From disability rights towards a rights-based approach to long-term care in Europe

Building an index of rights-based policies for older people

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Throughout the report, the following abbreviations are used:

Austria	(AT)
Finland	(FI)
Ireland	(IE)
Italy	(IT)
Poland	(PL)
Portugal	(PT)
Slovakia	(SK)
Slovenia	(SI)
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1 Introduction and conceptual background

Countries across Europe, and indeed around the world, are confronting the social, economic and political challenges of an ageing population. Among the most pressing of these challenges is the organisation and financing of long-term care (LTC) and support for older people. While people are living longer than previous generations, they are not necessarily living these additional years in good health, and most will require some form of care or assistance in later life (Colombo et al., 2011). There is growing consensus that long-term care services should look beyond a medical model of 'care' to take a broader, more holistic view in which older people's wellbeing and quality of life and their preferences regarding care and support are central to the design of services in line with existing human rights standards.

In past decades, the debate surrounding the role of the state, the family, and the community in bearing the financing and provision of long-term care services has been framed primarily as a question of state's obligations vis-à-vis its citizens, with the issue of sustainability of public sector financing serving as a pivotal aspect of the discussion. More recently, another discourse from the human rights perspective has emerged, emanating primarily from the civil society sector but increasingly being taken up by policymakers internationally and at the EU level. The influence and impact of this approach is evidenced by the inclusion of the right to long-term care in the recently signed European Union's Pillar of Social Rights, the ongoing work of the UN Open-ended Working Group on Ageing, the recently concluded research study by the European Network of National Human Rights Institutions (ENNHRI) on the rights of older people in residential long-term care, and the work of AGE Platform Europe in collaboration with other advocacy groups.[1]

While existing human rights standards do provide provisions for the fulfilment of the universal rights (including civil and political, as well as social, economic and cultural rights) of all individuals including older adults, there is currently no distinct international convention specifically addressing the rights of older people that is comparable to the instruments covering women, children, or persons with disabilities. At regional level, in 2015, the Organization of American States (OAS) adopted the Inter-American Convention on Protecting the Human Rights of Older Persons, to which 7 Latin-American States are party to.

The provisions set down in the UN Convention on the Rights of Persons with Disabilities (UN CRPD) come closest to providing a legal framework for the protection of the rights of older people with care and support needs. According to the UN, more than 46 % of older persons – those aged 60 years and over—have disabilities and more than 250 million older people experience moderate to severe disability worldwide.[1] The CRPD contains several provisions which highlight the intersectionality of ageing and disability, including article 5 (equality and non-discrimination), article 9 (accessibility), article 19 (living independently and being included in the community), article 20 (personal mobility) and article 25 (health), among others. Yet in the detailing of the basic principles and rights underpinning the Convention, and in its interpretation in multiple General Comments by the Committee on the Rights of Persons with Disabilities, some scholars are of the opinion that older people ageing into disability and their particular circumstances are not well represented (Harpur, 2016). In this context, it is important to distinguish between persons with disabilities growing old and people ageing into disability. This may explain the documented implementation gap in the enforcement of the rights of older individuals with care and support needs (Council of Europe, 2014; Doron & Apter, 2010).

The UN Open-ended Working Group on Ageing has been discussing the possibility of a new UN convention on the rights of older people generally (i.e not restricted to older people with care and support needs). Advocacy groups like AGE Platform Europe, HelpAge International, and ENNHRI have advanced the discourse in this regard, indicating widespread agreement that the rights of older people are not considered adequately within current human rights standards. A human rights approach to ageing would secure older people's legal right to access quality care and support should they require it. On the other hand, several UN Member States, citing the aforementioned implementation gap, oppose a new convention on the grounds that it is the role of national governments to implement stronger legal protections and/or enforcement mechanisms (Poffé, 2015). Indeed, the human rights approach does not give much credence or space to economic theories of cost-utility and care rationing, which has proven to be a barrier to the realisation of rights across a range of domains (AGE Platform Europe, 2016; HelpAge International, 2013; 2015; Bershtling et al., 2016). In recognition of this barrier, human rights standards on social rights would fall under 'progressive realisation' clauses, conceding that a lack of resources can be an obstacle in the immediate realisation or fulfilment of human rights and that certain rights can only be fully achieved over a longer period of time (UN CESCR, 2000). Setting this debate aside, there nonetheless seems to be a need to examine how the rights of older people with care and support needs can most effectively be protected and enforced through the application of a rights-based approach.

When taking a comparative approach between the rights of persons with disabilities and the rights of older people with care needs, due to the unique overlaps in the support needs of both groups, some differences and nuances also become evident (Schulmann et al., 2018a). Among others, these include very different perceptions of and attitudes towards the concept of care and support, and the distinct form of age-based discrimination experienced by older people known as ageism. Ageism is systemic and pervades inter-personal interactions, decision-making at the systems level, and most insidiously, the self-perceptions and identities of older individuals themselves (see Schulmann et al., 2017).

Considering these developments, the research team developed a composite index and a scoreboard in line with the human rights-based perspective. The conceptual framework and initial domains and measures of the index were developed and validated in previous stages of the project (Schulmann et al., 2018a; 2018b). The Rights of Older People Index (ROPI) is a policy index based on structure and process indicators. Furthermore, a scoreboard was created to capture related policy outcomes. The present document describes in detail the ROPI and its results, as well as the results of the Scoreboard on Outcome Indicators. The purpose of these tools is to enable assessing and monitoring governments' policies and the outcomes of those policies in upholding the rights of older people with care and support needs in relation to long-term care. The results presented here refer to the 12 countries selected to be covered in the ROPI and in the scoreboard: Austria, Finland, Ireland, Italy, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden Switzerland, and the United Kingdom (UK).[2]

The indicators for the ROPI were selected through desk research and expert input. During the process of data collection, several indicators had to be modified and, in some cases, even dropped due to lack of existing data or in the absence of a reliable data source. The availability and replicability (over time) of information for all the countries participating in this study were paramount criteria in the selection of indicators. As with the scoreboard, the research team has tried to overcome these data challenges without compromising on the framework's original set of measures and on the quality and coherence of the ROPI. The process of indicator selection was already reflected in the pilot phase of this study: the research team used four coun-

tries (Austria, Poland, Slovakia and Sweden) as a testing ground for the indicators and analysis to be carried out. The results of the pilot countries did not allow broad conclusions or comparisons, nonetheless the main purpose of piloting was to test the validity of the indicators, domains and aggregation methods for the ROPI. The indicators comprising the ROPI were then populated through desk research and primary data collection by means of a questionnaire sent to selected national experts in the 12 participating countries.

The rest of the report is structured as follows: Section 2 of this report provides an overview of the ROPI for structure and process indicators, discussing its key features. Section 3 presents the results of the ROPI for the 12 participating countries starting with a brief analysis of the overall index results and then of each domain. Section 4 describes the results for the Scoreboard on Outcome Indicators. Section 5 explains the methodology used for constructing the index and the scoreboard, providing information on the selection of indicators, mode of data collection and aggregation and a discussion of possible limitations. The report then proceeds with a discussion of the results, data gaps and provides policy recommendations in Section 6, before concluding the study.

2 Introducing the Rights of Older People Index (ROPI) and the Scoreboard on Outcome Indicators

2.1 The Rights of Older People Index (ROPI)

The Rights of Older People Index (ROPI) is a multi-dimensional composite measure that uses a human rights-based approach and thus attempts to detail what the fulfilment of universal human rights entails when applied to the case of older people with care and support needs (Schulmann et al., 2018a). It is designed with the purpose of enabling the monitoring and assessment of a country's legislative and policy framework (structures), as well as national standards, guidelines, monitoring mechanisms and resources (processes) in relation to the rights of older people with care and support needs. In other words, the index is made up of structure and process indicators, which look at the legal and policy framework as well as the enforcing mechanisms that countries put in place to ensure the fulfilment of the rights of older people. It is important to note that the ROPI does not reflect the quality of those legislations, or policies, nor their implementation, or outcomes on the lives of older people. However, legislation determines the rights and responsibilities of individuals and authorities and thus their mere existence is an important foundation for the promotion and protection of the rights of older people.

The ROPI includes 35 indicators which are categorized under 10 domains.

Box 1:	**The ROPI domains**
I.	Equal access to & affordability of care & support
II.	Choice, legal capacity & decision-making capacity
III.	Freedom from abuse & mistreatment
IV.	Life, liberty, freedom of movement & freedom from restraint
V.	Privacy & family life
VI.	Participation & social inclusion
VII.	Freedom of expression, freedom of thought, conscience, beliefs, culture & religion
VIII.	Highest standard of health
IX.	Adequate standard of living
X.	Remedy & redress.

Figure 1 displays the domains and within each the structure and the process indicators that together form the ROPI (see Annex Table 1 for more information on the categories and values of each indicator).

To calculate the value score of the domains, the geometric average of the indicators is used. The grossing up of the indicators is undertaken within each domain and subsequently applied to the overall index by using the geometric mean of the domain values and applying equal weights both at the indicator and domain levels (see discussion in more detail in Section 5). The information on the indicators that comprise the ROPI was provided by country experts through a standardized questionnaire and supplemented by desk research.

The ROPI on structure and process indicators currently covers 12 European countries: Austria, Finland, Ireland, Italy, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, Switzerland and the UK.

Figure 1: The domains and indicators of the ROPI

RIGHTS OF OLDER PEOPLE INDEX (ROPI)										
DOMAINS > >	I. Equal access to & affordability of care & support	II. Choice, legal capacity & decision-making capacity	III. Freedom from abuse & mistreatment	IV. Life, liberty, freedom of movement & freedom from restraint	V. Privacy & family life	VI. Participation & social inclusion	VII. Freedom of expression, freedom of thought, conscience...	VIII. Highest standard of health	IX. Adequate standard of living	X. Remedy & redress
STRUCTURE INDICATORS > > > >	Restrictions in eligibility to home-based care Restrictions in eligibility to residential care Provisions for assistive devices & home modifications	Legislation ensuring choice of LTC provider Legal provisions enforcing user consent Supported decision-making legislation Advance Directive (AD) legislation	Legislation addressing abuse/mis-treatment of older persons	Legislation addressing the use of restraints	Legislation addressing maintaining family life	Legislation addressing accessibility of public spaces Legislation addressing (de)institutional-isation	Adoption of & monitoring compliance with equality & non-discrimination in national laws on grounds of religion or beliefs	Legislation providing for equal access to preventive, mental, health care, dental care & medication National legisla-tion/strategy on the integration of health & social care & support	Legislation ensuring the right to adequate housing Minimum income guaran-tees for older persons	Legislation addressing rights awareness Legal mechanism for complaint in case of breach of rights
PROCESS INDICATORS > > >	Percentage of GDP (or of expenditure on social services) allocated to public LTC expenditure	Procedures for user involve-ment in needs-assessment & care planning Older persons satisfied with involvement in care Procedures for supported decision-making Availability of AD registry	Monitoring mechanism against abuse/mis-treatment of older persons in care	Guidelines on alternatives to the use of restraints in care	Procedures addressing visitation rights Public infra-structure for safe storage of personal data	Procedures to ensure accessi-bility of public spaces	National stand-ards/guidelines require that care services respect for different beliefs, religion, culture	National poli-cies/guidelines to implement measures for older persons to access pre-ventive, mental, health care, dental care & medication	Housing support for older persons Pension at safety net level	Active policy of information on rights of older persons Complaint procedures to independent authority in case of breach of rights

2.2 The Scoreboard on Outcome Indicators

The Scoreboard on Outcome Indicators – henceforth scoreboard – measures country performance in actual outcomes (i.e. achievements in the fulfilment of rights) and aims to complement the structure and process indicators that comprise the Rights of Older People Index (ROPI).

The scoreboard is comprised of 17 indicators which are grouped under the same domains as used for the ROPI (see Annex Table 2 for more information on the categories and values of each indicator). However, in the absence of finding suitable and reliable outcome indicators for Domains III (*Freedom from abuse & mistreatment*) and IV (*Life, liberty, freedom of movement & freedom from restraint*), these two domains are not included in the scoreboard. Nevertheless, the original numbering of the domains is kept throughout the whole report whenever referring to the domains. Figure 2 displays the indicators within their respective domains.

The scoreboard indicators are based on statistical information collected from European comparative datasets. The scoreboard, like the ROPI, currently covers 12 countries.

Figure 2: The domains and indicators of the Scoreboard on Outcome Indicators

I. Equal access to & affordability of care & support	II. Choice, legal capacity & decision-making capacity	V. Privacy & family life	VI. Participation & social inclusion
• Care & support received by women • Care & support received by men • Access to housing modifications & devices	• Freedom to decide how to live life • Satisfaction with care	• Contact with family • Protection of personal data	• Access to public spaces • Loneliness/ Social isolation

SCOREBOARD ON OUTCOME INDICATORS

VII. Freedom of expression, freedom of thought, conscience, beliefs, culture & religion	VIII. Highest standard of health	IX. Adequate standard of living	X. Remedy & redress
• Discrimination on grounds of religion or beliefs	• Immunisation • Consultation with dentist • Satisfaction with GP	• Housing deprivation • Relative poverty	• Awareness of rights • Exercising of rights

3 Results for the Rights of Older People Index (ROPI) on Structure and Process Indicators

3.1 Results of the overall index on structure and process indicators (ROPI)

Results for the ROPI are presented in Table 1 for the 12 participating countries that the index currently covers. Sweden has the highest overall index score (2.2), a result of its exceptionally good performance in three domains: *Equal access to & affordability of care & support*; *Freedom of expression, freedom of thought, conscience, beliefs, culture & religion;* and *Highest standard of health*, as well as its generally high scores in Domains II, VI and X. Finland positions itself second, slightly ahead of Slovenia, Ireland and Austria on the overall index.

Poland has the lowest overall index score for the ROPI (1.8) which is explained by the fact that it does not achieve the highest score range in any of the domains and its generally poor performance in most of the domains. The three domains where Poland does relatively well include *Privacy & family life*; *Highest standard of health; and Remedy & redress*. Notably, none of the countries belong to the highest (2.6-3.0) or to the lowest (1.5-1.0) score range on the overall index and the variation among country scores is also quite low (between 2.2. and 1.8 in the overall index). Interestingly, there is no obvious geographical clustering in the overall ranking results.

The domain *Life, liberty, freedom of movement & freedom from restraint* shows the greatest extremes with Italy, Slovenia and the United Kingdom obtaining the highest possible score, while half of the countries falling in the lowest score range (Finland, Ireland, Poland, Portugal, Slovakia, and Switzerland). This makes Domain IV the poorest performing domain in the whole index, slightly ahead of Domains V, IX and X, highlighting some serious gaps in the protection of the rights of older people in those areas in the participating countries. Furthermore, there are three domains where no countries reached the highest score range (Domains II, IX, X), which means that there is room for improvement in all 12 countries in ensuring equal choices and legal capacity, adequate standard of living as well as remedy and redress in case of human rights violations for older people with care or support needs. *Equal access to & affordability of care & support* and *Participation & social inclusion* are the domains where all countries scored generally high and none of them would belong to the lowest score range. More detailed results regarding the 12 countries' performance in each domain of the index are discussed in the next section.

Table 1: Index and domain scores for the ROPI

		SE	FI	SI	IE	AT	PT	UK	ES	SK	CH	IT	PL
	ROPI	2.2	2.1	2.1	2.1	2.1	2.0	2.0	1.9	1.9	1.8	1.8	1.8
I.	Equal access to & afford-ability of care & support	3.0	3.0	2.2	2.4	2.2	2.1	2.0	2.0	2.0	2.7	2.3	1.7
II.	Choice, legal capacity & decision-making capacity	2.3	2.1	2.2	2.3	2.2	2.1	2.1	2.2	1.8	2.0	1.5	1.8
III.	Freedom from abuse & mistreatment	1.7	3.0	2.4	2.0	2.4	3.0	3.0	2.4	1.4	3.0	1.7	1.7
IV.	Life, liberty, freedom of movement, from restraint	1.7	1.0	3.0	1.4	2.4	1.4	3.0	2.0	1.4	1.4	3.0	1.4
V.	Privacy & family life	1.7	2.1	1.4	2.6	1.4	1.8	1.7	1.0	2.6	1.4	1.4	2.3
VI.	Participation & social inclusion	2.3	2.6	2.6	2.6	2.6	2.3	1.6	2.6	2.3	1.8	2.0	1.8
VII.	Freedom of expression, freedom of thought, etc. …	3.0	3.0	2.4	3.0	2.4	2.4	2.4	1.4	2.0	1.4	2.0	1.7
VIII.	Highest standard of health	3.0	2.1	2.6	2.0	1.8	3.0	1.4	2.1	2.3	2.0	1.6	2.1
IX.	Adequate standard of living	1.9	1.6	1.6	1.6	1.6	1.6	2.3	2.1	1.6	1.6	1.6	1.6
X.	Remedy & redress	2.1	2.0	1.4	1.4	1.7	1.4	1.4	1.7	1.9	1.7	1.4	2.1

Score: 3.0-2.6 2.5-2.1 2.0-1.6 1.5-1.0

Box 2: Reader's guide to the ROPI

- In the tables presenting the results of the ROPI by domains, indicators starting with '1' are the structure indicators and indicators starting with '2' are the process indicators.
- Each indicator has three possible answers or categories, ranging from 1 to 3, with a higher score (i.e. a score of 3) denoting better standards and/or protection of rights. For each indicator, therefore, the higher the score, the higher the ranking of the country in relation to the given indicator.
- The ranking of the countries in the ROPI overall score is to be read from left to right (the country on the far left is the best performer and the country on the far right is the worst performer). The same ordering of the countries is kept when presenting the scores for each ROPI domain (Table 2 to 11).
- For the ranking of the countries under each domain, the colour coding should be considered (numbers in dark green mark the highest score range, numbers in red mark the lowest score range).

3.2 Results by domains

3.2.1 Domain I *Equal access to & affordability of care & support*

Domain I *Equal access to & affordability of care & support* captures the extent of restrictions to eligibility to long-term care (both at home and in institutions) and assistive devices and home modifications. These are resources that are fundamental to ensure that older people in need of care and support can live independently without relying solely on their relatives to receive the care they need. Given the costs associated with long-term care (Muir, 2017), public support is often fundamental to access formal care. This is assessed through three indicators, each considering eligibility conditions enshrined in the legislation regarding: home care services, institutional care and provision of assisted devices and home modifications. This domain includes also an indicator on the public expenditure on long-term care as percentage of GDP, as a measure of public resources devoted to long-term care.

Sweden and Finland attain the highest possible score, with Switzerland close behind, which is coherent with the image of Nordic welfare states as being relatively generous in their care arrangements (EPC-AWG/EC, 2018). Although at some distance from this trio of countries, most other countries do not seem to fare too badly in this domain. The exceptions being Slovakia, Poland and the UK (England), all of which are countries whose eligibility for long-term care rests on means-tests.

Table 2: Scores and grades for Domain I Equal access to & affordability of care & support

		SE	FI	SI	IE	AT	PT	UK	ES	SK	CH	IT	PL
	I. Equal access to & affordability of care & support	**3.0**	**3.0**	**2.2**	**2.4**	**2.2**	**2.1**	**2.0**	**2.0**	**2.0**	**2.7**	**2.3**	**1.7**
1.1	Restrictions in eligibility to home-based care	3	3	2	3	2	3	2	n.a.	2	3	2	2
1.2	Restrictions in eligibility to residential care	3	3	2	3	2	3	2	2	2	3	2	2
1.3	Provisions for assistive devices and home modifications	3	3	3	2	2	2	2	2	2	2	n.a.	2
2.1	Percentage of GDP (or of social services) allocated to public LTC	3	3	2	2	3	1	2	2	2	3	3	1

Notes: For Austria, information in indicators I.1.1 and I.1.2 refers to Vienna. For Spain, information in indicator I.1.1 refers to Madrid. For Switzerland, information in indicators I.1.1 and I.1.2 refers to Canton Bern.

Regarding legislation on eligibility for home and residential care, there are basically two groups of countries (which are identical for both indicators). One group of countries has no eligibility restrictions besides the assessment of needs, and these include Sweden, Finland, Ireland, Portugal[3] and Switzerland. The remaining countries all restrict access based on income. This restriction takes the form of means-tests for the provision of care (e.g. UK [England]), or co-payments based on income (e.g. Austria [Vienna]). The latter, although not technically a means-test, can still be quite substantial and limit access to care (Muir, 2017). Co-payments in residential care can be substantial, with social assistance often subject to further assets-tests (Rodrigues et al., 2012). As long-term care is a devolved responsibility in many of the countries considered, geographical inequalities cannot be ruled out in access to care. However, location *per se* was not reported as an eligibility criterion (or restriction) in the countries considered, nor were age (within the old-age group), religion, gender or sexual orientation. In comparison with access to long-term care, there are more restrictions reported in access to assistive devices and home modifications. Only Sweden, Finland and Slovenia reported no restrictions beyond the medical assessment of needs that is a necessary condition in all the countries analysed. In the remaining countries, there were either means-tests (e.g. Spain); limits to the costs of devices or adaptations that are paid publicly (e.g. Switzerland); or de facto rationing of resources once the total budget was reached even though access itself was not legally restricted (e.g. Portugal).

The indicator on public expenditure on long-term care in percentage of GDP is assessed in relative terms (in reference to spending quartiles among EU countries). Austria, Finland, Italy, Sweden and Switzerland rank in the highest spending quartile, while Poland and Portugal are in the lowest quartile.

The conclusion to draw is that access to different forms of care necessary to live independently is not yet a guaranteed right by law (unlike access to health care, for example), outside of Sweden and Finland, and to some extent Switzerland. All other countries either restrict access based on income or devote too few resources to care despite seemingly generous legislation (e.g. Portugal).

3.2.2 Domain II *Choice, legal capacity & decision-making capacity*

Domain II *Choice, legal capacity & decision-making capacity* consists of eight indicators, which makes it the domain with the highest number of indicators in the whole index. The domain covers different aspects of choice and decision-making capacity, including legal capacity legislation, choice and user consent in accessing long-term care services, as well as Advance Directive (AD) legislation and procedures. People may need support in managing their care and making decisions, but they have the right, whether in their own home or in a residential care home, to make choices about their lives. Choice and control over decisions are of key importance to preserve one's autonomy and personhood, regardless of the functional limitations, or impairments. Furthermore, the shift from substituted towards supported decision-making to ensure equal recognition before the law are important provisions, namely under Article 12 of the UN Convention on the Rights of Persons with Disabilities (UN CRPD). This domain is a good example of how the ROPI is building on human rights standards that are outlined in existing UN Treaties (e.g. UN CRPD) and are not only relevant but should be also applicable to older persons.

While no country belongs to the highest score range in this domain, scores are generally higher than in most other domains. Sweden and Ireland obtain the best rank, slightly ahead of Slovenia, Austria and Spain. Italy performs especially poorly in this domain and scores are quite low for Poland and Slovakia.

Table 3: Scores and grades for Domain II Choice, legal capacity & decision-making capacity

		SE	FI	SI	IE	AT	PT	UK	ES	SK	CH	IT	PL
	II. Choice, legal capacity & decision-making capacity	**2.3**	**2.1**	**2.2**	**2.3**	**2.2**	**2.1**	**2.1**	**2.2**	**1.8**	**2.0**	**1.5**	**1.8**
1.1	Legislation ensuring choice of long-term care provider	3	2	3	3	3	2	2	1	2	2	1	2
1.2	Legal provisions enforcing (informed) user consent	3	3	3	2	3	3	3	3	2	3	2	3
1.3	Supported decision-making legislation	3	3	1	3	1	1	1	3	1	3	1	1
1.4	Advance Directive (AD) legislation	1	2	2	2	2	3	2	3	1	2	1	1
2.1	Standard procedures or guidelines for user (and family) involvement in needs assessment and care planning	3	3	3	3	2	2	3	2	3	2	3	3
2.2	Share of older persons reporting satisfaction with their level of involvement in the care process	3	3	3	3	3	2	3	3	2	n.a.	2	3
2.3	Standard procedures or guidelines for supported-decision making in care planning	3	1	3	1	3	2	3	2	3	2	2	1
2.4	Availability of AD registry	1	1	1	n.a.	2	3	1	2	n.a.	1	1	n.a.

Note: For Austria, information in indicators II.1.2, II.2.1 and II.2.3 refers to Vienna.

Based on the information from the national experts, five of the 12 countries (Finland, Ireland, Spain, Sweden, Switzerland) have a legal framework that is based on a supported decision-making approach. The other countries' legal systems are based on traditional substituted decision-making models, which means that an individual's decision-making capacity can be legally removed and another individual (a guardian), can be appointed to make decisions for the person. Despite that all EU Member States ratified the UN CRPD, not all States Parties to the Convention introduced in their national legislation the necessary supported decision-making provisions yet. Considering the growing ageing population, including the increase in the number of people living with Alzheimer's disease, as well as the longer life expectancy of persons with intellectual disabilities, it is important to reflect on these emerging challenges and develop frameworks that can respect the will and preferences of older people with support needs as much as possible.

There are two structure indicators that measure the fulfilment of choice and control more concretely: one concerns legislation ensuring the choice of long-term care provider and the other one on legislation enforcing informed user consent. In most countries, it is stated in the legal framework that older people with care or support needs can choose their care providers, but it is only in Austria, Ireland, Slovenia and Sweden where there is a legally granted possibility to replace in-kind benefits with cash benefits (e.g. to employ a personal carer). It is important to note that despite legal guarantees, geographical or other barriers (e.g. lack of different providers in rural areas) may still prevent older people from choosing freely the type of care ser-

vices they want to use. In almost all participating countries legislation exists that requires the consent of the care user to be obtained for all forms of care (including for institutionalization) and for all care tasks that can be considered invasive[4]. Ireland[5], Italy and Slovakia are the exceptions from this, however, informed consent is also required in these countries for most types of care. Even in the countries which have legislation on informed consent covering all care services, people who are under guardianship might fall out of the scope of that legislation.

For all countries, scores are generally very high for the indicator on existing standard procedures or guidelines for the involvement of users in their needs' assessment and care planning. From the information gathered from the national experts, it is unclear, however, whether the requirements of these guidelines on the involvement of users in developing their individual care plans is a one-off exercise or require regular revision of needs assessment and a more participatory approach in care provision. Nonetheless, in Austria, Finland, Ireland, Poland, Slovenia, Spain, Sweden and the UK a very high proportion of the population is satisfied with being informed and consulted about their long-term care services, based on the relevant data from the European Quality of Life Surveys (EQLS).[6]

Advance Directives are related to decisions or types of decisions, particularly regarding medical treatment and health care, that may have to be made in the future (both positive and negative). ADs are recognised in eight of the participating countries, but only in Spain and Portugal ADs are legally binding. In Austria, for instance, ADs are legally binding only under specific circumstances, excluding emergencies. In the case of the corresponding process indicator on the availability of Advance Directive registry, there are several missing values (Ireland, Poland and Slovakia). In half of the countries (Finland, Italy, Slovenia, Sweden, Switzerland and the UK) no AD registry exists.[7] Portugal is the only country where the Ministry of Health in 2014 created a Living Will National Registration and where it is obligatory to register all ADs.[8]

In general, most countries are doing well in promoting measures that respect the choice of older people with car, or support needs (e.g. Advance Directives) and their legislation is shifting towards supported decision-making. This positive trend probably relates to the recent developments in the area of legal capacity and equal recognition before the law in the disability field upon the entry into force of the UN CRPD. Respecting older persons' choice and control during care planning and involving them in the care process leads to higher satisfaction with the long-term care services.

3.2.3 Domain III *Freedom from abuse & mistreatment*

Domain III *Freedom from abuse & mistreatment* is composed of two indicators (one structure indicator and one system indicator) on legislation and monitoring mechanisms against abuse/mistreatment[9] of older persons in both residential and home-based care settings. Older people with care and support needs are more exposed to abuse, mistreatment and neglect than some others, due to functional limitations, or other support needs. The abuse and mistreatment of older adults is underreported and under-investigated (WHO, 2014), with some estimates showing a 6 percent abuse rate among older people (ibid.), which goes up to 25 percent for older adults with dementia or living in a residential institution (WHO, 2011). Abuse and mistreatment have also long-lasting consequences leading to poor health, harmful behaviour and early death.

Overall, Domain III is one of the best performing domains with four countries in the highest score range (Finland, Portugal, Switzerland [Canton Bern] and the UK) and just one country in the lowest score range (Slovakia). Data for the structure indicator was subtracted from the WHO Global Status report on violence prevention, in which Ireland was not included.

Most of the countries have legislation in place to protect older people from abuse/mistreatment (except Poland, Slovakia and Sweden). The discrepancies start when looking at provisions for the protection of older people in residential care where evidence shows that rates of abuse and mistreatment tend to be higher (Yon et al., 2018). In Finland, Portugal, the UK, Switzerland and Italy, elder abuse laws cover institutions, while this is not the case in Spain and Slovenia (WHO, 2014). Legislation against elder abuse in Austria covers only institutions.

Table 4: Scores and grades for Domain III Freedom from abuse & mistreatment

		SE	FI	SI	IE	AT	PT	UK	ES	SK	CH	IT	PL
	III. Freedom from abuse & mistreatment	**1.7**	**3.0**	**2.4**	**2.0**	**2.4**	**3.0**	**3.0**	**2.4**	**1.4**	**3.0**	**1.7**	**1.7**
1.1	Legislation addressing abuse/ mistreatment of older persons	1	3	2	n.a.	2	3	3	2	1	3	3	1
2.1	Monitoring mechanisms against abuse/mistreatment	3	3	3*	2	3	3	n.a.	3	2	3	1	3

Notes: Ranking provided by country experts, but with insufficient information to allow for its full validation. For Switzerland, information in indicator III.2.1 refers to Canton Bern.

The countries in the higher score range have also functional mechanisms to monitor abuse/mistreatment, including in residential care. Overall, countries have better scores for putting in place monitoring mechanisms than adopting legislation addressing the abuse/mistreatment of older persons (e.g. Poland, Spain, Slovakia, Sweden), except for Italy[10] where legislation is in place but no reinforcement mechanism.

The monitoring and inspection functions are delegated to the local authorities (e.g. Poland, Spain, Switzerland [Canton Bern]), but some countries have, in addition, national-level support systems that provide guidance, trainings and individual case inspection (e.g. Austria, Finland, Portugal, Sweden).

Ireland and Slovakia are in the process of improving the existing monitoring mechanisms. In Slovakia, an authority responsible for quality of social services' assessment is being introduced and will start to carry out its competency in 2019. In Ireland, the Health Information and Quality is the statutory independent regulator for the residential sector and currently a new system of regulation is being developed particularly for home care services.

Legislation is a critical component for prevention and intervention in case of violence or abuse against the older population. It is important that the legal provisions will come along with advocacy measures, awareness raising campaigns and education campaigns. Reinforcement mechanisms are equally important and although countries score generally well for this indicator, some countries should try to put in place further mechanisms for monitoring older people's rights. Efficient monitoring and control tools might give an indication of commitment at regional level to have a good quality of care. While the lack of national legislation indicates that the issue of abuse and mistreatment of older people is still not on the national agenda.

3.2.4 Domain IV *Life, liberty, freedom of movement & freedom from restraint*

In Domain IV *Life, liberty, freedom of movement & freedom from restraint* the structure indicator is looking at whether national legislation mandating that care providers minimise the use of restraints (chemical and physical) in residential long-term care and in home and community-based care (or only in one type of setting) exists, or not. There is a related process indicator covering existing guidelines on alternatives to the use of restraints in different care types. Respecting people's basic human rights to dignity, freedom and respect underpin good-quality social care and freedom from restraint is an important part of it.

Italy, the UK and Slovenia[11] obtain the highest possible score in this domain, meaning that their legislation on minimising the use of restraints covers both residential and home-based care services and they also have relevant guidelines available for care providers on alternatives to the use of restraints in both types of services. Notably, half of the countries are situated in the lowest score range in this domain (Finland, Ireland, Poland, Portugal, Slovakia and Switzerland) which makes Domain IV the worst-performing domain in the whole index (slightly ahead of Domains V, IX and X). It is also the domain with the lowest scores for Finland and Poland.

Table 5: Scores and grades for Domain IV Life, liberty, freedom of movement & freedom from restraint

		SE	FI	SI	IE	AT	PT	UK	ES	SK	CH	IT	PL
	IV. Life, liberty, freedom of movement & from restraint	**1.7**	**1.0**	**3.0**	**1.4**	**2.4**	**1.4**	**3.0**	**2.0**	**1.4**	**1.4**	**3.0**	**1.4**
1.1	Legislation addressing the use of restraints	1	1	3*	2	2	1	3	2	2	1	3	2
2.1	Guidelines on alternatives to the use of restraints in care	3	1	n.a.	1	3	2	3	n.a.	1	2	3	1

Notes: Ranking provided by country experts, but with insufficient information to allow for its full validation. For Austria, information in indicator IV.2.1 refers to Vienna. For Switzerland, information in indicators IV.1.1 and IV.2.1 refers to Canton Bern.

There is no country that has legislation on the use of restraints for home-based care services without having legislation covering residential long-term care services as well. The countries where legislation on minimizing the use of restraints is confined to residential care are Austria, Ireland, Poland, Slovakia and Spain.

Sweden, Finland, Portugal and Switzerland (Canton Bern) have no specific legislation prohibiting the use of restraints, but general legislation regulating social welfare services (e.g. in Finland), existing guidelines covering residential and/or home-based long-term care (e.g. in Portugal) or monitoring mechanisms (e.g. in Sweden) minimize the existence of restraints, according to our country experts. While acknowledging that a country without legislation may have better guidelines and monitoring mechanisms in place to protect the right of older persons with support needs to be free from restraints, legislation provides greater safeguards and systematic protection in different types of care facilities.

It is important to note that the structure indicator only measures whether legislation on minimising the use of physical or chemical restraints exists in different care settings, but it does not evaluate the appropriateness of those legislations. From a human rights perspective, the use of restraints is not appropriate, therefore a legislation that regulates the circumstances under which restraints can be used may not fulfil the requirements of minimising the use of restraints. For instance, the Austrian Home Stay Act regulates the implementation of three types of freedom-restricting measures in the field of nursing homes: a) mechanical restrictions (e.g. straps, bed rails, removal of a walker etc.), b) electronic restrictions (e.g. transmitters, alarm systems etc.) and c) medicinal restrictions (e.g. sedative medication). As the Austrian country expert informed us, restrictions on freedom are only permitted in case of a significant risk to oneself or others and if the restrictive measures cannot be averted by other, more lenient measures. In Poland, only doctors can decide about the use of restraints in psychiatric hospitals, or in social care homes, but in case of emergency when the doctor is not present, nurses may make that decision, however, they are obliged to report the case through strict documentation and inform the local authority that supervises the social care home.

The related process indicator measures whether there are existing guidelines on alternatives to the use of restraints (chemical and physical) in residential long-term care facilities and in home- and community-based long-term care. Only Austria (Vienna), Sweden and Italy have such guidelines available. In Austria, the development of those guidelines is the responsibility of the *Länder* (provinces). For Vienna, such guidelines exist and must be implemented and observed by social care providers operating in the city and receiving public funding. The guidelines also include information provided on minimising the use of restraints in various formats. Guidelines can also take the format of training provided to the staff of different types of care services, like in the case of the comprehensive training programme by the National Board of Health and Welfare in Sweden. Portugal and Canton Bern have guidelines on alternatives to the use of restraints for residential care settings, which in the case of Bern is a requirement for long-term care institutions to be adopted. There are currently no additional national guidelines in Ireland, Poland and Slovakia apart from the legally binding provisions minimizing the use of restraints in residential care. Finland is the only country that has neither specific legislation, nor guidelines on minimising the use of restraints, but as it was mentioned above, the Act on the Status and Rights of the Social Welfare Clients (882/2000) protects the client's right to self-determination in general.

Ensuring the freedom of restraint in different types of social care is a cornerstone of respecting the human rights of older people with care or support needs. There is clearly room for improvement in most countries to adopt legislation that minimises the use of restraints and to issue guidelines to care providers that offer alternatives to measures that unnecessarily confine older people's freedom of movement.

3.2.5 Domain V *Privacy & family life*

This domain assesses on the one hand, the ability to preserve the confidentiality of personal information from users. On the other hand, it captures the respect for family life, particularly when in institutional care, where barriers to maintain not only contacts but also living arrangements with close relatives (e.g. spouses) may be higher. Both the right to protection of personal data and to family life are part of the EU Charter of Fundamental Rights (articles 7 and 8, respectively). The indicators on family life include legislation on the right to a care home close to one's home or shared facilities for couples, as well the existence of guidelines or procedures to frame visiting rights in institutional care. Data privacy refers to the existence of a public authority responsible for safe storage of data.

This is a domain where most countries show relatively low scores overall. Ireland and Slovakia are the exceptions, together with Finland and Poland. The low scores achieved in this domain are mostly linked to areas of maintaining family ties.

Table 6: Scores and grades for Domain V Privacy & family life

		SE	FI	SI	IE	AT	PT	UK	ES	SK	CH	IT	PL
	V. Privacy & family life	**1.7**	**2.1**	**1.4**	**2.6**	**1.4**	**1.8**	**1.7**	**1.0**	**2.6**	**1.4**	**1.4**	**2.3**
1.1	Legislation addressing the maintenance of family life	n.a.	3	1	2	1	1	1	n.a.	2	2	1	2
2.1	Procedures addressing visitation rights	1	1	1	3	3	2	n.a.	1	3	1	1	3
2.2	Public infrastructure for safe storage of personal data	3	3	3	3	1	3	3	1	3*	n.a.	3	2

Notes: Ranking provided by country experts, but with insufficient information to allow for its full validation. For Austria, the information in indicators V.1.1 and V.2.1 refers to Vienna. For Spain, the information in indicator V.1.1 refers to Madrid.

The maintenance of family ties for older people in care homes is ensured the most in Finland. In this country, municipalities must provide services close to people's homes and spouses are granted the right to live together in a care home even if one of them does not need care. Most other countries do not have legislation guaranteeing any right to receive institutional care close to the community, nor to have spouses residing together. Even among the countries that stipulate the former, in practice this right may not be fulfilled if demand outstrips supply in a given area. Regarding guidelines for visitation rights, Ireland, Austria (Vienna), Slovakia and Poland have mandatory national regulations protecting visiting rights and thus score the maximum. In most countries, however, visiting rights are not secured through any sort of guidelines (mandatory or not), even if in practice relatives are usually considered free to visit.

Reportedly, the EU General Data Protection Regulation (GDPR) has already been transposed to the national legislation in all countries analysed and a public authority responsible for the safe storage and use of general personal data has been established (which corresponds to the minimum score in this indicator).[12] Most countries, however, go beyond the minimum requirements set by the EU Directive and have established an independent authority for safe use and storage of personal and health care data, although in some cases data may be stored with providers (e.g. Slovakia and Italy).

Maintaining family life, either through visiting rights or ensuring co-residency of spouses, remains an underdeveloped area in national legislation and procedures governing institutional care. Conversely, data protection seems to be much more safeguarded under the processes currently in place.

3.2.6 Domain VI *Participation & social inclusion*

Domain VI *Participation & social inclusion* is composed of two structure indicators (legislation addressing accessibility of public spaces and legislation addressing deinstitutionalisation) and one process indicator (procedures addressing accessibility of public spaces). Restricted participation and social exclusion limit the potential of individuals to contribute to and be a part of society and could result in poor health, poor quality of life and wellbeing. Age is correlated with exclusion and requires complex and age-tailored policy interventions (Bolton, 2012). Participation and inclusion are assessed through three indicators. Two indicators consider the existence of national legislation requiring that public facilities, transportation and public ICT platforms are accessible on an equal basis and the existence of national procedures to ensure accessibility of public spaces. This domain includes also an indicator on legislation or national strategy that stipulates measures for the transition from institutional to community-based care and support (i.e. deinstitutionalisation).

Overall, countries in Domain VI perform well, being one of the three domains with no country in the lowest score range. All countries have general provisions requiring that public facilities and public transportation, including road, railway and air transportation are accessible on an equal basis, irrespective of age and type of impairment. While legislation in all countries covers the accessibility of public facilities and transportation for older persons, there is less progress in covering ICT platforms. The most advanced countries in this regard are Austria, Poland, Spain and Switzerland.[13]

In all countries, building permissions for all new public facilities require that these should be barrier-free and accessible to all people. In Finland, Ireland, Portugal and Spain the procedures require that adaptations must be made also to the existing public buildings and facilities. At the same time, Finland, Ireland Slovakia and Slovenia have provisions in their legislation that stipulate accessibility when building private residential buildings where persons with disabilities or older people will move in.

Table 7: Scores and grades for Domain VI Participation & social inclusion

		SE	FI	SI	IE	AT	PT	UK	ES	SK	CH	IT	PL
	VI. Participation & social inclusion	**2.3**	**2.6**	**2.6**	**2.6**	**2.6**	**2.3**	**1.6**	**2.6**	**2.3**	**1.8**	**2.0**	**1.8**
1.1	Legislation addressing accessibility of public spaces	2	2	3*	2	3	2	2	3	2	3	2	3
1.2	Legislation addressing (de)institutionalisation	3	3	3	3	3	2	1	3	3	1	2	1
2.1	Procedures to ensure accessibility of public spaces	2	3	2	3	2	3	2	2	2	2	2	2

Notes: Ranking provided by country experts, but with insufficient information to allow for its full validation. In Austria, building regulations are within the competence of the *Länder* (provinces). For Spain, the information in indicator VI.1.1 refers to Madrid. For Switzerland, the information in indicator VI.1.1 refers to Canton Bern.

Austria, Spain (Madrid) and Slovakia have national strategies that directly address the deinstitutionalisation of the older population (the 'Ageing and the Future, 2015' in Austria and the 'National Action Plan for the Transition from Institutional to Community-based Care in the Social Services System 2016-2020', 'Action Plan for older People' in Spain plus the 'National Program on Active Aging 2014-2020' in Slovakia). Finnish, Slovenian and Swedish legislation focus more on measures to prevent institutionalization through development of community-based care and support. For example, the Swedish Social Services Act (2001) states that services should "support independence and the possibility to live at home and to have contact with others".

Poland and the UK have no specific legislation addressing deinstitutionalisation. The Polish 'Long-Term Senior Policy in Poland 2014-2020' refers to general support services to be provided to older people ('at home and outside home') but without specific measures addressing deinstitutionalisation. The UK has legislation that concentrates more on integrated support based on individual needs. In Switzerland, there is no national strategy or federal law that stipulates measures for the transition from institutional to community-based care, the services for older people are regulated at canton level. A deinstitutionalisation strategy is currently being drafted for the Bern canton. Italy and Portugal have deinstitutionalisation elements in various legislation supporting people with disabilities without particular reference to older people.

Countries have made good progress in putting in place the legal framework to ensure accessibility of public spaces but adapting the ICT platforms is problematic in most countries. While legal provisions are in place, the procedures to ensure accessibility of all spaces refer more to public and less to private places as well as more to the newly constructed buildings than adapting the existing ones. The approach to deinstitutionalisation differs and countries could be clustered based on two main principles: those that focus on prevention and community care and those that have an active deinstitutionalisation policy for older people. At the same time, very few countries have legislation referring directly to the specific needs of older people.

3.2.7 Domain VII *Freedom of expression, freedom of thought, conscience, beliefs, culture & religion*

Domain VII *Freedom of expression, freedom of thought, conscience, beliefs, culture & religion* has two indicators that seek to assess equality and non-discrimination on the grounds of religion and beliefs with a focus on the area of social protection and health care. Freedom of thought and religion is one of the rights included in the EU Charter of Fundamental Rights (Art 10). Still, as a recent report on the theme of religious discrimination has highlighted, the legal protection against discrimination based on religious grounds at the EU level is incomplete in the field of health and social services (Equinet, 2017). Furthermore, the issue of respect for one's beliefs, culture and religion is likely to become even more relevant as European societies (including older people) become more multicultural.

In this domain, there seems to be a dichotomy between a group of countries with very good overall scores (with Finland, Ireland and Sweden as the frontrunners) and a small group of countries with very poor scores (in particular Poland, Spain and Switzerland).

Religion and belief are among the grounds of discrimination that are explicitly protected in the national legislation of all 12 countries. In the case of Austria and Switzerland, this protection is guaranteed at both the federal- and regional- or cantonal-level legislations. Concerning the coverage of these two grounds of discrimination in the area of social protection and health care, the specific grounds of religion and belief are not mentioned in the related national legislation in Poland.[14] Apart from the existence of legislation forbid-

ding discrimination on the basis of religious and other beliefs, the indicator also provides information if there is an independent national equality body that supervises and monitors compliance with the legal provisions. Except for Switzerland, where no equality body exists at the federal level, all countries have national designated bodies that deal with all grounds and fields that are covered by national law, including religion and belief, in social protection and health care. However, in the case of Italy and Slovakia, this body appears to be not fully independent (Favilli, 2018; Debrecéniová & Durbáková, 2018). In Austria, the national equality body, the Ombudsman for Equal Treatment (Gleichbehandlungsanwaltschaft), covers discrimination in the aforementioned areas on the grounds of ethnic affiliation, but not of religion or belief (Schindlauer, 2018).

Table 8: Scores and grades for Domain VII Freedom of expression, freedom of thought, conscience, beliefs, culture & religion

		SE	FI	SI	IE	AT	PT	UK	ES	SK	CH	IT	PL
	VII. Freedom of expression, freedom of thought, conscience, beliefs, culture & religion	**3.0**	**3.0**	**2.4**	**3.0**	**2.4**	**2.4**	**2.4**	**1.4**	**2.0**	**1.4**	**2.0**	**1.7**
1.1	Adoption of and monitoring compliance with equality and non-discrimination in national laws	3	3	3	3	2	3	3	1	2	2	2	1
2.1	National standards or guidelines require that care services respect different beliefs, religion, culture	3	3	2*	3	3	2	2*	2*	2*	1	2	3

Notes: Information provided by country experts refers to legislation For Austria, information in indicator VII.2.1 refers to Vienna. For Switzerland, information in indicator VII.1.1 refers to Canton Bern.

As for respecting different beliefs, religion and culture in care services, according to information provided by country experts, there are national standards and guidelines in place and compliance is monitored by a relevant authority in Sweden, Finland, Ireland and Poland. In countries with a score of 2 on this indicator, the relevant legislation stipulates that provision of care services be in accordance with human rights and freedoms, also considering an individual's religion, beliefs, or culture, but without specifying standards or providing guidelines in this regard. In the case of Austria and Switzerland, no national standards exist as matters of care services (including monitoring compliance) fall under the competence of the provinces and the cantons, as is the case in Austria and Switzerland.

All in all, while all countries provide legal protection for freedom of religion and belief, not everywhere do these translate into specific national standards and monitoring mechanisms that would ensure that religious and cultural needs of all service users are respected and minimum requirements are effectively enforced.

3.2.8 Domain VIII *Highest standard of health*

The Domain *Highest standard of health* is assessed by considering the existence of legal provisions as well as national policies or guidelines to ensure equal access to several types of health care (e.g. mental

health, dental care and medication). In addition, this domain includes an indicator on the existence of a national legislation or strategy mandating the integration of health and social care and support. Although old-age is associated with a higher risk of poor health and a large share of health care expenditure is concentrated in old-age, access of older people to certain forms of health care may nonetheless continue to be hampered by several factors. These include low expectations regarding ageing (i.e. that ageing necessarily entails lower mental health, higher dependency, etc.) – particularly in the case of preventive care – or institutional factors that limit coverage of certain types of care (as is the case with dental care in many European countries [Kossioni, 2012]), which may disproportionately affect older people in need of care. Similarly, lack of coordination of care across the health and social sectors may also account for unmet needs among people with multimorbidity.

Sweden and Portugal have the highest scores in this domain, in which overall most countries have relatively high scores. The relatively positive results achieved by most countries are perhaps unsurprising as equal access to health care is for the most part enshrined in the laws and even constitutions of most EU countries and ensuring access is not limited by unfair reasons (such as lack of sufficient means to pay for care), a key policy goal in this area (OECD, 2017).

Most countries reported no statutory restrictions in accessing different forms of health care and as such they are all ranked with the maximum value on this indicator. The exceptions, such as the UK (England), mostly refer to dental care for which co-payments are required. However, as mentioned above, having no legal restrictions in place for health care may not be sufficient to ensure that older people are able to access it. There is some evidence of pervasive inequalities in access to health care in Europe (OECD, 2014). Despite this, most countries still lag behind in implementing national guidelines or policies to ensure that access is indeed equal for older people. While most countries have some sort of policy or strategy to enhance access of older people, these are far from being comprehensive. For example, Sweden reported guidelines to make access to all forms of care (including preventive care) available to older people; while Poland included specifically health promotion and disease prevention for older people in its National Health Program 2016-2020. It is also not clear whether these strategies are sufficient to tackle possible financial barriers to access care (not only in terms of co-payments but also in affording transportation to health care).

Table 9: Scores and grades for Domain VIII Highest standard of health

		SE	FI	SI	IE	AT	PT	UK	ES	SK	CH	IT	PL
	VIII. Highest standard of health	**3.0**	**2.1**	**2.6**	**2.0**	**1.8**	**3.0**	**1.4**	**2.1**	**2.3**	**2.0**	**1.6**	**2.1**
1.1	Legislation provides for equal access to preventive, mental health care, dental care, and medication (regardless of age, gender, nationality and income)	n.a.	3	3*	n.a.	3	3	2	3	3	2	2	3
1.2	National legislation or strategy on the integration of health and long-term care and support	3	3*	2	2	1	3	n.a.	1	2	2	1	1
2.1	National policies or guidelines on implementing measures for older persons to access preventive, mental health care, dental care, and medication	3	1	3*	n.a.	2	3	1	3	2	2	2	3

Note: Ranking provided by country experts, but with insufficient information to allow for its full validation.

The indicator on legislation or explicit strategies mandating the integration of health and social care for older people is arguably the indicator with the least positive results in this domain. In Austria, Italy, Poland or Spain, social and health care services remain firmly separated, despite some attempts at local level to improve coordination (not reflected in legislation, though). Sweden, Finland and Portugal arguably go the furthest in their attempt to integrate care. For example, Sweden recently enacted (2018) legislation that aims to improve coordination between health and social care when older people are discharged from hospitals. Portugal legislated the establishment of an integrated care network already in 2006, bringing together social and health care providers.[15]

Legislation mandating equal access to preventive, mental and dental health care and medication is present in many of the countries analysed. As older people face several barriers in accessing care, it is not clear, however, that this legislation is sufficient. Doubts subsist, however, as to whether countries are doing enough beyond approving legislation to ensure no unmet needs among older people in need of care and support. As many of these older people experience multimorbidity, the lack of integration between health and social care may further put into question the right to achieve the highest standard of health.

3.2.9 Domain IX *Adequate standard of living*

Domain IX *Adequate standard of living* refers to legislation and resources allocated to ensuring that older people have sufficient resources to live a dignified life. The right to an adequate standard of living is not enshrined in the EU Charter of Rights, but the recognition that poverty is a violation of human rights has gained momentum in the international agenda, underpinned by Amartya Sen's theories of capabilities and entitlements (Sen, 1984). Lack of resources is a negation of rights as it precludes the fulfilment of other rights (e.g. access to health or social participation) and limits older people's freedom and agency. The Sustainable Development Goals (SDG) recognize this in SDG1 which calls for halving the share of people in poverty of *all ages* till 2030.

Of the 10 domains, this domain shows the least variation in domain scores across the 12 countries, and scores are generally low. The UK and Spain have the highest domain scores closely followed by Sweden, with the remaining nine countries lagging somewhat behind.

Table 10: Scores and grades for Domain IX Adequate standard of living

		SE	FI	SI	IE	AT	PT	UK	ES	SK	CH	IT	PL
	IX. Adequate standard of living	**1.9**	**1.6**	**1.6**	**1.6**	**1.6**	**1.6**	**2.3**	**2.1**	**1.6**	**1.6**	**1.6**	**1.6**
1.1	Legislation ensuring the right to adequate housing for all including all dimensions of housing, such as affordability, quality, and security of tenure	1	1	1	1	1	1	n.a.	1	1	1	2*	1
1.2	Minimum income guarantees targeting older persons	3	3	3	3	3	3	3	3	3	3	3	3
2.1	Housing support for older persons	2	2	2	2	1	2	2	2	1	2	1	1
2.2	Pension at safety net level (in % of median income)	2	1	1	1	2	1	2	3	2	1	1	2

Notes: Ranking provided by country experts, but with insufficient information to allow for its full validation. For Switzerland, information in indicator IX.1.1 refers to Canton Bern.

All 12 countries have legal provisions in place to guarantee a minimum standard of living for older people either as part of the pension system or as part of general social assistance with specific provisions for older people. Within the old-age pension system, a minimum pension safety net is provided in the form of a pension supplement in Austria, a guarantee pension in Sweden and Finland, a means-tested minimum pension in Italy and Spain, and as a contribution-based minimum or basic pension in Poland, Slovakia, Slovenia, Switzerland, Ireland, Portugal and the UK. In some, further special supplements apply, such as the 'Over 80 allowance for pensioners' in Ireland or the basic pension top-up in Switzerland. In all countries, additional means-tested schemes are available as part of guaranteed minimum income or social assistance for individuals with no other or insufficient means of financial support. These include the so-called protective allowance for older people in Poland, the Slovakian permanent allowance for older residents, the maintenance support in Sweden or the old-age social pension and the solidarity supplement for the elderly in Portugal, for instance.

The indicator on pension safety net provides an indication of the adequacy of the minimum pension safety net in relation to the national median income.[16] In half of the countries, the related benefits account for less than 40% of the national median equivalised income, while in Austria, Slovakia, Poland, the UK and Sweden it ranges between 40% and 50%. Spain is the only country where it is above 60%, the commonly used at-risk-of-poverty threshold.

In eight of the 12 countries, there exists targeted housing support which serves the purpose of helping older people with their housing costs, which can represent a substantial burden especially in Eastern Europe (FEANTSA, 2017). The mode of provision varies across the countries. In some, such as Sweden, Finland and Switzerland, it is provided as a supplementary benefit or housing supplement for pensioners, while in others (e.g. Portugal, Slovenia) the specific housing support for the elderly is integrated within the social assistance system. In Spain, the housing allowance is linked to the non-contributory old-age pension. Finally, in Ireland and the UK, a heating and fuel supplement/allowance is available for pensioners. Housing support in Austria, Italy, Poland and Slovakia is targeted at low-income households as part of general social assistance, and not specifically aimed at older persons, which explains the lower values for these countries on this indicator.

Housing is an essential element of social inclusion. Inadequate housing affects not only living standards but also social relations, health etc. and is a major component of deprivation. In human rights laws, the right to adequate housing is recognized as part of the right to an adequate standard of living and is protected in various UN-based international- and regional-level legislative instruments (e.g. Universal Declaration of Human Rights, International Covenant on Economic, Social and Cultural Rights, Revised European Social Charter). At the national level, diverse legal traditions and policy settings mean that the right to adequate housing is articulated differently in the countries.

3.2.10 Domain X *Remedy & redress*

Domain X *Remedy & redress* captures on the one hand, whether there is any awareness-raising about the rights of older people among them and among members of society in general and on the other hand, what mechanisms of legal remedy exist when older people experience human rights violations in residential and community-based long-term care settings. The picture is much less positive regarding the associated process indicator: whether adequate processes are put in place to support complainants, or not. Considering the vulnerability of older persons with care and support needs who experience human rights violations in long-term care services, we chose to assess the adequacy of complaint procedures.

Domain X is one of the worst-performing domains in the whole index as five countries belong to the lowest score range (Ireland, Italy, Portugal, the UK and Slovenia) and none of the 12 countries has the highest score rank. Sweden and Poland (2.1) obtain the highest score among the participating countries (slightly ahead of Finland). Countries perform especially poorly on the indicator that refers to complaint procedures to independent authorities in case of breach of rights. Countries interpreted differently the indicator on legal mechanisms and some only provided information strictly referring to older people, whilst others also mentioned general mechanisms, or Ombudsman offices that protect the rights of older people as well as other groups.

Table 11: Scores and grades for Domain X Remedy & redress

		SE	FI	SI	IE	AT	PT	UK	ES	SK	CH	IT	PL
	X. Remedy & redress	**2.1**	**2.0**	**1.4**	**1.4**	**1.7**	**1.4**	**1.4**	**1.7**	**1.9**	**1.7**	**1.4**	**2.1**
1.1	Legislation addressing rights awareness	1	2	2	1	2	1	1	2	1	2	1	2
1.2	Legal mechanisms for complaint in case of breach of rights	3	2*	2	2*	2	2*	2*	2	3	2	2*	3
2.1	Active policy of information on rights of older persons[17]	2	2	1	2	2	2	2	2	2	1	2	1
2.2	Complaint procedures to independent authority in case of breach of rights	3	2	1	1	1	1	1	1	2	2	1	3

Notes: Ranking provided by country experts, but with insufficient information to allow for its full validation. For Switzerland information in indicators X.1.2, X.2.1 and X.2.2 refers to Canton Bern.

Only Switzerland (Canton Bern) and Poland have national legislation in place to increase awareness on older persons' rights in the context of care and support. Austria and Spain have developed national strategies that stipulate measures to increase awareness of older persons about their human rights in the context of care and support (e.g. the National Dementia Strategy in Austria). Nevertheless, none of the participating countries have both legislation and a strategy concerning rights awareness of older people. From the information we were able to collect through desk research, Equality Bodies in almost all countries carry out general awareness-raising activities and various campaigns about the rights of specific groups (e.g. Roma, migrants, children etc.), but in none of the countries we found specific campaign materials produced by these bodies on the rights of older people. In Poland, Slovenia and Switzerland (Canton Bern) there was no evidence on the website of the relevant Equality Bodies that providing information or raising awareness about the rights of older people, or about human rights more generally, would be part of their mandate or their activities.

In six countries (Austria, Poland, Slovakia, Slovenia, Spain, and Switzerland [Canton Bern]), there is legislation that stipulates measures through which older people can claim their rights and, in most countries, there is also a legally established independent authority to which older people can turn to claim their rights, albeit not specifically established for older people. Initially, this indicator aimed to look at age-specific measures to address rights-awareness and enable older persons to make complaints in case of breach of their

rights. During the validation process, it was realized that in several countries, while there is no age-specific independent authority (e.g. an Ombudsman for Older People), there is an independent Ombudsperson with a general mandate that covers older people and provides them with adequate protection when they seek remedies.[18]

Regarding the adequacy of complaint procedures, Poland and Sweden are the only countries that score the maximum, meaning that information about the complaint mechanism is available in accessible formats (e.g. large fonts, easy-to-read),[19] anonymity of complainants can be guaranteed throughout the complaint procedure, and the independent authority can represent the complainant in judicial proceedings. Seven countries (Austria, Ireland, Italy, Portugal, Slovenia, Spain and the UK) score the lowest and in general it is because their Equality Body neither can represent complainants in judicial proceedings, nor provides information in accessible format on its website.

There is certainly room for improvement in all countries to raise awareness on the rights of older people among the general public and among older people. While Equality Bodies are mandated to protect the rights of older people, current complaint procedures in case of breach of rights are not fully accessible and are especially difficult to use for those who are victims of violence or abuse in residential or in home-based care services. It would be interesting to observe in future discussions how efficiently Ombudsman offices with a general mandate are representing older persons, for instance by looking at how many of their cases concerned this target group.

4 Results for the Scoreboard on Outcome Indicators

4.1 Results of the overall scoreboard

The scoreboard shows the performance of countries in each domain based on a series of outcomes with a direct relationship with the structure and process indicators of the ROPI. The scoreboard therefore provides an overview of whether rights are being fulfilled in reality. Each outcome indicator has a link with at least some of the structure and process indicators in a given domain.

The ranking of countries is not as straightforward as with the ROPI (Table 12). Nonetheless, Sweden and Finland (the latter despite missing values) perform the best among the countries included in the scoreboard, as they have the highest number of indicators with "good but to monitor" values. On the other extreme, Poland and Slovenia seem to perform the worst among the countries considered.

The scoreboard also allows for the assessment of performance across domains. This assessment highlights domains or indicators where performance is systematically good or critical for all or most countries analysed. In carrying out this analysis of the scoreboard across domains, it is clear that for most domains there is quite some degree of consistency in the performance of countries. Either most or all countries constantly perform well, or most or all countries constantly perform poorly in a given domain. Thus, both Domain VII *Freedom of expression, freedom of thought, conscience, beliefs, culture & religion* and Domain IX *Adequate standard of living* show outcomes that are consistently good across all countries and indicators (although Domain VII only has one indicator). On the other extreme, Domain I on *Equal access to & affordability of care & support* and especially Domain X *Remedy & redress* consistently show weak or critical outcomes across most indicators and countries (including the above-mentioned forerunners Sweden and Finland). Domain VIII *Highest standard of health* is arguably the domain with greatest inter-country variation in the access indicators. It seems therefore that there are systematic differences between domains, with some – such as access to care (health and long-term care) and remedy and redress – clearly standing out as areas that deserve dedicated policy investment across all countries considered in this study.

Table 12: Scoreboard on outcome indicators

		SE	FI	SI	IE	AT	PT	UK	ES	SK	CH	IT	PL
I. Equal access to & affordability of care & support	Care & support received female	●	●	●	●	●	●	●	●	n.a.	●	n.a.	●
	Care & support received male	●	●	●	●	●	●	●	●	n.a.	●	n.a.	●
	Have access to housing modifications & assistive devices	●	n.a.	●	n.a.	●	●	n.a.	●	n.a.	●	●	●
II. Choice, legal capacity & decision-making capacity	Feel free to decide how to live life	●	●	●	●	●	●	●	●	●	●	●	●
	Satisfied with care received	●	●	●	●	●	●	●	●	●	n.a.	●	●
V. Privacy & family life	Have frequent (at least weekly) contact with family	●	●	●	●	●	●	●	●	●	●	●	●
	Trust in health & medical institutions to protect personal information	●	●	●	●	●	●	●	●	●	n.a.	●	●
VI. Participation & social inclusion	Have access to public spaces	●	●	●	●	●	●	●	●	●	n.a.	●	●
	Not reporting feeling lonely	●	●	●	●	●	●	●	●	●	●	●	●
VII. Freedom of expression...	No experience of being discriminated on grounds of religion/ belief	●	●	●	●	●	●	●	●	●	n.a.	●	●
VIII. Highest standard of health	Received vaccination for influenza	●	●	●	●	●	●	●	●	●	●	●	●
	Have regular consultation with dentist	●	n.a.	●	n.a.	●	●	n.a.	●	n.a.	●	●	●
	Satisfaction with personal attention received from GP/ family doctor	●	●	●	●	●	●	●	●	●	n.a.	●	●
IX. Adequate standard of living	Not experiencing housing deprivation	●	●	●	●	●	●	●	●	●	●	●	●
	Not in relative poverty	●	●	●	●	●	●	●	●	●	●	●	●
X. Remedy & redress	Being aware of rights	●	●	●	●	●	●	●	●	●	n.a.	●	●
	Able to exercise rights	●	●	●	●	●	●	●	●	●	n.a.	●	●

● Good but to monitor ● To watch ● Weak ● Critical

Each of the domains is analysed in detail in the next section. This individual domain analysis also includes a gender breakdown by indicator (where possible) to allow for differences between sexes to be assessed as well (see Box 3 below).

4.2 Results by domains and by gender

Domain I *Equal access to & affordability of care & support* is composed of three outcome indicators: percentage of dependent older women and men receiving long-term care services and percentage of dependent older people with access to at least one house modification (see Annex Table 2 for more details on the indicators and sources). Domain I arguably shows the worst outcomes among all the domains in the scoreboard. Sweden is the lone exception as it is the only country with good outcomes in the indicators referring to access to long-term care (for men and women). For all other countries, access to long-term care or adapted housing is critical or weak at best (Table 12). The observed outcomes on access to long-term care and adapted housing stand in contrast to the not-so-negative picture shown earlier by the structure and process indicators for this domain (see Table 2). The limited access to services by older people with limitations in activity of daily living (ADLs) provides an indication of possible unmet needs or/and of the relevance of informal care to meet the needs of older people.

Box 3: Gender differences in outcome indicators:

- Gender differences are assessed through a ratio between the outcome for women and for men. A ratio of 1 indicates absolute parity between men and women, while a ratio higher than 1 signals inequalities disfavouring men and a ratio lower than 1 indicates inequalities disfavouring women. As a rule of thumb, we considered ratio values between 1.2 and 0.96 as de facto equality for the purpose of the analysis.
- The ratio has the advantage of being independent on the level of outcome. The ratio does not say anything about the level of the outcome (e.g. inequalities may be low, while the outcome is itself low for both men and women) and is not symmetric (i.e. the ratio takes the value of 2 when women are twice as likely than men to report a given outcome and 0.5 when men are twice as likely than women to report a given outcome). The ratios shown do not include confidence intervals.

Table 13: Gender differences in Domain I Equal access to & affordability of care & support

Domain	Indicator	SE	FI	SI	IE	AT	PT	UK	ES	SK	CH	IT	PL
I. Equal access to & affordability of care & support	Care & support received	1.17	1.32	1.38	1.60	1.90	0.71	1.57	1.84	n.a.	1.29	n.a.	1.14
	Have access to housing modifications & assistive devices	0.99	n.a.	0.90	n.a.	1.00	1.40	n.a.	1.14	n.a.	1.43	1.31	0.56

Outcomes of Domain I are not only very low but they are also characterised by strong gender inequalities (Table 13). Access to long-term care shows strong gender inequalities disfavouring men in all countries (the ratio is higher than one). The exception to this is Portugal. This gender inequality in formal care receipt has been linked to several factors.[20] Living arrangements in old-age are themselves strongly gendered (i.e. women are more likely to live alone) due to gender differences in marriage and re-marriage patterns and life expectancy (Robards et al., 2012). Use of care services may thus compensate the lower availability of spousal care for older women.[21] Strongly embedded cultural notions of care as a female occupation may also underline the allocation of care to older women but not to older men, even if spouses are present (Schmidt, 2017). For the indicator on access to adapted housing, gender inequalities are also pervasive. The direction of inequalities is, however, not constant: in Portugal, Spain, Switzerland and Italy inequalities in access to adapted housing disfavour men, while in Slovenia and Poland they disfavour women.

Countries have few restrictions as regards access to long-term care and housing adaptations in their legislation although many condition access on a means-test. For all countries, however, eligibility is still conditioned on assessed need. The criteria underlying the assessment of needs or simply rationing of scarce resources may thus render access limited to a minority of older people with activity limitations, with affordability likely to be an important factor in this (Muir, 2017). This is a domain with pervasive gender differences, particularly in access to long-term care, that seem to reflect broader gender differences in caring roles and living arrangements.

Domain II *Choice, legal capacity & decision-making capacity* captures outcomes that are closely related to the agency or sense of control of older people in need of care and support. Specifically, the outcome indicators are: the percentage of older people with care and support needs that report feeling free to decide how to live their lives and the level of satisfaction of older people with the quality of care in their country. Overall, most countries show positive outcomes in this domain, although with clear room for improvement. Older people in most countries seem to report feeling free to live their lives (Table 12). Outcomes for this indicator are apparently better for countries whose GDP per capita is higher than the EU average. This could indicate that material resources may play an important role in allowing older people in need of care enough leeway to fulfil their life wishes. Despite the poor outcomes in terms of access to long-term care depicted in Domain I, the opinion of older people concerning the quality of the care services in their country is nonetheless positive. Portugal and Slovakia are somewhat exceptions to this and have the lowest figures in this indicator.

Table 14: Gender differences in Domain II Choice, legal capacity & decision-making capacity

Domain	Indicator	SE	FI	SI	IE	AT	PT	UK	ES	SK	CH	IT	PL
II. Choice, legal capacity & decision-making capacity	Feel free to decide how to live life	0.91	1.03	1.14	0.97	1.03	0.87	1.00	0.97	0.94	0.95	0.95	1.12
	Satisfied with care received	0.92	0.91	1.14	0.88	1.01	1.07	0.98	1.15	1.07	n.a.	1.10	0.82

The gender breakdown of the above outcome indicators shows that older women in need of care and support feel less agency than men in Sweden, Portugal, Slovakia and Italy, while in Poland and Slovenia the opposite is observed (Table 14). There are also marked gender differences as to the perceived quality of care

in each country, but also here there is no clear country pattern. In four out of the 10 countries for which there is data by gender, women have a worse opinion of services than men do, while men hold a more unfavourable opinion in an equal number of countries.

Older people seem to feel in control of their lives and report higher satisfaction with the quality of care in their countries. The latter outcome could, however, also signal relatively low expectations of older people regarding long-term care. Gender differences, although evident, do not show a clear pattern and may reflect specific country factors.

Domain V *Privacy & family life* contains two outcome indicators: one on the perceived trust in health and medical institutions to ensure privacy of personal information and another on maintaining at least weekly contacts with the family by older people. Overall the domain shows a positive picture, although much more in terms of trust in health and medical institutions to uphold data protection than on having frequent family contacts (Table 12). In Sweden, Finland, Portugal and Slovakia, at least ¾ of those aged 55 or older trust their health and medical institutions with regard to the handling of personal data. In the case of this indicator, the outcomes seem to reflect the existing legislation and infrastructure depicted in the ROPI for this domain (see Table 6). The indicator on regular contacts with relatives has little relation with the process and structure indicators reported under this domain in the ROPI. Still, regular contacts with relatives are highest in Mediterranean countries, Slovakia and Ireland. These patterns of family contacts may, to some extent, reflect cultural expectations as to the role of the family in general and could be replaced in some national contexts by contacts with friends and neighbours (Nicolaisen & Thorsen, 2013).[22] There is, nonetheless, a large share of older people who only sporadically have contact with their family.

Table 15: Gender differences in Domain V Privacy & family life

Domain	Indicator	SE	FI	SI	IE	AT	PT	UK	ES	SK	CH	IT	PL
V. Privacy & family life	Have frequent (at least weekly) contact with family	0.94	1.15	1.07	0.83	0.97	1.13	1.01	0.94	0.95	1.01	0.93	1.24

Reporting weekly contacts with relatives is also an indicator with significant gender differences, but as with other indicators above, there is no clear geographical pattern (see, for example, the diverging gender inequality patterns of Mediterranean countries), nor is the direction of gender inequalities always the same. While older men are less likely to live alone in old-age than women (WHO, 2018), they have less contact with their close relatives outside the household (Brandt et al., 2009) and are more likely to experience depressive symptoms if they have only infrequent contact with their children (Tosi & Grundy, 2018). As the social networks of older women tend to be wider and include other people besides family, women may be able to better endure the absence of frequent contacts with relatives in old-age.

There is quite a high degree of trust in medical institutions' ability to preserve the integrity of personal information, reflecting the legislation in place in this area. The ability of older people to maintain regular contacts with relatives is a highly culture-laden indicator. Still, many older people (both men and women) seem to have only limited contact with their relatives with possible consequences for their social inclusion, mental health and even access to services (see Domain VI below).

The two indicators in **Domain VI** intend to capture outcomes related to ***Participation & social inclusion***. The indicator on self-reported feelings of loneliness provides an indication of the extent of social isolation among older people, while accessibility to public buildings and essential services signals potential barriers

for older people to fully participate in society and lead an active and independent life.[23] The mixed outcomes in this domain suggest quite some room for improvement, especially regarding accessibility. Older people in Sweden and to a lesser extent in Spain and Slovakia tend to report the least difficulties with access to public spaces. In these countries, at least 50% report easy access to essential services such as public transport, banking and grocery, and recreational facilities. Only four out of 10 older people report the same in Austria, Ireland, Finland, Italy and the UK. Poland and Portugal, which score relatively high in terms of having legislation and procedures in place to ensure accessibility of public spaces (Table 7), have the lowest share of older people who can easily access public spaces and basic services. Most older people in the countries analysed did not report feeling lonely. In particular, Finland and Switzerland stand out as the two countries where over 80% of older people did not report feeling lonely. In Slovakia, most older people reported loneliness.

Table 16: Gender differences in Domain VI Participation & social inclusion

Domain	Indicator	SE	FI	SI	IE	AT	PT	UK	ES	SK	CH	IT	PL
VI. Participation & social inclusion	Have access to public spaces	1.13	0.86	0.81	0.70	1.09	0.84	0.86	0.94	0.81	n.a.	0.76	0.89
	Not feeling lonely	0.90	0.97	0.83	0.86	0.82	0.90	0.89	0.90	1.08	0.98	0.72	0.75

In nearly all countries (the exceptions being Austria and Sweden) men are more likely to report easy access to public spaces and basic services. The gender difference is most pronounced in Ireland, Italy, Slovakia and Slovenia. There are several possible factors that could explain these differences. Older men survive to later ages in better health (also due to selection because of higher early mortality) and may thus be more able to access services even in the presence of obstacles, as multi-morbidities are an important predictor of use of social participation (Galenkamp et al., 2016). Informal caregiving, particularly of high intensity, can also be a factor impacting access to some activities (including leisure) and this, too, is highly gendered (Dunn & Strain, 2001; Lahaie et al., 2012). Prevalence of loneliness is also consistently lower among men than among women. Living arrangements, particularly living alone, is a strong predictor of loneliness, even in the presence of broader social networks (Davidson & Rossall, 2015). Given the higher share of older women who live alone, the fact that they are more likely to report loneliness is thus not surprising.

Regarding social participation, access to public spaces remains limited among older people, despite legislative measures to make this access barrier-free. The more striking outcome in this domain is, however, the observed gender inequalities in both access to public spaces and not reporting loneliness, both of which clearly disfavour older women.

Domain VII *Freedom of expression, freedom of thought, conscience, beliefs, culture and religion* includes one indicator on personal experience of discrimination in relation to religion or belief. Overall, a very small share of older respondents (aged 55+) indicates that they have experienced discrimination or harassment based on religion or belief in the previous 12 months. Of the 12 countries, the highest shares of those reporting this can be found in Italy (6%) and Ireland (4%), closely followed by the UK and Austria (with around 3%). Information by gender is not available due to small sample sizes.

Older people in Europe report that their religious and personal beliefs are respected, making this by far the best-performing domain. This may reflect the homogeneous religious background of the present cohort of older Europeans, the long-standing separation between the State and religion in place in most European

countries (including the right to practice different religions) or an underrepresentation of religious or ethnic minorities among older people in existing surveys.

Domain VIII on the *Highest standard of health* includes two outcome indicators on access to (mostly) preventive care (influenza vaccination rates and regular dentist consultations) and one on perceived satisfaction with the attention received from General Practitioners (GPs) or family doctors reported by older people. As mentioned before, this domain shows considerable country variation among the two outcome indicators on access to health care (Table 12). Less than ¼ of older people receives this vaccination in Slovenia, Austria, Slovakia and Poland. This is well below the 75% target set by the WHO for 2010 (WHO, 2012). Vaccination rates are only marginally better in other countries, even among those countries with otherwise well-performing health care systems and high levels of GDP per capita (e.g. Sweden, Finland, Switzerland). Regular consultation with dentists is also far from a fulfilled right for the overwhelming majority of older people in the countries analysed. Sweden, Switzerland, and to some extent Austria, are the exceptions to this rule. These outcomes stand in contrast with the related structure indicator for this domain (Table 9). For the remaining indicator in this domain, there are clearly high levels of reported satisfaction with attention received from GPs by older people. This is undoubtedly a positive result as GPs and family doctors often act as gatekeepers to specialist consultations or preventive health care.

Table 17: Gender differences in Domain VIII Highest standard of health

Domain	Indicator	SE	FI	SI	IE	AT	PT	UK	ES	SK	CH	IT	PL
VIII. Highest standard of health	Received vaccination for influenza	1.04	n.a.	0.70	1.04	0.85	0.95	0.98	0.92	0.98	n.a.	0.99	0.78
	Have regular consultation with dentist	1.03	n.a.	0.97	n.a.	0.95	1.09	n.a.	1.07	n.a.	0.96	1.00	0.91
	Satisfaction with personal attention received from GP/ family doctor	0.97	0.99	1.00	1.01	1.04	1.11	1.02	1.03	0.96	n.a.	1.03	1.04

Vaccination rates for influenza show significant gender inequalities, which more often are to the disadvantage of women (Table 17). It is important to bear in mind that unlike the figures for the general population reported above, which are based on administrative data, the breakdown by gender is based on survey data and therefore not strictly comparable (see Annex Table 2 for detailed sources). However, the literature has thus far produced mixed findings regarding the relevance of gender as a determinant for vaccination rates (Blank et al., 2008; Jusot et al., 2012). Gender breakdown for regular dental care consultation is not available for many countries, but gender inequalities do not follow a clear geographical pattern. Moreover, gender inequalities in regular dental care do not seem to mimic those observed in influenza vaccination either (e.g. Portugal and Spain show gender inequalities of opposing sign in these two indicators). As for satisfaction with attention by GPs or family doctors, gender inequalities are relatively small.

Older people report an overall good satisfaction with quality of care provided by GPs, who are often their point of contact with health care. This, however, does not translate in greater access to preventive health care, such as influenza vaccination and dental care. This is also in spite of legislation stipulating equal access to care in most countries. Barriers to access include out-of-pocket payments, but also ageism or missed opportunities for vaccination (Jusot et al., 2012.). Taken together, these barriers hint at the limits of achieving full health care access through legislation alone.

Domain IX on *Adequate standard of living* has two outcome indicators: the percentage of older people not in relative poverty (i.e. with incomes above the 60% median or at-risk-of-poverty threshold), and the share of older people not experiencing severe housing deprivation.[24] In addition to the relatively good performance of countries on these indicators, results show little variation across the 12 countries. In terms of relative poverty, the share of older people aged 65 or more that are not at risk of poverty, ranges from 75% in Switzerland to 94% in Slovakia. Similarly, the proportion of older people not affected by severe housing deprivation is close to 100% in most countries. Nevertheless, it affects around 6% of the older population in Poland, while in Italy, Slovakia and Portugal the share of those facing severe housing deprivation is between 2% and 3%.

Table 18: Gender differences in Domain IX Adequate standard of living

Domain	Indicator	SE	FI	SI	IE	AT	PT	UK	ES	SK	CH	IT	PL
IX. Adequate standard of living	Not experiencing housing deprivation	1.00	1.01	0.99	1.00	1.00	0.99	1.00	1.00	1.00	1.01	1.00	0.98
	Not in relative poverty	0.88	0.92	0.87	0.98	0.94	0.95	0.94	0.99	0.98	0.93	0.95	0.93

Women are more likely than men to experience poverty in all 12 countries. The gender difference is highest in Slovenia and Sweden with over 10 percentage points, and smallest or close to non-existent in Spain, Ireland and Slovakia. Women are more likely to live longer and, because of this, to live alone. Those in retirement therefore tend to find their income diminished. In addition, their lower lifetime earnings – very often due to domestic work, part-time employment and career breaks resulting from caring responsibilities - tend to be reflected in lower pension entitlements. The gender difference in housing deprivation is very minor by comparison. With 2 percentage points, Poland records the largest gap.

What stands out regarding the standard of living of older people is not so much its lack of adequacy, but the gender differences, particularly in the risk of poverty. Older women continue to be in a relatively unfavourable position *vis-à-vis* older men, and while this picture may be attenuated in following cohorts (in which life-time labour market participation of women would be higher), it still highlights the need for gender-sensitive policies, including widowhood pensions to attenuate these differences.

Finally, **Domain X *Remedy & redress*** contains two outcome indicators on the percentage of older people who are aware of their rights and redress mechanisms and the percentage of older people who would know their rights in the event of discrimination or harassment. Overall, this is one of the domains with the lowest outcomes. Only a very small minority of older people are aware of their rights and mechanisms for redress regardless of the country (first indicator). In case of discrimination or harassment, it is only in Finland, Slovenia, Spain and Sweden that a majority of older people report knowing their rights (second indicator). However, even among these countries only Finland can really be considered to have a positive result, with 72% of older people reportedly knowing their rights in such situations. A gender breakdown of results is not possible due to small sample sizes.

There is an overall low awareness among older people in Europe of their rights and mechanisms for redress in case of harassment. This low awareness could have a deaccelerating effect in the fulfilment of other rights, if older people are unable to push for their rights.

5 Description of the methodology

5.1 Selecting and collecting information for the structure and process indicators

The indicators that comprise the 10 domains of the ROPI were selected based on the structure and process measures that were identified during the previous phases of the project (Schulmann et al., 2018a; 2018b). Indicators are defined as "A quantitative or qualitative factor or variable that provides a simple and reliable means to measure achievement, to reflect changes connected to an intervention, or to help assess the performance of a {development} actor" (OECD, 2002: 25). In the case of the structure and process indicators selected for the ROPI, the information gathered was mostly, although not exclusively, of qualitative nature. In order to standardize the information across indicators and domains, each corresponding structure and process indicator has three categories (numbered from 1 to 3, with a higher category number denoting better standards and leading to higher scores) to allow ranking of countries' performance on the specific matters – see section 5.2 below.

The list of indicators was finalized through desk research and multiple rounds of internal discussion and consensus-building within the research team. The guiding principle was that the selected indicators had to correspond to the integrity of the original set of rights and measures included in the framework to assess adequately the fulfilment of the rights of older people (Schulmann et al., 2018b). One of the biggest challenges in developing the indicators has been formulating indicators which can provide meaningful information on the protection, monitoring and fulfilment (or not) of the human rights principles identified in the conceptual framework.

The presented list of indicators is the result of analysis of the literature on the topic to date, expert input and careful consideration by the research team. The overarching aim was to maintain both *adequacy* (in terms of what the selected indicators can measure under each domain) and *feasibility* (in terms of how they can be best populated with existing, comparable, good-quality data). In some cases, structure or process indicators were not identified for a certain domain/key theme (e.g. in Domain VI).

The original intention was to match structure and process indicators with outcome indicators that measure the same issues/themes under each domain (see section 6.2). This, however, was not possible for all domains, due to the lack of available data. An example for matching indicators is Domain IX *Adequate standard of living*, which includes:

- a structure indicator, measuring legislation ensuring the right to adequate housing for all, including all dimensions of housing, i.e. affordability, quality, and security of tenure;
- a process indicator on housing support for older persons (either linked to old age pension, or provided as part of social assistance) and
- an outcome indicator on the share of older persons not reporting housing deprivation.

Having selected the indicators, the information was gathered through desk research of existing databases (e.g. EU Mutual Information System on Social Protection: MISSOC) and reports published regularly by international organisations (e.g. annual reports by Alzheimer Europe or the European Network of Equality Bodies). It was complemented by primary data collection through means of a questionnaire sent to national experts selected from among relevant Ministries or public bodies (including universities and research centres) in each of the participating countries. Information for 23 out of the 35 ROPI indicators was collected through expert questionnaires. A detailed list of sources for each indicator is presented in Annex Table 1. The questionnaire required national experts not only to provide a grade for each indicator (see section 5.2 below), but to justify or present evidence (e.g. reference to legislation or other documents, or description of regulations or procedures) to support the grade attributed. In the case of secondary data gathered through desk research, the research team assigned the grades to each country.

The information thus gathered was then validated by the team of experts. The grade attributed to a country in each indicator was independently checked against the information collected by two members of the research team. Disagreements on grades were solved through consensus or by a third member of the research team. The validation focused on checking the consistency between the provided descriptions and the allocated scoring and in principle aimed to ensure consistency between the scoring of countries (countries with similar standards should obtain the same score). [25] The guiding principle in our validation process of the primary data - collected through the expert questionnaires – was that first and foremost we relied on the input from the country experts. This means that in cases where the provided description was not fully satisfactory (or thorough), but in general provided at least a brief explanation of the choice of score, we accepted the scoring proposed by the expert with an insertion of an asterisk (*). In cases where there was inconsistency between desk research and information provided by the country experts (e.g. where the structure indicator was populated through desk research, but the process indicator through country expert input), the validation inclined towards the input of the expert.

During the validation process, the category ‘not available’ (n.a.) was introduced for cases in which it was not possible to allocate a score to the country:

- In case of primary data collection (expert questionnaires), when the country expert did not provide us with scoring, nor description.
- When the country expert allocated a score higher than 1, but the field in the questionnaire for the explanation was left empty.
- When the country expert identified the issue as a regional competence, but we were unable to obtain the information from the capital region.
- In case of secondary data collection (desk research), when the country was not part of the data source.

Finally, some of the legislation or procedures in some countries is within the realm of competences of local or regional levels of government. In these cases, the capital region or municipality was selected as proxy. This issue occurred in four participating countries: Austria, Italy, Spain and Switzerland.[26]

5.2 Aggregating the index

A key criterion in selecting the most suitable method for constructing the ROPI was that it should be in line with the conceptual framework and thus, enable the monitoring and assessment of government actions in upholding the rights of older people with regard to care and support needs. In addition, the chosen method should allow for the resulting index to be easily replicable (in the context of Europe and other developed countries), transparent and simple to understand. After a careful consideration of various aggregation and weighting methodologies and reviewing existing index constructions (e.g. OECD, 2008; Bradshow & Richardson, 2009; Klugmann et al., 2011; Zaidi et al., 2012; Huddlestone et al., 2015; Schulmann et al., 2018b), an aggregation method based on the geometric mean and a weighting method using equal weights were adopted.

The building of the index can be summarised in the following methodological steps:

1. First, for each indicator, the information collected through country experts and desk research is coded using the 1,2,3 category scale described earlier.
2. Second, for each domain, the geometric mean of individual indicator values is calculated assuming equal weights.
3. Third, the overall index value is obtained by aggregating the domain values using the geometric mean of each domain (again assuming equal weights).

To help interpretation of the final index and domain scores and make the subsequent country rankings more perceptible to the eye, colour-coded score-ranges (3.0-2.6, 2.5-2.1, 2.0-1.6, 1.5-1.0) are used. The highest performance band has been coloured dark green, while scores in the lowest range are marked red for needing the most improvement.

The choice of not assigning explicit weights either at the indicator or the domain level is in line with the conceptual framework according to which each identified domain and measure is of great importance in measuring older people's rights. The decision not to assign weights to domains also reflects the prevalent view of indivisibility of human rights (Schulmann et al., 2018b). However, as the domains are made up of a different subset of indicators, this implicitly means that the more indicators there are in a domain, the less implicit weight each individual indicator has. To assess the impact of imposing unequal weights (in this case based on expert opinion), as well as the impact of different aggregation methods on the index, a sensitivity analysis was carried out. The results are presented in the following section.

5.3 Sensitivity analysis

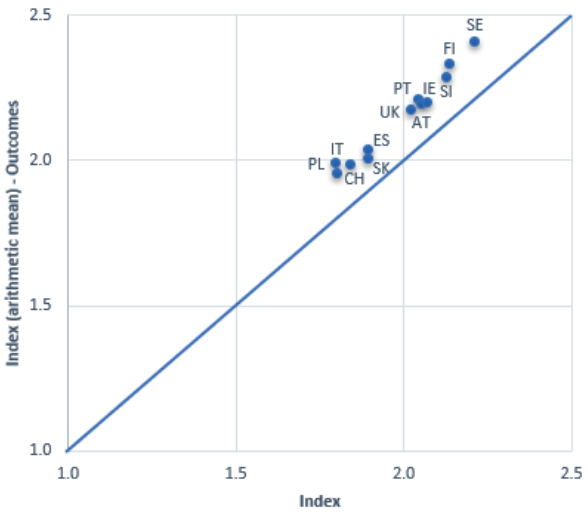
A sensitivity analysis was carried out to assess how different the ROPI scores and the country rankings are when using alternative methods of aggregation and weights. For each of these sensitivity analyses, results are presented in the form of graphs to aid the visualization of results. These graphs depict both the absolute impact (i.e. how much the score of the index changes for each country) and the relative impact (i.e. how much the country rankings change) of the different methodology choices. Finally, an assessment of how correlated the scores between each domain and the ROPI are, was also carried out.

In the following graphs (Figures 3 to 4), the distance between the dot for each country and the 45-degree line that transverses each graph represents the difference between the absolute value of the score (left-hand-side graph) or the ranking (right-hand-side graph) of each country under different methods. When the dot is above (below) the 45-degree line on the left-hand-side graphs, this means that a given country's score with the alternative method is higher (lower) than under the ROPI. For the right-hand-side graphs, the opposite holds: countries above (below) the 45-degree line have a higher (lower) ranking with the ROPI than with the alternative method.

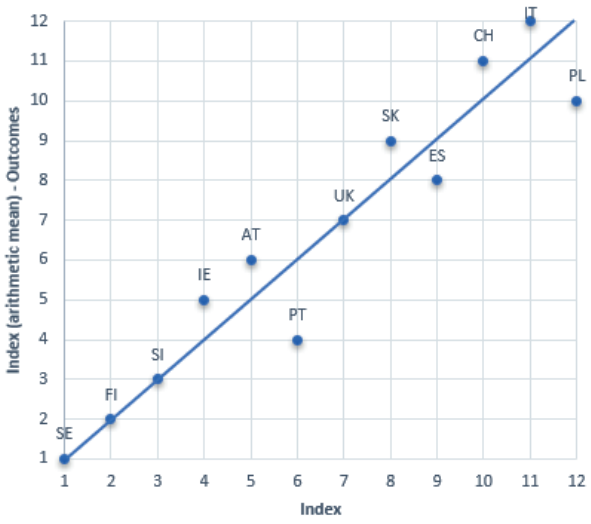
Beginning with the sensitivity analysis of different aggregation methods, Figure 3 shows how sensitive the ROPI is to use either the arithmetic or geometric mean to aggregate the domain scores (the latter is the one used in the ROPI). The geometric mean penalizes countries with lower scores in a given domain, which explains why on average the ROPI scores are lower than those that would have been obtained with an arithmetic mean (left-hand graph Figure 3). The ranking of countries is also affected, although the three top-ranking countries remain the same under both methodologies. However, among the countries that would have seen their rank position change, only Portugal would change more than one place in absolute value (from 6th place under ROPI to 4th place if the index was calculated using the arithmetic mean). We can, therefore, still consider the ROPI ranking to be relatively stable to changes in the aggregation method.

Figure 3: Sensitivity analysis for different methods of aggregation: arithmetic mean and geometric mean (ROPI)

Difference in the score of ROPI



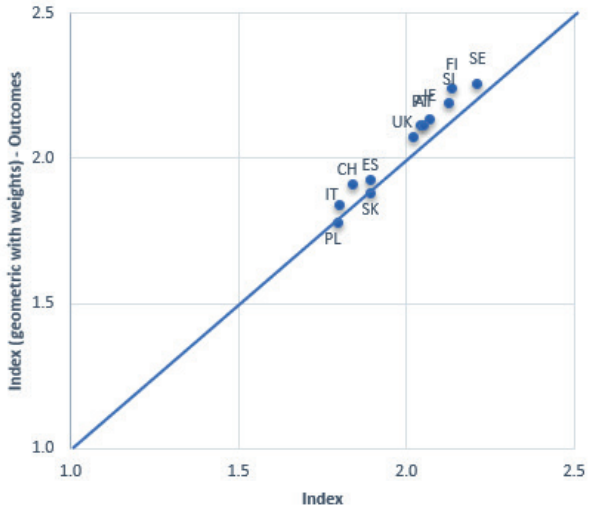
Difference in the ranking of countries



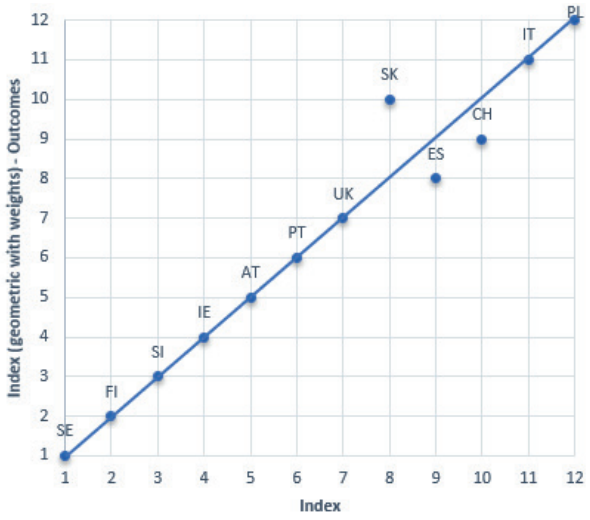
The ROPI does not use weights in its calculation. However, in the DELPHI study that validated the measures to be included in the ROPI, experts were also asked to rank the ten domains by allocating 100 points across them (Schulmann et al. 2018b: 9). The resulting allocation was then transformed into weights per domain, which were used to calculate the weighted geometric mean of the scores of all domains. The impact of the weights on the ROPI scores is relatively small both in absolute and relative terms (Figure 4). In fact, in comparison with using different aggregation methods (Figure 3 above), the ranking of countries changes the least when using weights (i.e. the number of countries that do not change their ranking position – depicted on the 45-degree line – is the highest). Only Slovakia, Spain and Switzerland change their rank when using weights.

Figure 4: Sensitivity analysis for impact of using expert-defined weights on the ROPI

Difference in the score of ROPI



Difference in the ranking of countries



Finally, the relationship between the domains and between each domain and the index is explored using the Pearson correlation coefficient or Pearson's r. As can be observed below (Table 19), there is a strong association (r >|0.5|) between the ROPI and Domains I (*Equal access to & affordability of care & support*) , II (*Choice, legal capacity & decision-making capacity*), VI (*Participation & social inclusion*) and VII (*Freedom of expression, freedom of thought, conscience, beliefs, culture & religion*). The correlation is moderate for Domain VIII *Highest standard of health* and otherwise weak (r<|3|) for all the remaining domains.

Regarding the relationship between the domains, they mostly appear to be only weakly associated with each other. Nevertheless, there is a strong correlation between Domain X *Remedy & redress* and Domain IV *Life, liberty, freedom of movement & freedom from restraint*, where the coefficient is the highest in absolute value (-0.577), between Domain VI and Domain II, between Domain V (*Privacy & family life*) and Domain IV, and finally between Domain VII and Domain I.

Table 19: Pearson correlation coefficients between domains

	Domain I	Domain II	Domain III	Domain IV	Domain V	Domain VI	Domain VII	Domain VIII	Domain IX	Domain X
I.	1.000									
II.	0.298	1.000								
III	0.188	0.381	1.000							
IV.	-0.290	-0.158	0.006	1.000						
V.	-0.049	-0.141	-0.406	-0.544	1.000					
VI.	0.234	0.544	-0.041	-0.164	-0.016	1.000				
VII.	0.505	0.409	0.040	-0.066	0.387	0.391	1.000			
VIII.	0.218	0.386	-0.084	-0.371	0.075	0.358	0.269	1.000		
IX.	-0.143	0.261	0.229	0.372	-0.341	-0.303	-0.059	-0.251	1.000	
X.	0.272	-0.032	-0.315	-0.577	0.257	0.012	-0.006	0.229	-0.099	1.000
ROPI	**0.543**	**0.716**	**0.245**	**-0.016**	**0.061**	**0.517**	**0.867**	**0.478**	**0.105**	**0.025**

5.4 Selecting and collecting information for the Scoreboard on Outcome Indicators

The set of outcome indicators used for the scoreboard was selected on the basis of the outcome measures that were identified during the previous phases of the project; in the course of the conceptual framework development and in consultations with experts (Schulmann et al., 2018a; 2018b). Besides the criteria outlined in the conceptual framework and the value-ratings of indicators of the two Delphi survey rounds, attention was given to data quality issues when deciding about inclusion of indicators.

A key factor for the choice of indicators was the international comparability of indicators across European countries. This criterion made European comparative datasets, such as the European Statistics of Income and Living Conditions (EU-SILC) from Eurostat, the Survey of Health, Ageing and Retirement in Europe (SHARE), the European Social Survey (ESS) and the European Quality of Life Survey (EQLS) from Eurofound, the primary datasets from which indicators were derived from. Additional data sources, such as Eurobarometer Surveys, were used only in cases when information on the selected indicator was not available or sufficient from either of our primary data sources. Relying on the above-mentioned datasets as our main sources for data also ensures broad coverage of European countries, another key criterion in the indicator selection. For instance, Eurostat, SHARE, ESS and the EQLS collect information on non-EU countries, in addition to EU Member States.

It was also considered important that the selected indicators are comparable over time, are collected regularly, and are likely to be available in the future so as to ensure consistency in monitoring trends in the years to come. By implication, this would exclude indicators which are available only from special studies, such as Special Eurobarometer surveys or ad-hoc modules of EU-SILC, which are conducted on a rotating basis, but at relatively large time intervals (often exceeding five years). On the other hand, these data provide valuable information that is simply not available in general surveys or is only collected in European surveys which have limited country coverage. Therefore, it was decided that indicators for which data was collected by Special Eurobarometer surveys (e.g. on discrimination and rights awareness) and EU-SILC modules (i.e. data on contact with family), are to be included in the scoreboard.

To further assess the timeliness of indicators, their currency (i.e. how recent are the data) and accessibility were regarded as necessary conditions. This entails that indicators are collected and disseminated at reasonably short time intervals and allow for estimations using the most recent data. In terms of accessibility, statistical information for some of the selected indicators is readily available from online databases (e.g. Eurostat) and access to micro-data for the surveys used is possible for all indicators of our choice.

Last but no less important is that the chosen indicators fulfil the statistical requirements of accuracy, reliability and validity. One issue that should be highlighted in this regard is that some of the indicators are based on subjective responses. This may limit comparability due to cultural factors that influence the way in which people perceive and assess, for instance, being discriminated or the extent of autonomy or feelings of loneliness. Again, these data provide information that is extremely relevant for the analysis and monitoring of older people's rights and vulnerabilities, and which is not available in standard 'objective' data. For these reasons, subjective variables were included unless they were matter of serious concerns about their quality.

Applying the above-described criteria led to the following set of indicators, listed in Box 4 below.

Box 4: Indicators selected for the Scoreboard

I. Equal access to & affordability of care & support

- Share of female older persons (65+) with care or support needs (with at least one ADL or IADL OR limitation in usual activities due to health problem) receiving care (all forms of care) (OECD, latest year)
- Share of male older persons (65+) with care or support needs (with at least one ADL or IADL OR limitation in usual activities due to health problem) receiving care (all forms of care) (OECD, latest year)
- Share of older persons (65+) with at least one ADL or IADL limitations who report having access to housing modifications and assistive devices (SHARE, 2015)

II. Choice, legal capacity & decision-making capacity

- Share of older persons (65+) with ADL limitations reporting they feel free to decide how to live their lives (EQLS, 2016)
- Satisfaction of older persons (65+) with ADL limitations with the quality of long-term care services in their country (EQLS, 2016)

V. Privacy & family-life

- Share of older persons (65+) reporting at least weekly interactions with family (relatives) (EU-SILC, 2015)
- Share of older person's (55+) who trust in health and medical institutions to protect their personal information (Eurobarometer, 2015)

VI. Participation & social inclusion

- Share of older persons (65+) reporting not having difficulties in accessing public spaces and essential services (EQLS, 2016)
- Share of older persons (65+) reporting not feeling lonely (ESS, 2014)

VII. Freedom of expression, freedom of thought, conscience, beliefs, culture and religion

- Share of older persons (55+) that have not felt personally discriminated or harassed on the grounds of religion or beliefs in the past 12 months (Eurobarometer, 2015)

VIII.Highest standard of health

- Share of older persons (65+) who received immunization for influenza (Eurostat database, latest year)
- Share of older persons (65+) who reported consultations with a dentist in the past 12 months (SHARE, 2015)
- Satisfaction of older persons (65+) with the personal attention they receive from their GP or family doctor (EQLS, 2016)

IX. Adequate standard of living

- Share of older persons (65+) not reporting housing deprivation (EU-SILC, 2016)
- Share of older persons (65+) not in relative poverty (EU-SILC, 2016)

X. Remedy & redress

- Share of older persons (55+) who report to be aware of their rights and existing redress mechanisms (Eurobarometer, 2015)
- Share of older persons (55+) who would know their rights if they were the victim of discrimination or harassment (Eurobarometer, 2015)

5.5 Limitations in selecting and populating the ROPI and the Scoreboard

Without an existing international human rights framework on the rights of older people, the indicators were selected and finalised based on the input provided by the selected experts during the two-round Delphi-survey and multiple rounds of internal discussion (Schulmann et al., 2018b). Expert participants for the DELPHI were recruited with a view to achieving geographic, disciplinary and institutional diversity. Despite all efforts to include all relevant stakeholders, no representative organisation of persons with disabilities (DPOs) participated, therefore the voice of this important stakeholder group for the purposes of the project was only represented through service providers (the European Association of Service Providers for Persons with Disabilities).

The process of gathering information on the indicators highlighted the lack of comprehensive European data sets on the rights of older people in all 10 domains. There were several indicators where relevant disaggregated data was available for persons with disabilities but not for older persons. This derives at least partly from the obligations under Article 31 of the UN CRPD that requires States Parties to "collect appropriate information, including statistical and research data" to implement the Convention and formulate adequate policies for persons with disabilities. In some very limited instances, European databases on the rights of persons with disabilities (e.g. ANED) could be used to populate the indicator (e.g. on indicators relating to legal capacity or access to assistive devices), if it was explicitly mentioned that the data referred to people without age limit.

In order to populate all indicators, it was necessary to reach out to national experts, including the public administration of each participating country. As the questionnaire spans several policy areas and requires coordination among various departments, it was up to the relevant Ministries to select the most suitable experts to compile the necessary information. The questionnaire distributed to national experts required them to provide a description of their choice of grade for each indicator. The descriptions were key to validate the received information and allowed the research team to analyse the results. However, the length and quality of these descriptions varied greatly and may influence some results, despite the efforts taken to ensure accurate, clear and comparable information.[27] In some cases, the originally allocated scores by the country experts have been modified after careful consideration by the research team. In cases where the domain is composed of few indicators, missing information has significant impact on the overall domain results.

It is important to bear in mind when interpreting the outcome indicators that the surveys from which they were derived from cover only people living in private households. Consequently, older people living in residential care are not captured by the surveys. This disproportionately affects those at the oldest age spectrum and those with typically high care needs. In addition, the exclusion of older people living in care homes from the samples has an impact on between-country comparisons as the size of the residential care population may differ considerably from one country to the next. The problem of coverage also extends to certain vulnerable groups of older people including older people with disabilities, older migrants or those from ethnic minorities who are likely to be underrepresented because they are not easy to reach.

Although the datasets we relied on allow for a sufficiently large sample size to study the older population, in the case of some indicators samples at the country level are too small to provide detailed outputs (see section 6.2).

Finally, it is also important to note that the final list of indicators presented in our index and scoreboard is not exhaustive. Further indicators could be added to measure the fulfilment of the rights of older persons with care and support needs in a more comprehensive way.

6 Discussion and recommendations

6.1 Discussion

This report presents the results of the ROPI on structure and process indicators and the Scoreboard for Outcome Indicators for 12 European countries: Austria, Finland, Ireland, Italy, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden, Switzerland and the UK. By bringing together legislation and policies, on the one hand, and actual outcomes, on the other hand, it allows for the assessment of entitlements (Sen, 1984) and the fulfilment of rights of older people in need of care and support.

The results for the ROPI show considerable room for improvement in most countries. The ROPI scores range from 1 to 3, which means that even the frontrunners only score about in the middle of this range (e.g. Sweden has a 2.2 overall ROPI score). The scope for improvement seems to be greater, on average across countries, for domains IV, V, IX and X. Domain IV refers to the use of restraints and the results show that legislation or guidelines on the use of restraints (physical or chemical) are still missing, or at best confined to institutional care. Not to mention the leeway afforded by legislation or guidelines when they are implemented – this was not directly assessed by the ROPI. A report by the OECD shows that although the use of physical restraints in care homes is minimal among people with good cognitive and physical function, it is as high as 9.5% (Belgium) and 23.1% (Italy) among those with poor physical function and good cognition and poor physical and cognition function, respectively (OECD, 2013: 113). Just as relevant, country differences were extremely high with physical restraints all but inexistent in the UK, clearly hinting at the effect of national policies. In Domain V, the concerns focus on the lack of sufficient safeguards (both legislation and guidelines) to allow older people living in institutions the possibility to maintain their family or community life. In this case, as well as in the use of restraints, the existing gaps highlighted by the ROPI focus on older people living in institutions. This is a particularly vulnerable group of older people and these gaps are therefore even more relevant.

Regarding Domain IX, it is mostly the entitlement to adequate and affordable housing for older people that is found missing. Although home ownership is relatively high among the present cohort of older people in many European countries, home ownership is *par excellence* an indicator that reflects life-course trajectories, circumstances, opportunities and constraints. Home ownership is likely to have strong imbedded inequalities and the absence of clear rights likely to be particularly damaging for the most vulnerable among older people who often are not home owners. Finally, in Domain X there are not many age-specific mechanisms in place to promote, protect or raise awareness of the rights of older people. Furthermore, the available complaint mechanisms are often not specifically accessible for older people to claim their rights in case of breaching.

Conversely, the ROPI showed the best results in the domains pertaining to *Participation & social inclusion* – which included legislation on accessibility of public spaces, for example – and *Freedom of expression, freedom of thought, conscience, beliefs, culture and religion*. In the area of social inclusion, recent developments in the human rights protection of persons with disabilities in the area of accessibility policies and deinstitutionalisation probably contributed to this positive result.

One important finding of the analysis carried out is the disconnection often found between the rights that are granted by legislation and the outcomes that are observed. In other words, the discrepancy between some of the domain scores in the ROPI and the outcome indicators displayed in the scoreboard. Domains I, VI and VIII stand out as domains where apparent generous entitlements do not fully translate into fulfilment of rights.

Regarding access to care and support (Domain I), the ROPI showed limited restrictions of age, gender, income or geography inscribed in the law. The reality is, however, different, due to strict needs assessment for publicly-financed LTC services or adapted housing, means-tests (in countries reporting restrictions based on income) and *de facto* geographical inequalities in LTC supply. In the majority of countries, a very limited share of older people with activity limitations receives the care and support they need through state support (Rodrigues et al., 2012; EPC-AWG/EC, 2018); while fully private solutions demand too high co-payments from users (Muir, 2017). In access to health care (Domain VIII), the barriers to access seem to go beyond high co-payments and include ageism and missed opportunities for vaccination, despite equal access being a key feature of legislation and policies in this area. In social participation (Domain VI), the disconnect is between the legislation and procedures on accessibility to public spaces and reported accessibility by older people. A closer look at the outcome indicators shows that it is mostly public transportation and indoor recreational spaces (e.g. cinemas and theatres) that are reported as relatively inaccessible public spaces, even though the former is covered by legislation in the countries analysed. The discrepancy seems to affect particularly women and is in line with gender differences found in social participation among older people in general (Galenkamp et al., 2016). This could signify that the barriers in accessing some public spaces may reflect gendered roles (e.g. in informal care) or gendered power structures much more than just physical hurdles. As financial resources act as a lever to fulfil other rights and are essential to ensure people's freedom and agency (Sen, 1984), these limitations are particularly relevant.

At the same time, some outcomes were also better than the underlying legislation and procedures. This is clearly the case for adequate standard of living, both in terms of relative poverty and housing deprivation (Domain IX). However, even in this case, the lack of legislation underpinning adequate standards of living is nonetheless a cause for concern. While the majority of older people may experience adequate standards of living, lack of an adequate legal framework may leave those at the margins – the minority not experiencing good outcomes – in a particularly vulnerable situation to see their rights fulfilled. Furthermore, this is also a domain with clear gender inequalities, again disfavouring women, for which gender-sensitive legislation could make an important difference – see the case of widowhood pensions.

In Domain X *Remedy & redress* both the ROPI and outcomes concurred: both showed countries faring badly. There has been some expectation that newer cohorts of older people will be more aware of and also demanding their rights, as they have come of age in a consumerism society. For the current cohort of older people, however, awareness of rights remains low, which could further hamper the fulfilment of other rights.

In terms of gender, there are three main findings arising from the Scoreboard on Outcome Indicators. The first refers to indicators where there is a clear gender gradient (i.e. one gender is systematically better-/worse-off), such as access to long-term care services, feeling lonely or having sufficient material resources. In these cases, gender is a determinant of the outcomes observed, placing women or men at a systematic disadvantage because of their gender. The second finding refers to indicators with pervasive gender inequalities but without a clear pattern. This is the case for access to housing modifications or indicators pertaining

to agency (Domain II), for example. In these cases, the causes of gender inequalities seem to be more country-specific. The third finding refers to inability to have a gender breakdown among older people for many of the indicators used, most notably due to low sample sizes. This, too, signals a gap in the mainstreaming of gender in public policy.

In any case, the consistency of both good and bad outcome indicators across countries for a given domain in the scoreboard – i.e. the fact that all (or nearly all) countries either perform well or badly across a given domain – is somewhat a remarkable finding given the mix of countries included in this study. Whether this pattern holds will be tested once more countries are included in the ROPI and scoreboard. However, as it stands, it seems that certain domains consistently stand as *laggards* and *frontrunners* in terms of rights of older people in need of care and support. The domains lagging behind should stand as priorities for policy-makers committed to improving the rights of older people in need of care and support.

6.2 Gaps in data

Despite the relevance of care in the context of ageing societies, there is still a dearth of indicators related to older people in need of care and support, specifically on long-term care. For example, long-term care indicators are for now not included in the Social Scoreboard of the EU (European Commission, 2017). One of the outcomes of this study was to expose the data gaps currently existing in this area.

A good overview of the existing data gaps is given when comparing the measures that were validated in the DELPHI study (Schulmann et al., 2018b) and the indicators included both in the ROPI and scoreboard. The gaps were arguably more visible in the scoreboard – as it relied on existing secondary data. Among the data gaps uncovered are those related to indicators on quality of long-term care, such as the use of physical or chemical restraints. While several countries collect these data (cf. OECD, 2013), the geographical coverage is still limited. Similarly, on elder abuse the only data on prevalence is that collected by reviews, with little or no country information (Yon et al., 2017; Yon et al., 2019). Similarly, the comparability of data from national-based studies on the prevalence of elder mistreatment may be hampered due to the absence of systematic and regular data collection and lack of standardised definitions used (WHO, 2014). Indicators on general satisfaction with care received are available, but other indicators on the degree of choice afforded by long-term care systems are not. Self-reported information on out-of-pocket expenditure is collected in several surveys (e.g. SHARE), but the figures reported point to possible incongruences with data on the amount of care received. Similarly, data disaggregation on some expenditures is also missing (e.g. public resources devoted to the deinstitutionalisation process across Europe).

One sub-population that has been systematically left out of surveys Europe-wide and for which only limited data exists, are those in institutional care. Besides the aforementioned examples of use of restraints and elder abuse, data on maintaining family life is fundamentally missing – the indicator on the scoreboard refers to contacts with the family for those older people living in their home, as no such indicator exists for institutional care.

Finally, another transversal data gap is the lack of disaggregation of indicators on basic socio-demographic variables such as gender (e.g. for Domain X in the scoreboard) or income. While several European-level surveys collect valuable information on older people, sample sizes are often limited unless older people are

over-sampled. This is an issue that is also liable to affect the accuracy and reliability of results. The issue of sample size is particularly relevant for those sub-groups that are concentrated among the oldest-old, such as those using long-term care services. For instance, information on indicators from Eurobarometers could only be retrieved for the 55+ population and without gender breakdown. Also, while the 2016 EQLS collects valuable information on quality of care services, which is not available in other comparative datasets, samples for some survey items (e.g. inquiring respondents about certain aspects of long-term care services used, such as being informed or consulted about care) were too small to provide reliable estimates and were therefore not included among the outcome indicators.

6.3 Policy recommendations

Policy-making at the national level is fundamental to create the necessary structures as well as social and health care services that are accessible to older people with care and support needs and are in line with their human rights. Some key policy recommendations arising from the results of the ROPI and the Scoreboard on Outcome Indicators are:

- It is important to collect more disaggregated data along the 10 domains presented in this study. For example, indicators on long-term care as one of the principles of the European Pillar of Social Rights could be included in the Scoreboard of the European Commission.[28]
- In domains where the results of the outcome indicators do not exactly match the results of the structure and process indicators, more research would be needed to better understand the impact of the existing legislation and policies on the quality of life of older people.
- Mainstreaming the challenges and needs of older people in policy discussions both at the EU and national levels that feed into cross-European developments, like the European Pillar of Social Rights, is essential. Older people and their representative organisations should be directly involved in decision-making processes affecting their life.
- More efforts should be made to have measures tailored to the specific needs of the older population, for instance in the areas of remedy, prevention and community-based support, among others. These measures should place specific focus on those who are in institutional care.
- There are several areas where the achievements of the disability rights movement could positively impact the protection of the rights of older people (e.g. supported decision-making systems, or transition from institutional to community-based care), with special regard to the growing number of people with Alzheimer's disease and dementia. Yet, it requires further research to understand to what extent these legal guarantees are implemented and whether older people have real choice and control over the type of care they want to receive.
- This index covers both residential and home-based care settings where older persons receive care or support. It is important to ensure that both institutional and home-based services are regularly monitored to avoid violence and abuse and to assess if there are any differences in terms of the protection of human rights and available monitoring mechanisms.

- During the implementation of the Agenda 2030, policy-makers and other stakeholders should pay attention to the needs and situation of older people. While none of the Sustainable Development Goals are explicitly focusing on older people, considering the rapidly growing ageing population and intersectionality with many of the SDGs, it is important to respond to the needs of those with care and support needs in a sustainable way, but also keeping the human rights approach in mind.

7 Conclusions

This report presents the results of the ROPI on structure and process indicators and the Scoreboard on Outcome Indicators for 12 European countries: Austria, Finland, Ireland, Italy, Poland, Portugal, Slovakia, Slovenia, Spain, Sweden Switzerland and the UK. As it was discussed throughout the report, the list of indicators is the result of analysis of the literature on the topic to date, expert input and careful consideration by the research team. The ROPI and the scoreboard contribute to fill an important gap, as multi-dimensional tools to monitor the situation of older people with care and support needs, based on a human-rights approach. Compared to other existing composite indices, the ROPI and the Scoreboard on Outcome Indicators enable an assessment of legislation and policies and link structure and process indicators to outcomes. Furthermore, the ROPI and the Scoreboard on Outcome Indicators highlight gaps in legislation and the implementation of policies, as well as gaps in data.

The selected countries represent a wide geographical mix within Europe with different care systems in place, however, the growing ageing populations pose similar challenges everywhere. Despite the differences in the economic and social status of the countries, it is somewhat surprising that there is no greater variation in the countries' performance to promote and protect the rights of older people with care and support needs. Notably, none of the countries belongs to the highest or to the lowest score range on the overall index and there is no obvious geographical clustering in the overall ranking results. Positive or negative patterns were more apparent among the domains. For instance, most countries need to make significant improvements in the areas of *Life, liberty, freedom of movement & freedom from restraint, Privacy & family life, Adequate standard of living*, and *Remedy & redress.* Another important finding was the apparent frequent disconnect between the rights that are granted by legislation and the outcomes that are observed in the countries, especially in the areas of social inclusion and access to care and support.

During the process of populating the indicators, several gaps in existing data sets were uncovered. In order to improve the knowledge about the fulfilment of the human rights of older people, more data on key indicators (e.g. elder abuse, outcomes of care), special groups in the population (e.g. those living in residential care settings) and further disaggregation (e.g. on gender, enabled by larger sample sizes and surveys over-representing older people) should be collected at European level. The needs of older people should be mainstreamed across European policy discussions, with special regard to the gender dimension and other intersectional issues.

As a next step, it would be important to expand the ROPI and include the remaining EU countries in the analysis. Perhaps clearer regional trends appear once the index is completed for the whole Union. Nevertheless, considering the challenges that a rapidly aging population poses on countries with weaker long-term care systems in place, it would also be worth looking at how the index could be further expanded to regions outside the EU, for instance, to the rest of the United Nations European region. When expanding the index, the list of indicators could entail some revision, or be limited in scope due to the lack of comparable data.

In order to create prosperous societies and to provide adequate responses to the demographic changes of this century, there is a need to adopt legislation and policies, as well as to invest in social and health care systems that can support older people in need of care and support. Such services must respect the human rights of all older people and ensure that they can live independently and in dignity for as long as possible.

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9 Annex

Table A1: Description and data source of structure and process indicators used for the ROPI

Domain	Indicator	Values and categories	Data source
I. Equal access to & affordability of care & support	**1.1 Restrictions in eligibility to home-based care**	Eligibility restrictions on access to home-based care services based on the following categories: a) age; b) income; c) gender; d) geographical unit (regional or local); e) sexual orientation and f) religion and personal beliefs, the assessed country has: 1. Some restrictions in most or all of the categories 2. Some restrictions in some of the categories 3. No restrictions in none of the categories	Country Expert
	1.2 Restrictions in eligibility to residential care	Eligibility restrictions on access to home-based care services based on the following categories: a) age; b) income; c) gender; d) geographical unit (regional or local); e) sexual orientation and f) religion and personal beliefs, the assessed country has: 1. Some restrictions in most or all of the categories 2. Some restrictions in some of the categories 3. No restrictions in none of the categories	Country Expert
	1.3 Provisions for assistive devices and home modifications	1. No legislation or strategy exists to cover the financing of assistive devices or home modifications. 2. Legislation or strategy exists that guarantees access to partial financing for assistive devices and home modifications. 3. Legislation, or strategy exist that guarantees access to full financing for assistive devices and home modifications.	BMASK (AT) HMS Act, SS Act (SE) PPA&CDP Act 39/2006 (ES) AANP (SK) LTSP (PL) OSCHI and HI Law (CH) Resolution on the NHCP / 2016-2025 (SI) SAPA guide (PT) HG, C&RA 1996, Care Act / 2014 (UK) HC&ISG Act, 128 / 2004/ (FI) AGOP&PD, S.I. No. 104/2014 (IE) Report on implementation of Law 112 / 2016 on Provisions of assistance in favour of people with serious disability living of family support (IT)

Domain	Indicator	Values and categories	Data source
	2.1 Percentage of GDP (or of expenditure on social services) allocated to public LTC expenditure	1. Last EU-27 spending quartile 2. Second or third EU-27 spending quartile 3. Highest EU-27 spending quartile	Ageing Report of the European Commission / 2018 (page 144)
II. Choice, legal capacity & decision-making capacity	**1.1 Legislation ensuring choice of long-term care provider**	1. No choice of care provider (e.g. different organisations) stated in the legal framework 2. Choice of care provider (e.g. different organisations) stated in the legal framework 3. In addition, the legal framework states the possibility to replace in-kind benefits with cash benefits (e.g. to employ personal carer)	MISSOC / 2018
	1.2 Legal provisions enforcing (informed) user consent	1. Existing legislation allows for unilateral decision-making from the side of care professionals with regard to the care type that can be accessed and the specific care procedures to be applied 2. Existing legislation requires (informed) consent for some types of care and care tasks, but it is not strictly binding 3. Existing legislation requires the consent of the care user be obtained for all forms of care (including for institutionalization) and for all care tasks that can be considered invasive	Country Expert
	1.3 Supported decision-making legislation	1. The legal framework is based on a substitute decision-making approach 2. The legal framework is based on a substitute decision-making approach but includes provisions in support of supported decision-making 3. The legal framework is based on a supported decision-making approach	Alzheimer Europe's Policy in Practice
	1.4 Advance Directive (AD) legislation	1. AD's are not legally recognised 2. Specific legislation on AD's exists and they are legally binding under certain conditions/in certain situations 3. Specific legislation on AD's exists and they are binding documents	Alzheimer Europe's Policy in Practice Nys H., Raeymaekers P., Rights, autonomy and dignity of people with dementia. Can competence assessment and advance directives help to find the right balance between autonomy and protection?, King Baudouin Foundation / 2013

Domain	Indicator	Values and categories	Data source
	2.1 Standard procedures or guidelines for user (and family) involvement in needs assessment and care planning	1. No guidelines or standard procedures for user involvement in needs assessment and care planning exist 2. Guidelines on user involvement in needs assessment and care planning exist, but they are optional/ voluntary for care providers or exceptions apply for specific user groups 3. National standards are in place that ensure users are actively involved in decision-making processes relative to their care	Country Expert
	2.2 Share of older persons reporting satisfaction with their level of involvement in the care process	1. Less than 25% 2. Between 25% and 75% 3. More than 75%	EQLS / 2016
	2.3 Standard procedures or guidelines for supported decision-making in care planning	1. No guidelines or standard procedures for supporting user participation in care decision-making/planning 2. Guidelines on supporting user participation in care decision-making/planning exist, but they are optional/ voluntary for care providers or exceptions apply for specific user groups 3. National standards are in place for supporting user participation in care decision-making/planning	Country Expert
	2.4 Availability of AD registry	1. No registry for AD's exist 2. A registry exists but it is either localized or specific to a particular type of AD (e.g. medical procedures, contracts) 3. A national registry exists and there is an obligation to register all AD's	Alzheimer Europe's Policy in Practice Nys H., Raeymaekers P., Rights, autonomy and dignity of people with dementia. Can competence assessment and advance directives help to find the right balance between autonomy and protection?, King Baudouin Foundation / 2013

Domain	Indicator	Values and categories	Data source
III. Freedom from abuse & mistreatment	**1.1 Legislation addressing abuse/ mistreatment of older persons**	1. There is no national legislation protecting older persons from abuse and/or mistreatment 2. There is national legislation protecting older persons from abuse and/or mistreatment in general 3. There is national legislation protecting older persons from abuse and/or mistreatment including in institutions	WHO Global Status Report on Violence Prevention / 2014
	2.1 Monitoring mechanisms against abuse/ mistreatment of older persons in care	A: There is a (independent) national or regional body carrying out regular inspections of residential long-term care facilities to establish quality of care, including incidence of mistreatment/abuse in its various forms B: There is a (independent) national or regional body carrying out regular inspections of home- and community-based long-term care to establish quality of care, including incidence of mistreatment/abuse in its various forms 1. Neither A nor B 2. Only A or B 3. Both A and B	Country Expert
IV. Life, liberty, freedom of movement & freedom from restraint	**1.1 Legislation addressing the use of restraints**	A: There is national legislation mandating that care providers minimise the use of restraints (chemical and physical) in residential long-term care B: There is national legislation mandating that care providers minimise the use of restraints (chemical and physical) in home- and community-based long-term care 1. Neither A nor B 2. Only A or B 3. Both A and B	Country Expert
	2.1 Guidelines on alternatives to the use of restraints in care	A: Guidelines on the minimisation of the use of restraints (chemical and physical) in residential long-term care facilities have been produced B: Guidelines on the minimisation of the use of restraints (chemical and physical) in home- and community-based long-term care have been produced 1. Neither A nor B 2. Only A or B 3. Both A and B	Country Expert

Domain	Indicator	Values and categories	Data source
V. Privacy & family life	**1.1 Legislation addressing the maintenance of family life**	A: There is legislation mandating that older persons can choose from residential care services in geographic proximity to their family members B: There is national legislation granting spouses the right to co-habitation in residential care, where both spouses are in need of care C: There is national legislation granting spouses the right to co-habitation in residential care, where only one spouse is in need of care 1. None of the above 2. One or two of the above 3. All of the above	Country Expert
	2.1 Procedures addressing visitation rights	1. No guidelines or standard procedures for family visitation rights in residential long-term care facilities exist 2. Guidelines on family visitation rights in residential long-term care facilities exist, but they are optional and unenforced (e.g. guidelines from provider associations, NGOs) 3. National standards are in place protecting family visitation rights in residential long-term care facilities	Country Expert
	2.2 Public infrastructure for safe storage of personal data	1. A public authority responsible for the safe storage and use of general personal data has been established 2. A public authority responsible for the safe storage and use of general personal data and personal health data has been established 3. A public authority responsible for the safe storage and use of general personal data, personal health data, and personal social care data has been established	Country Expert
VI. Participation & social inclusion	**1.1 Legislation addressing accessibility of public spaces**	1. There is national legislation requiring that public facilities are accessible on an equal basis, irrespective of age and type of impairment 2. There is national legislation requiring that public facilities and public transportation is accessible on an equal basis, irrespective of age and type of impairment 3. There is national legislation requiring that public facilities, public transportation, and public ICT platforms are accessible on an equal basis, irrespective of age and type of impairment	Country Expert

Domain	Indicator	Values and categories	Data source
	1.2 Legislation addressing (de)institutionalisation	1. There is no legislation/national strategy in place which stipulates measures for the transition from institutional to community-based care and support 2. There is legislation/strategy in place which stipulates measures for the transition from institutional to community-based care and support for specific target groups among older people 3. There is legislation/strategy in place which stipulates measures for the transition from institutional to community-based care and support and this is the general policy for older people	BMASK / 2015 (AT) NDS, SS Act (SE) APOP / 2017, MIPAA Report (ES) AANP / 2014 (SK) LTSP / 2014, MIPPA 2017 (PL) UNECE / 2017(CH) Report on implementation of the RS of the MIPAA, UNECE for MIPAA / 2107 (SI) Report on implementation of the RS of the MIPAA, UNECE for MIPAA / 2107 (PT) Care Act / 2014 (UK) Quality recommendation to guarantee a good quality of life and improved services for older persons, MSAH 2014, Act on Supporting the Functional Capacity of the Older Population and on Social and Health Care Services for Older Persons, MSAH / 2012 (FI) National Carers' Strategy HD/ 2012, (IE) Law 112 / 2016 (IT)
	2.1 Procedures to ensure accessibility of public spaces	A: Building permissions for all new public facilities require that these be barrier-free/accessible B: Building permissions for all new public and private (residential) buildings require that these be barrier-free/accessible C: Building standards mandate that existing public buildings/ facilities undergo adaptations to make them barrier-free/accessible 1. None of the above 2. One or two of the above 3. All of the above	Country Expert

Domain	Indicator	Values and categories	Data source
VII. Freedom of expression, freedom of thought, conscience, beliefs, culture & religion	**1.1 Adoption of and monitoring compliance with equality and non-discrimination in national laws on grounds of religion or belief**	1. Equality and non-discrimination adopted in Constitution or national laws (whether at federal or regional level) do not specifically address the grounds of religion or belief in the fields of social protection including social security, health care 2. Equality and non-discrimination adopted in Constitution or national laws (whether at federal or regional level) do specifically address the grounds of religion or belief in the fields of social protection including social security, health care 3. Equality and non-discrimination adopted in Constitution or national laws (whether at federal or regional level) do specifically address the grounds of religion or belief in the fields of social protection including social security, health care and these grounds in these fields are covered by an independent national equality body tasked to supervise compliance with the respective equality and non-discrimination laws	UN Human Rights Index; European Equality Law Network: A comparative analysis of anti-discrimination law in Europe / 2017 Equinet / 2018
	2.1 National standards or guidelines require that care services respect different beliefs, religion, culture	A: National standards or guidelines exist B: Compliance with these standards or guidelines is monitored by a relevant authority 1. Neither A nor B 2. Only A or B 3. Both A and B	Country Expert
VIII. Highest standard of health	**1.1 Legislation provides for equal access to preventive, mental health care, dental care, and medication (regardless of age, gender, nationality and income)**	1. Restrictions in all 2. Restrictions in some 3. No restrictions	Country Expert
	1.2 National legislation or strategy on the integration of health and long-term care and support	1. No legislation or strategy 2. National strategy 3. National legislation	Country Expert

Domain	Indicator	Values and categories	Data source
	2.1 National policies or guidelines on implementing measures for older persons to access preventive, mental health care, dental care, and medication	1: No policies or guidelines 2. There exist national policies or guidelines, but not covering all care types 3. There exist national policies or guidelines covering all care types	Country Expert
IX. Adequate standard of living	**1.1 Legislation ensuring the right to adequate housing for all including all dimensions of housing, such as affordability, quality, and security of tenure**	1. There is no national legislation ensuring the right to adequate housing for all or national legislation does not explicitly refer to affordability, quality (i.e. minimum standards) and security of tenure 2. There is national legislation ensuring the right to adequate housing for all with explicit reference to affordability, quality (i.e. minimum standards) and security of tenure 3. There is national legislation ensuring the right to adequate housing for all with explicit reference to affordability, quality (i.e. minimum standards), and security of tenure and provide for an independent authority with jurisdiction to monitor and enforce the right to adequate housing	Country Expert
	1.2 Minimum income guarantees targeting older persons	A: There is national legislation on provision of minimum/basic pension for elderly B: There is national legislation guaranteeing minimum resources for the elderly 1. Neither A nor B 2. A or B 3. Both A & B	MISSOC / 2018
	2.1 Housing support for older persons	1. There is no special housing supplement linked to old-age for pensioners or housing/heating allowance specifically for older persons 2. There is special housing supplement linked to old-age for pensioners or special housing/heating allowance specifically for older persons 3. There is special housing supplement linked to old-age for pensioners and special housing/heating allowance specifically for older persons	MISSOC / 2018

Domain	Indicator	Values and categories	Data source
	2.2 Pension at safety net level	1. Below 40% of the national median equivalised household income 2. Between 40% and 60% of the national median equivalised household income 3. Above 60% of the national median equivalised household income	MISSOC / 2018 Eurostat database (EU-SILC) for the median income
X. Remedy & redress	**1.1 Legislation addressing rights awareness**	A: There is a national strategy/action plan in place which stipulates measures to increase awareness of older persons' rights in the context of care and support B: There is national legislation in place on increasing awareness of older persons' rights in the context of care and support 1. Neither A nor B 2. Only A or B 3. Both A and B	Country Expert
	1.2 Legal mechanisms for complaint in case of breach of rights	A: There is national legislation that provides for the establishment of an independent authority to which older people can turn in order to claim their rights. B: There is national legislation which stipulates measures through which older people can claim their rights 1. Neither A nor B 2. Only A or B 3: Both A and B	Country Expert
	2.1 Active policy of information on rights of older persons*	1. No active policy of information 2. Policy of information on generic basis 3. Policy of information specifically targeted at older persons	Equinet Europe / 2017 (FI, IE, IT, SI and UK) NOET (AT) Equality Ombudsman (SE) Council for the Elimination of Racial or Ethnic Discrimination (ES) NCHR (SK) CHR (PL) Ombudsman of the City of Bern, AR (CH (Canton Bern) Portuguese Ombudsman, AR 2016 (PT)
	2.2 Complaint procedures to independent authority in case of breach of rights	A: Information about the complaint mechanism is available in accessible formats on the website of the independent authority (easy-to read, large fonts etc.) B: Anonymity is guaranteed throughout the complaint procedure C: The independent authority can represent the complainant in judicial proceedings. 1. None or only one of the above 2. Two of the above 3. All of the above	Equinet / 2018

Table A2: Description and data source of outcome indicators used for the scoreboard

Domain	Indicator	Values and categories	Data source/Year
I. Equal access to & affordability of care & support	**Share of older women (65+) with care or support needs (with at least one ADL or IADL OR limitation in usual activities due to health problem) receiving care (all forms of care)**	The indicator shows the share of older women/ men, aged 65 and over, receiving long-term care, both home-based and in institutions (other than hospitals), expressed as a percentage of the older female/male population (65+) with care and support needs. Older women/men with care and support needs is defined as those with self-reported long-standing limitations in usual activities due to health problems (level: “some” or “severe”).	OECD / Latest year (2014-2016) Statistik Austria / 2016 Bundesamt für Statistik, Switzerland / 2016 Eurostat EU-SILC
	Share of older men (65+) with care or support needs (with at least one ADL or IADL OR limitation in usual activities due to health problem) receiving care (all forms of care)		
	Share of older persons (65+) with at least one ADL or IADL limitations who report having access to at least one housing modification and assistive devices	Card 33: Which of the following special features that assist people who have physical impairments or health problems does your home have, if any? 1. Widened doors or corridors 2. Ramps or street-level entrances 3. Hand rails 4. Automatic or easy-open doors or gates 5. Bathroom or toilet modifications 6. Kitchen modifications 7. Chair lifts or stair glides 8. Alerting devices (button alarms, detectors...) 96. None of these	SHARE / 2015

Domain	Indicator	Values and categories	Data source/Year
II. Choice, legal capacity & decision-making capacity	**Share of older persons (65+) with ADL limitations reporting they feel free to decide how to live their lives**	EQLS 2016: Q7: To what extent do you agree or disagree with the following statements? d. I feel I am free to decide how to live my life 1. **Strongly agree** 2. **Agree** 3. Neither agree nor disagree 4. Disagree 5. Strongly disagree 98. Don't know 99. Refusal Q50: Are you limited in your daily activities by this physical or mental health problem, illness or disability? [Follow-up question to those reporting to have any chronic (long-standing) physical or mental health problem, illness or disability] 1. **Yes, severely** 2. **Yes, to some extent** 3. No 98. Don't know 99. Refusal ESS 2012 (for Switzerland): CARD26: Using this card, please tell me to what extent you agree or disagree with each of the following statements. D16: I feel I am free to decide for myself how to live my life 1. **Agree strongly** 2. **Agree** 3. Neither agree nor disagree 4. Disagree 5. Disagree strongly 8. Don't know C8: Are you hampered in your daily activities in any way by any longstanding illness, or disability, infirmity or mental health problem? If YES, is that a lot or to some extent? 1. **Yes, a lot** 2. **Yes, to some extent** 3. No 8. Don't know	EQLS / 2016 (ESS 2012 for Switzerland)
	Satisfaction of older persons (65+), with ADL limitations, with the quality of long-term care services in their country (mean)	Q58: In general, how would you rate the quality of each of the following public services in your country? Please tell me on a scale of one to 10, where one means very poor quality and 10 means very high quality. e. Long-term care services	EQLS / 2016

Domain	Indicator	Values and categories	Data source/Year
V. Privacy & family life	**Share of older persons (65+) reporting at least weekly interactions with family (relatives)**	PS070: Frequency of contacts with family (relatives) 1. **Daily** 2. **Every week (not every day)** 3. Several times a month (not every week) 4. Once a month 5. At least once a year (less than once a month) 6. Never PS070_F: Flags 1 Filled -1 Missing -2 NA (no relatives) -3 No selected respondent	EU-SILC / 2015
	Share of older persons (65+) who trust in health and medical institutions to protect their personal information	QB18: Different authorities (government departments, local authorities, agencies) and private companies collect and store personal information about you. To what extent do you trust the following authorities and private companies to protect your personal information? Health and medical institutions 1. **Totally trust** 2. **Tend to trust** 3. Tend not to trust 4. Do not trust at all 5. Don't know	Special Eurobarometer 431 / 2015
VI. Participation & social inclusion	**Share of older persons (65+) reporting not having difficulties in accessing public spaces and essential services**	Q56: Thinking of physical access, distance, opening hours and the like, how easy or difficult is your access to the following services? a. Banking facilities (e.g. bank branch, ATM) b. Public transport facilities (bus, metro, tram, train etc.) c. Cinema, theatre or cultural centre d. Recreational or green areas e. Grocery shop or supermarket 1. Very difficult 2. Rather difficult 3. **Rather easy** 4. **Very easy** 5. Not applicable /service not used) 98. Don't know 99. Refusal	EQLS / 2016
	Share of older persons (65+) reporting not feeling lonely	CARD 53: I will now read out a list of the ways you might have felt or behaved during the past week. Using this card, please tell me how much of the time during the past week… E24 (D9 for 2012):… you felt lonely? 1. **None or almost none of the time** 2. Some of the time 3. Most of the time 4. All or almost all of the time 8. Don't know	ESS / 2014 (2012 for Italy and Slovakia)

Domain	Indicator	Values and categories	Data source/Year
VII. Freedom of expression, freedom of thought, conscience, beliefs, culture and religion	**Share of older persons (55+) that have not felt personally discriminated or harassed on the grounds of religion or beliefs in the past 12 months**	QC2: In the past 12 months have you personally felt discriminated against or harassed on one or more of the following grounds? 1. Ethnic origin 2. Gender 3. Sexual orientation 4. Being under 30 years old **5. Religion or beliefs** 6. Disability 7. Gender identity 8. For another reason 9. No 10. Don't know	Special Eurobarometer 437 / 2015
VIII. Highest standard of health	**Share of older persons (65+) who received immunization for influenza**	Number of people aged 65 and over who have been immunized against influenza (or "flu") during the last 12 months (covers the last influenza season or calendar year) divided by the average annual population aged 65 and over. (No gender breakdown is available)	Eurostat / Latest year (2017 for IE, FI, IT, ES; 2016 for SI, SK, SE, UK; 2015 for PT; 2014 for AT and PL)
		Data on immunization by gender refer to self-reported vaccination against influenza (percentage of the population reporting to have been vaccinated against flu during the past 12 months).	Eurostat European Health Interview Survey (EHIS) / 2014
	Share of older persons (65+) who reported consultations with a dentist in the past 12 months	During the last 12 months, have you seen a dentist or a dental hygienist? (visits for routine controls, for dentures and stomatology consultations included) **1. Yes** 5. No	SHARE / 2015
	Satisfaction of older persons (65+) with the personal attention they receive from their GP or family doctor (mean)	Q62: You mentioned that you used GP, family doctor or health centre services. On a scale of 1 to 10, where 1 means very dissatisfied and 10 means very satisfied, tell me how satisfied or dissatisfied you were with each of the following aspects the last time that you used the service. c. Personal attention you were given, including staff attitude and time devoted	EQLS / 2016
IX. Adequate standard of living	**Share of older persons (65+) not reporting severe housing deprivation**	Percentage of population NOT living in a dwelling which is considered as overcrowded, while also exhibiting at least one of the following housing deprivation measures: a leaking roof or no bath/shower and no indoor toilet, or a dwelling considered too dark.	Eurostat EU-SILC / 2016
	Share of older persons (65+) not in relative poverty	Percentage of people with an equivalised disposable income (after social transfers) NOT below the at-risk-of-poverty threshold, which is set at 60 % of the national median equivalised disposable income after social transfers.	Eurostat EU-SILC / 2016

Domain	Indicator	Values and categories	Data source/Year
X. Remedy & redress	**Share of older persons (55+) who report to be aware of their rights and existing redress mechanisms**	Q1: Are you familiar with the EU Charter of Fundamental Rights? **1. Yes, and you know what it is** 2. Yes, you have heard about it, but you are not sure what it is 3. No, you have never heard of it 4. Don't know	Flash Eurobarometer 416 / 2015
	Share of older persons (55+) who would know their rights if they were the victim of discrimination or harassment	QC8: Would you know your rights if you were the victim of discrimination or harassment? **1. Yes** 2. No 3. It depends 4. Don't know	Special Eurobarometer 437 / 2015

10 Notes

1 For instance, as part of the DAPHNE Eustacea project to develop the European Charter on the Rights and Responsibilities of Older People in Need of Long-term Care and Assistance.

2 In the ROPI the data refers to England, unless it is stated otherwise.

3 Information refers to care services provided under the integrated care network (RNCCI).

4 For Austria, information in indicator II/1/2 refers to Vienna.

5 The Assisted Decision Making (Capacity) Act 2015 is not fully commenced yet, but once the Act fully enters into force, it is expected that informed consent for all care purposes will be required and will be legally binding.

6 Switzerland is not part of the European Quality of Life Surveys (EQLS), thus there is a missing value for Switzerland for indicator II/2/2.

7 We have contacted the national members of Alzheimer Europe to obtain information whether they are aware of national registries of Advance Directives in the participating countries.

8 Alzheimer Europe (2016).

9 According to WHO definition of elder abuse: elder abuse is any act of commission or omission (in which case it is usually described as “neglect”), that may be either intentional or unintentional and involves persons aged 60–65 years or more (the age bracket for “old age” varies by country but often coincides with the official age of retirement). The abuse may be physical, sexual, psychological (involving emotional or verbal aggression), or financial, or involve other material maltreatment and result in unnecessary suffering, injury or pain, the loss or violation of human rights, and a decreased quality of life for the older person, WHO Global Status Report on Violence Prevention 2014, page 82.

10 Italy has no monitoring mechanisms against abuse/mistreatment of older persons in care. There is a specific police unit that does controls and inspections in the residential care facilities but not on a regular basis.

11 However, it is important to note that in the case of Slovenia the information provided by the country expert was insufficient for the full validation of the structure indicator and there is a missing value for the process indicator, which impact significantly the validity of their score in Domain IV.

12 This indicator has a missing value for Switzerland as they are not obliged to have the Personal Data Protection Office established under EU law.

13 Finland scored 2 due to limited coverage of ICT platforms, but it is important to note that a government proposal was issued by the Ministry of Finance at the time of data collection on guaranteeing that public information & communication technology (ICT) platforms and services are accessible on an equal basis, irrespective of age and type of impairment. The legislation was envisaged to come into force in 2018.

14 Specifically, in Poland, the 2010 Equal Treatment Act prohibits discrimination in the area of social protection and health care listing a number of grounds, but not of religion or belief. The same is the case with the Social Security Act, which is the basic statute for the social security area (Bojarski, 2018).

15 Although a parallel and earlier established network of mostly social care services exists that remains strictly separated.

16 The benefits considered for this calculation relate to the pension supplement in Austria, the guarantee pension in Finland and Sweden, the means-tested minimum pension in Italy and Spain, the contributory minimum pension in Poland, Portugal, Slovakia and Slovenia, the first-pillar basic pension in Switzerland, the new state pension in the UK and the state pension in Ireland.

17 For example, dedicated websites, campaign material at national (regional) level.

18 Therefore, for indicator X.1.2, generic law that provides the establishment of an independent authority where older people can claim their rights, is considered.

19 Accessibility of the complaint mechanism by the independent authorities is measured through whether there is accessible information available on their website in the form of large fonts, easy-to-read, or sign language. The research team considered that in case older people in residential or home-based long-term care experience human rights violations, the lack of accessible information about how they can issue a complaint, may prevent them from contacting the Equality Bodies (or equivalent authority). Obviously, providing accessible information on the website does not alone ensure that the whole complaint process is accessible for people with functional limitations or impairments.

20 Among these factors are also the gender inequalities in health observed among older people; these inequalities are, however, accounted for in the indicators used as they refer to the share of older people with at least one ADL or IADL.

21 Although care service use may be disproportionately concentrated among older women, this could mean that older female spousal carers may find themselves shouldering most of informal care alone.

22 As a sensitivity analysis (not reported here), this indicator was also calculated using weekly interaction with friends. While in Sweden a greater share of older people regularly interacts with friends than with relatives, overall the opposite is true, with Portugal as front-runner regarding interactions with friends. The indicator is thus unlikely to vary significantly with the choice of indicator on social interactions.

23 The indicator covers the following facilities and services: banking facilities (e.g. bank branch, ATM), grocery shop or supermarket, public transport (bus, metro, tram, train etc.), recreational or green areas, cinema, theatre or cultural centre. Accessibility relates to physical access, distance, opening hours and the like (Eurofound, 2016).

24 Severe housing deprivation shows the proportion of population living in dwellings that are overcrowded while also exhibiting at least one of the housing deprivation measures (leaking roof, no indoor bath/shower, no indoor toilet or dwelling is considered too dark) (Eurostat online glossary).

25 Similar to the pilot study, the validity of the content of national legislation, documents, links and other resources referred to by the country experts, was not checked against original sources, beyond the parts quoted in the descriptions provided along the scoring. This was due to the limited internal resources to thoroughly check all the information in the national languages.

26 Of the total 35 structure and process indicators, in Austria 23, in Italy 3, in Spain 3 and in Switzerland 12 indicators were identified as matters of regional competence. Therefore, for those indicators, we collected information from Vienna, Lazio, Madrid and Canton Bern respectively.

27 This included the request for further information and clarification sent to national experts.

28 The Social Scoreboard monitors the implementation of the European Pillar of Social Rights by tracking trends and performances across EU countries in 12 areas and feeding into the European Semester of Economic Policy Coordination. The Social Scoreboard of the Pillar is not to be mixed up with the Scoreboard on Outcome Indicators presented in this report. More information about the EU Social Scoreboard is available at: https://ec.europa.eu/eurostat/web/european-pillar-of-social-rights/indicators/social-scoreboard-indicators (last accessed 11/03/2019).