petitioners.[125] In contrast with the broad-scoped system of the United States, the Hungarian Civil Code[126] provides an exhaustive list of petitioners: the spouse, civil partner or domestic partner (in case they live in the same household), lineal relative, sibling, guardianship authority or the attorney general. The Danish system shares a similar approach, however, the police, local and regional councils as potential petitioners show a more paternalistic approach.[127] The Korean reform of guardianship also implemented an exhaustive list, allowing close relatives (within fourth degree of kinship) to petition.[128] The strictly drawn exhaustive list is somewhat eased through the guardianship authority's ex lege obligation to initiate the guardianship proceeding if it is notified of its necessity. Therefore, under this authority any person can be capable of—indirectly—achieving the initiation.[129]

The list of potential petitioners fundamentally defines the availability of social support through guardianship. If the state prescribes a too narrow group of potential petitioners it risks that mentally disabled individuals will not come within sight of the social network, whereas providing the right to initiate too broadly may lead to an increase in the misuse and abuse of guardianship.[130]

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[124] PAMELA B. TEASTER et al., PUBLIC GUARDIANSHIP: IN THE BEST INTERESTS OF INCAPACITATED PEOPLE? 19 (2010) [hereinafter TEASTER, PUBLIC GUARDIANSHIP].

[125] *See*, *e.g.*, Værgemålsloven Jan. 1, 2018, Foxylex 2018, 20 at § 16(1)(4-6); Minebob, [Civil Act] Act. No 10429, Mar. 7, 2011, amended by Act. No. 11728, Apr. 5, 2013, arts. 9, 12, 14-2 (S. Kor.).

[126] Polgári Törvénykönyvrõ [Ptk.] [Civil Code] tit. VII, § 2:28 (Hung.) [hereinafter Ptk].

[127] Værgemålsloven Jan. 1, 2018, Foxylex 2018, 20 at § 16(1)(4-6).

[128] Minebob, [Civil Act] Act. No 10429, Mar. 7, 2011, amended by Act. No. 11728, Apr. 5, 2013, arts. 9, 12, 14-2 (S. Kor.).

[129] Ptk. tit. VII § 2:28(2).

[130] Abuse and misuse of initiating guardianship procedures may occur if the petitioner initiates the procedure for reasons other than the individual's well-being and best interests. Examples of such ulterior motives might be financial (to remove an elderly parent from his or her home and gain possession of it or to assert control of someone's financial means) or other personal interests (e.g. to attempt to use an ongoing guardianship procedure as a trump card against the other party in a divorce or custody of children case).

Preliminary Selection of Guardian or ex lege Order

This Article asserts that most legal systems strive to provide individuals with extensive opportunities to control or influence who will be appointed as their guardian. Preliminary selection of potential guardians ensures that the guardian will be a person previously deemed most suitable by the individual himself.[131] Therefore, the fundamental importance of this safeguard is to guarantee that the individual's personal preferences and opinion are taken into account to the greatest possible extent, resulting in a guardianship that is most suitable to effectively serve the individual's best interests in the long term.

There are multiple ways of implementing this safeguard—one of them being the appointment of a guardian the individual names in his statements during the procedure.[132] Another possibility that similarly safeguards the mentally disabled person's right to self-governance is a preliminary statement of the individual naming the potential guardians in case of future loss of legal capacity.[133] Conversely, in such preliminary statements the individual should also be allowed to exclude certain persons from being appointed as guardian.[134] A further possibility is the normative approach where the hierarchy and order of potential guardians is prescribed by

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[131] *See* Andrew B. Cohen et al., *Guardianship and End-of-Life Decision Making*, JAMA INTERNAL MED. (Oct. 1, 2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4683611/.

[132] This approach can be observed in the German regulation, prescribing that the adult may make a suggestion on the peson of the Betreuuer the court generally has to follow. The mentally disabled person also has the right to refuse a person to be appointed. Relevant provisions of the German Civil Code, BGB, are §§ 1908 I; 1908 d; 1896 I and the right to self-determination based on Article 2 Abs. 2 of the Grundgesetz, Basic Law of Germany. Taiwan also prescribes that the ward's opinion should be defining in appointing the guardian as states in art. 1111-1 of the Civil Code of Taiwan.

[133] International Guardianship Network, *Yokohma Declaration on Adult Gaurdianship Law*, § II(3) (Oct. 4, 2010), https://www.international-guardianship.com/pdf/IGN. Measures taken by the individual prior to restriction of legal capacity should take precedence according to this declaration. The Argentine, Austrian, German, Hungarian regulations (among others) are also in line with the Declaration.

[134] TEASTER, PUBLIC GUARDIANSHIP, *supra* note 124, at 22. Similar provisions can be found in Ptk. tit. VII §§ 2:39(1), (2)(a)–(b).

law.[135] A specific subcategory of the normative approach may be identified as the family model, which gives priority to family members in the ex lege hierarchy of persons to be appointed as guardian.[136]

The German regulation of guardianship underwent a paradigm shift leading to greater respect for personal autonomy. The new legal instrument of legal care ("Betreuung") is a subsidiary to a power of attorney appointed by the mentally disabled person, guaranteeing the right to self-determination. If the person appoints a power of attorney ("Vorsorgevollmacht"), Betreuung can be avoided.[137] Thus, in the German system the person does not only have the right to decide on the person but also to choose the applicable protective regime.[138] In the case of a Betreuung, through the agreement between Betreuuer and the mentally disabled person, the latter's influence on the outcome is greater in an effort to further enhance the person's right to self-determination.[139] A similar solution can be found in Japan's guardianship law, which allows for a hybrid measure where the individual's right to self-determination is exercised by appointing a continuing power of attorney that is complemented by a court-appointed supervisor.[140]

Requirements for a guardian: authorization and 'background check'

Distinction has to be made between professional and private guardians[141] based on the required qualification: the former being a

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[135] Ptk. tit. VIII § 2:31(3); Taiwan follows an approach similar to the 2009 guardianship reform. *See* Civil Code, arts. 1111–13 (Taiwan).

[136] The family model can be clearly observed in the Austrian, Hungarian, Japanese and Korean systems.

[137] Dagmar Brosey, *Supported Decision-making and the German Law of BETREUUNG*, *in* DAGMAR COESTER-WALTJEN, LIBER AMICORUM MAKOTO ARAI 130, 130 (2015).

[138] *See id.* at 130–31.

[139] Bürgerliches Gesetzbuch [BGB] [Civil Code], § 1901 [hereinafter BGB].

[140] Kees Blankman, *The Yokohama Declaration and Maximizing Autonomy in the Netherlands*, *in* DAGMAR COESTER-WALTJEN, LIBER AMICORUM MAKOTO ARAI 115, 123 (2015). The author also notes the similarity between the German and Japanese regulation.

[141] The author intends to differ from the general terminology of public and private guardians: instead of distinction based on the private, contractual nature of private

professional care person for the mentally disabled has to fulfil higher standards. The stricter criteria derives from the fact that in most cases professional guardians are appointed (by court or by contract) when the individual lacks relatives or family members that are capable or willing to become private guardians.[142] It must be noted that not all states allow professional guardians to be appointed, when the services of professional guardians are available according to the rules of the private market.[143]

Appointing a suitable guardian is a safeguard of the individual's fundamental rights on several grounds. First, the guardian requires the necessary qualifications (skills, qualities and experience) to effectively represent the ward's best interests. These qualifications have to be viewed separately for professional and private guardians. Professional guardians are required to fulfil standards of expertise in the care of the mentally disabled. As noted above, professional guardians are most often appointed if the person lacks the social ties (and often the financial means as well) to provide for his care. Therefore, supporting the person's financial and social well-being has to be carried out without significant help from others. Moreover, the lack of social ties also results in a lack of oversight. Thus, not only does it raise concerns of intentional abuse, but it also eliminates the possibility of correcting accidental mistakes. As the guardian cannot expect assistance in carrying out his duties, the best interests of the ward are largely subject to the guardian's own professional expertise.

In practice, these professional standards are regulated by norms that are placed lower in the hierarchy of norms (usually decrees or not even legally binding norms) than the regulation of the rights and duties of both ward and guardian. To ensure that guardians are able

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guardianship compared to the social security aspect of public guardianship, the term professional guardianship is used in reference to social workers specialized in professional care of mentally disabled individuals with restricted legal capacity, whereas private guardian is used as a category for relatives or acquaintances taking up the position of guardian based on their private life ties to the individual, without necessarily having expertise in their care.

[142] Pamela B. Teaster et al., *Wards of the State: A National Study of Public Guardianship*, 37 STETSON L. REV. 193, 229–30 (2008) [hereinafter Teaster, *Wards of the State*].

[143] TEASTER, PUBLIC GUARDIANSHIP, *supra* note 124 at 23.

to achieve the core aim of professional guardianship, the Yokohama Declaration urges the development of professional standards.[144] The CRPD takes more concrete steps towards prescribing the training of professionals by providing more detailed provisions.[145] However, training and education of guardians (both professional and private) in many countries or states lack not only a clear set of rules but also sufficient governmental funds.[146] A counterexample can be observed in the Netherlands where the governmentally funded "in safe hands" project aims at raising awareness and growth in training persons.[147] Mentorschap Nederland organises special courses and trainings on the topic.[148]

On the other hand, private guardians are already familiar with the person's diachronic identity,[149] social or family ties, and relations, as well as will, preferences and general worldview. In this case, supporting the person's best interests is not only a matter of professional knowledge. Guardianship being a deeply sensitive and intimate relation between ward and guardian, personal aspects are inevitable for effective cooperation. Private guardians take the position voluntarily, therefore it can be assumed that they are dedicated to supporting a person they already have close ties to. In determining the most suitable support of (or most suitable decision to be made on behalf of) the ward, a private guardian may make up for the lack of professional expertise by more elaborate interpersonal knowledge.

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[144] Yokohama Decl. § 5 (1)-(2) (revised 2016).
[145] United Nations, Convention on the Rights of Persons with Disabilities arts. 4, 13, 20, 24–26, Dec. 13, 2006 https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html
[146] The author based this statement on information he gathered during consulations with experts from around the world at the 16th ISFL World Conference in Amesterdam.
[147] Gov. of the Netherlands, *Action Against Elder Abuse: The Government is Keen to Break the Taboo on Elder Abuse, and to Prevent and Tackle it Where Possible, Mainly by Raising Awareness of the Problem,* https://www.government.nl/topics/abuse-of-the-elderly/action-against-elder-abuse (last visited July 12, 2020).
[148] Blankman, *supra* note 140, at 117.
[149] Burch, *supra* note 42, at 395.

Location of Guardian in the Legal System

Institutionalisation of guardianship constitutes a fundamental safeguard as a requirement of legal certainty. A detailed regulation that successfully implements the latest findings and paradigms of non-legal studies (most importantly psychology and medicine) provides a higher possibility of serving the best interests of the mentally disabled. Moreover, legal clarity provides transparent information to society, helping not only vulnerable persons requiring protection but also anyone who is in close contact with mentally disabled persons. Furthermore, transparency of information promotes the social inclusion and acceptance of persons living with mental disabilities.

In constituting guardianship or other similarly aimed protective regimes states may choose an explicit or implicit scheme.[150] According to Schmidt, states expressis verbis regulating availability of guardianship follow the former scheme, while the latter approach constitutes other equivalently protective legal measures without explicitly naming them guardianship.[151] The difference between the two seems merely formal, however, the explicit regulatory method often signals the state's progressive and devoted attitude towards providing a more developed protective regime for mentally disabled persons.[152]

Most continental legal systems follow an explicit regulation by constituting guardianship in either their civil codes or in a special law.[153] A shift towards the explicit system can also be observed in the United States: twenty-six implicit and fourteen explicit regulations[154] were present in 1981,[155] whereas by 2005 the number

[150] WINSOR C. SCHIMDT & FLORIDA STATE UNIVERSITY. INSTITUTE FOR SOCIAL RESEARCH, PUBLIC GUARDIANSHIP AND THE ELDERLY 26 (1981).
[151] *See id.*
[152] *Id.*
[153] The Austrian, German and Hungarian civil codes are examples of the former while the Danish Guardianship Act or the Mental Capacity Act of England and Wales may stand for the latter.
[154] Some states constituted multiple, parallel legal regimes.
[155] TEASTER, et al., PUBLIC GUARDIANSHIP AFTER 25 YEARS: IN THE BEST INTEREST OF INCAPACITATED PEOPLE? 34 (2007) (available online at https://www.americanbar.org/content/dam/aba/administrative/

of implicit regulations dropped to eighteen compared to the twenty-eight explicit schemes.[156] Besides the shift towards explicit systems it can also be observed that an increasing number of states provided legal protection for persons with mental disabilities.[157]

As of today, most countries regulate the legal protection. Schmidt describes four models of guardianship office based on the Regan and Springer classification:

- the court model establishes the guardianship office as an arm of the court that bears jurisdiction over guardianship;
- in the independent state office model, the public guardianship office is part of the executive branch of the government, without providing direct services to individuals;
- as a division of a social service agency the guardianship office may provide services directly to mentally disabled persons, raising serious concerns of conflict of interests; and
- the county model places public guardianship functions at the local or regional level with central coordination.[158]

The four models are useful to understand and compare the functioning of the guardianship office in various countries. Even though a more detailed analysis leads to the conclusion that several exceptions and adjustments are present in the legal systems, the four core schemes are inevitable to provide credible comparison between guardianship regulations of different jurisdictions.

The Right to a Public Guardian

In 2005 most states in the United States provided access to a guardian in cases where the necessity of guardianship was declared by the court but the individual had no other person or organisation

law_aging/PublicGuardianshipAfter25YearsIntheBestInterestofIncapacitatedPeople.pdf) [hereinafter TESTER, PUBLIC GUARDIANSHIP AFTER 25 YEARS].

[156] *See id.*

[157] *See id.* at 108.

[158] *Id.* at 108–09.

willing to take up the position of the guardian.[159] Modern guardianship systems departed from the traditional diagnostic based approach and moved towards mental capacity or vulnerability based assessment.[160] However, there are still state codes requiring special conditions for guardianship; four states of the U.S. name elderly with limited capacity as the target group, while four states set abuse or ill-treatment as a condition for protection.[161] Continental European systems follow a significantly different path. Persons of restricted legal capacity are entitled to a public guardian per se by the decision of the court if no private guardian is willing to take the position, without regards to the mental condition or health of the individual.[162]

Financial matters may also obstruct the right to a public guardian. Several states of the U.S. prescribe a certain financial limit for public guardianship.[163] Connecticut restricts the right to a public guardian to those possessing no more than $1,500 in assets,[164] while Illinois provides for two different schemes for public guardianship (Office of State Guardian for incapacitated individuals with estates under $25,000; and a system of county guardians for those with estates of $25,000 and over).[165] Florida prescribes that "public guardianship programs must primarily serve incapacitated persons

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[159] *See* Pamela B. Teaster et al., *Wards of the State: A National Study on Public Guardianship*, AMERICAN BAR ASSOCIATION (Apr. 2005) 4 https://www.americanbar.org/content/dam/aba/administrative/law_aging/wardofstatefinal.pdf.

[160] *See* Margaret Isabell Hall, *Mental Capacity in the (Civil) Law: Capacity, Autonomy, and Vulnerability*, 58 MCGILL L.J 61, 64–69 (2012).

[161] *Capacity Definition & Initiation of Guardianship Proceedings (Statutory Revisions as of August 2020)*, AM. B. ASS'N COMM'N ON L. AND AGING 3, 7, 17, 22–23, 25, 29, https://www.americanbar.org/content/dam/aba/administrative/law_aging/chartcapacityandinitiation.pdf (last visited Jan. 25, 2021).

[162] *See* Kees Blankman, *Guardianship Systems in Europe and Continuing Powers of Attorney in Adult Guardianship Law for the 21st Century*, *in* MAKOTO ARAI ET AL., ADULT GUARDIANSHIP LAW FOR THE 21ST CENTURY 39, 39–45 (Makoto Arai et al. eds., 2010).

[163] TEASTER, PUBLIC GUARDIANSHIP, *supra* note 124, at 29.

[164] *Id.*

[165] *Id.*

of limited financial means."[166] In contrast, similar restrictions based on financial matters are not present in the compared European systems.[167]

Scope of Guardianship

The supportive scope of guardianship can cover two main areas: (1) guardianship of the person, which ensures the protection of best interests in issues directly related to the ward as a person; and (2) guardianship (or conservatorship) of property, which is designed to manage financial matters of the ward.[168] Although the UGPPA model act of the United States clearly distinguishes between the two areas, not all European guardianship systems involve clear distinction.[169]

The two areas are by nature significantly different. Financial matters require a more pragmatic approach and may be considered a rational field where the possible cost and profit calculations can provide clear-cut answers indicating the best interests of the individual. On the other hand, guardianship of a person covers

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[166] *Id.* at 128.

[167] *See* EUROPEAN UNION AGENCY FOR FUNDAMENTAL RIGHTS, LEGAL CAPACITY OF PERSONS WITH INTELLECTUAL DISABILITIES AND PERSONS WITH MENTAL HEALTH PROBLEMS (2013) (available at https://fra.europa.eu/sites/default/files/legal-capacity-intellectual-disabilities-mental-health-problems.pdf). This report discusses European "standards and safeguards concerning the legal capacity of persons with intellectual disabilities and persons with mental health problems," which includes factors qualifying mentally incapacitated people for guardianship procedures. *Id.* at 7. Notably absent from the sixty-four-page report is any requirement relating to the financial hardship or limitations of the individuals seeking guardianship. Instead, many European countries focus on "the individual circumstances and the needs of the person concerned." *Id.* at 23.

[168] *See* National Conference of Commionsers on Uniform State Laws, *Uniform Guardianship, Conservatorship, and Other Protective Aranagements Act*, §§ 102, 424 (July 2017) https://www.guardianship.org/wp-content/uploads/2018/09/UGCOPPAAct_UGPPAct.pdf [hereinafter UGPPA].

[169] EUROPEAN UNION AGENCY FOR FUNDAMENTAL RIGHTS, *supra* note 167, at 31. This report compared types of protections in different European countries. *Id.* For example, the Dutch Civil Code distinguishes between protection of property and protection of the person, whereas some countries, like Slovakia, distinguish between the level of control a guardian has, such as control over all legal acts, or only some specified legal acts. *Id.* at 30–31. Therefore, there is no uniform European standard for what aspects of a ward's life the guardian has the power to control.

heterogeneous issues ranging from family matters to the place of residence or even voting rights.[170] The directly personal matters are more subjective as they are directly linked to the ward's human dignity and right to develop his or her own personality by exercising the right of choice based on personal subjective values and preferences. However, the distinction between objective and subjective may sometimes be misleading. Financial decisions also inevitably reflect personal aspects such as the subjective value of luxuries or the willingness to take financial risk are ultimately subjective preferences.

Guardianship regimes also differ based on whether they appoint different guardians of the person and of property, or if support is provided by the same guardian in both fields.[171] Few states still do not provide for guardianship of the person (only Alabama and South Carolina).[172] Another differentiating point is the scope of guardianship of the person. Guardianship regimes show great diversity in explicitly excluding certain personal choices from the restrictions of guardianship.[173]

B. Strictly Procedural Fair Trial and Due Process Safeguards

Another distinction is required to compare various, strictly procedural fair-trial safeguards. Despite the following safeguards originally being procedural in nature, purely procedural safeguards may be distinguished from the substantive-procedural safeguards that affect both the outcome decision and the procedure itself. The difference may be shown by the example of the right to be heard. Prescribing merely the mandatory hearing of the person belongs to the former category, while the latter would be to prescribe a hearing in a way the mentally disabled person can properly understand and effectively participate in a hearing that responds to the special needs of the individual.

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[170] *See* UGPPA, *supra* note 168, at § 310.
[171] *See id.* at § 309.
[172] TEASTER, PUBLIC GUARDIANSHIP, *supra* note 124, at 29.
[173] *See id.*

Preliminary safeguards require a proactive stance from the legislator, while the strictly procedural fair trial safeguards are mostly dependent on legal practice and practitioners.

Right to Counsel and Legal Representation

Guardianship proceedings are initiated because of vulnerability based on an alleged lack of capacity.[174] This vulnerability caused by mental disorders often means a lack of ability for affected individuals to advocate for themselves, which hinders them in the guardianship procedure as well as in their everyday lives.[175] The right to counsel and obligatory legal representation aims to counterbalance their vulnerable state during the procedure.[176] The right to counsel was granted in twenty-two states of the U.S. in 1981, an underwhelming number that rose significantly by 2005.[177] Furthermore, the positive quantitative trend in the U.S. was complemented by qualitative improvements as twenty-five states prescribed mandatory legal representation in guardianship procedures.[178] Therefore, a reflex of the right to counsel has been developed: the authorities' legal obligation to ensure legal representation. Lack of legal representation can obstruct the legal process, while violation of the obligation could result in the annulment of the decision. Closely linked is Schmidt's research which found that seventeen states provided free legal counsel for those in need, a number that rose to over twenty by 2005.[179]

The European Court of Human Rights also emphasised the outstanding importance of the right to counsel among the elements of the right to a fair trial. The ECtHR held in the Winterwerp[180] and Shtukaturov[181] cases that the essence of the right to a fair trial cannot be derogated and went on to identify the right to counsel and

[174] *Id.* at 5.
[175] *Id.*
[176] *Id.* at 30.
[177] *Id.*
[178] *Id.*
[179] *Id.*
[180] Winterwerp v. The Netherlands, 33 Eur. Ct. H.R. 1, ¶ 21 (1979).
[181] Shtukaturov v. Russia, 33 Eur. Ct. H.R. 1, ¶¶ 55, 68, 71 (2008).

representation as such core elements of a fair trial.[182] Examining the European systems, according to Hungarian law a guardian ad litem has to be appointed ex officio[183] and the costs of legal representation are covered by the state.[184] This example further promotes the right to representation because a litigation supporter may be appointed to help the individual understand and participate in the legal process.[185] The presence of a special supporter or procedural advocate is also prescribed by procedural rules in Germany[186] and the United Kingdom,[187] while the guardian ad litem as a safeguard on the lawfulness of the procedure is shared by the Argentinian system.[188]

Right to Question and Cross-examine

According to the dogmas of civil procedure the right to question and cross-examine (along with similar rights e.g. the right to make statements, remarks and the right to access court documents) can be subsumed under the legal tools for effective defense.[189] The right to question is the fundamental guarantee that the mentally disabled person is an active participant in guardianship procedures and not the object of litigation.[190] Furthermore, active participation of the individual not only safeguards his human dignity but also enables the court to have a clearer understanding of the unique aspects of that person's circumstances, leading to a tailor-made final decision that will better suit the specific needs of the person.[191]

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[182] *Id.*; Wintherwerp, 33 Eur. Ct. H.R. at 21.
[183] Polgari Perrendtartas [Civil Procedure Code] [Pp] § 308(1) (Hung.).
[184] *Id.* § 82(2).
[185] *Id.* § 65 (C).
[186] BGB, *supra* note 139, at §271(3).
[187] The mandatory appointment of a litigation friend for children and protected parties is prescribed by UK Civil Procedure Rules [CPR] §§ 21.2–21.7.
[188] Codigo Procesal Civil Y Comercial De La Nacion [Civil and Commercial Civil Code] [Cod. Proc. Civ. Y. Com.] arts. 34–37 (Argentina).
[189] *See generally* Zoltán Csehi, *Litigation and Enforcement in Hungary: Overview* (Mar. 1, 2012), Westlaw, Practical Law Country Q&A (discussing the right to cross-examine in dispute resolution proceedings in Hungary).
[190] *See* Convention on the Rights of Persons with Disabilities and Optional Protocol art. 13, Dec. 13, 2006, 2515 U.N.T.S. 11 (ratified by Hungary on July 20, 2007) (available online at https://www.un.org/disabilities/documents/convention/convoptprot-e.pdf).
[191] *Id.*

In examining the extent of the right to question and cross-examine the difference in attitude between continental and common-law jurisdictions should be noted. Contrasting the originally adversarial common law civil procedure and the more inquisitorial civil law jurisdictions a difference in the role of the judge may be observed: common law judges (in procedural terms) act as a neutral arbiter between the parties, who have to present all evidence necessary whereas civil law judges usually adopt a more proactive stance in guiding the legal procedure.[192] However, the extent of civil law judges' procedure-guiding activity varies within civil law jurisdictions. The difference in the role of the judge opens up a new aspect of the right to question. The more it rests on the parties to present the case the greater importance to the right to question and cross-examine should be attributed.

While in 1981 only nine states of the U.S. had explicit rules on the right to cross-examine; this number rose to thirty-five states by 2005.[193] The Hungarian civil procedure rules regulate the right to question in various provisions of the Pp., identifying the different elements of the right.[194]

> States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations, *in order to facilitate their effective role as direct* and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages.

Id. (emphasis added).

[192] *See* Victoria Cromwell, *Common Law vs. Civil Law: An Introduction to the Different Legal Systems*, QLTS PREP BY BARBRI (Apr. 1, 2019), https://barbriqlts.com/common-law-vs-civil-law-an-introduction-to-the-different-legal-systems/#:~:text=Whilst%20common%20law%20systems%20have,apply%20them%20to%20individual%20cases.&text=In%20a%20civil%20law%20system,found%20in%20the%20codified%20law.

> Whilst common law systems have laws that are created by legislators, it is up to judges to rely on precedents set by previous courts to interpret those laws and apply them to individual cases . . . . In a civil law system, a judge merely establishes the facts of a case and applies remedies found in the codified law.

Id.

[193] TEASTER, PUBLIC GUARDIANSHIP, *supra* note 124, at 31.

[194] P.p, ¶ 126 § (4), 133 § (1), ¶ 173 § (3) and ¶180 § (3).

Presumption of Capacity and Standard of Proof

As the consequences of guardianship decisions are severe, affecting the everyday life of the individual and restricting a wide variety of human rights it is of utmost importance that the decision on the necessity of guardianship is based on the well-grounded conviction of the judge that is the result of sufficiently broad-scoped and thorough presentation of evidence. Similar to the presumption of innocence, a presumption of legal capacity is present in most legal systems, meaning that a person is to have legal capacity unless a final and binding court decision restricts it.[195] As guardianship and restriction of legal capacity affects the individual's dignity and personality directly, it has to be based on a qualified standard of proof. However, the actual standard of proof differs in the various legal systems:

> Today, a total of 36 states [in the U.S.] require clear and convincing proof that the respondent lacks decisional capacity and requires a guardian. One state (New Hampshire) uses a standard of "beyond a reasonable doubt"; two (North Carolina and Washington) use a standard of "clear, cogent, and convincing evidence"; Wyoming uses a mere "preponderance of the evidence"; two (Idaho and South Carolina) state that the court must be "satisfied" that a guardian is necessary; and the remaining eight states provide no statutory standard.[196]

The standard of proof has also been interpreted by the ECtHR in the Winterwerp case.[197] Mr. Frits Winterwerp (married, Dutch citizen) was institutionalised and became subjected to involuntary psychiatric treatment based on the expert opinion of a general

[195] The assumption of capacity can also be found in the Yokohama Declaration. Yokohama Decl. § 3 (1)–(2) (rev. 2016).
[196] TEASTER, PUBLIC GUARDIANSHIP, *supra* note 124, at 21.
[197] Winterwerp v. Netherlands, No. 6301/73, § 39, ECtHR 1979.

practitioner in a procedure initiated by his wife.[198] The Court defined three conditions on restriction of liberty:

- the individual concerned has to be reliably shown to be of unsound mind;
- a mental disorder "of a kind or degree" that warrants compulsory confinement;
- established before a competent national authority based on objective medical expertise.[199]

The ECtHR does not provide a clear definition for unsound mind. Furthermore, the Court rejects a definitive interpretation of the term, qualifying it as "a term, whose meaning is continually evolving as research in psychiatry progresses, . . . treatment is developing and society's attitude to mental illness changes."[200] Therefore, as unsound mind is a main deciding factor in guardianship cases, a wide margin of appreciation is given to the legislator as well as the deciding judge.

The Hungarian civil procedure is also based on the wide discretion of the judge vis-à-vis the rejection of presented evidence and in interpreting them.[201] However, there are more substantive requirements for the decision itself: based on credible and proven facts the judge has to reach a valid conclusion.[202] The requirements set forth by Hungarian civil procedure are still rather vague and abstract. Substantive law gives guideline for the discretion of the judge; declaring guardianship as the ultima ratio—a last resort when no less restrictive legal measures can provide suitable protection for the mentally disabled individual.[203] The ultima ratio approach is also present in the German system, where a guardian (Betreuuer) can be appointed by the court based on necessity of support (that is based

[198] *Id.* at § 10.
[199] *Id.* at § 39.
[200] *Id.* at § 37.
[201] P.p, ¶ 3 (Hung.).
[202] *See* Act CXXX of 2016 on the Code of Civil Procedure, at p. 115–16, § 346 (Hung.); *see also Civil Proceedings*, COURTS OF HUNGARY, https://birosag.hu/en/civil-proceedings (last visited Jan. 23, 2021).
[203] *See* Act V of 2013 on the Civil Code of Hungary, 2:19. § (4) (Hung.) [PTK].

on impairment or inability)[204] on the condition that the person cannot manage with the support of social services only.[205] Austria also follows the paradigm of subsidiarity declaring guardianship subsidiary to all other instruments that are suitable to protect the person from harm because of mental disorder.[206] In a similar fashion the UGPPA as well as the Third National Guardianship Summit uses the paradigm of least restrictive alternative on two dimensions: guardianship is only applicable if no less restrictive measures are equally capable of providing sufficient protection for the individual and only powers that are absolutely necessary for the protective aim may be subjected to guardianship.[207] The Yokohama Declaration further develops the principle of last resort, limiting guardianship measures to be the least restrictive measure providing the minimum support and protection that is necessary.[208] England and Wales also implement more elaborate provisions on the principle of guardianship as ultima ratio, specifying in the Mental Capacity Act "that a person is not to be treated as unable to make decisions, unless all practicable steps to help him . . . [are] without success."[209]

The 'Nothing about Us, without Us!' Principle

One of the most fundamental safeguards may be that the person is notified in due time that a guardianship proceeding is to commence. Closely linked is the fair trial requirement that the individual should—to the best of his abilities and capacity—actively participate in the procedure. Therefore, mandatory hearing of the person concerned is also of imperative importance.

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[204] § 1896(1)–(2) BGB(Germany) (available online at https://www.gesetze-im-internet.de/englisch_bgb/englisch_bgb.html#p6423).
[205] Examples of such social services are psychiatric centers, advisory services, youth welfare services, direct payments, debt counselling, a visiting nurse, or assisted living.
[206] § 268 para. 2 ABGB; *see also* Michael Ganner & Maria Isolina Dabove, Arai, Makoto: Liber Amicorum Makoto Arai, Developments in Austrian and Argentine Guardianship Law, 1. Aufl. ed., 320 (2015) (Ger.)
[207] UGPPA, *supra* note 168, at §§ 311 (a)(1)(B), 409 (b); *Third National Guardianship Summit Standards and Recommendations*, 2012 UTAH L. REV. 1191, 1193 (2012) (see Recommendation 2.2).
[208] Yokohama Decl. § 3(5) and 4(13) (revised 2016).
[209] Mental Capacity Act 2005, §1 (3) (Eng.).

The provision of notice in due time is present in the UGPPA.[210] The paradigm shift in the United States resulted in a great increase in the number of states that require notice and a hearing in guardianship proceedings—from only 29 states in 1981 to all of the states by 2005; additionally, many states provide right to receive court documents in plain language and large print.[211] The Hungarian civil procedure rules similarly apply the principle of notice in due time and mandatory hearing of the person,[212] however, the hearing is not an absolute requirement[213] as the possibility of a hearing may at times be contradicted by the unique circumstances and symptoms of the mental disability itself, constituting a "natural obstacle."[214] Danish law gives a rather elaborate set of rules on notice requirements, which involves the notice of not only the individual but also the spouse (unless they separated) or close family members.[215]

Guardianship is an exceptionally personal legal measure as it is inseparably linked to the person's future life. Every individual is different and so are each case mental disability, thus the direct involvement of the mentally disabled person in the guardianship procedure is the key guarantee that the decision on restriction of personal autonomy is based on the unique and individual circumstances of the person concerned. However, effective participation of the individual may require special measures that reflect mental disorders. An example of providing for effective participation is the use of people-first language[216] or plain language

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[210] UGPPA *supra* note 168, at §§ 304(b)(4); 309; 403(b)(6); 404 (1997) (these sections require notification when a guardianship proceeding is going to commence).
[211] TEASTER, PUBLIC GUARDIANSHIP, *supra* note 124, at 20.
[212] P.p. § 309(3) (Hung.).
[213] *Id.* ("In actions for placement under guardianship . . . the defendant may be omitted [from the hearing] only if his whereabouts are unkown or if any insurmountable obstacles exist.")
[214] Examples of such "natural obstacles" may be a mentally disabled (oligophrenic) person who is unable to be contacted, in a therapeutically induced coma, or in a coma as a result of a traumatic brain injury.
[215] LBK nr 1015 af 20.08.2007 Værgemålsloven (known in English as The Guardianship Act, § 20 of this act provides notice requirements).
[216] *See Third National Guardianship Summit Standards and Recommendations*, *supra* note 207, at 1199.

that helps the mentally disabled person understand the court procedure that is necessary if he is to actively and effectively participate. This is ensured by the German legislation that prescribes the court procedure to be conducted with the participation of the adult with assistance from a guardian—either a special supporter, procedural advocate, or an attorney.[217]

A further safeguard may be derived from this principle. As the General Comment on the CRPD[218] concludes, "recognition . . . as persons before the law" necessarily means that the person is an active participant in the procedure instead of merely being subjected to it. Agreeing with the Committee's argumentation that restriction of legal capacity can only be based on a fair procedure in which the person is to bear full legal capacity, I argue that the presumption of capacity also imperatively prescribes that the person has complete legal standing as well as legal agency in the guardianship procedure in order to be given an equal recognition before the law. Agency in the guardianship procedure cannot be denied based on an alleged lack of mental capacity as declaring the lack of capacity can only be the outcome of the procedure, not a preliminary ruling. Therefore, not granting complete agency would presuppose the outcome of the procedure, making it an empty formality (and resulting in a petition principia fallacy).

However, this does not mean that their special circumstances should be ignored; granting them agency on an equal basis does not only mean access to the same rights (formal equality), functional equality calls for equal exercise of rights and equal opportunities to do so. I argue that legal representation of the mentally disabled person in the guardianship procedure is valid and legitim,

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[217] *See* §§ 1896, 1901, BGB (Germany) (available online at https://www.gesetze-im-internet.de/englisch_bgb/englisch_bgb.html#p6423); Ali Türk et al., *German Guardianship Law*, INSTITUT FÜR TRANSKULTURELLE BETREUUNG, https://www.mj.niedersachsen.de/download/58853#:~:text=The%20statutory%20basis%20for%20legal,to%20manage%20his%20affairs%20himself. (last visited Aug. 16, 2020).

[218] Convention on the Rights of Persons with Disabilities and Optional Protocol art. 12, Dec. 13, 2006, 2515 U.N.T.S. 10 (ratified by Hungary on July 20, 2007) (available online at https://www.un.org/disabilities/documents/convention/convoptprot-e.pdf).

nevertheless it cannot substitute the person's own full agency, only complement and enhance it.

Assessment Based on Expertise; Expert Evidence

The nature of individual autonomy that is external to law as well as the fact that reduced mental capacity is always the consequence of some form of mental disorder it is inevitable to implement non-legal expertise into guardianship procedures. Exploration and assessment of a person's mental status is not the competence of legal professionals as examination of mental disorders falls within scope of medicine (more specifically psychiatry, neurology, gerontology and paediatry) and psychology. Due to the intrinsic nature of mental disorders clear and precise distinction of competence within the latter disciplines would be difficult and without significant practical benefits.

A decision on restriction of personal autonomy is inevitably a legal construct, however, it is not a legal question per se as the individual's circumstances legitimising the restriction cannot be fully understood with legal tools only. Medical-psychological expertise has to be channelled into the procedure as well. Expert evidence is supposed to provide the necessary link between law and studies of mental disorders.

Almost all legal systems regulate the process by which a person is determined to lack capacity, which includes using evidence of evaluation by a medical expert, with a significant majority (showing a further increasing trend) requiring it as a mandatory element of guardianship procedures.[219] All states of the U.S. prescribe mandatory medical report while thirty-one states specifically require psychological assessment to complement the medical evidence.[220] The ECtHR has also elaborated on medical experience in procedures

[219] *See, e.g.*, TEASTER, PUBLIC GUARDIANSHIP, *supra* note 124, at 21 (discussing the number of U.S. states that require expert evaluation before guardianship is required); UGPPA § 306 (1997) ("If the court orders [an] evaluation, the respondent must be examined by a physician, psychologist, or other individual appointed by the court who is qualified to evaluate the respondent's alleged impairment.")

[220] TEASTER, PUBLIC GUARDIANSHIP, *supra* note 124, at 21.

involving mentally disabled persons.[221] Despite the importance of medical diagnoses, doctor's reports alone are not sufficient to restrict or remove one's legal capacity—courts rarely accept the lack of direct hearing of the individual concerned during the procedure.[222] This approach by the Court is articulated clearly in *Shtukaturov*, where the Court (without prejudice to the qualification of experts) declares that notwithstanding the severity of the mental disability, a medical diagnosis cannot per se provide the grounds for guardianship.[223]

The ECtHR also defines strict conditions on admissibility of expert evidence, when it rejects the usage of contradictory or otherwise not completely clear expert evidence.[224] However, the Court did not object to the involvement of psychologists instead of psychiatrists, even though it might raise concerns on the credibility of the expert opinion from a medical point of view.[225] As the disciplines of psychology and psychiatry have a fundamentally different approach and set of tools, their training and practice revolves around different types of mental disorders (a clear difference in methodology can be seen from the fact that many psychological examinations are based on various intelligence and personality tests while psychiatric examination also involve the physical condition of the patient).[226] The ECtHR did not object to the credibility of a report of a general medical practitioner in the Winterwerp case even though it discussed issues of psychiatric competence.[227] Furthermore, it may raise concerns that the Court refrains from effectively referring to mental disabilities other than merely mentioning the major symptoms.[228] It may suggest that mental disorders are of subsidiary importance in proving the

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[221] *See*, *e.g.*, A.N. v. Lithuania, No. 17280/08, ECtHR 2016-IV.
[222] Shtukaturov v. Russia, No. 44009/05, §§ 93–94 ECtHR 2008.
[223] *Id.* at §§ 71–74.
[224] *Id.* at §§ 93–94.
[225] *Id.*
[226] Philip Monroe, *Psychiatric vs. Psychological Evaluations: What is the Difference?*, MUSINGS OF A CHRISTIAN PSYCHOLOGIST (Apr. 10, 2009), https://philipmonroe.com/2009/04/10/psychiatric-vs-psychological-evaluations-what-is-the-difference/.
[227] *See* Winterwerp v. Netherlands, No. 6301/73, ECtHR 1979.
[228] *Id.*

necessity of guardianship despite being the primary cause of reduced mental capacity. Since each case is based on its own individual circumstances, reference to medical knowledge varies significantly in the decisions of the ECtHR.[229] Some continental legal systems also prescribe the necessity of medical expert evidence in guardianship procedures.[230] A better focus on medical competence can be observed in the Korean system which prescribes a mandatory psychiatrist or psychologist examination.[231]

An effective method could be the mandatory prescription of interdisciplinary assessment, where a team of experts of the disciplines concerned jointly assess the person's mental, physical and social circumstances, giving broad-scoped expert evidence. The benefits of interdisciplinarity are numerous, the various aspects of mental disabilities and the unique aim of legal restriction of autonomy necessitate a thorough assessment procedure that is flexible enough to competently reflect on all issues that may arise. The downside of a board of experts is, however, that cooperation between the different sciences may be problematic, as each discipline works with different tools and have a different aim as well as approach to mental disorders. Nevertheless, cooperation issues of experts can be tackled by integrated professional training of these experts. The interdisciplinarity approach is an innovative solution

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[229] *E.g.*, *Thematic Report: Health-Related Issues in the Case-Law of the European Court of Human Rights*, EUROPEAN COURT OF HUMAN RIGHTS (June 2015), https://www.ECtHR.coe.int/Documents/Research_report_health.pdf. This report breaks down the types of health-related cases that the ECtHR has jurisdiction to hear, including Medical Negligence, Health and Bioethics, Health of Detainees, Health and Immigration, Health and the Environment, and others. *Id.* Further, the report provides an alphabetic list of major health-related cases decided by the ECtHR, showing representation from most European countries in these decisions. *Id.* Therefore, based on the ECtHR's policy that "health-related matters[] will be determined by the circumstances of the individual case submitted," it is clear that the ECtHR, while inclusive, can often provide inconsistent application of medical knowledge in its decisions. *Id.*

[230] *E.g.*, p.p. § 310 (2); BGB§ 271. However, the Danish regulation does not constitute it as an absolute necessity. LBK nr 1015 af 20.08.2007 Værgemålsloven (see Article 18(2)).

[231] Je, *supra* note 133, at 399.

that implements scientific methods in the legal procedure to the greatest extent.[232]

Right to Effective Remedy

The right to effective legal remedy is a fundamental right that is explicitly protected by several international legal documents.[233] The described system of strictly procedural fair trial safeguards is also applicable to the remedy procedure with some adjustments that derive from the special aim of the appellate process. The right to remedy is a fundamental human right, therefore its importance in a human rights point of view safeguard system is hardly questionable.

C. Follow-up Safeguards

Review

A unique quality of mental disorders is that they may, with the passage of time, significantly shift spontaneously in either a positive or negative direction.[234] The fluctuating nature of mental health and capacity requires review of guardianship decisions to ensure that their necessity and legitimacy is persistent.

This Article proposes two main models for review:

- periodic ex lege review that takes place at certain, legally defined intervals
- ad hoc review that is initiated in case of an irregular change of circumstances.

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[232] *See generally* Carolyn L. Dessin et al., *Creating and Sustaining Interdisciplinary Guardianship Committees*, 2012 UTAH L. REV. 1667 (2012).
[233] ECtHR, *supra* note 12, at art. 13; ICCPR, *supra* note 12, at art. 2(3); Universal Declaration of Human Rights art. 8, Dec. 10, 1948 (available online at https://www.un.org/en/universal-declaration-human-rights/); Charter of Fundamental Rights of the European Union art. 47, Dec. 18, 2000 (available online at https://www.europarl.europa.eu/charter/pdf/text_en.pdf).
[234] *E.g.*, Pia Schönfeld et al., *Positive and Negative Mental Health Across the Lifespan: A Cross-Cultural Comparison*, 17 INT'L J. CLINICAL AND HEALTH PSYCHOLOGY 197 (2017).

Review of guardianship as a safeguard is the most efficient if both forms of review are provided; if guardianship is reviewed regularly by an independent authority while also providing the opportunity to initiate an ad hoc review in case of a sudden improvement of deterioration. International documents on mental disabilities also enshrine the dualist review system (in particular the Yokohama Declaration).[235] Generally, the aim of guardianship review is to examine the changes that have occurred based on the ward's circumstances which may have affected the ward's personality, mental or physical health, mental capacity, and social or family relations.[236] These changes have to be addressed and, in the case that the current guardianship decision does not fit due to changed circumstances, the guardianship has to be adjusted accordingly to protect the ward's best interests. If the review finds that guardianship is no longer necessary, it must be terminated as soon as possible.[237] As the review has to be able to terminate guardianship, it is inevitable that it is carried out "by a competent, independent and impartial authority or judicial body."[238]

The European Court of Human Rights reiterates multiple times in its decisions that a person's mental and decision-making capacity

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[235] Yokohama Decl. § 3(5)–(6) (revised 2016). Adopted by the First World Congress on Adult Guardianship Law, Yokohama, Japan, October 4th, 2010, revised and amended by the Fourth World Congress on Adult Guardianship Law, Erkner/Berlin, Germany, September 16th, 2016.

[236] *E.g.*, D.C. Code § 21-2045.01 (2017). The D.C. Code is representative of many state laws that require periodic updates of the ward's physical, medical, and social circumstances to determine whether a guardian is still required. *Id.* Additionally, many states have forms for the guardian to fill out at the periodic review, seeking information such as whether the guardian believes the guardianship is still necessary and describing the living, physical, and emotional situation of the ward. As an example, copy of the State of Michigan Probate Court, Oakland County's Report on Review of Guardianship of Legally Incapacitated Individual can be accessed at https://www.oakgov.com/courts/probate/Documents/in-house/pemh1022_report_rev_gd_lii.pdf.

[237] *See e.g.*, Fla. Stat. 744.464(3)–(4) (requiring the court to restore legal capacity to an individual who properly petitions and proves, through medical examination, that restoration would be appropriate, and mandating that the court "shall give priority to any suggestion of capacity and shall advance the cause on the calendar)".

[238] Convention on the Rights of Persons with Disabilities art 12 § 4, Dec. 13, 2006, 2515 U.N.T.S. 3.

may change with time.[239] In several of its decisions regarding mentally disabled persons under guardianship the Court finds a violation of the Convention on the grounds of a lack of review in reasonable time.[240] However, the interval cannot be identified precisely from the latter cases, as the Court decides on a case-by-case basis what reasonable time means.[241] The Court also decided in *Shtukaturov* and *Lashin*[242] that not providing the ward direct opportunity to initiate a review process constitutes a violation of the Convention, as in both cases the wards could only apply for review indirectly, through their respective guardians.[243] A further issue is whether a certain capacity should be required to initiate an ad hoc review. According to the Yokohama Declaration, the individual's right to institute a review exists irrespective of capacity.[244] Linking the right to institute review to capacity is controversial on multiple grounds. The core aim of the review is to assess the changes (if any) in the mental status of the ward, thus the requirement of regained capacity to initiate such review would mean to assess the outcome of the review as a preliminary condition, leading to severe fair trial and access to court concerns.

As of today, U.S. states provide procedures to adjust or terminate guardianship measures, while at least forty-five states specifically provide the ward with the right to initiate such procedures.[245] Act V of 2013 of the Hungarian Civil Code prescribes an exhaustive list of potential petitioners who may initiate guardianship procedure while also providing extensive flexibility

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[239] *E,g.*, Shtukaturov v. Russia, No. 44009/05, § 103 ECtHR 2008.
[240] *Id.* § 102; Lashin v. Russia, No. 33117/02, § 75 ECtHR 2013.
[241] *Compare* Lashin v. Russia, No. 33117/02, § 75 ECtHR 2013 (two years was an unreasonable amount of time), *with* Shtukaturov v. Russia, No. 44009/05, § 102 ECtHR 2008 (ten months was an unreasonable amount of time).
[242] Shtukaturov v. Russia, No. 44009/05, § 124–25 ECTHR 2008; Lashin v. Russia, No. 33117/02, § 97 ECtHR 2013.
[243] *Id.*
[244] Yokohama Decl. § 3(6) (revised 2016).
[245] TEASTER, PUBLIC GUARDIANSHIP, *supra* note 124, at 6; *see also Restoration in Adult Guardianships (Statutes)*, AM. B. ASS'N (June 2013), https://www.americanbar.org/content/dam/aba/administrative/law_aging/2013_CassidyRestorationofRightsChart7-13.authcheckdam.pdf (the American Bar has provided a chart detailing each state's restoration statutes).

for adjustments in the guardianship measures.[246] Periodic ex lege review of guardianship takes place every five—or, in certain cases, ten—years.[247] The Dutch Civil Code also implements a 5-year period within which the guardian has to report to court on whether the measure should be upheld.[248]

Monitoring and Supervision of the Guardian

Monitoring and review of the guardian's actions can be achieved in multiple ways. Joint application of these measures leads to a sufficiently broad-scoped supervision that ensures the protection of the ward. Regarding property and financial matters the guardian's duty to provide annual reports and financial plans as well as ad hoc reviews upon request by the court or other persons related to the ward provides transparency to ensure that management of the ward's property is carried out in a lawful, reasonable and efficient way.[249] To ensure transparency and allow effective supervision the Yokohama Declaration promotes the use of accurate account records the duty of the guardian to "be ready to produce them immediately" upon request.[250] The Dutch regulation is similar to the Yokohama Declaration providing detailed provisions on record keeping. The record keeping requirements state that the guardian is to open a separate file (the content of the file is also prescribed in detail) for every client, keep it up to date every week and close it properly.[251] Danish law also regulates in detail the rules on accounting while also giving legal permission for the Ministry of Justice to establish further rules.[252]

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[246] PTK § 2:30(2)(a)–(e).
[247] A legal representative for minors is not present in the list, as Hungarian law does not allow minors to be put under guardianship. *See* p.p. § 312; PTK § 2:28–30.
[248] Art. 1:385(2), 1:446a, 1:459(3) (BW). The Dutch Civil Code is available online at http://www.dutchcivillaw.com/civilcodegeneral.htm.
[249] *Id.*
[250] Yokohama Decl. § 4(15) (rev. 2016).
[251] Besluit kwaliteitseisen curatoren, beschermingsbewindvoerders en mentoren 29 Jan. 2014, Art. 7 (The Netherlands). *See also* Blankman, *supra* note 147, at 118.
[252] LBK nr 1015 af 20.08.2007 Værgemålsloven (see Articles 28–30).

Other forms of supervision may—among others—include on-site visit by authorities (with or without prior notice) to observe the living conditions of the ward.[253] An exhaustive list of tools for supervision cannot and should not be universally prescribed as tailor-made guardianship measures are fundamentally different based on the ward's specific circumstances, therefore various means of supervision are needed to adapt to this flexibility. Theoretically, any form of supervision may be regulated on the conditions that it respects the human rights of the ward as well as the guardian; and it is suitable to provide credible information on whether the guardianship measure achieves aim. The guardian's duty to report to the court as well as the court's monitoring duty in the UGPPA[254] prescribes that the guardian has to keep the court informed about the well-being of the ward as well as the status of the estate at least annually or whenever requested by the court.[255] The UGPPA also prescribes the supervisory tools for personal and financial plans, appraisals, inventory and accountings.[256] According to the UGPPA the guardian has to specify future plans that give a credible basis for supervision.[257] Similar provisions can be found in the Standards drawn by the Third National Guardianship Summit,[258] while a Recommendation of the summit provides details of an effective monitoring system.[259]

Supervision of the guardian is carried out by the court as an authoritative and independent forum.[260] However, the court's

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[253] *Guardianship Law and Legal Definition*, US LEGAL, https://definitions.uslegal.com/g/guardianship/ (last visited Jan. 23, 2021).
[254] UGPPA, *supra* note 168, at § 317.
[255] *Id.*
[256] *See id.* § 104(c). The general comments under Section 104 state "[w]hile a recipient of funds is not a fiduciary in the normally understood . . . a recipient under this section is subject to fiduciary obligations. Under subsection (c), the recipient may not derive any personal benefit from the transfer and must preserve funds not used for the minor's benefit and transfer any balance to the minor upon emancipation or attainment of majority."
[257] *See id.*
[258] *Third National Guardianship Summit Standards and Recommendations*, *supra* note 215, at 1192–98.
[259] *Id.*, at 1200–01 (see Recommendations 2.3 and 2.4).
[260] *See*, *e.g.*, *id.* (Recommendation 2.4 states "The court should provide continuing assistance to the guardian about guardianship law and procedures, the guardian's duties

supervision can never be as consistent as persons' interacting with the ward on a daily (or at least regular) basis. The regulation of supervision in the United States and Europe grant these persons an indirect right to initiate a review of the guardian's activity. The ward can notify the guardianship office or the court directly, then it is up to these forums' discretion whether they deem ad hoc supervision necessary.[261] A different approach can be found in Taiwan's legislation: the "family council" serves as a special group with supervisory power over the guardian.[262] The reason behind allocating certain supervisory powers to a family council is that they have regular contact with the guardian and the ward, thus their monitoring activity is constant and coherent.[263] Further grounds for social control over the guardian may be that persons close to the ward have a better understanding of the ward's previous lifestyle, opinion, preferences and values than the court.

However, following the principles of legal certainty and the rule of law, the purpose of social supervision—in line with the European and American systems—is to trigger court review without delay if

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and responsibilities, community resources and the rights of the person."); *Guardianship Basics*, TWELFTH JUDICIAL CIRCUIT COURT, http://www.jud12.flcourts.org/About/Divisions/Probate-Guardianship/Guardianship-Basics (last visited Sept. 6, 2020) ("In order to ensure the guardian is acting in accordance with the law, Florida Statutes require guardians to submit reports to the court. These reports help the court to supervise the affairs of the ward and to monitor the action of the guardian."); *See generally* Judge David Hardy, *Who is Guarding the Guardians? A Localized Call for Improved Guardianship Systems and Monitoring*, NEVADA LEGISLATURE (Feb. 2, 2008), https://www.leg.state.nv.us/74th//Interim_Agendas_Minutes_Exhibits/Exhibits/SeniorCitizens/E020508P-2.pdf.

[261] *See*, *e.g.*, *Disputes Between Wards and Guardians*, STIMMEL LAW, https://www.stimmel-law.com/en/articles/disputes-between-wards-and-guardians (last visited Sept. 9, 2020) ("A guardian may be removed if a court determines that the ward no longer needs the services of the guardian . . . . Given the central role of the guardian, it is not uncommon for wards and guardians to become engaged in disputes.").

[262] Sieh-Chuen Huang, *Adult Guardianship and Care in Taiwan: An Analysis on Decisions Relating to Compensation for Guardian*, in DAGMAE COESTER-WALTJEN, VOLKER LIPP & DONOVAN W.M. WATERS, LIBER AMICORUM MAKOTO ARAI 375, 375, 383 (Nomos 2015).

[263] *Id.* at 385.

they discover ill treatment or misuse of the guardian's powers.[264] This shift towards the priority of courts' authoritative supervision can also be observed in Taiwan, as the 2009 legal reform transferred most of the supervisory powers to courts.[265] Korean guardianship law also regulates the family council as a form of supervision.[266] Furthermore, it constitutes yet another form of supervision for private guardians, namely, the mandatory appointment of a supervisory guardian, that may be considered effective in balancing the lack of professional requirements for private guardians. A supervisory guardian can also be appointed for public guardians as a replacement of the family council.[267]

IV. Conclusion

Autonomy is not only a quality of one's life: self-governance is core to personality. Protection via legal intervention is a Janus-faced approach, as it centres around the delicate balance between protection of the vulnerable adult and respect for autonomy. The human rights approach suggests that it is necessarily a tailor-made protective regime that evaluates on a case-by-case basis whether the threat of harm outweighs the value of preserving autonomy. The mentally disabled—due to their mental disorder—often lack the ability to effectively stand up for their rights; they have to rely on the legal system to serve as their aegis, the proactive presence of the

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[264] *See Incapacitated Adults: Oversight of Federal Fiduciaries and Cout-Appointed Guardians Needs Improvement*, U.S. GOVERNMENT ACCOUNTABILITY OFFICE (July 2011), https://www.gao.gov/
assets/330/321761.pdf (stating that monitoring courts serve to "prevent financial exploitation of incapacitated adults and stop it when it occurs"); *e.g.*, *Guardian Review Program*, JUDICIAL BRANCH OF ARIZONA, https://superiorcourt.maricopa.gov/probate-and-mental-health-department/guardian-review-
program/#:~:text=The%20Guardian%20Review%20Program%20was,been%20placed%20under%20guardianship%2Fconservatorship (last updated Oct. 22, 2018, 4:39 PM).

[265] Huang, *supra* note 262, at 377, 380.

[266] *See* OFFICE OF THE PUBLIC ADVOCATE, GUARDIANSHIP AROUND THE WORLD 24–25 (2012).

[267] *Id.*

state prescribed by the positive state obligation paradigm of human rights dogmatics.[268]

Restriction of legal capacity is a delicate but double-edged trade-off: effective protection of vulnerable adults is achieved at the price of partial loss of individual autonomy and freedom. The ultimate goal of the procedure is to reach an ideal compromise between the values at stake. The procedure is prescribed and governed by law, yet other disciplines are also necessarily and inevitably involved. Invoking once again the Hungarian Constitutional Court's statement as "in many cases only by observing the procedure as a whole can it be concluded whether it fulfilled the requirements of a fair trial"[269] supports the argument that the core focus of a fair and just legal procedure respecting human rights safeguards should be based on a holistic approach.

Originally, autonomy is not a legal concept, nonetheless, used in a legal environment it has to adapt to the special needs of law and the legal approach. As Immanuel Kant describes, individuals seek to impose lawfulness on the world they live in, denying the existence of universal norms and values.[270] John Stuart Mill further supports this view when identifying the ability to make our own choices as key to human dignity.[271] However, adopting the philosophical reasoning provides a rather abstract a priori account that may fail to respond to the material needs of mentally disabled persons. As a result of their condition, they do require support and protection. Therefore, I argue that the focus should be to find the described ideal trade-off, the delicate balance.

Even though the U.S. Supreme Court stated that "the right to autonomy is free from all restraint or interference . . . unless by clear and unquestionable authority of law,"[272] there is seldom explicit

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[268] The enforceability of which is clearly stated by the ECtHR in the Tysiac case. Tysiac v. Poland, No. 5410/03, § 128–29 ECtHR 2007.

[269] Bán Tamás: A tisztességes eljárás és annak egyik fontos vonása: az ártatlanság vélelme. In: Személyi szabadság és tisztességes eljárás, Budapest, 1999 INDOK.

[270] *See generally Kant's Moral Philosophy*, STANDFORD ENCYCLOPEDIA OF PHILOSOPHY (Feb. 23, 2004), https://plato.stanford.edu/entries/kant-moral/#ForUniLawNat.

[271] *See generally John Stuart Mill*, STANDFORD ENCYCLOPEDIA OF PHILOSOPHY (Aug. 25, 2016), https://plato.stanford.edu/entries/mill/.

[272] Union Pac. R. Co. v. Botsford, 141 U.S. 250, 251 (1891).

reference to a right to autonomy in legal documents or civil codes. Nevertheless, autonomy being the basis of a wide array of fundamental human rights, its restriction calls for effective safeguards. To respond to this concern, invoking the right to a fair trial provides a well elaborated and more concrete standard for legal procedures on restriction of legal capacity. Article 12 of the CRPD calls for the mentally disabled to be recognised "as persons before the law" as well as "legal capacity on an equal basis . . . in all aspects of life."[273] The strong wording of the convention is further supported by the proactive stance that is clearly expressed in the General Comments by the Committee.[274] Therefore, in spite of the lack of explicit reference to a right to autonomy due to its roots in human rights and the flexibility of the right to a fair trial it clearly and imperatively calls for effective safeguards.

The procedure of restriction of legal capacity is ab ovo defined by mental disorders: the procedure is initiated as a response to vulnerability by mental disorder that fundamentally shapes the further stages of the procedure as well. Mental disorders being at the heart of the restriction of autonomy it is inevitable that medical expertise is key in the procedure. However, the emphasis on medical evidence cannot mean a return to the status-based approach dismissed by jurisprudence as well as the Council of Europe.[275]

Mental disorders show outstanding variety in their origins, symptoms and impact on the person's everyday life.[276] Assessment of decision-making capacity as a prerequisite for legal capacity needs to be flexible in order to be able to respond accordingly. The mental capacity approach[277] that dominates the current legislations is a suitable paradigm, however, recent developments should, if not replace, complement it. The will and preferences approach[278] raise

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[273] CRPD, *supra* note 12, at art. 12 § 1–2.
[274] *See generally Committee on the Rights of Persons with Disabilities: General Comments*, UNITED NATIONS HUMAN RIGHTS, https://www.ohchr.org/en/hrbodies/crpd/pages/gc.aspx (last visited Sept. 7, 2020).
[275] Council of Europe, *Committee of Ministers of the Council of Europe Recommendation,* No. R(99)4, (1999).
[276] *See infra* Part I.
[277] *See infra* Part II(3).
[278] *See infra* Part II(4)(A).

serious concerns if it should be considered an alternative to mental capacity. However, this Article suggests a different relationship between the two paradigms: instead of viewing them as alternatives to each other, implementing will and preferences into the mental capacity paradigm provides significant advantages. The required threshold of having a discernible will or preference may be too inconsistent to serve as the ultimate condition for legal capacity, however, if a person bears such will or preferences it has to be respected as part of the assessment of mental capacity and in appointing a person of support (supported or substitute decision-maker). The person's preferences can be the solution to achieve a genuinely tailor-made decision, that reflects the very specific needs and circumstances of each individual.

The vulnerability paradigm also seems to be too vague and ambiguous to provide the basis for the "clear and unquestionable authority of law."[279] Nonetheless, as the core aim of guardianship is to counterbalance the vulnerability of the person, this Article argues that vulnerability should, instead, remain the overarching guiding principle of all procedures on restriction of autonomy; one that ensures that the outcome decision fulfils its aim.

Furthermore, as the difficulties of these procedures (prejudices, circumstances that cannot be wholly addressed by legal methodology, interdisciplinarity) affect all participants, the safeguard system has to be sufficiently broad-scoped. Certain safeguards may be applicable only to certain actors (the mentally disabled person, the judge, witnesses or medical experts) while others may be umbrella principles that govern the entire procedure with all its participants (such as the focus on vulnerability or the ultima ratio principle).

State sovereignty and discretion leads to great diversity in de facto legal systems. Therefore, drawing a dogmatic exhaustive list of the concrete safeguards (safeguards that all necessarily have to apply under any circumstances while excluding the possibility that other safeguards exist that may also prove to be necessary or beneficial) as the elements of the right to a fair trial is not only

[279] Union Pac. R. Co. v. Botsford, 141 U.S. 250, 251 (1891).

unrealistic but it would also fail to reflect the nature of mental disorders as well as of personal autonomy itself. Instead, this Article argues that a more holistic approach should be pursued, identifying principles and paradigms, more abstract and flexible safeguards. In the end these safeguard paradigms, if developed appropriately, would lead to a natural convergence of the various legal systems, achieving a general understanding of procedural safeguards governing procedures of restriction of legal capacity—that is, if not universally accepted—at least equivalent on a global scale in terms of level and efficiency of protection.

Building on the findings of these chapters, this Article returns to its central question. Comparing the various legal systems, this Article concludes that despite the different approaches to restriction of autonomy, key similarities exist among them. The compared regulations of guardianship procedures in European, American and Asian jurisdictions share several protective aims, such as the least restrictive measure and ultima ratio paradigms or provisions protecting explicit fundamental rights of the mentally disabled. Even though the substantive aspects of restriction of autonomy may be fundamentally different, procedural aspects of guardianship procedures are strikingly similar.

An interdisciplinary human rights-based approach that implements philosophical, ethical, and medical knowledge can transcend the boundaries of differences in legal systems. Defining values and interests that require protection allows states to implement such safeguards into their legal systems without contradicting their aim to emphasize sovereignty. Once the aspects to be protected are defined, states can constitute customised safeguard provisions in line with their legal traditions while also achieving equal protection on a global scale. The value of identifying fundamental rights' safeguards lies here.

Therefore, this Article proposes that a system of safeguards should be divided into groups of safeguard provisions based on which part of the procedure they apply to. The proposed system of preliminary, strictly procedural, and follow-up safeguards is suitable to reflect the different needs of each stage of the procedure. Nevertheless, more detailed categorisations can also be followed—

for instance, to break down the procedure itself to different stages such as a preliminary investigative phase, trial or hearing phase, medical examination, or even to include a mediation phase. The dogmas of categorisation provide a more thorough understanding on the applicability and substance of these safeguards. However, notwithstanding the benefits of elaborate categorisation, it is more pressing for states to provide precise and concrete provisions as safeguards that effectively build and follow up on each other. The possible de facto safeguard provisions are numerous; nevertheless, the overall effectiveness of the safeguard system as a whole is what must be in line with the right to a fair trial.

Because restriction of legal capacity is significantly different from other civil or administrative procedures, this Article suggests that instead of a classical civil procedural perspective, a human rights approach is more suitable to reflect the differences arising from mental disorders. Regulating civil procedure falls within state sovereignty, whereas fundamental human rights are internationally recognized and enforceable. However, this Article does not suggest replacing civil procedure jurisprudence with human rights dogmas; instead, a human rights perspective should be considered and implemented into the legislation of civil procedures relating to guardianship or the rights of people with disabilities. This would provide imperative fundamental safeguards that are required to protect the human rights of mentally disabled persons subjected to restriction of legal capacity. Even if intervention is necessary, the person's values and preferences—their manifestations of dignity and self-determination—should be respected to the fullest possible extent, ensuring that they feel recognised as equal members of the same society.

> [The mentally disabled] are the most vulnerable . . . because no one cares deeply if they live or die . . . . [N]o one's life will be fundamentally changed . . . . [W]e owe it to them to

> protect them from over-treatment and from under-treatment; . . . we owe it to them to help them to live better.[280]

The law has no choice but to be the aegis of the voiceless. Therefore, prescribing effective safeguards in legal procedures that might otherwise lead to the significant restriction of fundamental human rights is an ethically and legally imperative obligation on governing bodies worldwide.

[280] Naomi Karp et al., *Incapacitated and Alone: Health Care Decision-Making for the Unbefriended Elderly*, AM. B. ASS'N, July 2003, at 1, 1.

MEDICARE IN CANADA

Doug Surtees[*]

As a Canadian, thinking about the Canadian Medicare system is a bit like thinking about how food goes from the producer to my local grocery store. I know that if I want to buy a block of cheese, all I have to do is go to the grocery store, and there it is. I don't really think about all the regulations involved in producing milk and cheese, marketing boards, importation rules and tariffs, naming protocol, health regulations and so forth; I just go buy it. Similarly, if I am ill, I don't generally think about legislation, policies, and historic struggle, which created the Canadian Medicare system; I just go see a doctor.

The purpose of this article is to give readers a thumbnail sketch of Medicare in Canada. Most Canadians in the workforce today are too young to remember how this marvelous Canadian institution came to be. The story of how Medicare became established, first in Saskatchewan, and then in the rest of Canada, may be useful for Americans who believe in a system of Medicare. Of course, Canada and the United States are culturally and historically distinct, so the Canadian system is not simply "transplantable" into the U.S. context. In addition, times have changed since the introduction of Medicare in Saskatchewan. If the Medicare struggle occurred in Saskatchewan today, the struggle itself and no doubt the peculiarities of the resultant Medicare program, would be quite different. Yet, in spite of this, Americans interested in their own national Medicare discussion, might find it useful to hear the story of how the first widespread Medicare system in North America came to be.

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Canada's initial "Hospitalization" program, and the later full-fledged Medicare system which it became, grew out of the Province of Saskatchewan. I think that any stable system of Medicare must be a reflection of the people and place where it was created. There is a simple but not obvious reason for this. In order to survive, any system of Medicare must have long-term, solid support from people on all sides of the political spectrum.

Medicare involves life and death decisions, decisions impacting peoples' quality of life, and the expenditure of large sums of money. These are decisions which will engender very strong emotions and foster deeply held beliefs, which may be positive or negative, depending upon one's experience. A person who experiences a vastly increased quality of life as a result of a surgery is likely to believe the system works very well. A person who has just been told there is no medical benefit in treating a dying loved one is likely to believe the system didn't do enough. No medical system can treat everyone at the same time. There must of necessity be some manner of allocating priority to certain individuals. A system could allocate priority to individuals based on their status, based on what they are willing to pay, or based on medical need. There must, however, be some way to allocate medical services, as demand will always be greater than supply. In a system like Canada's, priority is determined by medical need. Those who have to wait for services will often think the system works too slowly. This is particularly so where private and public services exist side by side (such as MRI tests), and individuals such as star athletes are able to access tests with no wait at all.[1]

Medicare is an imperfect system run by imperfect people. It will be attacked. Some will say it is too expensive and so should be scaled back and the money used for other purposes. Some will say that its scope isn't broad enough so further investments are required to "keep up" with new technologies. Some will say it is inefficient

[1] For example, professional sports teams routinely pay for their stars to receive an MRI or other test. *See e.g.* Mark Masters, *Marner Undergoes MRI, No Timeline for Ankle Injury*, TSN (Nov. 10, 2019), https://www.tsn.ca/mitch-marner-undergoes-mri-no-timeline-for-ankle-injury-1.1395758.

and so control over the system should be centralized. Others will say the system isn't responsive enough to local needs and so control should devolve down to local authorities. All of these critiques, and others, have been made in relation to Canada's Medicare system.[2] Yet, the Canadian Medicare system continues to be supported by the majority of Canadians of all political stripes[3] – and that the reason for the support is that the compromises made to forge Medicare and keep it working have resulted in a system which is a reflection of the majority of Canadians and Canadian values.[4] This article argues that this continued support extists because most Canadians are able to see the values they hold reflected in Medicare. Criticism of the system, regardless of the maker's political views, is usually an expression of honestly held beliefs of how Medicare can be reformed and improved, but never abolished.

1. Where Did Canadian Medicare Come From?

A. Where is Saskatchewan?

Saskatchewan is north of Montana and North Dakota.[5] It is the fifth largest of the ten Canadian provinces by area.[6] It has an area of

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[2] *See, e.g.,* David Gratzer, *The Ugly Truth About Canadian Health Care: Socialized Medicine Has Meant Rationed Care and Lack of Innovation. Small Wonder Canadians are Looking to the Market*, CITY J. (Sept. 2007), https://www.city-journal.org/html/ugly-truth-about-canadian-health-care-13032.html.

[3] 85.2% of Canadians report being satistfied with the way health care services are provided. *Healthy Canadians: a Federal Report on Comparable Health Indicators*, GOV'T OF CAN. 31, https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-system/healthy-canadians-federal-report-comparable-health-indicators-2008.html (last visited Jan. 5, 2021).

[4] *See infra* Sec. 1(C).

[5] *The Province of Saskatchewan*, GOOGLE MAPS, https://www.google.com/maps/d/u/0/viewer?ie=UTF8&hl=en&msa=0&ll=55.153766000000005%2C103.183594&spn=13.764796%2C36.035156&z=5&mid=1o_qpyp86q5E1dTyn4pfdSzqHGTU (last visited Dec. 11, 2020).

[6] Joyce Chepkemoi, *The Largest And Smallest Canadian Provinces/Territories By Area*, WORLD ATLAS (Aug. 8, 2019), https://www.worldatlas.com/articles/the-largest-and-smallest-canadian-provinces-territories-by-area.html.

651,900 square kilometers (251,700 square miles).[7] This is approximately the combined area of Florida, Georgia, South Carolina, North Carolina, and Virginia (which would be 253,795 square miles).[8] The population of Saskatchewan is approximately 1.1 million, which is less than the 1.4 million in Hillsborough County, Florda, where Tampa is located.[9] Approximately half of the Saskatchewan population lives in one of the two major cities: Saskatoon and Regina.[10]

B. Constitutional Law: The federal and provincial roles

The Constitution Act, 1867 (originally called *The British North America Act, 1867*)[11] united Upper Canada (Ontario), Lower Canada (Quebec), Nova Scotia, and New Brunswick into the Dominion of Canada.[12] Saskatchewan became a province in 1905.[13]

Unlike the United States, which is a republic, Canada is a constitutional monarchy, with the Queen as Head of State.[14] Like the United States, Canada has a federal system of government.[15] The country is made up of ten provinces and three territories.[16] Section 91 of *The Constitution Act, 1867* sets out the exclusive powers of

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[7] *Id.*

[8] *Size of States*, STATE SYMBOLS USA, https://statesymbolsusa.org/symbol-official-item/national-us/uncategorized/states-size (last visited Dec. 11, 2020).

[9] *Saskatchewan Population 2020*, 2020 WORLD POPULATION BY COUNTRY, https://worldpopulationreview.com/canadian-provinces/saskatchewan-population (last visited Dec. 11, 2020); *QuickFacts: Hillsborough County, Florida*, U.S. CENSUS BUREAU, https://www.census.gov/quickfacts/fact/table/hillsboroughcountyflorida/PST120219 (last visited Dec. 11, 2020).

[10] *Saskatchewan Population 2020*, *supra* note 9.

[11] *Constitution Acts 1867 to 1982*, CAN. DEP'T OF JUST. § 92, cl. 5, https://laws-lois.justice.gc.ca/pdf/const_e.pdf (last updated Jan. 1, 2013) [hereinafter Constitution Acts].

[12] *Id.* § 2, cl. 5.

[13] *See id.*

[14] *See generally id.* § 3.

[15] *See id.* §§ 3–4.

[16] *Get to Know Canda – Provinces and Territories*, GOV'T OF CAN., https://www.canada.ca/en/immigration-refugees-citizenship/services/new-immigrants/prepare-life-canada/provinces-territories.html (last updated July 12, 2017).

the federal government, and Section 92 sets out exclusive provincial powers.[17] Although Canadians refer to the formation of the country as "Confederation," modern Canada is actually a federation.[18]

Medicare as we think of it today was not conceived of in 1867. Therefore, the Canadian Constitution does not directly assign responsibility for Medicare to a specific level of government.[19] Jurisdiction over matters involving quarantine and marine hospitals was given to the federal Parliament[20] whereas jurisdiction over hospitals (except marine hospitals) was given to the provincial legislatures.[21]

If a Canadian legislator set out today to design a Medicare system, it likely would not look much like the current Canadian Medicare system. That is, perhaps until it came time to actually implementing it. A Royal Commission looking into provincial and federal jurisdiction in 1940 (the "Rowell-Sirois Commission") said: "One of the principal differences between government and business is that the objectives and policy of government, in democratic states, at any rate, are generally arrived at as a result of bargaining and compromise among a wide variety of interests concerned."[22] This necessity, of bargaining and compromise, was clearly evident in the years when Medicare was first established. This necessity for bargaining and compromise has remained evident throughout the decades since. Advancing technologies, increased citizen expectations, government fiscal realities, and increasing ease of access to international medical services including tests, surgeries, drugs, and treatments in the United States, Mexico, and elsewhere,

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[17] *Constitution Acts*, *supra* note 11 §§ 91–92.

[18] *The Federation at a Glance*, GOV'T OF CAN., https://www.canada.ca/en/intergovernmental-affairs/services/federation.html (last updated Oct. 22, 2019).

[19] *See generally Constitution Acts*, *supra* note 11.

[20] *See id.* § 91(11).

[21] *See id.* § 92(7).

[22] Rowell-Sirois Commission, *Report of the Royal Commission on Dominion-Provincial Relations*, SOLON 256, https://www.solon.org/Constitutions/Canada/English/Committees/Rowell-Sirois/book1-ch9.pdf (last visited Dec. 10, 2020) [hereinafter 'Rowell-Sirois Report'].

present functional challenges which have to be negotiated. How is the Canadian system to respond to individuals who jumped the queue by paying for weight loss surgery in Mexico, or tests in the United States, and now require extensive follow-up care? All possible responses will be problematic, so governments, medical care providers, and patients will have to negotiate to find a workable compromise.

In addition to its specific enumerated s. 91 constitutional powers, the federal government has the right "to make Laws for the Peace, Order, and good Government of Canada, in relation to all Matters not coming within the Classes of Subjects by this Act assigned exclusively to the Legislatures of the Provinces."[23] This is the so-called "POGG power" of the federal level of government. The provinces on the other hand have responsibility for "Property and Civil Rights."[24]

In the 1930's the Privy Council[25] held certain federal social programs to be *ultra vires*, as they impinged upon provincial jurisdiction.[26] This quashing of federal programs prompted the appointment of a Royal Commission, called the Rowell-Sirois Commission.[27] This Commission was to look into the effects of overlapping (federal and provincial) programs and services.[28] It

[23] *Constitution Acts*, *supra* note 11 § 91.
[24] *See* § 92(13).
[25] The Judicial Committee of the Privy Council in London was at the time a court of last resort for Canada. All appeals to the Privy Council were abolished by 1949. D.M.L. Farr, *Judicial Committee of the Privy Council*, CANADIAN ENCYCLOPEDIA, https://thecanadianencyclopedia.ca/en/article/judicial-committee-of-the-privy-council (last updated May 1, 2020).
[26] *See* Sujit Choudhry, *Recasting Social Canada: A Reconsideration of Federal Jurisdiction over Social Policy*, 52 U. TORONTO L.J. 163, 172–73 (2002); *Canadian Municipalities and the Regulation of Radio Antennae and their Support Structures*, GOV. OF CAN., https://www.ic.gc.ca/eic/site/smt-gst.nsf/eng/sf09387.html (last updated Aug. 31, 2012) (defining *ultra vires* as "beyond the legitimate scope of the enacting body).
[27] W.H. McConnell, *Constitutional History of Canada*, CAN. ENCYCLOPEDIA, https://www.thecanadianencyclopedia.ca/en/article/constitutional-history (last updated Apr. 24, 2020).
[28] MICHELLE SALVAIL, FEDERAL-PROVINCIAL PROGRAM OVERLAP (1992) (available at http://publications.gc.ca/collections/Collection-R/LoPBdP/BP/bp321-e.htm).

would not be the last such inquiry.[29]This Comission concluded that healthcare was a primarily a provincial responsibility, but that the federal government could use its spending power to play a role.[30] It is fair to say that there were those in the federal government during this period who believed in a much expanded social development role for the federal government.

In Canada, it is not unusual for the federal government to design national programs, or establish national standards for provincial programs, by making federal funds available to provinces that comply.[31] This is called the federal "spending power" or sometimes "fiscal federalism," if the speaker is being derisive.[32] While some argue that this ability to use its spending powers reduces provincial innovation and diversity, others believe that Canadians have the right to minimum national standards of care, no matter which province or territory they live in.[33] The result is that Canada actually has a mosaic of at least thirteen different healthcare systems, all of which share certain pan-Canadian features.[34] This article focuses on where Canadian Medicare started, and that is Saskatchewan.

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[29] *Id.*

[30] *Canada's Health Care System*, GOV'T OF CAN., https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-system/canada.html (last updated Sept. 17, 2019).

[31] *Id.*

[32] *Fiscal Federalism*, QUEBEC SECRETARIAT FOR CAN. REL., https://www.sqrc.gouv.qc.ca/relations-canadiennes/federalisme/federalisme-fiscal-en.asp (last updated May 7, 2015); Pierre-Gerlier Forest & Howard A. Palley, *Examining Fiscal Federalism, Regionalization and Community-Based Initiatives in Canada's Health Care Delivery System*, 23 SOC. WORK IN PUB. HEALTH 69, 73 (2008).

[33] *See* Burton H. Kellock & Sylvia LeRoy, *Questioning the Legality of the Federal "Spending Power"*, 89 PUB. POL'Y SOURCES 1, 6 (2007).

[34] Roosa Tikkanen, et al., *International Health Care System Profiles: Canada*, THE COMMONWEALTH FUND (June 5, 2020), https://www.commonwealthfund.org/international-health-policy-center/countries/canada. In addition to the thirteen provincial and territorial systems, the federal government is responsible for providing health care to individuals who come under federal responsibility under the Canada Health Act. *Canada's Healthcare System*, *supra* note 30. This list includes Indigenous Canadians, members of the armed forces, and those in federal penitentiaries. *Id.*

Today, federal legislation called the *Canada Health Act*[35] provides the common principles under which Medicare has developed in Canada.[36] In that legislation the federal government agrees to make annual cash payments to provinces for health care expenditures, provided the province's health care system abides by the *Canada Health Act*.[37] The five pillars of the *Canada Health Act* are:

(a) public administration;
(b) comprehensiveness;
(c) universality;
(d) portability; and
(e) accessibility.[38]

C. A Brief History

Saskatchewan and Alberta became provinces in 1905.[39] At the time, Saskatchewan seemed destined to become the economic engine of western Canada.[40] Saskatoon Board of Trade promotional material from 1908 had a headline boasting "Crop Failure is entirely unknown in Saskatoon District," adding "It is not surprising that our farmers succeed so well, the crop never fails."[41] Saskatchewan was generally the most populous western province up until the Great

[35] Canada Health Act [R.S.C.], cl. C-6 (1985).
[36] *Canada's Healthcare System*, *supra* note 30.
[37] Canada Health Act §§ 4–7.
[38] *Id.* § 7.
[39] *Alberta and Saskatchewan (1905)*, GOV'T OF CAN., https://www.bac-lac.gc.ca/eng/discover/politics-government/canadian-confederation/Pages/alberta-saskatchewan-1905.aspx (last updated Sept. 9, 2020).
[40] Bill Waiser, *Our Shared Destiny?: Saskatchewan in 1905 and 2005*, UNIV. OF SASKATCHEWAN, https://journals.lib.unb.ca/index.php/acadiensis/article/view/10606/11229 (last visited Dec. 11, 2020).
[41] SASKATOON BOARD OF TRADE, SASKATOON (1908), *microformed on* CIHM Microfiche Series (Canadian Inst. For Histoical Microreproductions); *see generally* MARC C. DENHEZ, THE CANADIAN HOME FROM CAVE TO ELECTRONIC COCOON (1994).

Depression.[42] In 1931 the population of Saskatchewan was 921,785.[43] Today it is only about 20% higher.[44]

While all Canadian provinces suffered during the Great Depression, Saskatchewan was devastated.[45] In addition to the problems created by a collapse of commodity prices, drought persisted throughout the 1930s.[46] Farming practices of the day exacerbated erosion.[47] The Canadian Encyclopedia says: "Saskatchewan experienced the lowest price for wheat in recorded history. The province's income plummet[ed] by 90 per cent within two years. Sixty-six per cent of the rural population was forced onto relief."[48]

Recovery was slow, and in 1937, when some other provinces were recovering from the Depression, Saskatchewan had its most

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[42] *See* Bruce Dyck, *Dirty Thirties: Fact and Myth*, THE WESTERN PRODUCER (July 28, 2005), https://www.producer.com/2005/07/dirty-thirties-fact-and-myth/.

[43] DOMINION BURUEA OF STATISTICS CANADA, SEVENTH CENSUS OF CANADA, 1931 at 153 (available at http://publications.gc.ca/collections/collection_2017/statcan/CS98-1931-1-eng.pdf). The population of Saskatchewan was 257,763 in 1906, 492,432 in 1911, 647,835 in 1916, 757,510 in 1921, 820,738 in 1926 and 921,785 by 1931. *Id.* at 152–53. Saskatchewan was the most populous western province throughout this period, except for 1906 when the much earlier established province of Manitoba's population exceeded that of Saskatchewan. *Id.* at 152.

[44] *Demography and Census Reports and Statistics*, GOV'T OF SASKATCHEWAN, https://www.saskatchewan.ca/government/government-data/bureau-of-statistics/population-and-census (last visited Apr. 18, 2021). Saskatchewan's population stagnated for decades following the Great Depression; in 1961 the population was 925,181 and in 2006 it was 968,157. By 2016 the population was 1,098,352. *Id.*

[45] Elizabeth Mooney, *Great Depression*, THE ENCYCLOPEDIA OF SASKATCHEWAN, https://esask.uregina.ca/entry/great_depression.jsp#:~:text=The%20province%20of%20Saskatchewan%20experienced,known%20as%20a%20dust%20bowl (last visited Dec. 11, 2020).

[46] *Id.*

[47] Zeynep K. Hansen & Gary D. Libecap, *Small Farms, Externalities, and the Dust Bowl of the 1930s*, NAT'L BUREAU ECON. RES., https://www.nber.org/system/files/working_papers/w10055/w10055.pdf (last visited Dec. 11, 2020) (Working Paper No. 10055).

[48] James Struthers, *The Great Depression in Canada*, THE CAN. ENCYCLOPEDIA, https://www.thecanadianencyclopedia.ca/en/article/great-depression (last updated Apr. 16, 2020).

wide-spread drought of the Depression.[49] In fact, the province had nine successive years of drought and crop failure between 1929 and 1938, inclusive.[50]

During the Depression there was some federal interest in creating a system of providing unemployment benefits and health benefits.[51] R.B. Bennett, who was Prime Minister from 1930 to 1935, could see his defeat coming.[52] In January 1935 he announced his "New Deal" for Canada and promised broad social reform including health insurance.[53] Although such measures were not opposed, Bennett's Conservative government had become unpopular and was defeated before passing any such legislation.[54] Following the election, aLiberal government under Prime Minister King was formed.[55] King had previously been Prime Minister from 1921 until 1930, with the exception of June to September 1926.[56] King referred the proposed legislation to the Judicial Committee of the Privy Council in London, which in 1937 ruled many of the

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[49] Bill Waiser, *History Matters: Drought and Dust a Legacy of Great Depression*, SASKATOON STARPHOENIX (Nov. 21, 2017), https://thestarphoenix.com/opinion/columnists/history-matters-drought-and-dust-a-legacy-of-great-depression.

[50] "The 1929 depression affected all of Canada. The impact, apparent in the autumn, struck hard in the following winter as prices for farm products fell, unemployment in towns and cities rose, tight money led to declining purchasing power an atmosphere of anxiety and gloom developed. Saskatchewan was to suffer an additional dreadful burden. The economic depression was made the more bitter by nine successive years of drought and crop failure. Impossible as it may seem, the net agricultural incomes for 1931 through 1934, and again in 1937, were reported in minus figures, a reduction in income quite unmatched in any civilized country" (footnote omitted). JOHN ARCHER, SASKATCHEWAN A HISTORY 215 (1980) at 215.

[51] *See* MICHIEL HORN, THE GREAT DEPRESSION OF THE 1930S IN CANADA 7–10, 19 (1984) (available at https://cha-shc.ca/_uploads/5c38ab6670bbf.pdf).

[52] John R. English, *R.B. Bennett*, THE CAN. ENCYCLOPEDIA, https://thecanadianencyclopedia.ca/en/article/richard-bedford-viscount-bennett (last updated Mar. 4, 2015).

[53] *Id.*

[54] *Id.*

[55] H. Blair Neatby, *William Lyon Mackenzie King*, THE CAN. ENCYCLOPEDIA, https://www.thecanadianencyclopedia.ca/en/article/william-lyon-mackenzie-king (last updated Mar. 4, 2015).

[56] John Whitney Pickersgill, *W.L. Mackenzie King*, ENCYCLOPAEDIA BRITANNICA (July 18, 2020), https://www.britannica.com/biography/W-L-Mackenzie-King.

initiatives unconstitutional. [57] This was the ruling which led to the Rowell-Sirois Commission.[58]

King, who went on to be Canada's longest serving Prime Minister, was a cautious Prime Minister and is regarded as a very tactically skilled politician[59]

The end of the 1930s brought rapid change to Saskatchewan. Canada declared war on Germany on September 10, 1939.[60] The start of World War II coincided with the end of the drought.[61] German occupation of countries that were formerly markets for Saskatchewan reduced the demand for the province's wheat.[62] The increased demand for cattle, hogs, and sheep, together with the increased demand for cereal crops to feed the animals, brought a heightened level of diversification of the Saskatchewan economy.[63]

The Co-operative Commonwealth Federation, known as the CCF, was elected as the Saskatchewan government in 1944.[64] It became known as the first social-democratic government in North

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[57] John R. English, *Bennett's New Deal*, THE CAN. ENCYCLOPEDIA, https://www.thecanadianencyclopedia.ca/en/article/bennetts-new-deal (last updated April 24, 2014).

[58] Int'l Labour Office, *The Rowell-Sirois Report: A Canadian Reaffirmation of the Democratic Faith in Social Progress*, 42 INT'L LAB. REV. 347, 347–49 (1940).

[59] Dean Oliver, director of research and chief curator at the Canadian Museum of History, said: "King was stubby, sweaty, and sneaky, but what a mind for tactics, openings, and leverage, for people and their foibles, for overarching strategies and destinations." Stephen Azzi & Norman Hillmer, *Ranking Canada's Best and Worst Prime Ministers,* MACLEAN'S (Oct. 17, 2016), https://www.macleans.ca/politics/ottawa/ranking-canadas-best-and-worst-prime-ministers/.

[60] *The War Begins*, VETERANS AFF. CAN., http://www.veterans.gc.ca/eng/remembrance/history/second-world-war/canada-and-the-second-world-war/warbeg (last updated Feb. 14, 2019).

[61] Gregory P. Marchildon et al., *Drought and Institutional Adaptation in the Great Plains of Alberta and Saskatchewan, 1914–1939*, 45 NAT. HAZARDS 392, 403 (2008).

[62] *World War II and Saskatchewan*, THE ENCYCLOPEDIA OF SASKATCHEWAN, https://esask.uregina.ca/entry/world_war_ii_and_saskatchewan.jsp (last visited Dec. 11, 2020).

[63] JOHN ARCHER, *supra* note 50, at 250.

[64] *Co-operative Commonwealth Federation (CCF)*, THE ENCYCLOPEDIA OF SASKATCHEWAN, https://esask.uregina.ca/entry/co-operative_commonwealth_federation_ccf.jsp (last visited Dec. 11, 2020).

America.[65] Its leader, T.C. ('Tommy') Douglas, became Premier.[66] Premier Douglas was a Baptist minister who had previously been a federal Member of Parliament.[67] The CCF had been formed in 1932 and stood for "universal cooperation for the common good."[68] The party championed initiatives such as "unemployment insurance, family allowance, Medicare[69] and universal old age pensions."[70] The CCF became the governing partyin Saskatchewan in 1944 and were re-elected in every election until 1964.[71]

By the end of World War II, the prairie drought was long over and a measure of relative prosperity returned to Saskatchewan.[72] The CCF government was focused on improving medical care.[73] As bold as the plan to establish universal medical care was, pockets of community-based medical care had long existed in Saskatchewan.[74] As early as 1932 the American Committee on the Costs of Medical Care noted that at least 30 rural municipalities in Saskatchewan employed at least one doctor to provide medical services.[75]

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[65] *Tommy Douglas*, ENCYCLOPAEDIA BRITANNICA, https://www.britannica.com/print/article/1368861 (last updated Feb. 20, 2020).
[66] *Id.*
[67] *Id.*; *Tommy Douglas*, CAN. MUSEUM OF HIST., https://www.historymuseum.ca/cmc/exhibitions/hist/medicare/medic-3g03e.html (last updated Apr. 21, 2010).
[68] *Co-operative Commonwealth Federation*, CBC LEARNING, https://www.cbc.ca/history/EPISCONTENTSE1EP13CH3PA1LE.html (last visited Dec. 11, 2020).
[69] "After 1944, with the election of the Cooperative Commonwealth Federation (CCF), the province established itself as a leader in health reforms." ERIKA DYCK & ALEX DEIGHTON, MANAGING MADNESS : WEYBURN MENTAL HOSPITAL AND THE TRANSFORMATION OF PSYCHIATRIC CARE IN CANADA 87 (2017).
[70] *Id.*
[71] *See Co-operative Commonwealth Federation (CCF)*, *supra* note 64.
[72] Marchildon et al., *supra* note 61.
[73] Among other initiatives, the government of Saskatchewan actively recruited medical researchers to the province, and partially funded research including psychiatric research using LSD. *See generally* ERIKA DYCK, *supra* note 69, at 87.
[74] STAN RANDS, PRIVILEGE AND POLICY: A HISTORY OF COMMUNITY CLINICS IN SASKATCHEWAN 1–2 (Gregory Marchildon & Catherine Levington-Reid eds., 2012).
[75] Arthur J. Viseltear, *Medical Care for the American People: The Final Report of the Committee on the Costs of Medical Care. Adopted October 31, 1932*, NCBI, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1775375/pdf/amjph00801-0086a.pdf (last visited Dec. 11, 2020).

Premier Douglas' CCF government introduced the country's first provincial hospitalization plan in 1947.[76] Similar plans were announced in Alberta and British Columbia by 1950.[77] In 1957 the federal government passed legislation to reimburse provinces and territories one half of the cost of providing specific in-hospital services and tests.[78] By 1961 all provinces and territories would be providing these services.[79] Canadians across the country could now receive tests and treatment in hospitals at no cost to them.[80] And perhaps more importantly, the Douglas government would now recoup fully half of the costs associated with Hospitalization.[81] This meant the provincial budget would have funds available for other initiatives.[82]

Among other social reforms, the CCF government had promised to establish medical and hospital services on "a universal, tax-financed" basis.[83] The new government established a commission headed by Henry Sigerist, a professor of medical history from Johns Hopkins University in Baltimore.[84] The Sigerist Report came out in 1944 and included a hospitalization insurance plan for the province. [85] This plan, which became known as simply

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[76] STAN RANDS, *supra* note 74, at 81.
[77] *Canada's Health Care System*, *supra* note 30 .
[78] *Id.*
[79] *Id.*
[80] *Id.*
[81] *Id.*
[82] *Id.*
[83] DENNIS GRUENDING, THE FIRST TEN YEARS (1974) (available at https://www.saskatooncommunityclinic.ca/wp-content/uploads/2017/03/the-first-ten-years.pdf).
[84] *Henry E. Sigerist, MD, PhD*, JOHNS HOPKINS BLOOMBERG SCH. PUB. HEALTH, https://www.jhsph.edu/about/history/heroes-of-public-health/henry-e-sigerist.html (last visited Apr. 18, 2021); *see generally* Elizabeth Fee, *The Pleasures and Perils of Prophetic Advocacy: Henry E. Sigerist and the Politics of Medical Reform*, 86 AM. J. PUB. HEALTH 1637 (1996).
[85] C. Stuart Houston, *Sigerist Commission*, ENCYCLOPEDIA OF SASKATCHEWAN, https://esask.uregina.ca/entry/sigerist_commission.jsp (last visited Apr. 18, 2021).

"Hospitalization" was implemented throughout Saskatchewan in 1947.[86]

Premier Douglas first announced the Saskatchewan government's plan to create a universal Medicare system in a speech in April 1959.[87] Soon after, the College of Physicians and Surgeons[88] announced their opposition to such a plan.[89] Some doctors feared they would become civil servants, although Premier Douglas indicated this was not what the government was pursuing.[90] In November 1959, Premier Douglas announced that a planning committee would be formed.[91] A period of negotiations with the College of Physicians and Surgeons followed.[92]

The 1960 Saskatchewan election was hotly contested.[93] The central issue was the introduction of a single-payer medical care insurance program.[94] The College of Physicians and Surgeons played an active role in opposing Medicare.[95] During the 1960 election period they spent more on media advertising than any

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[86] *Id.*
[87] Danielle Martin et. al., *Canada's Universal Health-Care System: Achieving its Potential*, 391 LANCET 1718, 1720 (2018).
[88] The (Royal) College of Physicians and Surgeons is a statutorily created self-regulating body charged with among other things, licencing and disciplining medical practitioners. *About*, ROYAL COLL. PHYSICIANS AND SURGEONS CAN., http://www.royalcollege.ca/rcsite/about/our-history-e (last visited Oct. 5, 2020).
[89] Roger Collier, *Doctors v. Government: The First Major Fight Over Pay*, 187 CAN. MED. ASS'N J. E146, E146 (2015).
[90] Luke Savage, *They Said Medicare for All Wouldn't Work in Canada, Too*, JACOBIN MAG., https://jacobinmag.com/2020/03/canada-medicare-for-all-single-payer-history (last visited Apr. 18, 2021).
[91] *Saskatchewan Leads the Way*, CAN. MUSEUM OF HIST., https://www.historymuseum.ca/cmc/exhibitions/hist/medicare/medic-5h02e.html (last updated Apr. 21, 2010).
[92] Gregory P. Marchildon & Klaartje Schrijvers, *Physician Resistance and the Forging of Public Healthcare: A Comparative Analysis of the Doctors' Strikes in Canada and Belgium in the 1960s*, 55 MED. HIST. 203, 211–12 (2011).
[93] *See* Collier, *supra* note 89, at E146.
[94] *Id.*
[95] *Id.*

political party.[96] They were not successful.[97] The CCF was re-elected with an increased majority, on their promise to expand the hospitalization plan into full fledged Medicare.[98]

In 1962, fifteen years after it introduced Hospitalization, the Saskatchewan government finally announced plans to expand the hospitalization plan into full fledged Medicare.[99] Doctors were not impressed.[100] The College of Physicians and Surgeons issued a statement that it was "unalterably opposed to a compulsory program of state-controlled medical care."[101] The Canadian Medical Association supported the College's position.[102] Clearly the implementation of the next stage of Medicare would not be easy.

Legislation was passed and July 1, 1962,[103] was set as the implementation date for Medicare.[104] "Keep Our Doctors" committees were formed to oppose the implementation of

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[96] ALLAN BLAKENEY, THE STRUGGLE TO IMPLEMENT MEDICARE, IN MAKING MEDICARE: NEW PERSPECTIVES ON THE HISTORY OF MEDICARE IN CANADA 277 (Gregory Marchildon ed., 2012).

[97] Collier, *supra* note 89, at E146.

[98] Canadian Museum of History, *Medical Opposition in 1960*, MAKING MEDICARE, https://www.historymuseum.ca/cmc/exhibitions/hist/medicare/medic-5h03e.html (last updated Apr. 10, 2010).

[99] *See generally*, Candian Museum of History, *Conflict and Compromise*, MAKING MEDICARE, https://www.historymuseum.ca/cmc/exhibitions/hist/medicare/medic-5h06e.html (last updated Apr. 10, 2010).

[100] There were of course a few doctors such as Orville Hjertaas who publicly supported Medicare. STUART HOUSTON & BILL WAISER, TOMMY'S TEAM: THE PEOPLE BEHIND THE DOUGLAS YEARS 60–65 (2010).

[101] JOHN ARCHER, *supra* note 50, at 303.

[102] *Id.*

[103] LORNE BROWN & DOUG TAYLOR, THE BIRTH OF MEDICARE: FROM SASKATCHEWAN'S BREAKTHROUGH TO CANADA-WIDE COVERAGE 27 (2012). July 1 is a significant date in Canada. It is a national holiday to celebrate Confederation as *The British North America Act, 1867* came into effect July 1, 1867. In 1962 it fell on a Sunday, so it would be a long weekend. The holiday was known as Dominion Day until 1982 when it was renamed Canada Day. *See*, Matthew Hayday, *Canada Day*, THE CAN. ENCYCLOPEDIA (Feb. 27, 2017), https://www.thecanadianencyclopedia.ca/en/article/canada-day.

[104] BROWN & TAYLOR, *supra* note 103, at 27.

Medicare.[105] There was fear that many doctors would leave Saskatchewan and move to the United States or elsewhere.[106]

The province's medical profession made the decision to go on strike as of July 1, 1962.[107] Doctors had received two copies of a sign stating they would be closed after July 1, 1962.[108] They were urged to post the signs in a "conspicuous place."[109] They also received a copy of a "personal" letter, which they could choose to send to patients if they wished.[110] That letter said among other things that the sender "cannot, in all conscience, provide services under the [Medical Care Insurance] Act and thus my office will be closed on July 1st. It will stay closed until the Government will allow me to treat you, as I have in the past, without political interference or control."[111]

The doctors attempted to direct blame for their strike at the provincial government.[112] They announced that only 29 of the 148 hospitals in the province would remain open.[113] The Saskatoon Board of Trade advised tourists that the province was not safe to visit.[114] Beginning on July 1, most of the province's doctors refused to provide anything but emergency services, and posted the following sign on their doors:[115]

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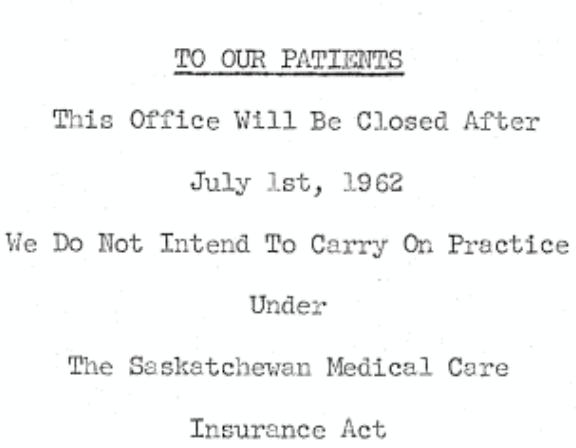
[105] *Id.* at 29.
[106] JOHN ARCHER, *supra* note 50, at 309.
[107] "*Keep Our Doctors" Committees,* CAN. MUSEUM OF HISTORY, https://www.historymuseum.ca/cmc/exhibitions/hist/medicare/medic-5g03e.html (last visited Dec. 11, 2020).
[108] *Id.*
[109] ROBIN F. BADGLEY & SAMUEL WOLFE, DOCTORS' STRIKE: MEDICAL CARE AND CONFLICT IN SASKATCHEWAN 53 (1967).
[110] *"Keep Our Doctors" Committees*, *supra* note 107.
[111] *Id.*
[112] BADGLEY & WOLFE, *supra* note 109, at 56.
[113] *Id.*
[114] *Id.* at 57.
[115] *See generally* AHMED MOHIDDIN MOHAMED, KEEP OUR DOCTORS COMMITTEES IN THE SASKATCHEWAN MEDICARE CONTROVERSY (1963) (unpublished M.A. thesis, University of Saskatchewan) (on file with Murray Library, University of Saskatchewan).


TO OUR PATIENTS

This Office Will Be Closed After

July 1st, 1962

We Do Not Intend To Carry On Practice

Under

The Saskatchewan Medical Care

Insurance Act

British influence remained strong in Canada in the early 1960's.[116] For example, until 1970 British subjects resident in Canada could vote in Canadian elections without becoming citizens.[117] Believing it would be more difficult for the College of Physicians and Surgeons to use its regulatory powers to delay or deny British doctors from practicing medicine in Canada, the provincial government actively sought out British doctors.[118]

In preparing for the doctors' strike, the provincial government advertised in the British medical publication *Lancet* for doctors who wished to come to Saskatchewan to practice medicine.[119] The provincial government feared the College of Physicians and Surgeons might use the pretext of needing to investigate the

[116] Shannon Conway, *From Britishness to Multiculturalism: Official Canadian Identity in the 1960s*, 84 ETUDES CANADIENNES/CANADIAN STUDIES 9, 9 (2018).
[117] A fact that is all the more surprising considering Indigenous Canadians living on reserve were not allowed to vote until 1960. *The Evolution of the Federal Franchise*, ELECTIONS CAN. (Dec. 2014), https://www.elections.ca/content.aspx?section=vot&dir=bkg&document=ec90785&lang=e.
[118] Marchildon et al., *supra* note 61, at 278.
[119] *Id.*

education and training of American doctors to delay their certification, thereby gaining an advantage in the strike.[120]

It was not at all certain that the provincial government would be able to attract a sufficient number of British doctors, so as a backup plan, they also made arrangements to bring in doctors "from the Auto Workers medical plan in Detroit and the Steel Workers plan in Pittsburgh."[121] Presumably these "union doctors," and their employers would be more sympathetic to the government's goal of establishing universal Medicare.[122]

In anticipation of the doctors' strike, citizen groups began to obtain space so that doctors who wished to see patients would have the facilities to do so.[123] The first of these community-based clinics opened in Prince Albert on July 1, 1962, with Dr. O.K. Hjertaas providing services.[124] The second opened in Saskatoon (immediately following the long weekend) on July 3, 1962 with Dr. Joan Daphne Witney providing services.[125] Today, not for profit organizations continue to operate Community Clinics in Saskatoon, Prince Albert, Regina and other centres in Saskatchewan.[126]

Reporters arrived from all over the world to cover the story of the doctors' strike.[127] The Premier[128] held daily news conferences with 50-70 reporters in attendance[129], which must have seemed like an extraordinary occurrence for a Saskatchewan Premier in 1962. Local coverage was initially very poor. The Winnipeg *Free Press*

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[120] *Id.*
[121] *Id.* at 279.
[122] *Id.*
[123] Samuel Wolfe, *Viewpoints: Saskatchewan's Community Clinics*, 91 CAN. MED. ASS. J. 225, 225 (1964).
[124] *Id.*
[125] *Id.*
[126] Marchildon et al., *supra* note 61 at 280.
[127] *Id.*
[128] In November 1961 Tommy Douglas resigned as Saskatchewan Premier to become the federal leader of the New Democratic Party, which was the successor to the CCF. At the time of the doctor's strike, the Saskatchewan Premier was Woodrow Lloyd. *See* Tabitha Marshall, *Tommy Douglas*, The CAN. ENCYCLOPEDIA, https://www.thecanadianencyclopedia.ca/en/article/tommy-douglas (last updated June 7, 2019).
[129] Marchildon et al., *supra* note 61, at 280.

ran a story focusing on how badly the two Saskatchewan papers were covering the events- a story which appears to have led to better local coverage.[130] Although momentum seemed to be with the doctors in the early days of the strike, the tide eventually turned.[131] A "Keep Our Doctors" rally on July 11 in front of the Legislature was expected to bring in 20,000 people, but only attracted 4,500-5,000.[132] The inability of the well-funded College of Physicians and Surgeons led opposition to Medicare, to attract more protesters is generally seen as a turning point in the conflict.[133] Momentum appeared to be behind Medicare and the provincial government.[134]

The doctors' strike lasted 23 days.[135] Lord Stephen Taylor, a British physician and member of the (U.K.) House of Lords was able to negotiate a compromise, called the Saskatoon Agreement, on July 23, 1962.[136] Medicare had arrived in Saskatchewan.

I share this historical account in order to try and provide a small sense of the place that gave birth to Medicare in Canada. Former Saskatchewan Premier and Chair of the "Commission on the Future of Health Care in Canada" Roy Romanow said of the prairies "The harsh, often snow-blown conditions, droughts, distance and isolation, and small population, forced us together… we all learned to see survival and progress as a test of our ongoing ability to organize collectively and to remain united around shared values."[137]

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[130] *Id.*
[131] *Id.*
[132] *Id.* at 279–280.
[133] *Id.* at 280.
[134] *Id.*
[135] *Lord Stephen Taylor,* CAN. MUSEUM OF HIST., https://www.historymuseum.ca/cmc/exhibitions/hist/medicare/medic-5g05e.html (last updated Apr. 21, 2010).
[136] *Id.*
[137] Roy J. Romanov, Speech at the University of Calgary, Calgary, Alberta, Canada to the Faculty of Medicine: *Canada's Shared Destiny and the Future of Medicare* (Jan. 17, 2007) (transcript at https://uwaterloo.ca/canadian-index-wellbeing/sites/ca.canadian-index-wellbeing/files/uploads/files/2007-Thefutureofmedicare_Romanow.pdf).

While Medicare continues to evoke strong political debate in Canada, most Canadians take great pride in what has been called "Saskatchewan's gift to Canada."[138] Many Canadians consider Medicare a source of national pride, although we will continue to debate what should be included in that national symbol.[139]

2. What Does Medicare Look Like in Saskatchewan?

The five pillars of the *Canada Health Act* are: (a) public administration; (b) comprehensiveness; (c) universality; (d) portability; and (e) accessibility.[140] These pillars help shape what Medicare looks like in each of the provinces and territories.

Health care outside of a hospital, is generally provided in private clinics, or in one of the province's member-owned community clinics.[141] The community clinics, created during the doctors' strike,

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[138] *See*, *e.g.*, Tom McIntosh, *Saskatchewan's Commission on Medicare: Five Commentaries, A Fyke in the Road: The "New" Politics of Health Reform*, SASK. INST. OF PUB. POL'Y 1–4 (Apr. 2001), https://ourspace.uregina.ca/bitstream/handle/10294/6655/SIPP%20Public%20Policy%20Papers%2003.pdf?sequence=1&isAllowed=
("One does not tinker with 'Saskatchewan's gift to Canada' just for the sake of it."); Edward Greenspon, *PM May Ask Romanow to Help Save Medicare*, THE GLOBE AND MAIL (Mar. 22, 2001), https://www.theglobeandmail.com/news/national/pm-may-ask-romanow-to-help-save-medicare/article760283/
("Mr. Romanow would serve as a passionate advocate of a public system, which he loves to call Saskatchewan's gift to Canada.");

> **CANADA HEALTH ACT.** More correctly known as the Medical Care Act (1966), this act owed its origin to the Saskatchewan experience: Saskatchewan's Co-operative Commonwealth Federation implemented a Medicare program in 1962. Advice to Ottawa was also provided by Justice Emmett Hall, who headed the Royal Commission on Health Services. This has been called Saskatchewan's gift to Canada.

BARRY M. GOUGH, HISTORICAL DICTIONARY OF CANADA 53–54 (1999).

[139] *See* Maire Sinha, *Canadian Identity*, STATISTICS CAN., https://www150.statcan.gc.ca/n1/pub/89-652-x/89-652-x2015005-eng.htm (last modified Nov. 30, 2015).

[140] *Canada's Health Care System*, GOV'T OF CAN., https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-system/canada.html (last updated Sept. 17, 2019).

[141] *Id.*

operate on a different philosophy than that of private clinics.[142] Community clinic doctors are employed on a salary.[143] Services are free to members.[144] The services available include all provincially insured services, as well as some services that are not insured.[145] Clinics typically have physical therapists and dietitians on staff.[146]

Doctors at private clinics are paid a fee for service.[147] The provincial government negotiates a fee schedule in advance with the College of Physicians and Surgeons.[148] Doctors are not allowed to charge additional fees.[149] Some private clinics offer 'walk-in' services to the public, while others are restricted to existing patients of the doctors who make up the practice.[150] In either case, the doctor bills the Ministry of Health and is paid the negotiated fee.[151] At community clinics, the clinic receives the fee for services provided to the members, and the doctors receive a salary.[152]

Reviews into Medicare are common. Typically, these reviews examine how well the system is administered, how well it treats illness or promotes wellness, and how well it produces better health in Canadians.[153]

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[142] *See id.*
[143] *Id.*
[144] *See id.*
[145] *Id.*
[146] *Id.*
[147] *Canada's Health Care System*, *supra* note 30.
[148] *See generally* Daw, Rice & Raza, *Fees for Uninsured Services: A Cross-sectional Survey of Ontario Family Physicians*, NCBI (Jan.–Mar. 2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7065529/.
[149] *See* Tikkanen et al., *supra* note 34.
[150] *See generally* Daw, Rice & Raza, *supra* note 148.
[151] *See generally It's For Your Benefit: A Guide to Health Services in Saskatchewan*, GOV'T OF SASKATCHEWAN 12, https://pubsaskdev.blob.core.windows.net/pubsask-prod/104987/104987-104987-Its-For-Your-Benefit-Jan2018.pdf (last visited Dec. 11, 2020).
[152] *See generally* Daw, Rice & Raza, *supra* note 148.
[153] *See generally* ROY J. ROMANOW, BUILDING ON VALUES: THE FUTURE OF HEALTH CARE IN CANADA – FINAL REPORT 153 (2002).

Changes in administration occur frequently. Beginning in the 1990's Saskatchewan was divided into 12 health regions.[154] The creation of those districts was seen as a positive innovation.[155] Those 12 health regions have recently been amalgamated into one Health Authority.[156] Such ongoing structural changes, aimed at striking an appropriate balance between local delivery of services and control on one hand, and specialization, centralized planning and administration on the other, are to be expected. Every large undertaking, including private corporations, will oscillate between emphasizing greater centralized control and more local control. There are advantages and disadvantages to each. It should be expected that a system of Medicare will at times lean towards centralized control, and at other times favour localized control.

Many factors can prompt a review into how well our system treats illness. An increase in wait times or a delay in implementing new tests or procedures may serve as a catalyst for review.[157] I think it is fair to say that while reviews virtually always make a series of recommendations, some of which will be implemented while others will not, no review has found the Medicare system fatally flawed. Our system seems to work well for Canadians, although there is, and always will be, room for improvement.

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[154] Pam Cowan, *In Monumental Change, Saskatchewan to Move from 12 Health Regions to One Provincial Health Authority*, SASKATOON STARPHOENIX (Jan. 4, 2017), https://thestarphoenix.com/ news/local-news/province-to-move-from-12-health-regions-to-one-provincial-health-authority.

[155] "Districts have made major progress in integrating services and advancing the wellness model." Ken Fyke, *Caring For Medicare Sustaining A Quality System*, COMMISSION ON MEDICARE 5 (Apr. 6, 2001), https://qspace.library.queensu.ca/bitstream/handle/1974/6876/medicare-commission-final-report_fyke.pdf?sequence=1&isAllowed=y.

[156] Wendy Winiewski, *Saskatchewan Health Authority Launches, Replacing 12 Provincial Health Regions*, GLOBAL NEWS (Dec. 4, 2017), https://globalnews.ca/news/3896216/saskatchewan-health-authority-launches/.

[157] *See generally* Fyke, *supra* note 155, at 5.

Most reviews discuss the issue of preventing health problems.[158] This aspect is as important as it is challenging.[159] I do not think any serious person doubts the great advantage of prevention of health problems. The challenge is to determine effective and appropriate methods of prevention (including early treatment to prevent further complications) *within* the Medicare system. Some aspects, such as designing 'walkable' communities built to allow individuals to age in place, are clearly beyond the Medicare system. Other aspects such as addiction recovery services are clearly part of a Medicare system.

Every resident of Saskatchewan is entitled to health care.[160] In the case of some individuals (including Indigenous Canadians and members of the armed forces) the federal government provides the coverage.[161] Everyone else is covered under the provincial plan.[162] The only people who do not have coverage are non-residents.[163] The principle of portability means that Canadian residents from other provinces may access medically necessary services within Saskatchewan, just like Saskatchewan residents can when they travel to other provinces. There is some variation in which services are covered from province to province.[164]

Newcomers receive coverage on the first day of the third calendar month of their residency. Up until that date, coverage is provided by their home province. Refugees, international students,

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[158] *See generally id.* at 2.
[159] *See generally* PREVENTION VS. TREATMENT: WHAT'S THE RIGHT BALANCE? (Halley S. Faust & Paul T. Menzel eds., 2011).
[160] *Health Benefits Coverage*, GOV'T OF SASKATCHEWAN, https://www.saskatchewan.ca/residents/health/prescription-drug-plans-and-health-coverage/health-benefits-coverage#:~:text=Fully%20Covered%20Services (last visited Dec. 11, 2020).
[161] Tikkanen et al., *supra* note 34.
[162] *See generally id.*
[163] *See generally Health Care in Canada*, GOV'T OF CAN., https://www.canada.ca/en/immigration-refugees-citizenship/services/new-immigrants/new-life-canada/health-care-card.html (last updated July 11, 2017).
[164] *See id.*

returning residents and those discharged from the Canadian Forces generally receive immediate coverage.[165]

The provincial plan does provide some coverage to Saskatchewan residents travelling to the US or elsewhere.[166] Many larger employers provide additional private health care insurance to employees.[167] In addition to providing higher out of country coverage, this insurance typically covers non-insured services such as prescription drugs, eye glasses, dental care, massage therapy and so forth.[168] Medical costs in the US and some other countries are considerable higher than in Canada and the costs therefore may not be fully insured by Medicare. Canadians travelling outside the country who do not have coverage through their employer, may opt to buy additional private insurance to cover this risk.

Medicare in Canada provides coverage for all 'medically necessary services'.[169] Provincial legislation defines what counts as 'medically necessary'.[170] Inpatient and outpatient services provided by a physician are fully covered.[171] Medicare developed in Canada with a focus on doctors and hospitals.[172] As a result, 'traditional' health care provided by doctors and hospitals is the most likely to be fully covered. It has long been recognized that Medicare's focus must go beyond these services to include other services, including prevention services.[173]

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[165] GOV'T OF SASKATCHEWAN, *supra* note 151, at 4–5.
[166] *Health Coverage Outside of Saskatchewan and Canada*, GOV'T OF SASKATCHEWAN, https://www. saskatchewan.ca/residents/health/prescription-drug-plans-and-health-coverage/health-benefits-coverage/out-of-province-and-out-of-canada-coverage (last visited Dec. 11, 2020).
[167] *See generally* Tikkanen et al., *supra* note 34.
[168] *Id.*
[169] *See Canada's Health Care System*, *supra* note 30.
[170] *Id.*
[171] Gavin Prout, *Canada's Provincial Health Plans*, SPECIAL BENEFITS INS. SERVICES, https://www.sbis.ca/canadas-provincial-health-plans.html (last visited Dec. 11, 2020).
[172] *See* ROMANOW, *supra* note 153, at xvii.
[173] *See generally id.*

There are different ways that health care services are paid for, based in part on how Medicare developed.[174] Some services are completely publicly paid.[175] Traditional services from physicians and hospitals are fully funded, largely because this is historically how Medicare developed.[176] There is no 'private market' in these services.[177] Providers have agreed to accept the negotiated fee for their services, and no 'extra-billing' is permitted.[178]

Other services are paid for by a mix of public and private funding.[179] Ambulances and long-term care are examples.[180] The consumer is responsible to pay for these services but they are subsidized by the state, so the price paid by the consumer is lower than the actual cost of the service.[181]

Some services are uninsured so the actual cost must be paid for privately.[182] Dental care is an example.[183] Dental surgery which traditionally occurred in a hospital, generally is covered.[184]

Some services such as mental health counseling, physiotherapy and occupational therapy are fully covered, although services on a fee for service basis are also readily available.[185] This results in a patchwork where services are available publicly and privately. In reality this means that there is generally a waiting time for those who wish to access public services and therefore not have to pay.[186] Those willing to pay can generally see a service provider more quickly.[187]

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[174] *See Canada's Health Care System*, *supra* note 30.
[175] *See* Tikkanen et al., *supra* note 34.
[176] *Canada's Health Care System*, *supra* note 30.
[177] *See generally id.*
[178] *Id.*
[179] *Id.*
[180] *Id.*
[181] *See generally id.*
[182] *See* Tikkanen et al., *supra* note 34.
[183] *Id.*
[184] *Canada's Health Care System*, *supra* note 30.
[185] *See* GOV'T OF SASKATCHEWAN, *supra* note 151, at 16, 18.
[186] ROMANOW, *supra* note 153 at 138.
[187] *See id.* at 8.

Individuals on Social Assistance and children of low-income families are often entitled to supplementary services including dental, prescription drugs, optical services and ambulance services.[188] Those in a palliative care program also have a range of services covered.[189]

The particular services covered in Saskatchewan or elsewhere in Canada is likely of little importance to others considering Medicare. After all, no jurisdiction would simply adopt another's program. The people of Saskatchewan fought long and hard to create a system of Medicare that works for us all; I am proud to share this short story of how the first Medicare plan in North America was established, and I hope that others can learn from it.

Those who wish to establish a system of Medicare should expect powerful opposition. They should expect conflict and if they are successful, compromise. They should expect that progress will be slow. But, if a small, poor Canadian province can establish universal Medicare, and inspire its nation to follow suit, there is hope that Medicare can be established everywhere.

[188] *Canada's Health Care System*, *supra* note 30.
[189] *See id.*

THE CRISIS OF AGING AND CARING FOR THE ELDERLY: COMPARING LONG-TERM CARE POLICIES IN THE UNITED STATES AND JAPAN

Arienne Valencia

I. Introduction

> *"'I'm going to run out of money and my mother might still be alive,' she says. 'And I don't see anything, anywhere that can help that.'" – Bobbie Preddy*[1]

In 1990, the world's average life expectancy at birth was 64.2 years old and now it is about 72.6 years old.[2] Current trends estimate the life expectancy to be 77.1 years in 2050.[3] With more people of the world growing older, the aging population is also significantly increasing.[4] In 2015, there were 617 million people over the age of 65 and the aging population is expected to double to 1.6 billion by 2050.[5]

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[1] Deidre McPhillips, *The Age-Old Dilemma*, U.S. NEWS (Dec. 27, 2016, 9:00 a.m.), https://www.usnews.com/news/best-countries/articles/2016-12-27/funding-long-term-care-for-an-aging-global-population/. Bobbie Preddy's mother is 98 years old and requires round-the-clock care at an assisted living facility. *Id.* Preddy's mother ran out of money years ago and Preddy has been using her own funds to cover her mother's costs of care. *Id.* If Preddy's mother lives longer than six months, Preddy will have exhausted her funds. *Id.*

[2] UNITED NATIONS DEP'T OF ECON. AND SOC. AFFAIRS, WORLD MORTALITY 2019: DATA BOOKLET 4 (2019) (available at https://www.un.org/en/development/desa/population/publications/pdf/mortality/WMR2019/WorldMortality2019DataBooklet.pdf).

[3] UNITED NATIONS DEP'T OF ECON. AND SOC. AFFAIRS, WORLD POPULATION PROSPECTS 2019: HIGHLIGHTS (2019) (available at https://population.un.org/wpp/Publications/Files/WPP2019_10KeyFindings.pdf).

[4] *Id.* In 2019, one in eleven people (9%) were over the age of 65. *Id.* It is estimated that one in six people (16%) will be over the age of 65 in 2050. *Id.* For purpose of this paper, the aging or elderly population is defined as persons over the age of 65.

[5] WAN HE ET AL., AN AGING WORLD: 2015, at 3 (2016) (available at https://www.census.gov/

As people are living longer, they are also facing an increased risk of age-related disabilities, chronic health diseases, and cognitive illnesses.[6] Some prominent examples include age-related loss of hearing, sight, and movement, dementia, and Alzheimer's disease.[7] The aging population with these kinds of health issues will require long-term care in order to live.[8] Long-term care (LTC) services are typically used to assist an individual with activities of daily living (ADLs)[9] and come in a variety of forms such as institutional care in facilities, at home care services, and respite care for caregivers.[10] The ability to live longer coupled with a rapidly growing aging population is creating a great need for long-term care around the world.[11] Countries are now grappling with creating comprehensive long-term care systems.[12]

With a population of approximately 128 million[13] and 28.4% being over the age of 65, Japan has the world's largest elderly population.[14] The people of Japan also have the highest life

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content/dam/Census/library/publications/2016/demo/p95-16-1.pdf). This author would like to acknowledge that there are discrepancies between statistics depending on availability of reports.

[6] UNITED NATIONS DEP'T OF ECON. AND SOC. AFFAIRS, THE GROWING NEED FOR LONG-TERM CARE: ASSUMPTIONS AND REALITIES 1 (2016) (available at https://www.un.org/esa/socdev/ageing/documents/un-ageing_briefing-paper_Long-term-care.pdf).

[7] *Id.*

[8] *Id.*

[9] U.S. Dep't of Health and Human Services, *What is Long-Term Care?*, LONGTERMCARE.GOV, https://longtermcare.acl.gov/the-basics/what-is-long-term-care.html (last updated Oct. 15, 2020). Activities of daily living include eating, bathing, dressing, continence, toileting, and transferring. *Id.* There are also Instrumental Activities of Daily Living (IADLs) which are activities needed to live independently such as managing money, grocery shopping, and taking medication. *Id.*

[10] AM. ASS'N OF RETIRED PERSONS, PLANNING FOR LONG-TERM CARE: YOUR RESOURCE GUIDE 3, 9 (2010) (available at https://assets.aarp.org/www.aarp.org_/cs/health/ltc_resource_guide.pdf).

[11] THE GROWING NEED FOR LONG-TERM CARE, *supra* note 6, at 1.

[12] *Id.* at 2; Some countries have raised retirement age, reduced pension benefits, or started investing in elderly care. Faraz Haider, *Countries with the Largest Aging Population in the World*, WORLDATLAS (Apr. 25, 2017), https://www.worldatlas.com/articles/countries-with-the-largest-aging-population-in-the-world.html.

[13] *Japan,* WORLD HEALTH ORG., https://www.who.int/countries/jpn/en/ (last visited Dec. 19, 2020).

[14] *Elderly Citizens Accounted for Record 28.4% of Japan's Population in 2018, Data Show*, THE JAPAN TIMES (Sept. 15, 2019),

expectancy in the world.[15] As of 2000, 2.8 million elderly people needed help with ADLs and that number is expected to increase to 5.2 million by 2025.[16] These demographics created the "problem of the aging society"[17] for the Japanese government.[18] Likewise, the United States is facing a "graying of America,"[19] having a population of approximately 322 million[20] with 16% over the age of 65.[21] The baby boomer[22] cohort is one of the main contributors to this statistic, where 10,000 baby boomers turn 65 every day.[23] Of those people turning 65, they have a 70% chance of needing long-term care in the future.[24] To address the rapidly growing and inevitable problems related to long-term care, Japan implemented

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https://www.japantimes.co.jp/news/2019/09/15/national/elderly-citizens-accounted-record-28-4-japans-population-2018-data-show/. This percentage is expected to increase to 32.2% meaning one-third of Japan's population will be elderly. Haider, *supra* note 12.

[15] *Japan Has the Highest Life Expectancy - The World Health Statistics 2017 Report*, WORLD HEALTH ORG. (May 22, 2017), https://extranet.who.int/kobe_centre/en/news/WHS2017report_20170522#:~:text=2017%2D05%2D22,Japan%20has%20the%20highest%20life%20expectancy%20%2D%20the%20World%20Health%20Statistics,by%20WHO%20on%20May%2017th. The average life expectancy for males is 81 years old and 87 years old for females. *Japan*, *supra* note 13.

[16] Vanessa Yong & Yasuhiko Saito, *National Long-Term Care Insurance Policy in Japan a Decade After Implementation: Some Lessons for Aging Countries*, 37 AGEING INT'L 271, 272 (2011).

[17] John Creighton Campbell & Naoki Ikegami, *Long-Term Care Insurance Comes to Japan*, 19 HEALTH AFF. 26, 28 (2000).

[18] *Id.*; Other contributing factors will be discussed in Part III(A).

[19] "[A] term that describes the phenomenon of a larger and larger percentage of the population getting older and older." *The Graying of the United States*, LUMEN LEARNING 2–3, https://courses.lumenlearning.com/alamo-sociology/chapter/reading-the-graying-of-the-united-states/ (last visited Feb. 16, 2021).

[20] *United States of America,* WORLD HEALTH ORG., https://www.who.int/countries/usa/en/ (last visited Feb. 16, 2021). The average life expectancy for males is 76 years old and 80 years old for females. *Id.*

[21] *Population Ages 65 and Above (% of Total Population)*, THE WORLD BANK, https://data.worldbank.org/indicator/SP.POP.65UP.TO.ZS (last visited Feb. 16, 2021).

[22] Generation of people born between 1946 to 1964. *The Graying of the United States*, *supra* note 19.

[23] *Cost of Care Survey*, GENWORTH (Dec. 2, 2020), https://www.genworth.com/aging-and-you/finances/cost-of-care.html.

[24] U.S. Dep't of Health and Human Services, *How Much Care Will You Need?*, LONGTERMCARE.GOV, https://longtermcare.acl.gov/the-basics/how-much-care-will-you-need.html (last updated Oct. 15, 2020).

the Long-Term Care Insurance Act in 2000 (LTCI Act).[25] The radical legislation moved the country towards a socialized long-term care system providing coverage to its citizens that are 65 years old or older.[26] The United States, on the other hand, has not majorly addressed this looming problem and continues to rely on private methods to pay for long-term care costs.[27]

This article will argue that Japan has an exceptional long-term care policy and the United States should move towards Japan's policy. Because there is not a uniform long-term care policy in the United States, this paper will use Florida law to discuss specific examples. Part II of this paper will discuss a brief history of long-term care and provide an overview of the United States' long-term care policy. Part III examines Japan's history and long-term care policy. Part IV will compare the two systems and analyze what areas in the United States system can be improved upon with Japanese aspects. Part VI will conclude with a summary of Japan's superior policy aspects.

II. United States Long-Term Care Policy

> *"'It's the middle-class bind,' she said. 'Too much money to qualify for Medicaid or subsidized housing, but not enough to pay for long-term care, an industry that has primarily pursued the well-off.'" – Gretchen Harris*[28]

[25] Long-Term Care Insurance Act, Law. No. 123 of Dec. 17, 1997, as last amended by Law. No. 110 of 2007 (Japan) [hereinafter Long-Term Care Act]; Yong & Saito, *supra* note 16, at 272.
[26] Yong & Saito, *supra* note 16, at 272, 274.
[27] *See infra* Part II(A).
[28] Paula Span, *Many Americans Will Need Long-Term Care. Most Won't Be Able to Afford It*, N.Y. TIMES, (May 10, 2019), https://www.nytimes.com/2019/05/10/health/assisted-living-costs-elderly.html. Gretchen Harris, 72, is a retired attorney that will need long-term care. *Id.* She is among a cohort of middle-income seniors called "The Forgotten Middle" that will face financial issues with affording long-term care. *Id.*

"This group gets ignored and underserved in today's long-term care market, and it's a problem that's going to explode over the next 20 years." – Caroline Pearson[29]

A. History

Long-term care services are expensive and can vary in cost depending on certain considerations such as level of care needed and where you live.[30] According to Genworth's Cost of Care Survey 2019, the national annual median costs for a home health aide is $52,624, $48,612 for an assisted living facility (ALF), and $90,155 for a semi-private room in a skilled nursing facility (SNF).[31] The median salary for a United States household is $61,937[32] with elders having a median income of less than $19,604.[33] Based on these figures alone, an average adult would barely be able to afford a home health aide or ALF and definitely would not be able to afford a room at a SNF.[34] This is especially true for the elder who will not be able to afford any of the services, partially due to earning significantly less in their older age and when they would need the services.[35] The

[29] *Id.*

[30] *Cost of Care Survey*, *supra* note 23. The website allows you to check median costs for different types of long-term care services in all states. *Id.* Florida's annual median costs for 2019 are: $48,048 for homemaker services, $50,336 for home health aide, $17,680 for adult day care, $42,000 for ALF, $102,565 for a SNF semi-private room, and $112,639 for a SNF private room. *Id.* The website also notes changes in price from 2018 and overall, it has been increasing. *Id.*

[31] *Id.*

[32] Gloria Guzman, *New Data Show Income Increased in 14 States and 10 of the Largest Metros*, U.S. CENSUS BUREAU (Sept. 26, 2019), https://www.census.gov/library/stories/2019/09/us-median-household-income-up-in-2018-from-2017.html.

[33] KE BIN WU, SOURCES OF INCOME FOR OLDER AMERICANS, 2012, (2013) (available at https://www.aarp.org/content/dam/aarp/research/public_policy_institute/econ_sec/2013/sources-of-income-for-older-americans-2012-fs-AARP-ppi-econ-sec.pdf). The average income of the elderly is $31,742. *Id.*

[34] Span, *supra* note 28.

[35] ZHE LI, THE SOCIAL SECURITY RETIREMENT AGE, CRS REP. NO. R44670, at 4 (2021) (available at https://fas.org/sgp/crs/misc/R44670.pdf). The current retirement age where workers can receive full Social Security benefits is 65 but is set to increase to 67. *Id.* at 1.

ability to pay for these costs by an individual is unrealistic, so the person must turn to other methods for long-term care.[36]

The United States primarily relies on informal caregiving, or unpaid caregiving from a family member, as the main source of long-term care.[37] Although the person receiving the care does not pay a price, there is still a cost paid by the informal caregiver such as: (1) lost income caused by reduced work hours at their main job and (2) loss of income providing valuable work without pay and for extensive periods of time.[38] The opportunity cost of informal caregiving for elders is $552 billion annually while costs of formal caregiving is $211 billion annually.[39] As a result, informal care is more economical than formal caregiving, keeping the burden of caregiving on individuals.[40] This method will become unstable as informal caregivers inevitably age and lose abilities to function, requiring them to have their own caregivers.[41]

Legislation

The United States does not have a law devoted purely to long-term care.[42] Instead, there are a combination of legislative acts that

[36] Max Richtman, *Opinion: America's Long-Term Care Crisis is Worsening*, MARKETWATCH (July 22, 2019, 1:45 p.m. ET), https://www.marketwatch.com/story/americas-long-term-care-crisis-is-worsening-2019-07-22.

[37] Amalavoyal V. Chari et al., *The Opportunity Costs of Informal Elder-Care in the United States: New Estimates From the American Time Use Survey*, 50 HEALTH SERVICES RES. 871, 871 (2015).

[38] *Id.* at 880. Emotional and physical impacts and costs were not accounted for. *Id.*

[39] *Id.* at 871. Given the nature of this informal and unregulated setting, there is a lack of data that details the value of the caregiving and time spent providing care; the study used the federal minimum wage to calculate unskilled paid care and the rate of a home health aide to calculate skilled paid care. *Id.* at 871, 874–75.

[40] *Id.* at 879.

[41] Janice Cooper Pasaba & Alison Barnes, *Elder Law Symposium: Article: Public-Private Partnerships and Longterm Care: Time for a Re-Examination?*, 26 STETSON L. REV. 529, 533 (1996).

[42] Based on my research, the long-term care policy is based on the effects of other laws.

shape its policy.[43] The Social Security Act (SSA)[44] was enacted in 1935, which provided federal money to poor seniors.[45] Amendments were later made to the SSA that created Medicare and Medicaid.[46] Medicare became an entitled healthcare benefit for the elderly, but it only covered acute care, not long-term care.[47] Medicaid covered long-term care in institutions but not in the home.[48] Additional amendments were later made to expand Medicaid to cover for community-based services.[49] In 2010, the Patient Protection and Affordable Care Act (ACA)[50] provided incentives for states to improve their long-term care programs and expand community-based services.[51]

Currently, the United States continues to rely on private long-term care insurance.[52] In 1988, a published study titled *Caring for the Disabled Elderly: Who Will Pay?* outlined a theory regarding the "potential for the public sector to aid private markets in assuming a larger role in the financing of long-term care."[53] The Robert Wood Johnson Foundation then provided seed money to four states to develop programs that would finance long-term care insurance through public-private partnerships.[54] The success of the programs led to the Deficit Reduction Act of 2005[55] that allowed all states to

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[43] THE HENRY J. KAISER FAMILY FOUNDATION, LONG-TERM CARE IN THE UNITED STATES: A TIMELINE 1 (2015) (available at https://www.kff.org/wp-content/uploads/2015/08/8773-long-term-care-in-the-united-states-a-timeline1.pdf).
[44] Social Security Act, Pub. L. No. 74-271, 49 Stat. 640 (1935).
[45] LONG-TERM CARE IN THE UNITED STATES: A TIMELINE, *supra* note 43, at 1.
[46] *Id.*
[47] *Id.* Medicare covers nursing home stays for up to 100 days. U.S. Dep't of Health and Human Services, *Who Pays for Long-Term Care?*, LONGTERMCARE.GOV, https://longtermcare.acl.gov/the-basics/who-pays-for-long-term-care.html (last updated Oct. 15, 2020).
[48] LONG-TERM CARE IN THE UNITED STATES: A TIMELINE, *supra* note 43, at 1.
[49] *Id.* at 2.
[50] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).
[51] LONG-TERM CARE IN THE UNITED STATES: A TIMELINE, *supra* note 43, at 5.
[52] This conclusion is based on my research where the United States and individual states enacted laws to have the government help private long-term care insurance markets.
[53] JULIE STONE-AXELRAD, MEDICAID'S LONG-TERM CARE INSURANCE PARTNERSHIP PROGRAM, CRS REP. NO. RL32610, at 1 (2005).
[54] *Id.* at 2. These four states were California, Connecticut, Indiana, and New York. *Id.*
[55] Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (2006).

establish Qualified State Long Term Care Partnership Programs, and 45 states have partnership program.[56] Florida has enacted a partnership program which will be explained in Paragraph II.B.3. below.[57]

Given the limited legislation for long-term care, there are four methods to pay for long-term care costs: (1) out-of-pocket, (2) long-term care insurance, (3) Medicaid,[58] and (4) informal care.[59] Out-of-pocket and informal care was discussed above so the other methods will be described below.

B. Long-Term Care Insurance

Florida enacted its own Long-Term Care Insurance Act and all policies need to follow certain requirements.[60]

1. Traditional

The traditional long-term care policy is a contract between an insured client and an insurance company where the insured client will pay premiums on a policy that will later pay out a certain amount of benefits when long-term care services are needed.[61] The policy is based on the daily benefit option, length of coverage, type of inflation protection, and an elimination period before the benefits

[56] *State Long Term Care Partnerships: Policies and Programs*, LTC PARTNER, https://www.longtermcareinsurancepartner.com/long-term-care-insurance/state-long-term-care-partnerships-policies-programs (last visited Feb. 20, 2020).
[57] FLA. STAT. § 409.9102 (2019); FLA. STAT. §§ 627.94075, 627.94076, § 627.9403, § 627.9407 (2019); FLA. STAT. § 641.2018 (2019); Fla. Admin. Code Ann. r. 69O-157.201, 69O-157.1155 (2019), 65A-1.712 (2019); Attachment to Title XIX of the Social Security Act Medical Assistance Program.
[58] U.S. Dep't of Health and Human Services, *Costs & How to Pay*, LONGTERMCARE.GOV, https://longtermcare.acl.gov/costs-how-to-pay/index.html (last updated Oct. 15, 2020).
[59] AM. ASS'N OF RETIRED PERSONS, *supra* note 10, at 10.
[60] *See generally* FLA. STAT. §§ 627.9401 to 627.9408; Fla. Admin. Code Ann. r. 69O-157.001 to 69O-157.023; BULLETIN 88-224 (1988); Memorandum 2006-16; Memorandum 2007-011 (2007).
[61] Michael J. Amoruso & Howard S. Krooks, *Long-Term Care Insurance in New York, in* MICHAEL E. O'CONNOR, ESTATE PLANNING AND WILL DRAFTING ch. 12, at 1, 5 (2018).

are paid.[62] Most long-term care insurances are pricey, and it can be difficult to find a policy with insurers leaving the market.[63]

2. Hybrid

Due to expensiveness and inflexibility of traditional policies, hybrid policies were developed.[64] Hybrid policies combine the benefits of life insurance with a rider that will pay for long-term care.[65] There can be a variation of rider benefits such as an acceleration of the death benefit to pay for the long-term care or have the ability to invest into a life insurance pool and a long-term care pool in one policy.[66]

3. Partnership

Medicaid will be discussed in more detail in Paragraph II.C., but generally, Medicaid has strict income and asset limits.[67] The value of the long-term care policy would immediately disqualify the person from applying.[68] To "encourage individuals to purchase private long-term care insurance" and cover the gap between private pay and public assistance, Florida's partnership program was created.[69] The partnership policies are tax qualified, provide

[62] *Id.* at 5–6; An example can be found in the Appendix.
[63] *Id.* at 2. The average premium for a 55-year-old male is $2,050/year and $2,700/year for a female. Richtman, *supra* note 36.
[64] Amoruso & Krooks, *supra* note 61, at 13.
[65] *Id.* at 12–14; An example can be found in the Appendix.
[66] *Id.* at 15.
[67] *Id.* at 47.
[68] *See* Program Policy Manual: SSI-Related Medicaid, State Funded Programs, Fla. Dep't of Children and Families, § 1640.0594 (available at https://www.myflfamilies.com/service-programs/access/program-policy-manual.shtml) [hereinafter "Fla. ESS Program Policy Manual"]. Life insurance is counted as an asset based on surrender value, and the long-term care insurance would be higher than the allowed asset amount. *Id.*
[69] *Florida Long-Term Care Partnership Program: A Public-Private Partnership for Long-Term Care Insurance Coverage*, AGENCY FOR HEALTH CARE ADMIN., https://ahca.myflorida.com/medicaid/ltc_partnership_program/index.shtml (last visited Feb. 20, 2021).

inflation protection, and provide total asset protection if the policyholder needs to apply for Medicaid.[70] For example, "[i]f an applicant received $100,000 in benefits through a partnership program insurance policy or certificate, they may retain up to $102,000 in assets."[71] Once the long-term care insurance benefits run out, the person may apply for Medicaid and not worry about the long-term care insurance value.[72]

C. Medicaid

Medicaid is a federal-state program that provides health coverage and long-term care coverage to certain groups of people, typically those with low economic status.[73] Along with other requirements,[74] the person has to meet a strict three part test: needs test,[75] income test[76] and asset test.[77] For institutional services, a person can only have a monthly income of $2,313 and a monthly asset limit of $2,000.[78] After qualifying, the person can apply for Institutional Care Programs (ICP)[79] that is your typical nursing home care or Home and Community Based Services (HCBS), which is assisted living facilities or other services that can keep the individual in the community.[80] Even though Medicaid helps pay, the

[70] *Id.* Tax qualified policies allow the policyholder to take a deduction for paid premiums. *Id.*
[71] *Id.*
[72] *See* Fla. ESS Program Policy Manual, *supra* note 68, at § 1640.0594.
[73] REBECCA C. MORGAN ET AL., PLANNING FOR THE ELDERLY IN FLORIDA §7.02 (2d ed. 2019). For purposes of this paper, Medicaid will refer to "programs based on institutional policy."
[74] Fla. ESS Program Policy Manual, *supra* note 68, at § 0240.0103.
[75] REBECCA C. MORGAN ET AL., *supra* note 73, §7.01.
[76] *See generally* Fla. ESS Program Policy Manual, *supra* note 68, at § 1830.0000–1830.1200.
[77] *Id.* at § 1640.0000–1640.0600.
[78] Fla. ESS Program Policy Manual, *supra* note 68.
[79] *Id.* A qualified person becomes entitled to Medicaid the first day of the application is received and the person is placed into the facility. Fla. ESS Program Policy Manual § 1640.0502.
[80] *Florida Medicaid's Covered Services and Waiver*, AGENCY FOR HEALTH CARE ADMIN., https://ahca.myflorida.com/Medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/LTC.shtml (last visited Feb. 23, 2021). A qualified person becomes entitled

person is still expected to pay for part of their care called the "patient responsibility amount" (PRA).[81] Notwithstanding the PRA, Medicaid financed about 40% of the United States' long-term care costs ($150 billion) with 44% spent on nursing homes in 1998.[82]

III. Japanese Long-Term Care Policy

> *"My home help does cooking, cleaning and washing clothes. If the system weren't in place, I would have hired someone privately to help us. Compared to that, it's very reasonable . . . ." – Female, 76, service user.*[83]

A. History

There are four main factors that contributed to Japan's reform of long-term care: (1) rapidly growing elderly population, (2) changes in caregiver values, (3) social hospitalization, and (4) insufficient welfare laws.[84] Part I addressed the growing elderly population, so the other factors are discussed below.

1. Changes in Caregiver Values

Traditionally, Japan followed the Confucian based system where family members are responsible for caring for the elderly.[85] Women are the main caregivers under this scheme.[86] However, demographic trends have decreased the ability for family members to care for the

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to Medicaid the first day the application is received, and the person is enrolled in the waiver. *See* Fla. ESS Program Policy Manual, *supra* note 68, at § 1640.0502.

[81] Fla. Admin. Code Ann. r. 65A-1.701(50)(2020).

[82] Judith Feder et al., *Long-Term Care in the United States: An Overview*, 19 HEALTH AFF. 40, 41 (2000).

[83] Misa Izuhara, *Social Inequality Under a New Social Contract: Long Term Care in Japan*, 37 SOC. POL'Y & ADMIN. 395, 404 (2003).

[84] Yong & Saito, *supra* note 16, at 272–73.

[85] Yumiko Arai et al., *Factors Related to Feelings of Burden Among Caregivers Looking After Impaired Elderly in Japan Under the Long-Term Care Insurance System*, 58 PSYCHIATRY AND CLINICAL NEUROSCIENCES 396–97 (2004).

[86] Yong & Saito, *supra* note 16, at 273. Daughter-in-laws were the main people responsible for caring for the elderly. *Id.*

elderly such as an increase in female participation in the labor work force, decrease in elderly parents living with their adult children, increase in elderly living alone, and an increase in positive opinions of moving toward publicly provided long-term care.[87]

2. Social Hospitalization

Because family members were no longer able to adequately care for their elderly, they began admitting their elders to the hospital which became a phenomenon called "social hospitalization."[88] Elders were admitted merely because they did not have a place to go rather than for medical need, exacerbated by shortages of long-term care facilities and at home care services.[89] During these stays, hospitals charged the same amount for an acute stay which became extensive when multiplied by the elders' long period of stay.[90]

3. Inadequate Welfare Laws

Japan's first long-term care program was the Social Welfare Law for the Elderly in 1963.[91] The program was for low-income elderly people and for those that do not have family support.[92] Under this program, a low-income elderly person would pay almost nothing to be admitted into a nursing home, while a person above the income limit would have to pay the full amount for care out-of-pocket.[93] This discrepancy in eligibility criteria created dissatisfaction among the elderly population.[94] Because only a small group of people were actually eligible for care under the welfare

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[87] Martha N. Ozawa & Shingo Nakayama, *Long Term Care Insurance in Japan*, 17 J. OF AGING & SOC. POL'Y 61, 63, 64 (2005).
[88] Yong & Saito, *supra* note 16, at 273; Ozawa & Nakayama, *supra* note 87, at 65.
[89] Ozawa & Nakayama, *supra* note 87, at 65.
[90] Yong & Saito, *supra* note 16, at 273.
[91] Ozawa & Nakayama, *supra* note 87, at 66.
[92] *Id.*
[93] *Id.*
[94] *Id.* Another weakness to the long-term care program is the lack of coordination between the health system and the welfare law causing elders to apply for long-term care separately from health care. *Id.*

law, it was grossly inadequate for a rapidly growing aging population.[95]

B. Long-Term Care Insurance Act

In 2000, the *Kaigo Hoken Ho*, or LTCI Act, was enacted into law to "improve health and medical care and to enhance the welfare of the citizens."[96] The national government is active in implementing uniform standards for facilities, eligibility and care, prices for services, and payments.[97] The municipal governments ("Insurer") also play a major role in this scheme by collecting all the premiums into a separate fund and insuring the people.[98]

To be eligible for coverage, the applicant must be (1) aged 65 and above or aged 40 to 64 with an age-related disability, and (2) pay LTCI premiums.[99] The applicant must then complete an objective 85 item questionnaire and receive a certification of care from the Insurer.[100] Certifications span from less support to more support with level one ("support needed") to level five ("care required"), and they determine which services the applicant qualifies for.[101] The applicant is then assigned to a trained care manager who creates the care plan, monitors the applicant, and helps renew or change the care plan as needed.[102]

The LTCI insurance provides "Long-Term Care Benefits," "Prevention Benefits," and "Municipal Special Benefits."[103] Long-term care benefits cover fifteen "home-based care services."[104] such

[95] *See id.* at 66–67.
[96] Long-Term Care Act, Law. No. 123, art. 1.
[97] Yong & Saito, *supra* note 16, at 276.
[98] *Id.*; Long-Term Care Act, Law. No. 123, art. 3.
[99] Long-Term Care Act, Law. No. 123, art. 9; Yong & Saito, *supra* note 16, at 277. A person under age 40 that requires long-term care is covered by the welfare system for people with disabilities. *Id.* at 274.
[100] Yong & Saito, *supra* note 16, at 275. The insurer uses a trained and knowledgeable person to assess people on their level of care. *Id.* This test does not take income or ability of family support into consideration. *Id.*
[101] *Id.*
[102] *Id.* at 276.
[103] Long-Term Care Act, Law. No. 123, art. 18.
[104] Yong & Saito, *supra* note 16, at 274.

as home-helper services, rehabilitation, and respite care.[105] The benefits also covers three long-term care institutions: "(1) nursing homes for people who do not have severe medical or mental problems (*Kaigo rojin fukushi shisetsu*), (2) skilled nursing homes for people who need medical attention (*Kaigo rojin hoken shisetsu*), and (3) sanatorium-type nursing homes for people with dementia and other chronic illnesses (*Kaigo ryoyo gata iryo shisetsu*)."[106] The prevention benefits were included in a 2006 reform to promote early healthy habits and reduce future health costs.[107]

The LTCI program is funded 50% by government taxes with the three levels contributing a certain percentage: 25% by national, 12.5% by prefectural, and 12.5% by municipal.[108] The remaining 50% is funded by the mandatory premiums of persons aged 40 and above.[109] Persons between 40 to 64 pay 0.9% of their income and the elderly also pay an income-based premium.[110] LTCI pays for 90% of the services so the users pay a 10% copay and "hotel" costs.[111]

IV. Analysis

> *"As far as long term care is concerned, private insurance isn't going to be the answer for most people," he says. "You're going to need some government intervention." – Paul Van de Water*[112]

This section will now compare the long-term care policies between the United States and Japan. Both countries are facing a

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[105] *Id.* at 274–75.
[106] *Id.* The Act, however, specified thirteen long-term care benefits. Long-Term Care Act, Law. No. 123, art. 40.
[107] Yong & Saito, *supra* note 16, at 279; Long-Term Care Act, Law. No. 123, art. 52.
[108] Yong & Saito, *supra* note 16, at 277.
[109] *Id.*
[110] *Id.*; *See Appendix, infra*, for a table calculating annual premiums for the elderly.
[111] Yong & Saito, *supra* note 16, at 277. Hotel costs are paid out-of-pocket expenses for meals and services that help make the stays in a nursing home similar to home care. *Id.* at 281. If the user cannot afford the copayment, they may ask for a waiver of the 10% copay or request the public assistance program cover costs. *Id.* at 279.
[112] Richtman, *supra* note 36.

rapidly growing older population that will need long-term care.[113] Twenty years ago, Japan took the initiative to solve the impending problem and implemented the LTCI.[114] On the other hand, the United States has not enacted any significant legislation to address long-term care issues. As a result, Japan's policy is superior because it: (1) has an unified system that regulates the quality of care, out-of-pocket costs, and payment of benefits; (2) expanded coverage to more of its population; and (3) acknowledged the informal caregiver burden which improved the country's situation socially and financially.

A. Advantages of Japan's Policy

Taking its unique history into consideration, Japan wanted to create a policy that would reduce the burden of intrafamily caregiving, provide coverage through a cost-sharing mechanism, integrate medical care and long-term care services to provide comprehensive coverage, reduce expensive and unnecessary stays in the hospital, create a needs-based system rather than a means-based system to cover more people and create a market to meet the increasing demand of long-term care while enhancing the quality of care.[115]

1. Unified System

As part of Japan's civil code, the LTCI Act contains the same standards that must apply throughout the country.[116] In order to qualify, the LTCI Act set an age-based eligibility requirement and mandated people aged 40 and above to pay a premium based on income.[117] Other significant standards include creation of an

[113] Campbell & Ikegami, *supra* note 17, at 28; *The Graying of the United States*, *supra* note 19.
[114] Yong & Saito, *supra* note 16, at 272.
[115] *Id.* at 273–74.
[116] *See id.* at 278–79.
[117] Long-Term Care Act, Law. No. 123, art. 9–13; Ozawa & Nakayama, *supra* note 89, at 71.

objective certification process that would determine services provided based on the person's level of care[118] and also set standards for caregiving providers.[119] This would mean higher quality of care as providers must meet the high standards to get paid.[120] Most importantly, the LTCI Act created a system where 90% of the services would be covered and the person only has to pay 10% out-of-pocket.[121] Services costs will still vary, but the LTCI Act regulates premium costs and out-of-pocket expenses to make it more affordable for qualified persons.[122]

Unlike Japan's uniform standards for long-term care insurance, the United States' standards vary on a state by state basis.[123] A Long-Term Care Insurance Model Act was enacted by the Nation Association of Insurance Commissioners (NAIC)[124] to "promote the public interest . . . and to facilitate flexibility and innovation in the development of long-term care insurance coverage."[125] Because it is a model act, it is nonbinding and states can choose whether to adopt it or use it as a guideline.[126] So far, no state has adopted this act and every state has its own variation[127] causing there to be different minimum standards for coverage.[128] The regulatory standards could also affect what insurance companies can sell in that state, thus, affecting the availability and affordability of long-term

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[118] *See* Yong & Saito, *supra* note 16, at 275.
[119] *See id.* at 276.
[120] *See* Izuhara, *supra* note 83, at 399.
[121] Yong & Saito, *supra* note 16, at 277.
[122] *See* Ozawa & Nakayama, *supra* note 87, at 71–72; Yong & Saito, *supra* note 16, at 281–82.
[123] LONG-TERM CARE INS. MODEL ACT, at ST-640-3–ST-640-8 (NAT'L ASS'N INS. COMM'R 2017).
[124] *FAQ*, NAT'L ASS'N INS. COMM'R, https://www.naic.org/documents/about_faq.pdf (last visited Feb. 18, 2021). The NAIC is a regulatory support organization created and governed by the chief insurance regulators from the fifty states. *About*, NAT'L ASS'N INS. COMM'R, https://content.naic.org/index_about.htm (last visited Feb. 23, 2021). One of its 2019 goals is to address issues related to long-term care insurance. *Id.*
[125] LONG-TERM CARE INS. MODEL ACT § 1.
[126] *See id.* at § 2.
[127] *Id.* at ST-640-3–ST-640-8.
[128] *See* FLA. STAT. § 627.94071 (2016); N.Y. INS. LAW § 1117 (MCKINNEY 2019); N.Y. COMP. CODES R. & REGS. TIT. 11, PT.52.

care insurance policies.[129] Similarly, not all states have enacted the Qualified State Long Term Care Partnership programs, which could make it more difficult for a person with long-term care insurance to apply for Medicaid in a state that does not have the program.[130] Even at the Medicaid aspect, states can choose to opt-in to more or less services and may have stricter requirements than federally required.[131] In addition, the varying standards at both the public and private level can affect the quality of care provided.[132] Consequently, there are 50 long-term-care policies within one country.[133]

2. Expanded Coverage

After hearing the dissatisfaction of the elderly with the old long-term care welfare law, the LTCI Act moved from means-based eligibility to needs-based eligibility.[134] This meant that the government could provide coverage to more people.[135] If following the old welfare law, only 15.6% of the population had the potential to qualify for long-term care benefits in 2015.[136] Whereas, the LTCI

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[129] *See* GENWORTH, DRIVERS OF THE COST OF CARE 9 (2020) (available at https://pro.genworth.com/riiproweb/productinfo/pdf/650501.pdf).

[130] *State Long Term Care Partnerships*, *supra* note 56; STONE-AXELRAD, *supra* note 53, at CRS-1.

[131] MORGAN ET AL., *supra* note 75.

[132] ENID KASSNER, PRIVATE LONG-TERM CARE INSURANCE: THE MEDICAID INTERACTION 1 (2004) (available at https://assets.aarp.org/rgcenter/health/ib68_ltc.pdf). There are nursing homes that do not accept Medicaid and, if they do, do not have many Medicaid beds. *Id.*

[133] LONG-TERM CARE INS. MODEL ACT, at ST-640-3–ST-640-8 (NAT'L ASS'N INS. COMM'R 2017).

[134] *See* Ozawa & Nakayama, *supra* note 87, at 66.

[135] Based on my research, Japan has a higher elderly population than impoverished population. *Elderly Citizens Accounted for Record 28.4% of Japan's Population in 2018, Data Show*, *supra* note 14. Japan's elderly consisted of 28.4% of the total population. *Id.* The author could not find a demographic of the 40-year-old to 64-year-old population nor a 40-year-old to 64-year-old population that has an age-related disability.

[136] The author could not find the eligibility requirements for the low-income person to qualify under the Social Welfare Law for the Elderly in 1963. For purposes of this paper, the poverty rate is used to define low-income. *Japan's Poverty Rate Remains Well Above OECD Average*, NIPPON.COM (June 27, 2017),

Act will cover at least 28.4% of the elderly population and persons aged 40 to 64 with an age-related disability.[137] Subsequently, Japan can help more of its people and live up to its standard of "enhanc[ing] the welfare of citizens."[138]

In contrast, the United States' Medicaid program continues to use means-based criteria to serve low-income individuals.[139] Following this criteria, Medicaid only provides long-term care services to about 2 million elders, essentially only covering 0.06% of the population.[140] While not means-based per government definition, private long-term care insurance also has a means-based component consisting of the person's means to afford the policy. Long-term care insurance premiums are expensive and will become difficult to maintain throughout life as the person becomes older.[141] Of the United States' 53 million elderly population,[142] about 10–20% of the elderly can afford long-term care insurance leaving 90% to find other methods for long-term care.[143] For instance, there is the middle-income senior group consisting of 14.4 million people and 80% of them will have less than $60,000 in income and assets.[144] Unfortunately, these people will have difficulty affording the long-term care services on their own, paying for long-term care insurance premiums, and qualifying for Medicaid.[145] If it moved to a needs-based system, the United States could be in a position that helps 16%

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https://www.nippon.com/en/behind/l10354/japan's-poverty-rate-remains-well-above-oecd-average-news.html.

[137] *Elderly Citizens Accounted for Record 28.4% of Japan's Population in 2018, Data Show*, *supra* note 14. The writer could not find a demographic of the 40-year-old to 64-year-old population nor a 40-year-old to 64-year-old population that has an age-related disability.

[138] Long-Term Care Act, Law. No. 123, art. 1.

[139] *See* Fla. ESS Program Policy Manual, *supra* note 70, § 1640.0000.

[140] Julia Paradise et al., *Medicaid at 50*, KAISER FAM. FOUND. (May 6, 2015), https://www.kff.org/
report-section/medicaid-at-50-the-elderly/.

[141] Richtman, *supra* note 36; AMORUSO & KROOKS, *supra* note 61, at 12-2; Guzman, *supra* note 32; Wu, *supra* note 33, at 1.

[142] *Population Ages 65 and Above*, *supra* note 21.

[143] KASSNER, *supra* note 132, at 1.

[144] Span, *supra* note 28.

[145] *See id.*; *see also Appendix* for cost of long-term care insurance premium.

of its people.[146] Instead, it only helps 0.06% and forces 51 million elders to figure a way to pay for long-term care.[147]

3. Acknowledges Informal Caregiver Burden

Japan recognized the demographic trends that were affecting informal caregiving,[148] which spurred the LTCI Act to address those issues socially and financially. Socially, 37% of the family members felt that their burden has been lightened.[149] Financially, the care provider standards provide an opportunity for the family member to become a certified caregiver.[150] Now the family member can get paid for the caregiving and the LTCI user can have people they trust in their home rather than strangers.[151] The LTCI user would now pay the family member, but this scheme provides a better balance of costs from both sides where previously the family member was the only one paying the price to care for an elderly loved one.[152]

Providing $552 billion in opportunity costs, most of the long-term care in the United States is "financed" by informal caregivers.[153] There are some programs that help pay for caregiver assistance such as Medicaid's Cash and Counseling, but working family members still bear a great economic burden.[154] Economists believe if the opportunity costs of informal care is lower than formal care, there would be cost savings for Medicaid;[155] however, opportunity costs of informal care are substantially greater than formal care.[156] Because informal caregiving is "more economical"

[146] *Population Ages 65 and Above*, *supra* note 21.
[147] *See* Paradise et al., *supra* note 140.
[148] Ozawa & Nakayama, *supra* note 87, at 63–64.
[149] Yong & Saito, *supra* note 16, at 280.
[150] Izuhara, *supra* note 83, at 407 (providing a daughter-in-law example).
[151] *See id.* at 407–08.
[152] Chari et. al, *supra* note 37, at 872.
[153] *Id.* at 877.
[154] *Id.* at 879.
[155] *Id.* at 872.
[156] *Id.* at 879.

for the government, the United States will continue to rely on family members to provide for the majority of long-term care.[157]

B. Challenges to Implementing Japan's Policy

In spite of the extensive benefits and coverage Japan's LTCI Act offers, there are barriers preventing the United States from switching over.

1. Prioritizing Private Expenditures

The United States does not have a law that prioritizes the elderly person's welfare like Japan.[158] Rather, its attempt at reform moves toward private means of long-term care through private insurance and informal caregiving thus reducing government involvement.[159] Basically, the United States is trying to lessen expenditures on Medicaid[160] causing individuals to pay the burden of long-term care with informal caregiver opportunity costs.[161] One of the effects of the enactment of the DRA was to allow states to form long-term care partnership programs that encourage people to purchase private long-term care insurance policies.[162] Even the CLASS Act, which is further explained in Part VI.B.3., created a separate account consisting of premiums paid privately by individuals.[163] The United States' reaction was to push for individuals to pay for their long-term care even though the individuals could not afford to do so in the first place.[164]

One of the factors that spurred Japanese reform was the dissatisfaction from the elderly about the inadequacy of the long-

[157] *Id.* The United States paid $150 billion for Medicaid long-term care services. Feder et al., *supra* note 82.
[158] *See* Long-Term Care Act, Law. No. 123, art. 3.
[159] *See* Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (2006); Chari et. al., *supra* note 37, at 879; *State Long Term Care Partnerships*, *supra* note 56.
[160] Chari et. al., *supra* note 37, at 872.
[161] *Id.* at 879.
[162] STONE-AXELRAD, *supra* note 53, at CRS-1.
[163] The CLASS Act was established under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).
[164] KASSNER, *supra* note 132, at 1.

term care welfare laws.[165] The elderly voice has a strong impact when it is about one-third of your population.[166] The very first article of the LTCI Act explicitly states that the act is "to improve health and medical care and to enhance the welfare of the citizens."[167] It is possible that the United States has not made significant developments because the elderly voice is not as prevalent, but it will be soon. Regardless, Japan took a drastically different approach than the United States by caring for its elderly with active government involvement and funding.[168]

2. View on Socialized Care

As a corollary to the United States' preference of having individuals pay more private costs and reduce government funding, is its general perspective of socialized care. Japan's LTCI is a socialized long-term care program. Japan had an easier transition into this kind of system because it had a separate socialized health care system already in place.[169] When the country began incurring excessive health care expenditures with the hospital stays accounting for one-third of the national health care costs, the unnecessary expenses became a motivating factor for long-term care reform.[170] Conversely, the United States has a mostly private health care system. As such, the United States has not had to deal with unnecessary expenses for healthcare and thus provides no motivation for it to change. Medicare is the closest socialized entitled health coverage benefit that applies to elders but it has some flaws.[171] One drawback is that Medicare does not cover long-term care expenses or stays and is only meant to cover acute stays.[172]

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[165] Ozawa & Nakayama, *supra* note 87, at 66.
[166] *See Elderly Citizens Accounted for Record 28.4% of Japan's Population in 2018, Data Show*, *supra* note 14.
[167] Long-Term Care Act, Law. No. 123, art. 1.
[168] *See id.* art. 3.
[169] Yong & Saito, *supra* note 16, at 272, 273.
[170] *Id.* at 273.
[171] *What's Medicare?*, MEDICARE.GOV, https://www.medicare.gov/what-medicare-covers/your-medicare-coverage-choices/whats-medicare (last visited Feb. 18, 2021).
[172] *See* U.S. Dep't of Health and Human Services, *supra* note 47.

Medicare also does not cover some medical services, causing there to be gaps in coverage and out-of-pocket expenses.[173] Private costs still play a role in the United States' social policy leading to inaction on public funding.

3. CLASS Act

Considering the issues above, the United States surprisingly did come close to having a long-term care law. The Community Living Assistance Services and Supports Act (CLASS) was enacted under the ACA to create a "national, voluntary long term services and supports (LTSS) insurance program financed by individual premium contributions."[174] The purposes of the program was to provide individuals with functional limitations, the ability to maintain independence, and live in the community, to construct an infrastructure to address the nation's long-term care needs, to reduce caregiver burden, and to finance a system that will foster independence in the community.[175]

Workers aged 18 and above and employers could volunteer to participate in the program.[176] Employers would withhold CLASS premiums through payroll deductions, similar to the process established for retirement plans.[177] The premiums would go into a fund called "[t]he Class Independence Fund" within the US. Department of Treasury and managed by the Secretary of the Treasury like the Federal Supplementary Medical Insurance Trust Fund under Medicare.[178] Premiums would be calculated based on actuarial values based on "age at enrollment."[179] To be eligible for coverage, the person has to have a functional limitation and meet

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[173] *An Overview of Medicare*, KAISER FAM. FOUND. (Feb. 13, 2019), https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/.
[174] LONG-TERM CARE IN THE UNITED STATES: A TIMELINE, *supra* note 43, at 5.
[175] KIRSTEN J. COLELLO & JANEMARIE MULVEY, COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS (CLASS): OVERVIEW AND SUMMARY OF PROVISIONS, CRS REPORT R40842, at 1 (2013) (available at https://www.ncsl.org/documents/statefed/health/CLASSOvrview21313.pdf).
[176] *Id.* at 5.
[177] *Id.*
[178] *Id.* at 12.
[179] *Id.* at 6.

requirements for payments.[180] The person would receive a cash benefit to purchase long-term care and supports (LTCSS).[181]

Sadly, the American Taxpayer Relief Act of 2012 (ATRA)[182] repealed the CLASS Act due to concerns on sustainability.[183] If it were still in existence, it would be a major improvement in addressing long-term care issues just like Japan's LTCI Act. CLASS mimicked some of the LTCI Act aspects such as having employees pay a premium and creation of a separate fund for the premiums that would be managed by the government.[184] The program also showed a transition to provide more at home services like Japan.[185] CLASS also transitioned to a needs-based criterion, applying to any person with a functional limitation. It actually goes beyond LTCI's age-based criteria in being able to cover more people.[186] CLASS does contain some flaws such as not providing as great a benefit as the LTCI Act, but it would be more help than what people are receiving now.[187] CLASS also appears to be based only on individual contributions and no government funding, potentially having a smaller budget.[188] Likewise, as a volunteer program, the contributions to premiums would vary on the number of persons that participate. The uncertainty in participation is most likely a concern that affected sustainability. A mandated program would at least create a guaranteed fund amount to be used for services like the LTCI Act. Nevertheless, because CLASS was repealed, there has been no major United States legislation that addresses long-term care.

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[180] *Id.* at 9.
[181] *Id.* The minimum average cash benefit is $50 but other factors can affect it. *Id.*
[182] American Taxpayer Relief Act of 2012, Pub. L. No. 112-240, 126 Stat. 2313 (2013).
[183] *Long-Term Care in the United States: A Timeline*, *supra* note 43; COLELLO & MULVEY, *supra* note 175, at Summary.
[184] *See* Long-Term Care Act, Law. No. 123, art. 3; COLELLO & MULVEY, *supra* note 175, at 12; Yong & Saito, *supra* note 16, at 277.
[185] Long-Term Care Act, Law. No. 123, art 40; COLELLO & MULVEY, *supra* note 175, at 4.
[186] Long-Term Care Act, Law. No. 123, art. 9; COLELLO & MULVEY, *supra* note 175, at 12.
[187] *See* COLELLO & MULVEY, *supra* note 175, at 9.
[188] *See id.* at 6.

V. Conclusion

The long-term care crisis is looming and inevitable. With one-third of its population about to become elderly, Japan took the initiative to address the impending crisis. The creation of a separate LTCI fund subsidized partially by private money from the population and partially by the government, combined with active government management produced an ingenious and comprehensive method of providing long-term care. Now with twenty years of experience with the LTCI Act, Japan has had many successes with the program by: (1) creating a unified system with high-quality minimum standards of care management, regulatory standards that make coverage affordable with out-of-pocket costs, and standards of benefits paid; (2) caring for the welfare of its people by covering as many people as possible; and (3) improving the caregiving burden socially and financially.

Notwithstanding all the benefits that Japan's socialized long-term care policy offered, the United States does have challenges implementing its own LTCI Act. One issue is the United States' preferred method of relying on private means and reducing government spending on long-term care. Correspondingly, another issue is the United States' view on socialized care. The country has limited socialized programs because the United States prefers to have individuals pay privately rather than have government aid. This preference is meaningless and should be changed when the individual cannot pay privately and has nothing else to use for long-term care.

The United States did attempt to implement a similar LTCI program through the CLASS Act. People had the option to contribute part of their income to pay for premiums and qualified participants would receive a cash benefit to pay for LTCSS. Although it is not a socialized program, CLASS would have been a radical reform for the United States. Alas, it was repealed shortly after it was established. Be that as it may, CLASS can serve as the foundation for a true long-term care law.

Overall, Japan created a remarkable long-term care policy and the United States should model some of Japan's aspects in creating its own long-term care act.

Appendix

Example for a traditional policy is from Michael J. Amoruso & Howard S. Krooks, *Estate Planning and Will Drafting- Chapter 12 Long-Term Care Insurance in New York*, N.Y. ST. B. ASS'N. J. 12-1, 12-5,6 (2018) (2020 revision forthcoming).

> In 2014, a consumer, at age 50, chose a policy with a financially sound company that provides three-year coverage for home care and facility care, a $200 daily benefit, 5% compound interest yearly inflation increase, and a 90-day elimination period. The consumer pays a $3,000 premium each year. In 2044, at age 80, the consumer becomes chronically ill and needs home health care or facility care . . . The consumer has paid premiums of $90,000 ($3,000 a year for 30 years) and is entitled to a total maximum benefit of $827,114 . . . .

Example for a hybrid policy is from Michael J. Amoruso & Howard S. Krooks, *Estate Planning and Will Drafting- Chapter 12 Long-Term Care Insurance in New York*, N.Y. ST. B. ASS'N. J. 12-1, 12-15 (2018) (2020 revision forthcoming).

> If a healthy, nonsmoking, 65-year-old woman with $175,000 in liquid assets deposits $50,000 into this account, approximately $87,000 in long-term care benefits would be created immediately. There would also be a death benefit of approximately $87,000 created from the life insurance component of the account. The policyholder an also select a benefit rider that would provide about $260,000 in long-term care benefits versus the original $87,000.

Table calculating Annual Premiums for the Elderly is from Martha N. Ozawa & Shingo Nakayama, *Long Term Care Insurance in Japan*, 17 JOURNAL OF AGING & SOCIAL POLICY 61, 71 (2005).

TABLE 1. Annual Premiums for Elderly Persons Aged 65 and Over, by Level of Income Status 2003-2005: The Case of Aioi City

Economic Status	Relative Premiums	Absolute Premiums
Group 1	0.50	¥17,400 ($145)
Group 2	0.75	26,100 (218)
Group 3	1.00	34,800 (290)
Group 4	1.25	43,500 (363)
Group 5	1.50	52,200 (435)

Note–Group 1, those on public assistance or receiving old-age pensions;
Group 2, elderly people who do not pay municipal taxes, neither do the rest of their household;
Group 3, elderly people who do not pay municipal taxes, but some of their household members do;
Group 4, elderly people with annual income less than ¥2,000,000;
Group 5, elderly people with annual income more than ¥2,000,000.

Source–City of Aioi, *Kaogo hoken ryo ni tsuite* (Aioi City : Author, 2003). (http://www.city.aioi.hyogo.jp/sections/c/if/if_about.html.)

Table calculating Maximum Monthly Payments for Home-Based Services and Institutional Services Provided to the Insured who Need Care, by Type of Facility and Level of Need is from Martha N. Ozawa & Shingo Nakayama, *Long Term Care Insurance in Japan*, 17 JOURNAL OF AGING & SOCIAL POLICY 61, 75 (2005).

TABLE 2. Maximum Monthly Payments for Home-Based Services and Institutional Services Provided to the Insured Who Need Care, by Type of Facility and Level of Need, 2003

Level of Care Needed	Maximum Payments per Month
Home-Based Services	
Group 1	¥165,800 ($1,381)
Group 2	194,800 (1,623)
Group 3	267,500 (2,229)
Group 4	306,000 (2,550)
Group 5 (high)	358,300 (2,986)
Institutional Services	
In kaigo rojin fukushi shisetsu	
(General nursing homes)	
Group 1	¥205,808 ($1,715)
Group 2	227,392 (1,895)
Group 3	248,672 (2,072)
Group 4	270,256 (2,252)
Group 5 (high)	291,536 (2,429)
In skilled kaigo rojin hoken shisetsu	
(Nursing homes for those in need of medical care)	
Group 1	¥248,976 ($2,075)
Group 2	263,872 (2,199)
Group 3	279,984 (2,333)
Group 4	296,400 (2,470)
Group 5 (high)	312,512 (2,604)
In kaigo ryoyo gata iryo shisetsu	
(Nursing homes for those with dementia and other chronic illnesses)	
Level of care needed	
Group 1	¥249,280 ($2,077)
Group 2	282,270 (2,356)
Group 3	355,072 (2,959)
Group 4	385,776 (3,215)
Group 5 (high)	413,440 (3,445)

Source–Health and Welfare Statistics Association, *Kokumin no Fukushi no Doko* (Tokyo: Author 2001b), Table 7, p. 190; Ministry of Health, Labor, and Welfare (2003). *Zenkoku kaigo hosyu zigyo unei kizyun tantousha kaigi siryo*. Tokyo: Author.