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# Care and the Human Rights of Older Persons

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AGAC ISSUE FOCUS

# Care and the Human Rights of Older Persons

ASEM Global Ageing Center

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We would like to express our gratitude to the AGAC Issue Focus Advisory Group—Jung-Hwa Ha at Seoul National University; Sabine Henning at the United Nations Economic and Social Commission for Asia and the Pacific; Mijin Lee at Konkuk University; Silvia Perel-Levin at the NGO Committee on Ageing in Geneva; and Margaret Young at the Global Alliance for the Rights of Older People and Age Knowble. They provided general guidance on the outline and theme of this report.

Valuable insight and input were provided by the contributors to this issue—Niki Kalavrezou at the European Centre for Social Welfare Policy and Research, Vienna; Craig Sinclair at the University of New South Wales' School of Psychology and Ageing Futures Institute, and Neuroscience Research Australia (NeuRA), Sydney; Sina Yi at the ASEM Global Ageing Center and Seoul Metropolitan Government; and Ketchuda Rodngern, Orawan Prasitsiriphon, Chadatan Osatis, and Ruttiya Bhula-or, all at the College of Population Studies, Chulalongkorn University, Bangkok.

As the world experiences rapid demographic transition, we hope that this edition will inspire advocates for the human rights of older persons and contribute to improving older people's quality of life, particularly with respect to care. We argue that those charged with thinking about and practicing care must aspire to develop systems in sync with human values, notably the dignity, autonomy, and agency of persons. We look forward to a world free of the injustices that harm our present systems of care; the ASEM Global Ageing Center will remain committed to this cause, and the struggle to achieve it.

HyeKyung Lee

**HyeKyung Lee**

Executive Director, ASEM Global Ageing Center (AGAC)

# AGAC ISSUE FOCUS ADVISORY GROUP

**The AGAC Issue Focus Advisory Group** is a group of experts focused on ageing and the human rights of older persons. They advise on the themes and topics of Issue Focus publications and provide feedback on the volumes. The advisors share their insights and views, bringing to bear expertise from around the world. Issue Focus addresses issues and agendas of ageing that are relevant to all ASEM partners.

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# Introduction

**Eunsun Lee** | *ASEM Global Ageing Center*

Vulnerability is the fundamental human condition, universally and constantly present in all human lives (Fineman, 2017). The manifestation (e.g., form and degree) will differ from individual to individual—some may suffer during experiences of a mental condition (see, e.g., ASEM Global Ageing Center, 2025, about dementia), while others may do so in a natural disaster (e.g., ASEM Global Ageing Center, 2024)—but dependency on others or on social structures in one's lifetime is a reality that has never been overturned (Emory University, n.d.). Care—the theme of this edition—involves activities that are "maintaining or regaining the optimum level of physical, mental, and emotional well-being" (Kornfeld-Matte, 2015, p. 13) for a care recipient, both directly (e.g., assistance with daily life activities like washing and dressing) and indirectly (e.g., household tasks; United Nations, 2024). Care, that is, "includes everything that we do to maintain, continue, and repair our world" (Fisher & Tronto, 1991, as cited in Tronto, 1993, p. 103), indicating its indelible place in our lives.

The fact that care is essential in all walks of life, however, often slips from the public agenda. In *Politics*, Aristotle discussed both paid and home labor, but 18th-century scholars, for example, discounted the latter (Bunting, 2021d). In Florence Nightingale's time, nursing was framed as a female vocation, self-effacing and essentially feminine; this framing, outdated as it is, has not been modified with the times and persists, inappropriately, to this day (Bunting, 2021b). In addition, our consciousness that, as people age and die, the disintegrating body and mind require care, has been marginalized in a society that is full of idealized images of life (Lawton, 1998) or that cannot bear to fathom the human abyss, leaving people oblivious of the significance of care in life and largely unprepared when it is needed.

## Irony in Care

Many societal injustices, such as gender inequality or stereotypes and discrimination based on age, disability, race, ethnic origin (United Nations High Commissioner for Human Rights, 2025), or migrant status, are mirrored in care systems for older people. This, along with the overall invisibility of care (and indeed of older people), may degrade care access and quality. Concerning access to care, in armed conflicts in Ukraine, for instance, older people have reported a lack of support in obtaining food (91%), clean drinking water (79%), urgently needed medicine (34%), heating (91%), and hygiene items (75%; HelpAge International, 2022). A person familiar with the situation noted, "Donations seem to be focusing primarily on the needs of babies and young children with the risk of overlooking the needs of older people (AGE Platform Europe, 2022, Section Emergency Response in Ukraine). A similar situation was observed in refugee camps in Bangladesh: "No one thought of psychosocial care for older people. [The humanitarian response is] deprioritizing older people's mental and physical well-being" (Amnesty International, 2019, p. 32).

Even if someone has access to care, the quality is likely to vary depending on their status in society. For example, a care worker in a home-care company that serves affluent clients (who can pay more than the budget of local-authority services allows) described how she could spend an hour or longer building a relationship with a client (Bunting, 2021a) which was beneficial to her job performance. In contrast, a care worker in a different company reported just 15-minute slots for contact with clients, and only three hours of basic health-and-safety training. She continued, "Sometimes there wasn't even time to make them a hot drink in the morning. … There was no time for eye contact … no time to get to know the person and their story" (Bunting, 2021a, para. 43).

The treatment of these care workers is not necessarily encouraging; often, their work is devalued, and its "importance, extent, subtlety, and complexity" are overlooked (Bunting, 2021c, para. 8). Women account for approximately two-thirds of global care workers (International Labor Organization, 2018). They complete 76.2% of all unpaid care work, or 3.2 times more than men (International Labor Organization, 2018). If the unpaid care work of women aged 15 and older were estimated globally, it would cost at least U.S. $10.8 trillion per year, which is three times the size of the world's technology industry (Oxfam, 2020). In the case of domestic workers, only 10% are covered by general labor laws as fully as other workers. It is estimated that 90% of them do not have access to social security. Overall, it is reported that women disproportionately carry out unpaid and underpaid care work, without adequate legal protection, and they are often from groups discriminated against for their race, ethnicity, nationality, sexuality, or class (Oxfam, 2020). The irony of care is that the less cared-for care more. That is, socially disadvantaged groups around the world perform care work—which is essential for society, and demanding and complex because it is "as much an art as a skill, as much competence as tact" (Bunting, 2021c, para. 14)—disproportionately, invisibly, and with little or no compensation or protection.

## Toward Transformed Care Systems

Echoing the urgent need to transform care systems, this edition publishes the work of four contributors who share their ideas. Niki Kalavrezou diagnoses long-term care in the European context, where people tend to live longer and live alone, and their care needs are increasing. However, the pool of care workers is shrinking, as are the fiscal resources to back up the necessary care. Migration may buy some time, but it will not be the solution. Even climate change adds to the complication. Some countries respond with universal coverage and stable public investment, leading to integrated care systems, while others shift care responsibility to the family and informal care sectors, providing only fragmented provision. Kalavrezou argues that public spending on long-term care is not a burden but an essential investment at the center of welfare services, and proactive initiatives based on a medium- and long-term vision are required. She also emphasizes the importance of recognizing and supporting care workers in society.

Having participated in advisory group discussions for national policy statements on supported decision-making within the Australian Aged Care Act 2024, Craig Sinclair discusses the extent to which the new act enables supported decision-making in the care of older people, as well as three major challenges concerning its implementation: Australia's federal system; the heterogeneity of older people, partly in relation to cognitive disabilities; and a lack of practical operationalization and interpretation of the rights-based concept of will and preferences. Sinclair explains that, unlike earlier aged care legislation, the new act explicitly addresses human rights, and it makes significant progress in the implementation of supported decision-making in health and social care provision for older Australians. Successful implementation requires consideration of Australia's distinct policy and demographic contexts, he concludes.

Sina Yi sets out to persuade readers that a dementia diagnosis can be the start of a new career, rather than reclusion, by presenting the Restaurant of Mistaken Orders in Japan and the Memory Cafe in Seoul. Inspired by Bère Miesen's Memory Cafe in the Netherlands, these two initiatives go above and beyond to create spaces for persons living with dementia not only to socialize but also to restore their social roles. As with all uplifting efforts around the world, they employ dialogue-style communication rather than monologues. People living with dementia serve customers food or drinks; customers frequently help them. Even if mistakes are made, customers accept them with open-mindedness, understanding, and enjoyment; they often laugh together. Yi argues that even short events such as these can have positive effects, ultimately leading to a more free and caring society.

Ketchuda Rodngern, Orawan Prasitsiriphon, Chadatan Osatis, and Ruttiya Bhula-or survey care systems in Thailand. They argue that with the strengths of universal health coverage and community-based long-term care to back it up, person-centered, home-first care in Thailand is successful both in practice and in culture. When assessed in relation to human-rights criteria, such as availability, accessibility, acceptability, and quality, it demonstrates substantial achievements. Rodngern and colleagues, however, identify areas where more efforts are needed, namely affordability; workforce fragility; participation, transparency, and redress; and equity tracking. They conclude that present advancements in Thailand's care systems are meaningfully consistent with international guidelines on healthy ageing and integrated care, and lay the groundwork for future reform.

This edition affirms that care is essential in human lives; its value should be clearly recognized, and its benefits should be shared equitably. Care responsibilities need to be fairly distributed among persons and entities in society; care justice necessitates that all people deliberate and act on problems and remedies in order to move forward. We hope that this edition helps point us forward in our journey *ad astra*.

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# Long-Term Care in Europe: Key Trends and Emerging Challenges

**Niki Kalavrezou** | *European Centre for Social Welfare Policy and Research*

The world is changing in more ways than one. Only a few years after the pandemic exposed the fragility of health and care systems, public attention has shifted toward new sources of uncertainty, such as geopolitical tension and financial instability. Alongside the European Union's so-called triple transformation (green, digital, and demographic; European Commission, 2023a), these developments define a decade of profound transition. Yet demographic ageing, while less visible than other crises, remains one of the most far-reaching structural forces reshaping European societies.

The demographic patterns are well known: Life expectancy continues to rise, while fertility rates remain well below the level required to maintain population stability. The result is a steadily ageing population, with more people living well into their eighties and beyond, and fewer young people available to support not only the economy but also society in a broader sense. Demographic change also means that more adults will be living alone across the life course, a trend that will have especially profound repercussions when today's younger generations reach old age. Migration can partially offset these patterns but is insufficient to reverse the overall trajectory, as socioeconomic and political constraints realistically limit its potential (European Commission, 2024; Organisation for Economic Co-operation and Development [OECD], 2024; United Nations [UN] Department of Economic and Social Affairs [DESA] Population Division, 2024).

Long-term care (LTC) is also being profoundly reshaped. Longer lives and smaller families mean that care needs are growing while the pool of potential informal carers is shrinking, and fewer fiscal resources are available to support public policies such as care (European Commission, 2022). While fiscal pressures cannot be discounted, there is significant scope for public investment in LTC to be scaled up, and even more for increasing its visibility and priority in national and European political discourse, given the structural forces behind demographic change.

This article explores how Europe's LTC systems are operating and evolving in this wider context. It first reviews the demographic, health, and social forces driving European population ageing, then examines how European LTC systems respond, focusing on their diversity, levels of investment, and emerging patterns of convergence regarding both trends and challenges. It concludes by reflecting on the broader implications for Europe and beyond, as many of these issues are shared by ageing societies worldwide.

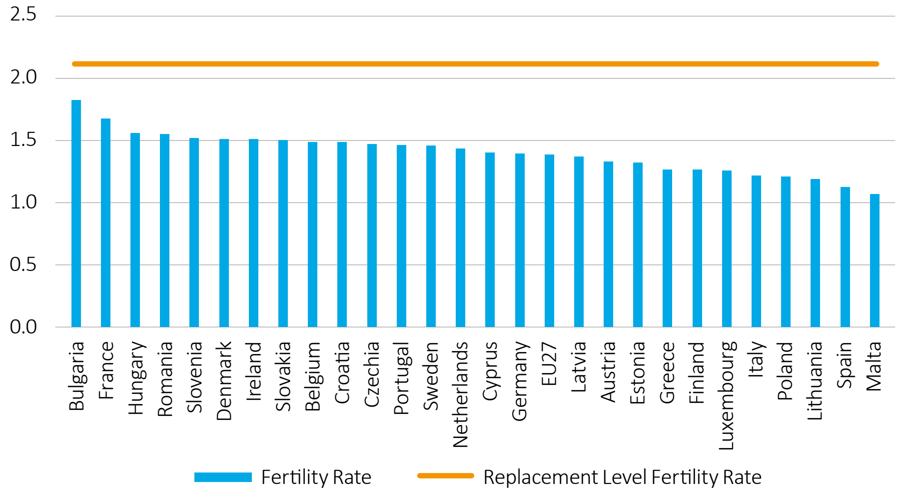
## Population Ageing in Europe: Demographic, Health, and Social Drivers

Life expectancy in Europe has increased steadily over recent decades, reflecting major advances in healthcare, living standards, and disease prevention (Eurostat, n.d.; World Health Organisation [WHO] Regional Office for Europe, 2022). People today can expect to live substantially longer than previous generations, with many enjoying extended periods of active participation in society. Yet, longevity gains have not always translated into equivalent improvements in healthy life expectancy (Eurostat, n.d.; WHO Regional Office for Europe, 2022). The gap between total and healthy years of life is widening, meaning that a growing share of later life is spent in poor health or with functional limitations that increase the need for support. The divergence is especially visible in countries where health inequalities are more pronounced and overall life expectancy remains below the European Union (EU) average, such as in several Central and Eastern European member states (Eurostat, n.d.). Across the EU, life expectancy at age 65 rose from about 18 years in 2004 to over 19 years in 2021, but progress has been uneven: While Spain and France lead with around 21 years, some Eastern European countries, such as Bulgaria, Romania, or Slovakia, remain far below the EU average (Eurostat, n.d.).

Falling birth rates remain the principal engine of demographic ageing. The EU's average fertility rate, about 1.4 births per woman, has long stayed below the replacement level of 2.1. This decline reflects profound social shifts, including economic uncertainty, and changing values around marriage and parenthood. Indeed, the postponement of childbearing and the rise of smaller households have become defining features of European societies. Although Nordic and some Western and Central European countries have maintained slightly higher fertility rates, no EU country reaches replacement level (Figure 1).

**Figure 1**

*Fertility Rates Across the EU, 2023*

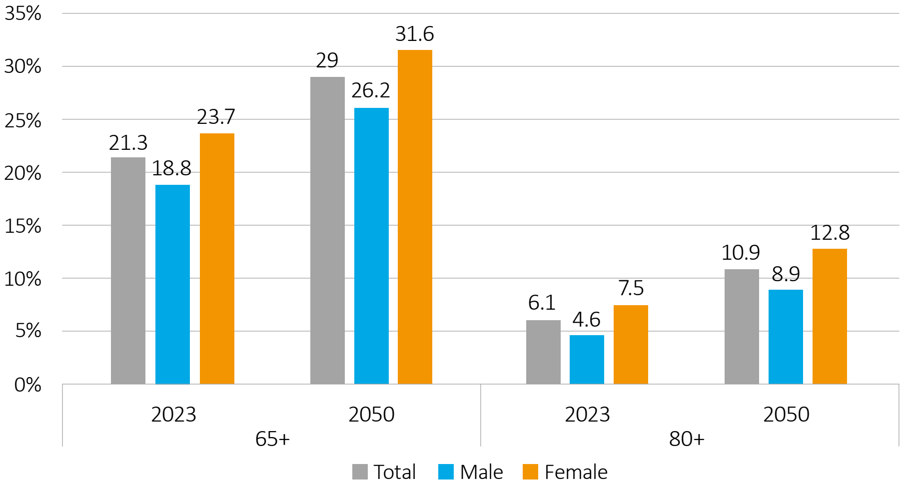


*Note.* The data are from *Total Fertility Rate*, by Eurostat, 2025b (https://doi.org/10.2908/TPS00199). CC by 4.0.

As a result the share of young people has declined and is expected to continue to decline as fewer babies are born. The most significant declines, observed between 2001 and 2023, occurred in the 20–30 age group (-18%), but reductions were recorded across all age groups up to 45 years of age (Eurostat, n.d.). According to the demographic projections extending to 2050, the share of young people in Europe is expected to continue to decline, up to and including the 60–65 age bracket. By contrast, the share of people 65 years and older and at least 80 years and older will increase considerably. By 2050, 29% of the total EU population will be at least 65 years of age, and 11% will be at least 80 years of age, up from 21% and 6%, respectively (Figure 2). Figures also indicate that the female population in Europe is expected to age more rapidly. These demographic dynamics are structural and long-term, ensuring that the working-age population will continue to contract relative to the number of older adults.

**Figure 2**

*Projections of the Share of the EU Population Aged 65+ and 80+, by Gender*



*Note.* The author calculated the figures. The data are from *Population on 1st January by Age, Sex, and Type of Projection*, by Eurostat, 2023 (https://doi.org/10.2908/PROJ_23NP). CC by 4.0.

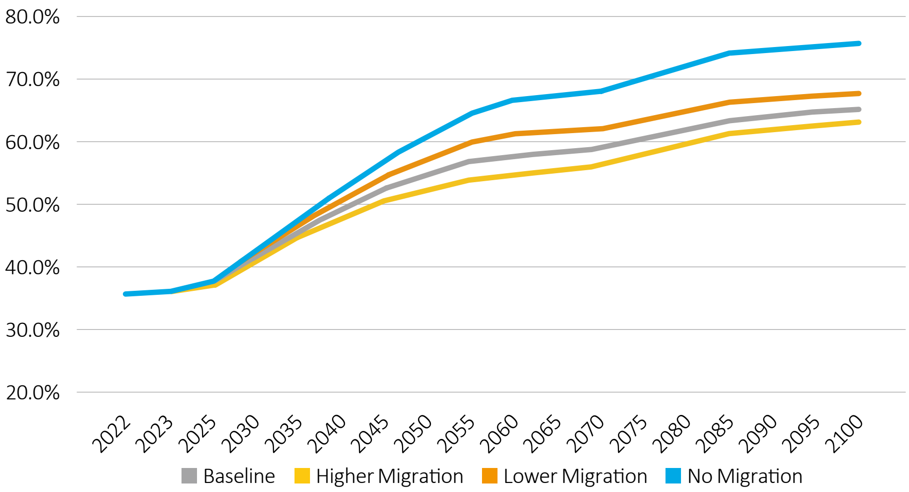
In the health sphere, Europe has long undergone its epidemiological transition (Olshansky & Ault, 1986; Omran, 1971), with chronic and degenerative conditions now dominating the burden of disease and driving demand for health and care services. Cardiovascular conditions and cancers now account for more than half of all deaths, while infectious diseases represent only a small share (Eurostat, n.d.). Improved survival from major diseases has contributed to longevity but also to an expansion of morbidity. Multimorbidity, defined as the coexistence of multiple chronic conditions, affects roughly two-thirds of adults aged 65–84 and becomes nearly universal among those aged 85 and older (OECD & European Commission, 2024). Cognitive decline and dementia add further complexity: Alzheimer's disease alone accounts for over 60% of dementia cases, and prevalence is projected to rise sharply, particularly in countries with older age structures such as Italy, Germany, and Greece (OECD & European Commission, 2024). These conditions do not automatically lead to care dependency, but their combination substantially increases the need for continuous and specialised long-term support.

Migration influences the pace of population ageing but cannot reverse it. Net immigration has softened population decline in several Western and Northern European countries, while sustained emigration from Central and

Eastern Europe has accelerated ageing there and contributed to care-labour shortages. Migrant inflows also play a dual role: They modestly replenish the working-age population and increasingly support Europe's care workforce. However, even under high-migration scenarios, projections indicate that the EU's old-age dependency ratio (the share of people aged 65 and over compared with the working-age population) will continue to climb—reaching about 55% by 2055 and 65% by 2100 (Figure 3). Migration can thus mitigate, but not fully offset, the structural effects of low fertility and rising longevity.

**Figure 3**

*Old-Age Dependency Ratio Projections Under Alternative Migration Scenarios (Population 65 Years or Over to Population 20 to 64 Years), EU, 2022–2100*



*Note.* The data are from *Population on 1st January by Age, Sex, and Type of Projection*, by Eurostat, 2023 (https://doi.org/10.2908/PROJ_23NP). CC by 4.0.

## Long-Term Care Systems in Europe: Key Trends, Diversity, and Convergence

Across Europe, long-term care (LTC) services encompass a wide range of support measures for individuals with chronic illnesses, disabilities, or age-related care needs. Yet their organisation and financing differ markedly across member states, reflecting their diverse welfare traditions and historical legacies. Some countries have developed integrated care systems with universal coverage and stable public investment, while others rely on fragmented provision and a heavy dependence on family and informal care (European Commission & Social Protection Committee, 2021a, 2021b; Kalavrezou et al., 2025).

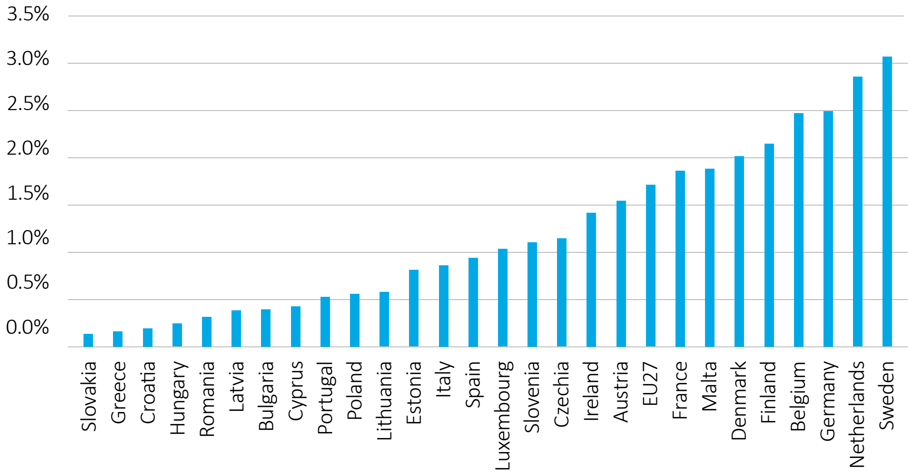
Nordic countries and the Netherlands are characterised by universal access, substantial public investment, and a strong focus on community- and home-based services. Continental systems, such as those in Germany, France, and Austria, typically combine tax- and insurance-based financing with mixed public–private provision. Southern Europe maintains a more familialist model, where care responsibilities remain largely within households. This approach often results in inequities in access and affordability, high opportunity costs for informal carers, particularly women, and slower progress toward gender equality (Bettio & Verashchagina, 2012). In Central and Eastern Europe (CEE), LTC systems remain comparatively underdeveloped, with limited formal provision, low public spending, and high levels of informality.

Public LTC expenditure as a share of gross domestic product (GDP) ranges from 3.1% in Sweden to 0.1% in Slovakia, with at least 14 EU countries reporting levels below 1% in 2023 (Figure 4). When measured per inhabitant aged 65 and over, spending varied from roughly €15,800 in the Netherlands to €271 in Greece, revealing striking contrasts in state commitment. These figures signal differing levels of preparedness to meet population ageing, as well as considerable fiscal space for expansion in underfunded systems. According to projections in the European Commission's *2024 Ageing Report*, public LTC expenditure is expected to increase in all EU Member States by 2070, even under baseline assumptions (European Commission, 2024).

Public attitudes strongly support such investment. A 2022 Eurobarometer survey found that 70% of Europeans favour increased government spending on health and LTC (the highest percentage amongst other areas; Eurobarometer, 2023), even if financed through higher taxes or social contributions (European Commission, 2022). Support is particularly pronounced in countries with the lowest current level of expenditure (such as Greece and Slovakia), suggesting a growing recognition of care as a social investment rather than a fiscal burden.

**Figure 4**

*Long-Term Care (LTC) Expenditure as a % of GDP Across the EU-27, 2023*



*Note.* The data are from *Health Care Expenditure by Function*, by Eurostat, 2025a (https://doi.org/10.2908/hlth_sha11_hc). CC by 4.0.

Private expenditure remains harder to quantify, partly due to data limitations and a shadow economy in the sector. Out-of-pocket (OOP) payments and undeclared paid care are substantial in many countries, particularly where public systems are weak. Analysis from our study indicates that higher public spending tends to correlate with lower OOP burdens, confirming the protective role of collective financing (Kalavrezou et al., 2025).

But also, intensive unpaid care often translates into considerable opportunity costs for households, as it often reduces carers' employability, income, and health. Employment outcomes for informal caregivers vary considerably across EU Member States. Women account for around 60% of all informal caregivers, a share that rises to over 66% among those providing intensive care, defined as at least 20 hours per week (Kalavrezou et al., 2025). The proportion of individuals who are not employed but would like to work, citing care responsibilities as the main reason for not seeking employment, is lowest in Sweden and Finland but highest in Ireland and Poland. Elevated shares are also observed in Southern European countries such as Spain, Greece, and Cyprus, suggesting that a substantial proportion of potential workers in these regions face significant barriers to labour market participation due to caregiving duties.

Despite clear differences in structure, funding, and maturity, LTC systems across Europe are increasingly converging around a common set of principles that emphasise community-based and integrated approaches promoting autonomy, participation, and inclusion (Greve, 2017; Ranci & Pavolini, 2013). This shift is most visible in countries such as Sweden, the Netherlands, and Belgium, where sustained public investment has expanded home- and community-based services, while other countries are gradually moving in the same direction—guided by international and European rights-based frameworks such as the UN Convention on the Rights of Persons With Disabilities (2006), the European Strategy for the Rights of Persons With Disabilities 2021–2030 (European Commission, 2021), and the European Care Strategy (European Commission, 2022).

Additional points of gradual convergence can be observed in the evolving discourse on LTC across Europe. One dominant tendency is the growing emphasis on integrating health, social, and preventive care, recognising that effective and sustainable support for older people depends on coordination across services and professions (Garattini et al., 2022; Leichsenring, 2012). Emerging models promote interprofessional collaboration between medical and care staff, continuity of support, and early interventions aimed at maintaining independence and delaying functional decline.

Another prominent tendency concerns the progressive professionalisation of care work, not limited to but including efforts to improve training and recognition for those already employed in the sector, as well as to acknowledge and support informal carers (European Commission, 2022; Llena-Nozal et al., 2022). While the latter shift can improve quality and recognition, it also raises important questions about the boundaries between family and formal care. For instance, it has been argued that professionalisation may shift the relationship from one grounded in affection and moral duty to one characterised by accountability and contractual obligations, potentially constraining the caregiver’s sense of autonomy and intrinsic motivation (Folbre & Nelson, 2000). At the same time, financial benefits alone, without adequate pay structures, contributory schemes, training opportunities, or employment safeguards, risk creating new forms of dependency and reinforcing existing inequalities (Bettio & Verashchagina, 2012; Eurofound, 2025; OECD, 2025). When remuneration is not linked to social insurance or transferable skills, caregivers may become financially reliant on benefits, facing income loss and limited employability once the care relationship ends. Such dynamics can entrench poverty traps, particularly for women who exit the labour market to provide care, thereby perpetuating gender inequality and long-term economic insecurity.

Although the organisation and financing of LTC remain firmly within national jurisdiction, common demographic and social challenges have prompted similar policy responses across Europe. Rather than coordinated reform, this represents a form of pragmatic convergence driven by necessity, fiscal constraints, and shared principles of dignity, inclusion, and autonomy.

## Emerging Challenges and the Role of Innovation

Broader socioeconomic and international dynamics are challenging European care systems, yet the most visible and immediate strain lies in the care sector itself, and in particular, its labour market. The care workforce remains among the most strained segments of Europe's labour market. Low wages, limited career progression, and physically demanding work make recruitment and retention increasingly difficult (European Commission, 2022; OECD, 2020; OECD & European Commission, 2024). Around one in three care workers report that their job negatively affects their health, compared with one in four across the general workforce (Eurofound, 2020). The sector's workforce is itself ageing, with many workers doubting their ability to remain in their roles until retirement. Inadequate recognition, high emotional stress, and limited social value further reduce its attractiveness, despite the essential and rewarding nature of care work.

Migrant labour plays a central role in sustaining care provision. While formally migrants make up about 8% of the formal long-term care (LTC) workforce—close to their share in the wider economy—many work in informal or undeclared arrangements, especially as live-in carers in Southern and Central Europe (Eurofound, 2020; Leichsenring et al., 2022). These workers are frequently underpaid, unprotected, and excluded from social insurance systems.

Beyond the labour market, there are broader emerging changes to be considered. Climate change poses profound and growing risks to older populations and those with chronic conditions. Heatwaves, air pollution, and extreme weather events disproportionately affect people with limited mobility or pre-existing health issues, while gender inequalities amplify vulnerability (European Environment Agency, 2022; WHO, 2025). Although consistent reporting of heat-related mortality in Europe is lacking, it is estimated that approximately 90% of fatalities caused by weather and climate events in the broader European region over the past 40 years (1980–2020) are attributed to heatwaves (European Environment Agency, 2022). Older women, who are more likely to live alone and experience chronic illness, are particularly exposed to heat-related mortality and social isolation (Anjum & Aziz, 2025). Countries that invest in inclusive urban design, green spaces, and climate-smart care infrastructure will be better equipped to protect vulnerable populations as environmental pressures intensify. Exposure to extreme heat, droughts, and wildfires places particular strain on Southern European regions, where larger segments of the populations are already at greater risk due to rapid ageing and care systems are underfinanced.

The rise of solo ageing also has long-term implications for care and highlights the need for strong public systems and community-based alternatives to familial care (Mudrazija et al., 2020). This transformation extends beyond the care sector: Housing, transport, and social infrastructure must adapt to ensure independence, accessibility, and dignity for an increasing number of people who will be ageing without family support. The private market will inevitably also play a growing role in meeting future care and housing needs, but governments will need to be proactive in safeguarding the quality, accountability, and affordability of these services. The need for such safeguards also stems from persistent care inequalities across Europe. For instance, an income gradient can be observed in care needs among older adults, with needs generally decreasing as income levels rise (Kalavrezou et al., 2025). This relationship may also involve reverse causality, which tends to be more pronounced in the context of long-term care (LTC) than in healthcare. Individuals with higher care needs often experience reduced income due to limited work capacity or the increased financial burden associated with formal care services.

In parallel, care systems must respond to increasing cultural and social diversity. Providing equitable and person-centred services requires an understanding of different cultural expectations, language barriers, and intersecting identities. Diversity-sensitive care stresses the need for inclusive care environments, workforce training, and communication practices that reflect the patients' diverse backgrounds and perspectives (Lauwers et al., 2024).

Technology and innovation hold considerable promise for addressing these challenges but raise new ethical and practical questions themselves. Advances in digitalisation, robotics, and assistive technologies can enhance autonomy, daily life management, and safety, particularly for people living alone. The European Skills Partnership for the Long-Term Care Sector aims to train 60% of care professionals annually in digital and person-centred competencies by 2030 (European Commission, 2023b). However, a significant digital divide remains: Around 60% of adults aged 65–74 lack basic internet skills, and half do not use email (Eurostat, n.d.). Without parallel investment in training, accessibility, and affordability, technological innovation risks deepening rather than reducing inequalities.

Moreover, sectors like care cannot be fully automated. Technologies such as remote monitoring, assistive robotics, and smart home systems may help address workforce shortages, but they cannot replicate empathy, trust, and social connection. Ethical concerns about data and overall privacy, depersonalisation, and the quality of human interaction remain central (Hui et al., 2021; Hung et al., 2022). The most promising innovations are those that strengthen, rather than replace, human relationships—supporting interprofessional collaboration, preventive care, and continuity of support. Innovation in LTC must therefore be understood not only as technological progress but also as social progress: the ability to adapt systems to new realities while preserving the dignity and humanity of care.

## Policy Priorities and Takeaways for Europe and Beyond

Public spending on long-term care (LTC) should be reframed as an essential investment rather than a burden on public finances, and LTC must be understood as a central welfare service instead of a marginal one. The sector offers a revealing benchmark of social commitment, showing how far societies are prepared to invest in protecting the well-being of their own populations. In Europe, it will serve as a test of the fairness and cohesion of the European social model itself.

While well-designed systems today help meet current care needs, demographic and epidemiological analyses suggest that future needs will be even greater. The solution is proactive action: using medium- and long-term projections to guide decisions rather than reacting to crises as they arise. Beyond the care sector, housing, transport, and community design will play as great a role in ageing policy as healthcare or pensions.

The care workforce is the cornerstone of this system and must be recognised and supported as such. Strengthening employment conditions, pay equity, and career pathways in the sector is a precondition for quality care and for attracting younger generations to care professions. Policies should also value and support informal carers, without pushing them into poverty or labour market exclusion. A sustainable LTC system is one that enables both paid and unpaid carers to live with dignity, balancing care responsibilities with opportunities for personal and professional fulfilment. Ageing populations themselves should also not be viewed as a burden. Older people have contributed throughout their lives, through work, taxes, caregiving, and civic participation, and deserve to age with dignity, irrespective of income, health, or family status.

The current European conversation is dominated by talk of resilience, namely, how to withstand shocks and strengthen strategic autonomy. While such a framing is justified, what truly sustains societies in the long run is their capacity to care for and support one another. Building robust care systems is not merely about surviving crises but about shaping humane and forward-looking communities amid rapid change.

Beyond Europe, ageing is accelerating in Asia, Latin America, and other regions of the world, offering opportunities for mutual learning. Countries at all stages of demographic transition can draw lessons from one another's experiences, recognising both the strengths and the limitations of existing models.

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# Human Rights and Supported Decision-Making in the Care of Older Adults: Progress and Challenges in the Implementation of the Australian Aged Care Act 2024

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Supported decision-making is a critical element of contemporary rights-based care, through which the fundamental right to equal recognition before the law can be enabled for people who have cognitive disabilities which impact their decision-making. While supported decision-making has a long history of established practice and evidence in disability services, it is recently coming to greater prominence in the health and social care of older adults. In this paper, I seek to analyse the extent to which supported decision-making is meaningfully enabled by the recent Australian Aged Care Act 2024 and its associated regulations and policies. I propose that while the new legislative provisions constitute significant progress in upholding the rights of older adults, there are a number of remaining challenges which need to be addressed. Following a brief description of supported decision-making and an outline of its recent history in the Australian context, I analyse three key challenges in effectively implementing supported decision-making in the care of older adults: a) the challenge of implementing legislation and policy for the aged care sector across Australia's federated system, b) the need to craft policy settings which uphold rights for the most vulnerable while avoiding government overreach, and c) operationalising and interpreting the rights-based concept of will and preferences in practice, which will be key to effectively implementing supported decision-making. I argue that addressing each of these challenges will require an appreciation of Australia's unique policy and demographic context, including the diversity of the older adult population, the capabilities and stressors impacting the aged care sector, and the relative recency of adopting human rights concepts into laws and policies with respect to aged care.

The United Nations Convention on the Rights of Persons With Disabilities (CRPD; 2006) requires governments and civil society to uphold the rights of persons living with disabilities. The CRPD is guided by principles of dignity, autonomy, non-discrimination, participation, inclusion, acceptance, equality, and accessibility. It articulates the ways in which people living with disabilities can experience barriers in accessing universal human rights, and the measures needed to uphold these fundamental rights, as outlined in the International Covenant on Civil and Political Rights (ICCPR; 1966) and the International Covenant on Economic, Social, and Cultural Rights (ICESCR; 1966). Developed through collaboration among disability advocates internationally, the CRPD has been one of the most widely ratified of any United Nations treaty, with 82 signatories on its opening day (the highest ever) and 164 signatory nations as of the time of publication of this manuscript (United Nations Department of Economic and Social Affairs, n.d.).

While the CRPD sets out rights across a range of domains, it is the right to equal recognition before the law (Article 12) that is considered one of its most paradigm-shifting elements. Article 12 requires governments to recognise that persons with disabilities enjoy legal capacity on an equal basis with others, and to provide access to support for people with disabilities in exercising their legal capacity, through measures that are safeguarded from abuse and undue influence and that respect the rights, will and preferences of the person (Convention on the Rights of Persons With Disabilities, 2006). The United Nations Committee on the Rights of Persons With Disabilities (2014) has stated that the CRPD requires signatory nations to replace substitute decision-making regimes with supported decision-making.

Supported decision-making has emerged as an important conceptual development, and a practical way of giving effect to the requirements of CRPD Article 12 (Gooding, 2013). While supported decision-making is not defined within the CRPD, in the international arena it has been broadly defined as "the process whereby a person with a disability is enabled to make or communicate decisions with respect to personal or legal matters" (United Nations Office of the High Commissioner on Human Rights, 2009, p. 15). Supported decision-making has been proposed as a means of enabling equal recognition before the law for people with disabilities, in particular for those with cognitive disabilities which may impact on their decision-making.

In the Australian setting, the Australian Law Reform Commission established a set of National Decision-Making Principles, which were promoted as a way of giving effect to the CRPD within domestic Australian laws and policy (Australian Law Reform Commission, 2014). The commission's inquiry and recommendations for a national response to elder abuse also promoted the use of the National Decision-Making Principles in future reforms of aged care legislation (Australian Law Reform Commission, 2017).

## The Australian Aged Care System and the Need for Supported Decision-Making

There have been recent efforts towards implementing supported decision-making, and related rights-based concepts and practices, in the formalised care of older adults (known as aged care in Australia). This section first outlines the context for the provision and regulation of aged care services in Australia, along with a description of the legislative and decision-making frameworks which govern supported or substitute decision-making for different types of decisions. Data indicating recent and projected future population and societal trends demonstrate the growing need to develop and embed supported decision-making in the care of older adults.

The Australian aged care system provides services for an estimated 1.3 million older adults, with over 840,000 receiving care at home (Alsaeed et al., 2025). Aged care services are delivered in residential aged care homes or in-home settings, and approved aged care providers are regulated and funded by the Commonwealth Government. Older adults can apply to access these aged care services through an assessment called "My Aged Care" (Australian Government Department of Health, Disability, and Ageing, n.d.b). A Complaints Commissioner is responsible for responding to complaints, and the Aged Care Quality and Safety Commission undertakes accreditation of approved aged care providers against the Aged Care Quality Standards (Australian Government Department of Health, Disability, and Ageing, 2025d). On a proportionate basis, Australia provides aged care services to more of its citizens than any other country in the Organisation for Economic Co-operation and Development (OECD; Alsaeed et al., 2025).

While aged care and disability services are funded and regulated by the Commonwealth (national) Government, state or territory jurisdictions control the laws relating to decisions about financial, healthcare, lifestyle, or personal matters. This creates policy and practice complexities in decision-making for older adults. These state and territory legal frameworks differ in a number of ways; however, they are each grounded in common law doctrines of voluntariness, informed consent, and the presumption of decision-making capacity. Aside from emergency situations involving imminent and serious risk of harm to a person or others, substitute decision-making requires a determination that the person is experiencing a loss of decision-making capacity, and this determination applies in a time- and decision-specific way (O'Neill & Peisah, 2021). An additional point of interest in Australia is a devolved system of administrative tribunals, which, while not perfect, provides a more low-cost and accessible mechanism for hearing disputes, encouraging resolution, and, where necessary, making orders and appointments relating to substitute decision-making (Tait & Carney, 2013).

Perhaps the most significant differences across the state and territory jurisdictions relate to the legislative frameworks underpinning supported or substitute decision-making. While all Australian states and territories make statutory provisions for substitute decision-making, Victoria is the only jurisdiction with a framework enabling the formal appointment of supporters (Office of the Public Advocate—State of Victoria, 2018). Across the other Australian states and territories, a functional capacity threshold forms the criterion for authorising substitute decision-making. The key jurisdictional differences relate to whether substitute decision-makers are required to uphold a substituted judgement standard (i.e., standing in the person's shoes and attempting to make the decision that the person would have made) or best interests standard (i.e., acting to promote what is judged to be best for the person; Blake et al., 2021).

Like in many countries around the world, Australia's population is ageing (Australian Institute of Health and Welfare, 2024), with implications for the planning and delivery of aged care services. Over 50% of older Australians (65 years or older) are living with some form of disability, and just under 96% of older adults live in private households or retirement units, with 39.8% of this group requiring assistance with one or more everyday activities of living (Australian Bureau of Statistics, 2024). 20% of older Australians were born in non-English-speaking countries, with 18% speaking a language other than English at home (Australian Bureau of Statistics, 2024).

An increasing number of older adults are experiencing ageing-related neurodegenerative conditions or other long-term conditions, which may contribute to cognitive disabilities. Dementia affects over 400,000 Australians, and it is the leading cause of death in Australia (Australian Institute of Health and Welfare, 2025). The diagnosis of dementia often prompts the need for a number of decisions, ranging from medical investigations and treatments to the provision of care in home or residential settings, financial management of existing assets, and planning for emerging care needs. Many people living with dementia wish to continue making decisions about their own life (Fetherstonhaugh et al., 2013; Sinclair et al., 2019), and active involvement in decision-making is associated with increased quality of life, reduced depressive symptoms, and lower relationship strain (Menne et al., 2008; Miller et al., 2019). However, dementia can also create individual and interpersonal challenges in decision-making (Peisah et al., 2006), and applications to tribunals seeking guardianship or financial administration orders for substitute decision-making involving people with dementia have increased rapidly in the modern era (Chesterman, 2013). Alongside the growing prevalence and impact of dementia, societal ageism and elder abuse also impact on the rights and effective participation of older adults, and require urgent action (Australian Law Reform Commission, 2017).

Collectively, these societal trends demonstrate the importance of effective laws and public policy to uphold the rights of older Australians and enable supported decision-making where relevant. However, in comparison with the disability sector, supported decision-making in the aged care sector is at an earlier stage of development. Some work has been undertaken to inform the practice of supported decision-making in the context of dementia; however, this has yet to be implemented broadly (Cognitive Decline Partnership Centre, n.d.). The next section outlines recent developments in the laws and policies governing aged care services in Australia, with implications for the broader use of supported decision-making.

## The Australian Aged Care Act 2024

Across the past decade, the Australian aged care system has been experiencing rapid, widespread, and fundamental reforms. These have included the expansion of services, changes in funding models, and the implementation and updating of quality standards. This sector has not been without controversy, with widespread failures and general agreement that the sector was not effectively responding to the contemporary needs of older adults (Royal Commission Into Aged Care Quality and Safety, 2019). This prompted the establishment of the Royal Commission Into Aged Care Quality and Safety, to examine legislation and the regulation, and delivery of services. The commission made a range of recommendations, including the need for a new rights-based legislative framework, built around the needs of older adults, rather than (as was previously the case) primarily a means of administering financing for aged care providers (Royal Commission Into Aged Care Quality and Safety, 2021). The Aged Care Act 2024 (the Act) was passed on November 25, 2024, and implemented on November 1, 2025 (Australian Government Department of Health, Disability, and Ageing, n.d.a).

The Act has been promoted as a once-in-a-generation opportunity to address inequities in the care of older adults, and embed a rights-based approach, which will equip Australia for the demographic and social changes associated with an ageing population (Rae, 2025). In contrast to the previous legislation governing aged care, the Act explicitly engages human rights through the Convention on the Rights of Persons With Disabilities (CRPD), including

CRPD's Article 12(2), as well as International Covenant on Economic, Social, and Cultural Rights (ICESCR) and International Covenant on Civil and Political Rights (ICCPR; Parliament of the Commonwealth of Australia, n.d.), and provides a definition of high-quality care, a statement of rights for older adults seeking or receiving aged care services, and principles that apply for funded aged care providers as well as the various agencies and departments involved in administering and regulating the aged care sector (Aged Care Act, 2024).

Importantly, the Act sets out requirements for supported decision-making. These include the Statement of Rights, which reads that "an individual has a right to exercise choice and make decisions that affect the individual's life" and also that they have a right to "be supported (if necessary) to make those decisions, and have those decisions respected" (Aged Care Act, 2024, Section 23). Supported decision-making is defined inclusively in a policy statement (Australian Government Department of Health, Disability, and Ageing, 2025a):

> [It involves] processes and approaches that enable people to exercise their legal capacity, including making or communicating their decisions, will and preferences, by provision of the support they may want or need to do so. This support may involve a range of persons, services, and assistive technologies. Supported decision-making does not mean making a decision for, or on behalf of, another person. (p. 3)

While supported decision-making can occur informally, the Act also provides a legislated framework for formally registered supporters of older adults (Aged Care Act, 2024, Chapter 1), with key components outlined below:

- Registered supporters can be nominated by an older person and have privileges (e.g., access to the older person and access to information about the older person's care in line with the will and preferences of the older person; Aged Care Act, 2024, Sections 27, 156).

- Registered supporters have duties (including assisting the older person in making and communicating decisions, promoting the older person's will and preference, acting honestly, and managing conflicts of interest; Aged Care Act, 2024, Section 30).

- Registered supporters do not have the authority to make decisions on behalf of an older person (Australian Government Department of Health, Disability, and Ageing, 2025b).

- Registered supporters are overseen by the "System Governor," an administrative body within the Department of Health, Disability, and Ageing. The System Governor may, under special circumstances, approve the registration of a supporter in cases in which the older adult is unable to provide consent (Aged Care Act, 2024, Section 37).

- The System Governor can undertake investigations, and may suspend or cancel a supporter's registration if needed (Aged Care Act, 2024, Sections 50–54).

The Act does not define decision-making capacity but instead embeds a presumption of decision-making capacity through the Statement of Rights and the roles and duties of supporters (Australian Government Department of Health, Disability, and Ageing, 2025c). Importantly, the Act does not authorise supporters to make substitute decisions—this can only be done under an authority from a relevant state, territory, or Commonwealth appointment (Australian Government Department of Health, Disability, and Ageing, 2025b). Ordinarily, the authority for substitute decision-making would require substantive evidence that the older person is unable to make the relevant decision themselves (e.g., through a medical certificate), and this authority is limited to the scope of the appointment made. These aspects of the Act give some assurance that substitute decision-making will become less common over time, at least in the context of decisions about funded aged care services.

While there are some positive developments associated with the greater prominence of supported decision-making within the new Act, there remain a number of significant challenges with the implementation of supported decision-making. Some of these are a product of the federated legislative environment, in which aged care services are regulated at the Commonwealth level while the mechanisms governing health, financial, lifestyle, and personal decision-making (including substitute decision-making) operate at a state and territory level. There are further challenges arising from the diversity of the older adult cohort to which the Act applies, and the need to craft policy settings that uphold rights for the most vulnerable, while avoiding bureaucratic interference or projecting ageist assumptions about disability or need for support upon older adults more broadly. These policy challenges coalesce in the third area to be discussed: defining, operationalising, and interpreting the rights-based concept of will and preferences in the context of the Act, with reference to the rights ascribed in the CRPD.

## *The Challenge of Implementing Legislation and Policy for the Aged Care Sector Across Australia's Federated System*

The first ongoing challenge in implementing supported decision-making in the care of older adults arises from the federated Australian system. A first iteration of this legislation, a consultation draft of the Aged Care Bill, proposed a system in which supporters or representatives (a type of substitute decision-maker) might be appointed through the Aged Care Act (Australian Government Department of Health, Disability, and Ageing, 2023). This proposal was roundly criticised for being unnecessarily complex and creating conflicting responsibilities between those appointed as representatives within Commonwealth legislation and those appointed under state or territory legislation (Carney et al., 2024; Chesterman, 2024).

Fortunately, the Act in its final form mostly departs from capacity-based substitute decision-making, and instead sets out processes and frameworks for supported decision-making. This means at least that the new legislation does not introduce additional and competing substitute decision-making roles. However, it remains that aged care providers still deliver their services within one or more state- and territory-based jurisdictions. Across these different states and territories, substitute decision-making mechanisms are still very much in play (Stewart, 2025). This situation creates a number of complexities.

Firstly, supporters under the new Act have a primary role in assisting the older person to make decisions and promoting the older person's will and preferences. A person appointed as a substitute decision-maker at a state or territory level can potentially have authority to override the supporter's efforts. The Act foresees this problem and clarifies that appointed substitute decision-makers can nominate to be registered as supporters on application to the System Governor. However, this still requires the substitute decision-maker to make the formal application, and provide evidence of their substitute decision-making authority.

Secondly, in states such as Western Australia and New South Wales, where the outdated best interests standard for substitute decision-making is still in use, appointed substitute decision-makers will be held to an entirely different standard of conduct in their role than they would in their role as a registered supporter within the new Act. This is likely to create confusion, and it remains to be seen whether this complexity increases complaints or tribunal applications (Stewart, 2025).

Thirdly, there is the quite probable scenario in which disputes arise between an older person's supporter and other family members or friends of the older person. Such disputes may result in these family members or friends lodging tribunal applications at a state or territory level, making the case that the supporter is enabling decisions that are too risky, with the broader aim of overriding the supporter. In this case, the ongoing support for the older person's rights would be subject to the decision made by the tribunal, which, in many cases, would operate under state or territory legislation that is not as explicitly rights-based as the Aged Care Act 2024. These practices may increase the volume of unnecessary tribunal applications and, in some cases, result in unnecessary appointments of substitute decision-makers. Aged care providers will have an important role in preempting such conflict by educating the community (particularly family and friends of older people) about the practice of supported decision-making and how it aligns with the older person's rights.

## *The Need to Craft Policy Settings Which Uphold Rights for the Most Vulnerable While Avoiding Government Overreach*

The implementation of supported decision-making within the Act creates a somewhat unique policy challenge. While the conceptual basis of supported decision-making has been developed within the context of disability advocacy, and given additional weight by international instruments such as the CRPD, it remains that a substantial number of older adults are not people with disabilities. While ageing does increase the likelihood of experiencing disability, conflating these two populations is an ageist assumption. In any case, for example, it is well established that dementia, which can have a negative impact on decision-making ability, is not a normal part of ageing (Dementia Australia, n.d.). Even if an older adult experiences functional changes that impair physical or communication abilities, their decision-making ability should not be assumed to be impacted.

Given the diversity of the older adult cohort, the definitions and frameworks for supported decision-making in the Act have been necessarily broad. It can be seen that the issues raised above (the risk of conflating older people with people with disabilities, as well as the broader diversity of older people) are foreseen and partially addressed, through explicit statements that having a supporter is voluntary, and there is no requirement to register a supporter (Australian Government Department of Health, Disability, and Ageing, 2025c). The breadth of the definitions and frameworks for supported decision-making is also illustrated by the inclusion of concepts like universal design as a component of supported decision-making. Universal design is undoubtedly an important aspect of providing accessible services, but such strategies should be adopted broadly across the aged care sector and not seen as a component part of supported decision-making. Including a reference to universal design within supported decision-making creates a risk that aged care providers will consider measures such as presenting written material in larger font, or making available translated materials, as constituting evidence that they are meeting the requirement to provide supported decision-making under the Aged Care Quality Standards, when in fact these accessibility measures should be provided routinely. I argue that these measures do not constitute supported decision-making, as envisioned in the international definition, which is more grounded in the needs of people with disabilities (United Nations Office of the High Commissioner on Human Rights, 2009). Ongoing policy-making in this area will need to continue to appreciate this diversity and nuance and to educate aged care providers about the individually tailored and needs-based approach that is required, while avoiding net-widening (Carney & Beaupert, 2013) or reinforcing ageist assumptions that all older adults need support.

## *Operationalising and Interpreting the Rights-Based Concept of Will and Preferences in Practice, Which Will Be Key to Effectively Implementing Supported Decision-Making*

This third section addresses a topic of key importance to the practical implementation of supported decision-making, the interpretation of the rights-based concept of will and preferences in the Act. The CRPD refers extensively to the concept of will and preferences, with a strong implication that this moral standard is superior to substitute decision-making via a best interests standard (Skowron, 2019). It also identifies that "where, after significant efforts have been made, it is not practicable to determine the will and preferences of an individual, the 'best interpretation of will and preferences' must replace the 'best interest' determinations" (United Nations Committee on the Rights of Persons With Disabilities, 2014, para. 21). Despite the substantive weight given to the concept of will and preferences, the CRPD does not define this term. Similarly, the Act uses will and preference terminology without providing a working definition.

Existing scholarship and discussion on the concept of will and preferences provide a number of interpretations that become particularly relevant in navigating complex cases (Carney et al., 2019). Szmukler (2019) proposes a differentiation between will and preferences: will as "a person's deeply held, reasonably stable and coherent personal beliefs, values, commitments and conception of the good" and preferences as "desires, inclinations or preferences expressed in the present" (p. 38). Flynn and Arstein-Kerslake (2014) recognise the role of interpretation in arriving at a true or authentic rendering of a person's will and preferences. While acknowledging the potential for this process to subvert the individual's rights, in all cases they consider this interpretive process to be superior to reference to a best interests standard. In particular, Skowron's (2019) careful reading acknowledges and illustrates the ways that the interpretive act can be either a facilitative or abusive influence on the person's rights but also steps into more radical territory by rejecting the epistemic reading that there is a knowable, true will and preferences, asserting instead that all attempts to ascertain a person's will and preferences necessarily involve some element of interpretation and (usually) co-construction. He concludes that rigorous reflection by those engaged in interpreting will and preferences, along with the involvement of people with disabilities in a dialogue of everyday interpretations of will and preference, is most likely to yield the most ethically defensible outcomes and most effectively uphold human rights (Skowron, 2019).

In the context of the Aged Care Act 2024, defining will and preferences comes with a number of policy challenges. As already described, the Act operates across a range of state and territory jurisdictions. Some of these jurisdictions adopt (to a greater or lesser extent) elements that would be aligned with a will and preferences approach to decision-making, while others retain a best interests standard (Blake et al., 2021). Secondly, unlike other relevant examples such as guardianship or mental health legislation, the cohort for which the Act applies is not limited to people with cognitive disabilities. Instead it must apply across the diverse population of older adults who may be seeking or accessing aged care services, whether this be due to the presence of a cognitive disability or any other requirement for assistance in activities of living. Thirdly, the context of dementia is one in which it is well understood that individuals can experience changes in their expressed preferences, sometimes as a result of the disease process (Peisah et al., 2013).

Intriguingly, and perhaps mindful of these concerns, the policy interpretation of will and preference which accompanies the Act departs significantly from existing scholarship or established policy examples in the mental health and disability sectors. The Department of Health, Disability, and Ageing's *Choice and Control Policy for Registered Supporters* adopts an explicitly literal reading of will and preferences:

> Registered supporters can only support an older person, receive information, or communicate an older person's decision if this is in line with their known will and preferences. Simply put, this means what the registered supporter knows the older person currently wants, now or in the future. A person's will and preferences can also change. If an older person is currently expressing a will or preference that is different to their previously expressed will and preference, the most current expression of their will or preferences can be considered their known will and preferences. (Australian Government Department of Health, Disability, and Ageing, 2025b, pp. 5–6)

This literal rendering of the will and preferences concept departs from existing understandings in two ways. Firstly, it emphasises direct expression (presumably evidenced through verbal or behavioural methods), obscuring any possibility of interpretation in the language of known will and preferences. Secondly, it explicitly privileges the most current expression of preferences. This varies substantially from the interpretation provided in the National

Disability Insurance Scheme's policy on supported decision-making, which explicitly acknowledges a lifespan approach and identifies situations in which a person's longer-term will should be balanced with their more immediate expressed preferences (National Disability Insurance Agency, 2023, p. 20).

It is likely that this interpretation is motivated by concern that any interpretative process or balancing of will and preferences, even if identified as acceptable in other settings, may be seen as a loophole through which supporters might cease to consult actively with the older person, or might apply ageist stereotypes to justify interpretations that infringe on the older person's rights. However, the blanket definition of the most current expression as the known will and preference potentially creates problematic situations, particularly given that will and preferences can be expressed through diverse methods (e.g., gesture or behaviour). For a person with advanced dementia or another cognitive disability, or someone experiencing an acute delirium, there are possibilities that enacting all expressed preferences might place them in situations of serious and imminent risk to their safety. At a deeper level, and echoing long-running philosophical debates (e.g., Dresser, 1995; Dworkin, 1986), some people living with dementia have expressed fears about what might happen under a supported decision-making framework in future situations, particularly if their expressed preferences contradict important life values (Flavin, 2025). Social science research has shown that substantial proportions of the general public want a way to ensure that preferences expressed in the advanced stages of dementia do not override prior directions made at a time of greater mental clarity (Schoene-Seifert et al., 2016). Inevitable complexities will arise in the aged care setting, and further discussion and debate are needed to ensure that reference to a person's narrative history does not obscure tailored, person-centred care and the person's forward-looking narratives as their dementia journey continues (Berendonk et al., 2020). In literal terms, a person's life story, or previously expressed values, should not hold them frozen in time, particularly on matters of everyday care that do not present serious risks or challenge core life values (Sinclair, 2025). The emerging field of narrative identity and narrative ethics focuses on the ways in which dementia can disrupt identity through memory loss, as well as how identity can be sustained through distributed memories, held and embodied by other people or assistive technologies (Heersmink, 2022). Rigorous and reflective practice, informed by work from this field, may be of value in resolving some of these ongoing ethical tensions (Ringkamp, 2023) and will be important in guiding future policy and practice in this area.

## Conclusion

In conclusion, the Aged Care Act 2024 has made a number of substantial developments in the implementation of supported decision-making in the provision of health and social care for older adults in Australia. While the scope of this Act is limited to decisions about funded aged care services, it can stimulate new efforts in implementing supported decision-making. It will be of interest to see whether this reform can drive similar developments in other Australian jurisdictions. The ongoing process of policy implementation will require an appreciation of Australia's unique policy and demographic context, including the diversity of the older adult population, the capabilities and stressors impacting the aged care sector, and the relative recency of adopting human rights concepts into laws and policies with respect to aged care.

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# Where Mistakes Are Welcome: New Approaches to Dementia Inclusion

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People living with dementia and their care partners face not only the physical and psychological challenges of the disease, with its disrupted communication and lack of connectedness, but also the social isolation and loneliness that follow (Alzheimer's Disease International, 2024). For those living with dementia, memory loss and cognitive decline are likely to narrow the scope of daily life, while family members, friends, or care partners often need to restrict their social activities in order to provide care, and thus experience heightened psychological stress. In response, the concept of the *Memory Cafe* has emerged as a space where individuals with dementia and their care partners can meet and interact, and thus alleviate their social isolation (Alzheimer's Disease International, n.d.). Also referred to as *Alzheimer Cafe,* these venues were first established in 1997 in the Netherlands, the brainchild of Bère Miesen, and offer a safe and welcoming environment for people living with dementia and their care partners; those with expertise or interest in dementia are also welcome (Alzheimer's Disease International, n.d.). Over time, Memory Cafes have spread throughout Europe (e.g., Engaging Dementia, n.d.; Francis, 2000; Seia & Baldo, 2025), and around the world their numbers are also growing steadily (e.g., Kakuchi, 2023; McFarlane, 2025), with positive consequences for social isolation prevention and improved psychosocial well-being (e.g., Dow et al., 2011; Innes et al., 2022; Protoolis et al., 2022).

Some have taken the idea of the Memory Cafe one step further, and created cafes and restaurants where people with dementia serve customers directly. These venues go beyond simply providing a space for socialization; they function as experimental models that encourage people with dementia to reclaim their roles as members of society and reshape public perceptions of the condition. A pioneering example of such a model is *注文をまちがえる料理店* [the Restaurant of Mistaken Orders], which was launched in Japan in 2017. A similar project, *기억다방* [Memory Cafe], has been running in South Korea since 2018. This paper discusses these two initiatives, with the aim of fostering new ideas in relation to care and promoting positive social change.

## The Restaurant of Mistaken Orders

*The Restaurant of Mistaken Orders,* a unique pop-up restaurant launched in Tokyo in 2017, was the idea of television producer Shiro Oguni (Oguni, 2018). Its name is a playful parody of Kenji Miyazawa's fairy tale *The Restaurant of Many Orders.* At this restaurant, people with dementia work as hall staff, taking orders from customers and serving dishes. Because of the symptoms of dementia, unexpected mistakes frequently occur—meals may be delivered to the wrong table, or table settings may take longer than usual—but both customers and staff embrace these situations with the relaxed, easygoing understanding that it is fine to make mistakes and be a little late. This philosophy is embodied in the logo of the restaurant: the letter K in "Mistaken" is tilted 90 degrees and accompanied by a playful face sticking out its tongue, representing the bashful expression that often follows a mistake. Conveying the message that small errors by people with dementia can be received with laughter and enjoyment, the logo symbolically reflects the values that the restaurant seeks to promote (Oguni, 2018): open-mindedness and tolerance, understanding and generosity, acceptance and inclusion, communication and connection, and, ultimately, freedom and care.

Individuals with dementia, even those who were once highly active in society, experience to a greater or lesser degree diminished memory, learning, and communication skills, and, as dementia progresses, become less able to carry out everyday tasks. These symptoms make it difficult for people with dementia to continue functioning in their (previous or current) roles, leading to a loss of confidence and social isolation. The Restaurant of Mistaken Orders offers them the reassurance that there are still meaningful jobs they can perform, as well as the opportunity to engage with a diverse group of people.

The restaurant recruits hall staff from among older adults with dementia who, despite their diagnosis, remain motivated and wish to continue working (Oguni, 2018). They receive an honorarium of roughly ¥1,000 (U.S. $6.40) per hour. On-site managers with experience in dementia care provide support whenever needed. The Restaurant of Mistaken Orders operates about four hours a day (e.g., from 11 a.m. to 3 p.m.), a schedule devised with people with dementia in mind, since, as the disease progresses, they easily become exhausted. The act of standing and serving continuously for a few hours presents a considerable challenge for individuals living with dementia, so the restaurant has a room with beds where they can rest. The order sheet lists both the table number and the menu number, and diners are instructed to circle the name of the dish, making the hall service easier to follow. Older adults with dementia who take orders may struggle to understand them quickly or forget what was requested. For this reason, staff hand the order sheet directly to customers so they can mark their choices themselves. Nevertheless, it is still quite common for a dish other than what was ordered to be served accidentally. Since customers are informed of this possibility in advance, such occurrences are not regarded as problems (Oguni, 2018).

In the Restaurant of Mistaken Orders, customers actually embrace mistakes, creating an atmosphere of shared enjoyment (Government of Japan, 2019). Under ordinary circumstances, the errors made by people with dementia are often regarded as troublesome inconveniences that need to be corrected with outside assistance. Here, however, customers not only accept mistakes as harmless but often view them as a source of entertainment, even anticipating with curiosity what kind of mistake might occur (Georgescu, 2023; Oguni, 2018). This shift both helps people with dementia live with greater confidence and contributes to reshaping social perceptions of what it means to live alongside them.

Shiro Oguni, who planned the restaurant, conceived the idea while he was working as a television producer and covering a group home for people with dementia (Oguni, 2018). There he observed residents selecting menus, shopping for ingredients, and preparing meals themselves. Although hamburger steak had originally been planned for lunch on the day he was visiting, what was actually served turned out to be boiled dumplings. Surprised at first, he noticed that no one else regarded it as a problem, and at that moment he realized there was no problem. This experience eventually inspired him to create the Restaurant of Mistaken Orders, bringing together experts from interior design, media, fundraising, dementia care and caregiving, as well as cooking and restaurant management, to establish an executive committee. Once funds had been raised through crowdfunding, the project was launched formally (Oguni, 2018).

Following a pre-opening event in June 2017, the first official session of the Restaurant of Mistaken Orders was held in Roppongi District, Tokyo, in September of the same year (Restaurant of Mistaken Orders, n.d.). The model did not go unnoticed, and the project was replicated in other locations, such as Machida in September 2017, Shizuoka in May 2018, and even the building of Japan's Ministry of Health, Labor, and Welfare in March 2019. The model went on to earn national and international recognition, winning Silver in the design category at the 2019 Cannes Lions, Silver and Bronze at the 2019 London International Awards, and the Grand Prix at the 2019 ACC Tokyo Creativity Awards (Restaurant of Mistaken Orders, n.d.), all of which are prestigious award programs in the field of communication. Similar Mistaken Orders initiatives have emerged, including 世界一やさしいレストラン [the Kindest Restaurant in the World] in Kurashiki City, Okayama Prefecture (KSB, 2019) and Toyota City, Aichi Prefecture (Murase, 2018) and ハプニングラーメン [Happening Ramen] in Sukagawa City, Fukushima Prefecture (NPO Houshinkai, n.d.); other projects continue to unfold across Japan today. Most projects have involved short-term events lasting one or two days, although in some places they happen on a more regular basis, like two or four times a month.

In 2018, a public interest incorporated association was established by the original members of the Restaurant of Mistaken Orders. The association was headed by Yukio Wada, a dementia care specialist who had worked alongside Shiro Oguni since the restaurant's inception. The group organizes short-term events across Japan in which people with dementia serve as hall staff in restaurants, as well as fundraising activities to raise public awareness of dementia. In addition, they provide consulting services for organizations interested in pursuing similar initiatives.

## A Related Case: The Memory Cafe in Seoul

In South Korea, where rapid population ageing is underway, similar efforts are being made to foster a dementia-friendly social environment. A representative example is the Memory Cafe operated in Seoul (Seoul Metropolitan Government, 2018). (Memory Cafe is the English translation of the project's name in Korean, *기억다방*, an acronym of *기억을 부르는 다양한 방법*, which means, literally, various ways to preserve memory.) This initiative has been conducted since 2018 as part of a dementia awareness campaign jointly organized by Handok (a pharmaceutical company), the Seoul Metropolitan Government, the Seoul Metropolitan Dementia Center, and the Dementia Relief Centers of all 25 districts in Seoul. At this venue, older adults diagnosed with mild dementia or mild cognitive impairment work as cafe staff, taking orders and preparing and serving beverages (see Figure 1). They are paid ₩10,000 per hour (around U.S. $7). In the same spirit as the Restaurant of Mistaken Orders, it is a rule that customers respond with understanding if the drink served differs from what was ordered or if service is somewhat delayed.

The Memory Cafe operates either in the form of a mobile food truck at local events (not always dementia-related) or as a permanent cafe located within district Dementia Relief Centers. Permanent Memory Cafes were first introduced in 2021, and are now in operation across 10 districts, including Gangdong-gu, Guro-gu, Geumcheon-gu, Dongjak-gu, Mapo-gu, Seodaemun-gu, Seocho-gu, Seongbuk-gu, Songpa-gu, and Eunpyeong-gu (Figure 2; Handok, 2024), all of which will continue in 2026 (Handok & Seoul Metropolitan Dementia Center, personal communication, November 26, 2025). Operating hours vary between centers; an older person living with dementia can work up to eight hours each month. In 2024 alone, the Memory Cafe was held 888 times in total—859 as permanent cafes and 29 as mobile cafes—serving 32,138 cumulative visitors and hiring 51 older persons living with dementia (Handok, 2025). In 2025, from January to October, 1,005 permanent cafes and 18 mobile cafes took place, with 27,754 cumulative visitors and 38 older persons living with dementia working at the cafes (Handok & Seoul Metropolitan Dementia Center, personal communication, November 26, 2025).

Such initiatives create opportunities for older people living with dementia and community members to interact naturally, helping restore the self-esteem of those with dementia and reducing the social stigma of dementia. For example, a server working at the cafe expressed her feelings of improved agency: “At first, I was concerned because the names of the drinks were difficult [to remember]. I now enjoy working here. It is fun” (Dongjak-gu Dementia Relief Center, 2023, 03:06). When a server forgot an order, a cafe patron responded: “We sometimes forget things. We are human beings after all” (Dongjak-gu Dementia Relief Center, 2023, 02:32).

Although the operating hours and scale remain limited, these efforts are gaining attention as a model of dementia care built collaboratively within local communities. According to Handok and the Seoul Metropolitan Dementia Center, the Memory Cafe has successfully established itself in the dementia care sector; it helps to alleviate social isolation among older adults with dementia and encourages them to engage in social activities (personal communication, November 26, 2025). Permanent Memory Cafes are conveniently located in the district Dementia Relief Centers, and this allows visitors and working staff also to take cognitive tests and get counseling in a welcoming environment. Mobile Memory Cafes are effective in enhancing public awareness of dementia outside of the center. The Seoul Metropolitan Government plans to increase community engagement employment opportunities for people with mild cognitive impairment in 2026, drawing on Memory Cafe’s operational experience. They say, “Memory Cafe is recognized as an excellent model for expanding and applying to other relevant projects” (Handok and Seoul Metropolitan Dementia Center, personal communication, November 26, 2025).

**Figure 1**

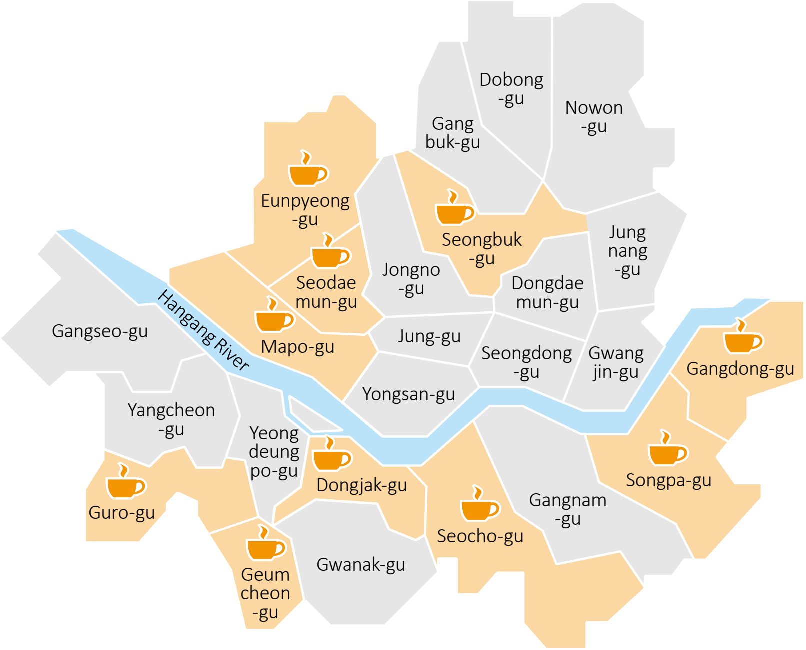
*Memory Cafes in Seoul*

(a) (b)

(c) (d)

*Note.* (a) A Mobile Memory Cafe took place in Gangseo-gu, Seoul, in 2024. Copyright by Handok. (b) The same mobile cafe as in (a). There was also a linked event where cognitive activities to prevent dementia were held (at the right of the photo). Copyright by Handok. (c) Permanent Memory Cafe at the Seodaemun-gu Dementia Relief Center in Seoul. By Seoul Metropolitan Government, 2021 (https://www.seoul.go.kr/news/news_report.do#view/339621). Korea Open Government License Type 4. (d) The same permanent Memory Cafe as in (c). By Seoul Metropolitan Government, 2021 (https://www.seoul.go.kr/news/news_report.do#view/339621). Korea Open Government License Type 4.

**Figure 2**



*Note.* Seoul's 10 districts with permanent Memory Cafes are marked with coffee cups on the map.

## Conclusion

The Restaurant of Mistaken Orders and the Memory Cafe are more than just dining venues. They stand as symbolic spaces, demonstrating that individuals living with dementia can continue to play meaningful roles as members of society. By embracing mistakes with a sense of freedom and care and transforming them into moments of shared laughter and enjoyment, these initiatives help to break down internal and external stigma about dementia and serve as small but definite steps toward building a society in which everyone is treated with dignity and respect. A guiding principle is that no harm should come to those involved in the project; for instance, extra care needs to be taken to avoid food or drinks that may be allergen-inducing or religiously or culturally forbidden. These initiatives carry significant implications not only for Japan and Korea but also for other countries facing rapid population ageing. As has been the case, even short-term events that create opportunities for people with dementia to reconnect with society can have positive effects not only on the individuals themselves but also on their families and the wider community. The spread of experimental and compassionate projects such as the Restaurant of Mistaken Orders and

Memory Cafe will lay the groundwork for building societies where no one is excluded.

(An earlier version of this article appeared in the ASEM Global Ageing Center's *Best Practices: Advancing Older Persons' Rights*, which was designed to highlight diverse Korean projects that contributed to the human rights of older persons. The essays in the project introduced instances of work not only by central and local government, but also by private bodies, such as social enterprises and non-profit corporations, to show how the public and private sectors can collaborate to promote the human rights of older persons.)

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# Advancing Rights-Based Long-Term Care in Thailand: Toward Inclusive and Equitable Care Systems

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Thailand's demographic transition has increased demand for long-term care (LTC) and sharpened debate on organising care within a rights-based framework. This paper conducts a desk-based analysis of Thai policy and programme documents in relation to international standards and technical guidance, complemented by insights drawn from publicly available expert materials. The community-based LTC model, introduced in Thailand in 2015–16, is assessed against the AAAQ criteria—availability, accessibility, acceptability, and quality—and in relation to the cross-cutting principles of non-discrimination, participation, transparency, and accountability.

The home-first delivery model is a core principle of Thailand's LTC system, prioritising the delivery of support services in the individual's home or community setting. This strategic approach serves as the operational mechanism enabling the broader goal of ageing in place to support the functional ability and dignity of older persons. Implementation involves integrated government actors: the National Health Security Office and Department of Health handle financing, while subdistrict health networks coordinate with local administrative organisations for local delivery and co-financing.

This paper identifies strengths in person-centred assessment, individualised care planning, home-first delivery through subdistrict health networks, and co-financing with local administrative organisations. Persistent gaps are observed in the affordability and coverage of social care, workforce stability and standards, participation and redress mechanisms, and the routine measurement of equity. The paper recommends codifying a national minimum social-care package, professionalising and protecting the workforce, institutionalising user councils with public performance reports and grievance procedures, developing an equity-weighted performance and financing system, and mainstreaming anti-ageism to align practice with international human rights obligations.

## Background and Motivation

Thailand is entering a new demographic era. In 2023, the country became an aged society, with persons aged 60 and over accounting for roughly one in five residents; by 2030, those aged 65 and over are projected to comprise around one in five, and by 2040, people aged 60 and over could constitute one-third of the population (Department of Older Persons, 2023; KPMG, 2024; United Nations Population Fund [UNFPA], n.d.; United Nations, 2024). This transition creates opportunities for longer, healthier lives, but it also raises pressing questions about care: Who provides it, who pays for it, who benefits from it, and how can it be organised on a foundation of human rights, equity, and dignity (World Health Organisation, 2015, 2024). These issues are far from abstract; they shape the daily lives of Thai people who must navigate chronic conditions, disability, and functional decline because of ageing. Thailand faces a widening caregiver gap and increasing pressure on informal carers alongside a shortage of paid care workers (International Labour Organisation, 2025). Moreover, in rural areas, youth out-migration has reshaped family structures, with many households increasingly composed of older members as younger generations move to cities for work—fundamentally altering care dynamics (HelpAge International & College of Population Studies, Chulalongkorn University, 2015; Khongboon & Pongpanich, 2018). The issues arising from demographic transition sit squarely at the intersection of health, social protection, labour markets, and local governance.

Global normative frameworks affirm that older persons are rights-holders. The International Covenant on Economic, Social, and Cultural Rights (ICESCR) articulates the right to the highest attainable standard of health (Committee on Economic, Social, and Cultural Rights, 2000) and the right to social security (Committee on Economic, Social, and Cultural Rights, 2008), while a specific comment on older persons urges states to pay particular attention to protecting their economic, social, and cultural rights (Committee on Economic, Social, and Cultural Rights, 1995). The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW; 2010) highlights the multiple forms of discrimination older women face and calls for comprehensive, affordable health care and social protection. The Madrid International Plan of Action on Ageing (MIPAA) and the United Nations Decade of Healthy Ageing, 2021–2030, urge integrated, person-centred systems that support maintaining intrinsic capacity and functional ability (United Nations, n.d.; World Health Organisation, 2015, 2024). Notwithstanding this guidance, the United Nations High Commissioner for Human Rights has concluded that international protection for older persons remains "fragmented and inconsistent," with notable normative and implementation gaps (Office of the High Commissioner for Human Rights, 2022, p. 1). Accordingly, care policy should be judged not only by efficiency or coverage but also by rights-based criteria such as AAAQ (availability, accessibility, including in its financial and informational aspects, acceptability, and quality), non-discrimination, participation, transparency, and accountability (Committee on Economic, Social, and Cultural Rights, 2000, 2008; Committee on the Elimination of Discrimination Against Women, 2010; Office of the High Commissioner for Human Rights, 2022).

In Thailand, the tax-financed Universal Coverage Scheme, administered by the National Health Security Office, has underpinned near-universal health care and significant equity gains since 2002, including in long-term care (LTC; National Health Security Office, 2020a). Over the last decade, Thailand has piloted and scaled a community-based LTC model that deploys care managers and trained caregivers through what are called Subdistrict Health-Promoting Hospitals; along with local administrative organisations, these offer home-based services for homebound and bedridden older persons (Asian Development Bank, 2020; Chanprasert, 2021; National Health Security Office, 2020b). Civil society innovations—such as the Foundation for Older Persons' Development (FOPDEV) in Chiang Mai and its Buddy HomeCare social enterprise—complement public efforts, particularly in the North, by mobilising volunteers and caregivers of various age groups. Nonetheless, fiscal pressures and labour shortages are mounting; sustained attention is required in terms of care affordability, workforce conditions, and gender inequities. In Thailand, the non-contributory old-age allowance remains modest relative to poverty thresholds, and out-of-pocket care costs can disproportionately burden low-income households, particularly where formal services are scarce (Foundation for Older Persons' Development, n.d.; Glinskaya et al., 2021; International Labour Organization, 2022b; Khongboon & Pongpanich, 2018; National Health Security Office, 2020a; Organisation for Economic Co-operation Development [OECD], 2024; Suriyanrattakorn & Chang, 2021).

Against this backdrop, this paper pursues two objectives. First, it discusses a rights-based framework for the care of older persons that is concrete enough to strengthen the care system in Thailand. Rather than treating care as a family responsibility or a narrow health-sector concern, we frame care as a public good grounded in international human rights law and in the principles of universal health coverage and social protection. Second, it synthesises the elements of Thailand's evolving care architecture (e.g., policy instruments, delivery models, financing, and actors), identifies persistent inequities and implementation bottlenecks, and draws lessons from them. The motivation is both scholarly and practical: to bridge an academic gap in the Thai literature, where care is often analysed as service delivery or welfare programming but less frequently as the realisation of rights; and to inform government, local administrative organisations, civil society, and development partners engaged in the United Nations Decade of Healthy Ageing.

## Care for Older Persons and Human Rights: Definitions and International Recommendations

Care for older persons spans health, social, and support services that help maintain functional ability and dignity. The World Health Organisation's healthy ageing paradigm centres on intrinsic capacity and functional ability rather than disease per se, and the Integrated Care for Older People (ICOPE) approach translates this paradigm into person-centred assessment, care planning, and community-based pathways across health and social sectors (World Health Organisation, 2015, 2024). The OECD defines long-term care (LTC) workers as paid personnel providing assistance with activities of daily living (ADLs) and related support at home or in institutions outside hospitals, highlighting the interface between health and social protection (OECD, 2023). Framed around human rights, care systems should satisfy the AAAQ criteria and be consistent with ICESCR and subsequent General Comments (e.g., Committee on Economic, Social, and Cultural Rights, 2000).

International recommendations converge on a concept of care that is integrated, community-anchored, and rights-respecting. MIPAA calls for the creation of enabling, supportive environments, and for ageing to be mainstreamed in development plans (United Nations, n.d.); the United Nations Decade of Healthy Ageing prioritises integrated care, age-friendly environments, combating ageism, and LTC as part of universal health care (World Health Organisation, 2021, 2024). The International Labour Organisation's 5R framework for decent care work—recognise, reduce, redistribute, reward, and represent—links care policies to decent work standards, gender equality, and sustainable financing (International Labour Organisation, 2022a). The OECD (2024) stresses access and affordability, given evidence that out-of-pocket costs can be prohibitive even in high-income settings. Several documents, notably the World Health Organisation's 2021 *Global Report on Ageism*, demonstrate how age-based discrimination undermines access to and quality of care, and call for legal, educational, and intergenerational interventions as part of care system reform (e.g., World Health Organisation, 2021).

Several legal instruments and interpretations are especially pertinent. As briefly mentioned in the previous section, the Committee on Economic, Social, and Cultural Rights addresses older persons' rights and urges elimination of age-based barriers (General Comment No. 6 in 1995); lays out the AAAQ framework (General Comment No. 14 in 2000); and underscores the role of social security in old age and cautions against retrogressive measures (General Comment No. 19 in 2008). CEDAW focuses on older women's rights in respect of health, social protection, and freedom from violence (General Recommendation No. 27 in 2010). In addition, the Inter-American Convention on Protecting the Human Rights of Older Persons recognises autonomy, LTC, and palliative care as rights (Organisation of American States, 2015); it provides useful comparative jurisprudence despite the absence of a universal convention.

The World Health Organisation estimates that roughly one in six people aged 60 and over experience abuse in community settings each year; it says that ageism is pervasive, and measurably damages health, social participation, and economic prospects (World Health Organisation, 2021). Without explicit rights-based safeguards and integrated services, older persons face compounded risks—violence, neglect, catastrophic care costs, and preventable functional decline (World Health Organisation, 2021, 2024). Corresponding global recommendations include enacting anti-discrimination legislation that includes age, integrating LTC within universal health care, regulating care quality, strengthening data on unmet need and abuse, and investing in a fairly paid, well-trained workforce with gender-transformative policies (International Labour Organisation, 2022a; OECD, 2024; World Health Organisation, 2024).

## Context of Long-Term Care in Thailand

Thailand's care system is built on the Universal Coverage Scheme, launched in 2002 and administered by the National Health Security Office; it covers the majority of the population in Thailand, alongside Social Health Insurance for private employees and the Civil Servant Medical Benefit Scheme. The Universal Coverage Scheme has reduced inequality in coverage and access and has progressively expanded benefits for chronic care and rehabilitation (Marshall et al., 2023; National Health Security Office, 2020a). In

2015–2016, as a "New Year gift" to dependent older persons, Thailand introduced a community-based long-term care (LTC) policy, managed by Subdistrict Health-Promoting Hospitals and co-financed and coordinated by local administrative organisations (Chanprasert, 2021; National Health Security Office, 2020b; Suriyanrattakorn & Chang, 2021). The National Health Security Office finances care-manager training and home-based service packages (that include, for example, assessment, home modifications, personal care, respite, and assistive products) for homebound and bedridden individuals. This approach integrates health and social support at the community level, leveraging village health volunteers and civil society (Chanprasert, 2021; National Health Security Office, 2020b; Suriyanrattakorn & Chang, 2021).

Policy architecture extends beyond health. The Second National Plan on the Elderly (2002–2021), anchored in the Older Persons Act, set strategies for income security, health services, and caregiver development (Department of Older Persons, 2009). The Phase III National Action Plan (2023–2027) emphasises inclusive, fair enhancement of quality of life, including readiness among pre-older age cohorts, and administrative integration (Department of Older Persons & Chulalongkorn University Platform for Ageing Research Innovation, 2023). The universal old-age allowance is a non-contributory, age-graded monthly benefit. Contributory pensions are provided through the Social Security Fund for workers who are covered, while pensions for government employees and officers are financed by the government. But recent analyses highlight low levels of benefit, lack of indexation in the non-contributory allowance, vulnerabilities in pension adequacy and sustainability (International Labour Organisation, 2022b), and the need for closer linkages between income security and care (Department of Older Persons, 2023; International Labour Organisation, 2022a; National Health Assembly, 2022).

Complementary to the old-age protection framework, Thailand also extends social welfare measures to persons with disabilities, including older adults with functional limitations. Since 2015, Thailand has provided monthly disability allowances of ฿800 nationwide (Thammasat University & United Nations Children's Fund [UNICEF], 2019). Under the Empowerment of Persons With Disabilities Act B.E. 2550 (2007), registered older persons with disabilities are entitled to welfare, rehabilitation, education, and employment support (Office of the Council of State, n.d.). In addition, both caregivers and persons with disabilities are eligible for tax deductions or exemptions up to ฿60,000 per person (Revenue Department, 2015).

Service delivery is primarily home- and community-based; residential facilities exist but are limited and largely serve those without family support. Subdistrict Health-Promoting Hospitals coordinate with local administrative organisations to deploy care managers and formal caregivers, while families and informal caregivers deliver much of the day-to-day support. Evidence indicates that when care projects are adequately funded and effectively coordinated, they enhance access to essential supports such as assistance with activities of daily living (ADLs) and home modifications, while also reducing caregiver burdens (Morikawa, 2014). Persistent challenges include uneven coverage across provinces; fragmented responsibilities between central (e.g., ministries) and local governments; workforce shortages and inconsistent training standards; unclear quality assurance and monitoring; and constrained fiscal space for scale-up. Household-level studies point to rural–urban disparities and potential financial strain from out-of-pocket spending when services are unavailable or entitlements are unclear (Asian Development Bank, 2020; Boontanon & Sonsri, 2023; Glinskaya et al., 2021; Khongboon & Pongpanich, 2018).

Civil society and social enterprises play a vital role, though current implementation remains limited in scale and coverage. The Foundation for Older Persons' Development (FOPDEV) in Chiang Mai, mentioned in the previous section, has supported volunteer-based home care for decades and operates Buddy HomeCare, an intergenerational model that trains local youth as paid caregivers serving isolated older persons (Foundation for Older Persons' Development, n.d.). These models complement public programmes, strengthen community ownership, and may reduce ageism through intergenerational contact. Sustainability, however, depends on stable financing, formal recognition in referral networks, and pathways to decent work (Foundation for Older Persons' Development, n.d.).

Regionally, Association of Southeast Asian Nations (ASEAN) frameworks on social welfare and ageing promote social protection, health access, and community participation. Although the ASEAN Secretariat lacks a binding rights instrument, the *Regional Plan of Action on Implementing the Kuala Lumpur Declaration on Ageing: Empowering Older Persons in ASEAN* provides a platform for collaborative efforts across members (ASEAN Secretariat, 2024).

## Methodology

This study employs desk-based documentary analysis and a scoping review. The objective is to synthesise authoritative, publicly available evidence on Thailand's care system through a human-rights lens and to map that evidence to the AAAQ criteria, together with the cross-cutting principles of non-discrimination, participation, and accountability. The process was the following:

- desk review—We reviewed five bodies of material: (a) global and regional standards and normative guidance that recognise older persons as rights-holders; (b) global technical guidance on integrated and long-term care; (c) Thai legal–policy instruments and governance arrangements; (d) peer-reviewed and grey literature on Thailand's long-term care (LTC) model, its coverage and equity, financial protection, and implementation experience across urban–rural settings; and (e) publicly available materials from civil-society initiatives that illuminate outreach, acceptability, workforce pathways, and sustainability.

- identification and selection—Searches were conducted across publisher and organisational websites, academic databases for peer-reviewed studies, and civil-society portals for programme documentation. Items were included if they (a) addressed older persons' care in Thailand or offered generalisable guidance relevant to Thailand; (b) were published by recognised institutions or in peer-reviewed venues; and (c) contained sufficient methodological or policy detail to map to AAAQ dimensions. Where duplicates or earlier versions existed, the most recent and authoritative source was retained. Search terms included "care" and "long-term care" in Thai and English, with coverage from 2010 to the present.

- extraction and synthesis—For each document, we extracted information on aims, instruments (e.g., laws, policies, benefits), delivery models (e.g., care-manager pathways, home-based services), financing (e.g., entitlements, co-financing formulas, out-of-pocket implications), workforce arrangements (e.g., roles, standards), data and monitoring (e.g., indicators, disaggregation), and explicit rights content (e.g., non-discrimination provisions, participation, grievance, and redress). We then synthesised findings thematically against AAAQ and cross-cutting principles and organised the results into system-level strengths and gaps.

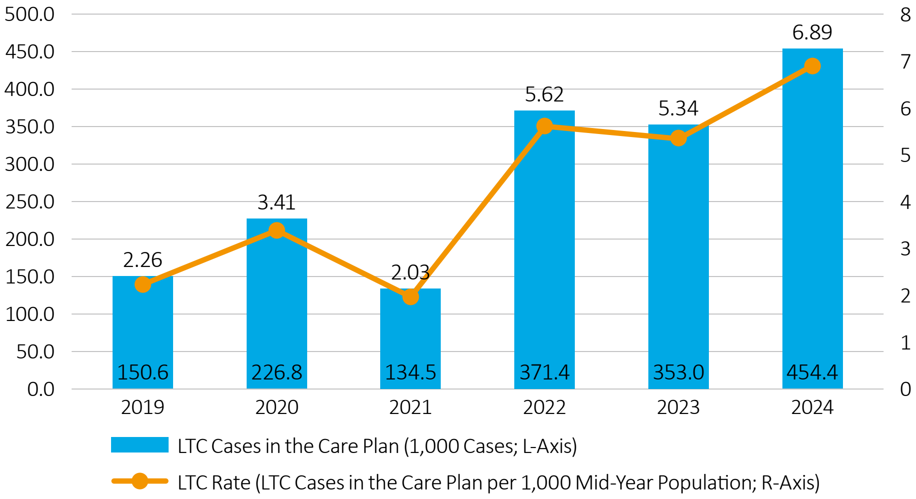
## Results and Discussion

Thailand's long-term care (LTC) reforms over the past decade have evolved toward a more decentralised, community-based system integrating health, social welfare, and local governance. The LTC framework, administered under the National Health Security Office and the Department of Health, Ministry of Public Health, aims to support dependent older adults through coordinated medical and social care. Within this framework, the care plan functions as an individualised assessment and management tool—developed by multidisciplinary teams to evaluate functional status, identify care needs, and assign appropriate home- and community-based interventions. It forms the operational backbone of the LTC system, ensuring that services are tailored to the health conditions, living environments, and caregiver capacities of older persons.

The overall trend of care plan implementation under Thailand's LTC system between 2019 and 2024 demonstrates a substantial expansion, indicating improved accessibility and coverage of LTC services for older adults nationwide. As shown in Figure 1, both the number of LTC cases in the care plan and the LTC rate per 1,000 mid-year population exhibited a pronounced upward trajectory during this period, notwithstanding a temporary decline in 2021. The number of registered cases increased from 150,600 in 2019 to 454,400 in 2024, while the LTC rate rose from 2.26 to 6.89 per 1,000 population over the same time period. The contraction in 2021 was likely attributable to service disruptions associated with the COVID-19 pandemic, after which both indicators rebounded sharply from 2022 onwards. Thailand's pattern may mirror global LTC trends, as many countries face growing pressures from population ageing, fiscal constraints, workforce shortages, and disparities in service quality. The pandemic further accelerated the transition toward home- and community-based care models and the adoption of digital health technologies to support monitoring and service delivery.

**Figure 1**

*Number of Dependent Persons Who Benefited From a Care Plan and Were Approved by the Sub-Committee of the LTC Fund, and the LTC Rate*



*Note.* The data for LTC cases are from *Aged Care Plan Dashboard,* by the National Health Security Office and Bureau of Elderly Health, Department of Health, Ministry of Public Health of Thailand, n.d. Copyright by the National Health Security Office and Ministry of Public Health of Thailand. The data for total mid-year population are from *Civil Registration,* by Department of Provincial Administration, Ministry of Interior of Thailand, n.d. Copyright by Ministry of Interior of Thailand.

Drawing on international guidance and Thai policy documents, the evidence indicates that Thailand's community-based LTC model has advanced in the last decades, while important rights-relevant gaps remain. Care programme materials show that the National Health Security Office model—built around care-manager assessment, individualised care plans, home-based service packages, and local administrative organisation co-financing—aligns well with the World Health Organisation Integrated Care for Older People (ICOPE) pathway and the United Nations Decade of Healthy Ageing's emphasis on functional ability and person-centred continuity of care across health and social sectors (World Health Organisation, 2015, 2024). These features, when assessed against the ICESCR's AAAQ criteria, strengthen proximity, cultural appropriateness, and continuity of care, particularly for homebound and bedridden older persons (Asian Development Bank, 2020; Chanprasert, 2021; Committee on Economic, Social, and Cultural Rights, 1995, 2000; National Health Security Office, 2020b). Early evaluations and syntheses of this study suggest improved access to support for activities of daily living (ADLs) or instrumental activities of daily living (IADLs), and to assistive products and home modifications in districts with active local administrative organisations as co-financiers and well-functioning subdistrict health networks (Beard et al., 2016; Boontanon & Sonsri, 2023; Glinskaya et al., 2021). These findings are consistent with comparative OECD evidence that community-anchored models can better preserve functional ability and reduce avoidable institutionalisation when the workforce is adequately trained and supported (OECD, 2023, 2024).

Affordability and equity remain the most prominent challenges. International comparisons show that out-of-pocket spending for LTC can absorb a substantial share of older people's income in the absence of robust social-care financing; Thailand is not immune to this risk (Glinskaya et al., 2021; OECD, 2024). The non-contributory old-age allowance, while an important universal floor, remains modest in level and unindexed, limiting its ability to offset recurring social-care costs for low-income households, older women living alone, and persons with disabilities (Department of Older Persons, 2023; International Labour Organisation, 2022b). Also, service quality issues persist across the continuum of care, from basic personal assistance to more complex, integrated support. There is a growing need for practical assistance with care navigation and accompanied transport to medical appointments, both of which are unevenly available nationwide. Care navigation encompasses structured, person-centred support to help individuals and families access, coordinate, and understand health and social care services (National Health Service England, 2016). It includes assessing needs, locating appropriate providers, facilitating referrals, and ensuring continuity of care across settings. Care navigators guide clients through fragmented systems, allowing them to make informed decisions and overcome barriers such as administrative burdens or limited health literacy. Demand for these services is likely to rise as household size continues to shrink and the pool of available family caregivers declines. However, responsibility for LTC is distributed across multiple agencies—including health, social welfare, and local administrative organisations—leading to more effort being needed to enhance coordination across sectors, a requirement identified in Thai responses to the Voluntary National Survey conducted for the Fourth Review and Appraisal of the Madrid International Plan of Action on Ageing in Asia and the Pacific (United Nations Economic and Social Commission for Asia and the Pacific [UNESCAP], 2021).

The workforce is both an enabler and a bottleneck. Thailand's approach depends on care managers, community caregivers, village health volunteers, and allied personnel. The OECD documents structural shortages, and calls for professionalisation involving standardised competencies, career pathways, and supportive supervision (OECD, 2023). The International Labour Organisation's 5R framework—recognize, reduce, redistribute, reward, and represent—provides a coherent labour policy anchor linking decent work to gender equality and service quality (International Labour Organisation, 2022a). Thai programmes to support its community-based LTC model detail rapid training scale-up and local administrative organisation-co-funded roles, yet wage levels, employment security, and supervision vary across districts, contributing to significant staff turnover and inconsistent service quality (National Health Security Office, 2022, 2023). International experience suggests that workforce conditions directly influence the safety of older people and the effectiveness of care; without stable contracts, social protection, and a competency-based ladder, service quality is difficult to guarantee (Asian Development Bank, 2020; OECD, 2023; World Health Organisation, 2024).

Participation, transparency, and redress are under-covered relative to rights guidance, given that the Committee on Economic, Social, and Cultural Rights emphasises meaningful participation, transparency, and grievance mechanisms in health and social security systems (Committee on Economic, Social, and Cultural Rights, 2000, 2008), and the United Nations High Commissioner for Human Rights calls for stronger safeguards against discrimination, abuse, and neglect across care settings for older people (Office of the High Commissioner for Human Rights, 2022). In Thailand, local administrative councils and district quality-of-life development committees may serve as platforms for the public voice, but overall what has been observed are uneven measurement of service timeliness and intensity, limited routine disclosure, and complaint channels that are merely ad hoc (e.g., Boontanon & Sonsri, 2023). Establishing user councils and publishing equity-focused reports would bring practice in line with rights obligations and allow for course correction.

Progress toward compliance with rights obligations requires strengthened data architecture and equity measurement; this entails tracking care coverage, unmet needs, timeliness, and financial protection, with data disaggregated by sex, income, disability, rurality, and ethnicity where applicable. Several LTC performance indicators from key international agencies may aid in comprehensive monitoring of how rights-based dimensions (e.g., AAAQ) are maintained in care. These indicators include the number of recipients per 1,000 persons aged 65 and over, hours of care delivered per month, wait time to first service, incidence of catastrophic social-care spending, caregiver strain, and basic safety indicators (e.g., falls, pressure injuries). These metrics should be accessible to all relevant entities in order to facilitate more responsive, data-driven policy and management (OECD, 2023). In Thailand, linking National Health Security Office LTC registries, administrative data from the Department of Older Persons, the MSO logbook (a central data infrastructure to identify vulnerable households) from the Ministry of Social Development and Human Security (MSDHS), and local administrative organisation data is feasible and would allow for performance-based, equity-weighted grants that channel resources to areas with higher need and deprivation (Glinskaya et al., 2021; United Nations, 2024).

Finally, normative alignment is advanced but incomplete. International law recognises older persons as rights-holders whose dignity, autonomy, and equal enjoyment of rights must be upheld (Committee on Economic, Social, and Cultural Rights, 1995; Committee on the Elimination of Discrimination Against Women, 2010). Evidence from the World Health Organisation's *Global Report on Ageism* demonstrates that age-based discrimination depresses service uptake and worsens health, social, and economic outcomes (World Health Organisation, 2021). Although the Universal Coverage Scheme, community-based LTC, and national strategies have incorporated many rights-based principles, explicit and justifiable social-care entitlements are not yet uniformly codified, and anti-ageism safeguards will require more attention (UNESCAP, 2021). Advancing full alignment will necessitate financing and governance reforms that clarify entitlements, protect the caregiving workforce, and institutionalise equity-oriented monitoring and accountability.

## Recommendations

A coherent, rights-based strategy should translate Thailand's care programme assets into enforceable entitlements, stable delivery capacity, and transparent accountability, while also addressing issues regarding affordability, workforce, participation, and measurement shortcomings.

First, it would be beneficial to codify a national minimum social-care benefits package with mixed benefit contributions. The government should issue clear quality-assured guidelines that also enhance accessibility. The guideline package should include baseline monthly personal-care hours, respite options, standardised home-modification and assistive-product bundles, and caregiver training. Delivery should occur through health networks with defined referral pathways, and financing should draw on a pooled arrangement that combines National Health Security Organisation allocations, earmarked local administrative organisation grants, and targeted social assistance. Public disclosure of service content, eligibility rules, and zero point-of-use guarantees for covered items (guarantees of no out-of-pocket spending at the point of service for such items) would help in meeting AAAQ obligations and reduce out-of-pocket spending while addressing equity concerns (Chanprasert, 2021; Committee on Economic, Social, and Cultural Rights, 2000, 2008; Glinskaya et al., 2021; National Health Security Office, 2020b; OECD, 2024). In addition, it would be desirable to index the old-age allowance, and pilot supplemental benefits for high-need conditions (e.g., dementia respite) to protect low-income households (Department of Older Persons, 2023; International Labour Organisation, 2022b).

Second, a rights-based strategy needs to professionalise and protect the care workforce through the 5Rs, namely, recognition, reduction, reward, representation, and redistribution of care work, paired with systematic skills development. This approach would involve competency-based certification in accordance with the World Health Organisation's Integrated Care for Older People (ICOPE) framework, wage floors and contracts ensuring social protection, along with safe staff ratio, professional supervision, continuing education, and a transparent career ladder from community caregiver to certified care manager. Local administrative organisations should link co-financing to decent-work norms and quality reporting, while social enterprises should be contracted under enforceable labour standards and data-submission requirements (Asian Development Bank, 2020; International Labour Organisation, 2022a; National Health Security Office, 2022, 2023; OECD, 2023; World Health Organisation, 2024).

Third, it is necessary to institutionalise participation, transparency, and redress by establishing district-level user councils of older persons and caregivers; publishing reports that are accessible and reader-friendly and provide information on care coverage, timeliness, service intensity, and complaint resolution; and adopting time-bound grievance procedures that include independent review and remedies (Boontanon & Sonsri, 2023; Committee on Economic, Social, and Cultural Rights, 2000, 2008; Office of the High Commissioner for Human Rights, 2022). In parallel, policymakers need to enhance roles and incentives for social enterprises to expand community-based LTC supply by deploying outcome-linked incentives with payment terms, providing performance bonuses for service delivery in underserved areas, and offering targeted tax credits or co-financing for workforce training, assistive-technology pilots, and home-modification programmes. It would be helpful to encourage tripartite partnerships (local administrative organisations–public providers–accredited social enterprises) to co-deliver respite care, caregiver training, and home-based supports, especially in rural districts, thereby crowding in mission-driven capacity while safeguarding quality and accountability.

Fourth, it is important to build an equity-focused performance and finance system by connecting existing databases to generate disaggregated indicators, and allocating equity-weighted performance grants (e.g., higher matching rates where poverty, dependency, and unmet need are greatest). To minimise measurement deficits and facilitate benchmarking, it would be useful to track a concise, comparable set of indicators (Department of Older Persons, 2023; Glinskaya et al., 2021; OECD, 2023; Poldrugovac et al., 2025; United Nations, 2024).

Finally, it is imperative to mainstream anti-ageism across policy, administration, professional education, and intergenerational initiatives, in order to counter documented harms and strengthen conformity with international human rights norms (Office of the High Commissioner for Human Rights, 2022; World Health Organisation, 2021). These steps, taken together, have the potential to transform aspiration into enforceable practice while also embedding equity and resilience throughout Thailand's life-course care architecture.

## Conclusion

Thailand stands at a pivotal juncture in the evolution of its care architecture for an ageing society. Building on the strengths of universal health coverage and a community-based long-term care (LTC) model anchored in Subdistrict Health-Promoting Hospitals and local administrative organisations, the country has demonstrated that person-centred, home-first care is both feasible and culturally consonant. When viewed through a human rights lens—operationalised via the AAAQ criteria of availability, accessibility (in terms of affordability and information), acceptability, and quality—Thailand's achievements are substantive: The care-manager pathway (an individualised assessment and management process that forms the operational backbone of the LTC system), individualised plans, and the use of volunteers and social enterprises have all improved proximity, care continuity, and acceptability for homebound and bedridden older persons. These advances reflect significant congruence with international guidance on healthy ageing and integrated care, and provide a credible foundation for further reform.

At the same time, this study shows that the promise of rights-consistent care will only be realised if Thailand consolidates programmatic gains (operational successes such as increased coverage and improved service proximity) into explicit, enforceable entitlements and stable delivery capacity. The most immediate constraint is affordability. Without a nationally guaranteed and budget-backed social-care package that encompasses personal-care hours, respite, home modification, assistive products, and caregiver training, older persons with low incomes, women living alone, and people with disabilities remain at heightened risk of unmet need and out-of-pocket strain. A parallel, systemic constraint is workforce fragility. Service quality and safety depend on a sufficiently large, fairly paid, and well-supervised cadre of caregivers and care managers, with competency frameworks that reflect geriatric complexity and clear pathways for progression. Unless workforce standards and decent-work protections are incorporated into financing rules and contracts, gains will be uneven and difficult to sustain.

Equally important are participation, transparency, and redress. Rights are realised not only through service content, but also through governance, which empowers older persons and caregivers to determine priorities, assess performance, and seek remedies. Establishing district-level user councils, publicising equity-focused indicators, and creating simple, time-bound grievance channels would help to translate diffuse local goodwill into structured accountability and measurable impact. These mechanisms can enhance cooperation across stakeholders, foster equitable decision-making, and boost public trust in the LTC system.

Finally, measurement must shift from activity to equity tracking. Linking administrative data across key actors will enable routine, disaggregated monitoring of coverage, timeliness, unmet need, financial protection, and safety—information essential for equity-weighted resource allocation and continuous improvement. Future work should prioritise empirical measurement and policy experimentation. It may be beneficial to employ mixed-methods evaluations to generate routine, disaggregated indicators that allow equity-weighted allocation formulas. Qualitative research on acceptability, dignity, and autonomy among high-risk groups (e.g., rural older women living alone, persons with disabilities) could supplement these methods. It may be necessary to implement and assess targeted policy pilots, such as a nationally specified minimum social-care package in diverse settings, dementia-focused respite supplements, contract models that incorporate social enterprises under decent-work clauses, and streamlined procurement for home modifications. To inform scale-up decisions, each pilot should include pre-registered metrics, public reporting, and a cost-effectiveness analysis. It may also be useful to develop an anti-ageism implementation index to track changes in organisational practices across districts and providers.

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[NIDA]; ASEAN Centre for Active Ageing and Innovation [ACAI]; Asian Development Bank; United Nations Population Fund [UNFPA]; Kenan Foundation Asia; HelpAge International; the Alliance on Longevity in Asia-Pacific [ALAP]; Tsao Foundation; Foundation for Older Persons' Development [FOPDEV]; ASEM Global Ageing Center [AGAC]; Thai Gerontology Research and Development Institute [TGRI]; Health Systems Research Institute [HSRI]; and Thailand Social Work Professions Council [SWPC].)

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Asia-Europe Meeting

# ASEM

**The Asia-Europe Meeting (ASEM)** is an intergovernmental process established in 1996 to foster dialogue and cooperation between Asia and Europe.

ASEM addresses political, economic, financial, social, cultural, and educational issues of common interest in a spirit of mutual respect and equal partnership. Its foremost event, the ASEM summit, is a biennial meeting between the heads of state and government, the president of the European Council, the president of the European Commission, and the secretary-general of ASEAN. In addition, ASEM ministers and senior officials also meet in their respective sectoral dialogues.

The initial ASEM partnership in 1996 consisted of 15 EU member states, 7 ASEAN member states, China, Japan, Korea, and the European Commission. Today, ASEM comprises 53 partners: 30 European and 21 Asian countries, the European Union, and the ASEAN secretariat.

Through its informal process based on equal partnership and enhancing mutual understanding, ASEM facilitates and stimulates progress but does not seek to duplicate bilateral and other multilateral relationships between Asia and Europe.

For more information, visit the ASEM Info Board website (www.aseminfoboard.org).

# ASEM PARTNERS

## Partner Organisations

**ASEAN Secretariat**
Joined 2008

**European Union**
Joined 1996

## Partner Countries

**Australia**
Joined 2010

**Austria**
Joined 1996

**Bangladesh**
Joined 2012

**Belgium**
Joined 1996

**Brunei Darussalam**
Joined 1996

**Bulgaria**
Joined 2008

**Cambodia**
Joined 2004

**China**
Joined 1996

**Croatia**
Joined 2014

**Cyprus**
Joined 2004

**Czech Republic**
Joined 2004

**Denmark**
Joined 1996

**Estonia**
Joined 2004

**Finland**
Joined 1996

**France**
Joined 1996

**Germany**
Joined 1996

**Greece**
Joined 1996

**Hungary**
Joined 2004

**India**
Joined 2008

**Indonesia**
Joined 1996

**Ireland**
Joined 1996

**Italy**
Joined 1996

**Japan**
Joined 1996

**Kazakhstan**
Joined 2014

**Korea**
Joined 1996

**Lao PDR**
Joined 2004

**Latvia**
Joined 2004

**Lithuania**
Joined 2004

**Luxembourg**
Joined 1996

**Malaysia**
Joined 1996

**Malta**
Joined 2004

**Mongolia**
Joined 2008

**Myanmar**
Joined 2004

**Netherlands**
Joined 1996

**New Zealand**
Joined 2010

**Norway**
Joined 2012

**Pakistan**
Joined 2008

**Philippines**
Joined 1996

**Poland**
Joined 2004

**Portugal**
Joined 1996

**Romania**
Joined 2008

**Russian Federation**
Joined 2010

**Singapore**
Joined 1996

**Slovakia**
Joined 2004

**Slovenia**
Joined 2004

**Spain**
Joined 1996

**Sweden**
Joined 1996

**Switzerland**
Joined 2012

**Thailand**
Joined 1996

**United Kingdom**
Joined 1996

**Viet Nam**
Joined 1996

# ASEM GLOBAL AGEING CENTER (AGAC)

**ASEM Global Ageing Center (AGAC)** is a specialized international institution based in Seoul that operates as a global hub for coordinating a wide variety of agendas surrounding the human rights of older persons for ASEM partners. The center aims to address various issues confronted by ASEM partners regarding the human rights of older persons and ultimately contribute to the promotion and protection of human rights of older persons through policy research, cooperation, awareness-raising and education, and information sharing.

ASEM Global Ageing Center

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## AGAC ISSUE FOCUS

AGAC Issue Focus is a biannual periodical that aims to address ageing and human rights issues in a timely fashion. The publication introduces relevant ASEM partner policies and responses to a wider audience in order to promote information sharing and awareness-raising and ultimately enhance ASEM partner cooperation. Each report focuses on a distinct theme that highlights current major concerns to do with ageing and the human rights of older persons in Asia and Europe.

For more information, visit the AGAC website (www.asemgac.org).

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