

Croatia

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Executive Summary

By taking part in the ENNHRI Pilot Group of the 'Human Rights of Elderly Persons in Long-term Care' project, we pledged to monitor human rights of elderly persons in LTC. As a part of project activities, we visited five public institutions specialising in LTC for the elderly.

Before going to the selected LTC providers, we had organized a one-day focus group gathering experts for LTC-related issues who had presented best practice examples in terms of protection of human rights of older persons in LTC. The participants had also discussed the relevant challenges and barriers they had to face in that respect.

Residential LTC services are available to beneficiaries according to the relevant Decision issued by the competent Social Welfare Centre (SWC) or according to the contract concluded with the service provider. Nevertheless, waiting lists for public care homes have grown to 17,000 people, which means that the average waiting-time for an individual is between four and eight years. On the other hand, more expensive private care homes have reported a 10% vacancy rate.

Although we did not notice any activity indicative of torture during our visits, we did perceive certain activities that could be seen as potentially violent. In certain cases, the decision to go

to a nursing home was made not by the beneficiary who has full legal capacity but by his or her family members. Lack of public policies that would ensure a work-life balance makes these situations even worse. In the present context, residents and their families often have no alternative options. Low pensions, financial stress and poverty may have adverse effect on human dignity of the elderly. The fact that residential care often includes hidden costs puts even more strain on individuals. Living conditions in residential LTC will vary depending on finances and the ownership structure of the institution.

Care providers have put significant effort in promoting social inclusion among residents and their involvement in daily activities conducted in the care/nursing home, as well as in the community life. With every new arrival, the social worker, chief nursing officer and occupational therapist, in direct collaboration with the resident, develop his/her individual plan of care. Residents put forward a name for their proposed representative in the Management Council of the nursing/care home, who is elected by the founding body at their proposal. All the homes we visited provided their Roman Catholic residents opportunities to practice their religion. Residents of other religions had not made similar requests. If a beneficiary dies, religious rites are ensured for all confessions.

Particular emphasis was placed on the provision of healthcare, given the target population. All nursing homes offer primary healthcare services provided by a general practitioner, but certain homes do not provide access to dental healthcare. Not a single home provides the specialist healthcare services of a gynaecologist.

Members of staff in the nursing homes are committed to their work and they respect their beneficiaries' privacy. Occasional problems may occur in multi-bed bedrooms and in stationary wards for residents who cannot or can barely move, as they cannot enjoy their privacy by using other rooms.

Although the majority of residents expressed their satisfaction with the provided services, we noticed that the homes did not have procedures for dealing efficiently with complaints, despite the legal provisions. Complaints were handled informally, on an *ad hoc* basis.

Introduction

Almost 18% of Croatia's population is aged over 65. This part of population calls for systematic social support, provided either in residential LTC facilities or organized in-home assistance.

Residential LTC for the elderly in the Republic of Croatia is available through state-owned social care homes, nursing homes founded by the county, city or municipality (hereinafter: public nursing homes) that offer their services within the Social Services Network or, alternatively, through the so-called private social care homes that provide their services inside or outside the Social Services Network.

The current demand-supply mismatch in terms of available beds in residential care has strengthened the role of informal care. According to the second European Quality of Life

Survey (EQLS), conducted in 2007–2008, Croatia is among the top three countries in Europe (after Italy and Estonia) with the greatest share of family care. In Croatia, spouses, especially wives, make primary caregivers for the elderly. However, informal care is also provided by friends and neighbours. There is no national policy with the aim of balancing family and professional life, so there is still a large number of the elderly population who live alone and who are at risk of having their LTC needs not met.

As a commissioner of the Croatian Parliament for protection and promotion of human rights and freedoms and as the central body for combating discrimination, the NHRI with the A and NPM status, the Office of the Ombudswoman of the Republic of Croatia has been dealing with issues regarding the rights of the elderly on a continuous basis. Our annual reports submitted to the Croatian Parliament regularly include chapters on social security of older persons, pension insurance and discrimination on grounds of age. Nonetheless, our involvement in the ENNHRI project *Human Rights of Elderly Persons in Long-term Care* has strengthened our engagement in the said area. As a member of the Project Pilot Group, we visited selected institutions providing residential LTC for the elderly and talked to residents and caregivers. This and the on-spot overview of the situation allowed us to gain an insight into the human rights situation of older persons.

In order to ensure high-quality project implementation, we established a special Working Group chaired by the Ombudswoman herself. It included representatives of all departments within the Office of the Ombudswoman – Department for Human Rights Protection, Departments for People Deprived of Liberty and National Preventive Mechanism (NPM) and Department for Suppression of Discrimination. Representatives of the Department for Promotion take part in the Working Group if needed.

In line with the recommendations issued by the Project Secretariat, we visited five public LTC providers specialising in LTC for the elderly, three decentralised homes (different occupancy rates) situated across the country¹ and two private nursing homes. Taking into consideration the project purpose, on these occasions, we tried to analyse all elements important for daily lives of the elderly in LTC, namely: residents' privacy and dignity, provision of information, respect for private and family life, high quality and continuous healthcare, confidentiality and protection of personal information, freedom of religion, freedom of movement, ban of torture and other cruel, inhuman or degrading treatment, availability of adequate professional treatment, right to lodge complaints, freedom and safety, right to ownership and voting rights. The following premises were inspected during the monitoring visit: the premises occupied or potentially occupied by residents: bedrooms, toilets, dining rooms, stationary wards, offices and employees' shared premises, kitchen, laundry rooms and morgues. The information regarding provision of social care services was collected from managers, professional staff and carers. The information regarding the way in which life was organized within service

¹ The term refers to homes at the regional level managed by the counties and initially founded by the Republic of Croatia. Pursuant to relevant legislation, the rights of the founding party were delegated to counties – regional self government units and the City of Zagreb.

providers and satisfaction with the services provided was given by the residents we interviewed.

Nursing Home ‘Sv. Josip (St. Joseph)’, Zagreb, Capacity: 350 residents (10 July 2015)

The nursing home ‘Sveti Josip’ in Zagreb operates as a decentralised public social care provider owned by the City of Zagreb. The nursing home provides a number of services: housing and accommodation, provision of meals, assistance with personal hygiene and grooming, healthcare, social work, psychological and social rehabilitation, physical therapy, occupational therapy, work activities, active leisure and organization of transport for older persons whose social and health problems affect their quality of life, depending on their needs and choice. Apart from residential LTC, the nursing home provides in-home assistance and home care services, including meals on wheels, domestic help for the elderly or other types of service, full- or half-day programmes for non-residents who are provided with meals, healthcare services, assistance with personal hygiene and grooming, social care services, organization of work activities and leisure time and organized transport. The nursing home implements a special project, entitled ‘Centre of Gerontology’ on its premises. The project is focused on provision of non-institutional care for the elderly. The home is located in the vicinity of a large hospital near the Zagreb city centre. It is accessible by public transport.

The nursing home consists of three housing units with the living area (hereinafter: housing block), healthcare and rehabilitation unit (hereinafter: healthcare unit), shared premises for leisure and work activities, full-day centre (hereinafter: day-care centre), a kitchen and shared premises for employees. The nursing home can accommodate up to 350 residents and 40 non-residents at the day-care centre.

The nursing home is constantly experiencing staff shortages. The staffing levels are 30% lower than the figures envisaged by jobs classification regulations, which puts a strain on the staff in provision of daily care services. Members of staff work in three shifts, which means that a certain number of qualified staff is always present at the premises.

County Nursing Home ‘Kantrida’, Rijeka, Capacity: 420 residents (12 and 13 October 2015)

The county nursing home ‘Kantrida’ in Rijeka is a decentralised public social care provider founded by the Primorsko Goranska County. Its core activity is provision of LTC for the functionally dependent elderly who are in need of constant care due to their chronic condition. It provides the following services: housing and accommodation, half and full day programmes, in-home assistance, organized housing in housing units, provision of meals, assistance with personal hygiene and grooming, healthcare, social care services, psychological and social rehabilitation, physical therapy, occupational therapy, work activities, active leisure and organized transport for older persons, depending on their needs and choice. The nursing home is located in the western part of the City of Rijeka, above the main road line leading to Opatija, in the vicinity of a health facility. It is accessible by public transport.

The nursing home consists of three housing units (buildings), named A, B and C, with the living area (hereinafter: housing block), healthcare and rehabilitation unit (hereinafter: healthcare unit), shared premises for leisure and work activities, full-day centre (hereinafter: day-care centre), a kitchen and shared premises for employees. The nursing home can accommodate up to 420 residents, of which 150 posts are covered by the Social Services Network (on the basis of the Decision issued by the relevant Centre for Social Welfare).

Currently, 133 employees are employed at the nursing home. According to the manager, given the number of residents in LTC and the shift work, the nursing home is understaffed.

Private Nursing Home Sv. Polikarp, Pula, Capacity: 64 residents (19 and 20 October 2015)

The nursing home 'Sv. Polikarp' operates as a social care provider for adults (the elderly and infirm) whose social and health problems affect their quality of life. It provides the following services: housing and accommodation, provision of meals, assistance with personal hygiene and grooming, healthcare, social care services, psychological and social rehabilitation, physical therapy, occupational therapy, work activities, and active leisure. The home is privately owned, and, as such, it operates outside of the Social Services Network. It is located in the area of a former military base, in the vicinity of an outpatient clinic and hospital, not far from the city centre. It is within walking distance (10 minutes) of the nearest stops served by public transport.

The home currently employs 39 employees. According to employees and residents and given the two-shift work, the number of staff is sufficient to handle the work.

County Nursing Home 'Slavonski Brod', Slavonski Brod, Capacity: 232 residents (26 and 27 October 2015)

The County Nursing Home 'Slavonski Brod' is a decentralised public social care provider founded by the Brod-Posavina County. The nursing home is a service provider for the functionally dependent elderly and infirm. It provides the following services: housing and accommodation, provision of meals, healthcare, assistance with personal hygiene and grooming, social care services, psychological and social rehabilitation, work activities, management of leisure time, provision of staff to accompany residents, organized transport and counselling. In line with its Statute, the home is a registered out-of-home care provider for persons suffering from Alzheimer's or other types of dementia.

Apart from its main location in the centre of Slavonski Brod, the nursing home operates a branch 'Sv. Vinko' (Saint Vincent) at Nova Kapela. The home can provide housing and accommodation for 264 residents. It did not operate at full occupancy on the day of the monitoring visit.

The institution currently employs 90 employees. This number includes members of staff working at the Sv. Vinko branch. They are assisted by three trainees undergoing a special

vocational training without employment programme. According to the manager, given the number of residents, the home is understaffed. Members of staff work in three shifts.

Private Nursing Home Vita Nova, Bjelovar, Capacity: 200 residents (30 November and 1 December 2015)

The core activity of the home is provision of social care services for the functionally dependent elderly who are in need of constant care due to their chronic condition. The nursing home is privately owned, and, as such, it operates outside of the Social Services Network. It is located at the village of Klokočevac, next to the entrance to Bjelovar. It is just one kilometre away from the nearest bus stop. The surrounding area, 30000 m² in size, is extremely well maintained and it includes a park, two ponds and 800-meter-long promenade. The nursing home boasts numerous other attractions, such as courts for traditional ball sport of ‘bocce’ and the outdoor version of nine-bin bowling, a barbecue hut where people meet and socialize, an orchard etc.

Currently, 23 people work at the nursing home. Organizational and logistical activities are carried out by the founder (i.e. private company). The number of staff is adequate due to the fact that the company provides the necessary workforce to manage procurement and carry out other activities, such as preparation and serving of meals, cleaning, washing or ironing. In addition, employees work in shifts so an adequate number of staff is located at the premises in relation to the number of residents.

Purpose of Report

The purpose of the survey of the selected LTC providers was to monitor the existing human rights standards relevant to their residents. In accordance with the project activity plan, each country that took part in the pilot phase has pledged to draw up a report describing the findings and conclusions, as well as the recommendations for improvement of the existing situation at the national level.

The findings, recommendations and conclusions of the relevant bodies will be used as a joint database to identify key points important for introduction of human-rights based approach relevant to older persons with a special emphasis on residential LTC.

The review of the submitted reports will be used to draw up recommendations whose aim is to improve the human rights situation of older persons in LTC.

Mandate of the Monitoring

In accordance with the Ombudsman Act, the Ombudswoman shall monitor the human rights situation and point out to the need for its protection. He/she shall also carry out research and analytical activities and maintain and update the relevant databases and documentation, inform the public and interested parties regularly and timely, actively promote and maintain cooperation with civil society organisations, international organisations and research institutions, and promote the alignment of legislation with international and European

standards and its application. In accordance with the Anti-discrimination Act, the Office of the Ombudsman acts as a central national body to suppress discrimination, with the powers to take act in terms of all natural and legal persons. The Office carries out the activities of the National Preventive Mechanism (NPM) for prevention of torture and other cruel, inhuman or degrading treatment or punishment.

In line with the powers vested by the law, the Ombudswoman may, at any time and without prior notice, visit institutions in which persons deprived of liberty, persons whose freedom of movement is restricted or groups whose rights and freedom the Office protects are held. The Ombudswoman is entitled to contact all persons that may give her relevant information, with or without the presence of the institutional staff during monitoring visits.

After the monitoring visit the Ombudswoman may, if necessary, produce a report that will be delivered to the monitored institution and its manager. This was the case with monitoring visits of the selected nursing homes. The Ombudswoman has also submitted accompanying recommendations for the LTC providers to remedy the shortcomings that were observed.

Methodology (including ethical principles)

The NPM methodology was used for the purposes of monitoring residential care providers. All the monitoring visits were conducted without prior notice, apart from Zagreb. We freely choose which residents and employees to interview. The interviews were conducted without the presence of third parties, i.e. the staff. Taking into account our powers granted by the law, we inspected all the premises used by residents and employees. We conducted interviews with the staff, management and residents. All the interviewees were briefed about our privacy and confidentiality policies.

Before making the monitoring visits, we had gathered the leading experts from the field of LTC for the elderly with a view to prepare ourselves for the visits in the best possible way. The expert group included nursing homes' management, representatives of centres for social welfare (SWCs), the Ministry of Social Policy and Youth, departments for social welfare of local and regional (self)government units, civil society organizations (CSOs) advocating interests of the elderly. We organized a one-day focus group meeting during which best practice examples in terms of protection of human rights of older persons in LTC were presented. The participants had also discussed the accompanying challenges and barriers, necessary improvements and practices perceived as violations of human rights of the elderly.

According to the participants, the desired model of social services included: available services, social inclusion or residents, tailor-made services, right to choice, respect for diversity, needs monitoring, respect for human rights, maintenance and creation of social bonds and protection of physical and mental abilities. The main barriers to introduction of best practice models were identified: lack of resources and staff, lack of information and limited access to information regarding human rights of the elderly and protection mechanism, insufficient and discriminatory general acts and inappropriate cooperation among the line ministries / relevant stakeholders.

It was emphasised that inadequate services (provision of food, assistance with personal hygiene and grooming, rehabilitation etc.) and lack of adequate support to strengthen residents to go back to the environment they came from could lead to violations of human rights of older persons in LTC. Lack of staff could trigger violations of human rights of persons in LTC, it was added.

In addition to identification of problems, possible solutions were highlighted, such as potential engagement of volunteers to increase the quality of services and respect for residents' human rights.

By taking into consideration the conclusions of the focus group, we concentrated on the highlighted elements during the monitoring visits.

Findings 1: Legislative and Policy Context

LTC is regulated by the Act on Social Welfare. Social welfare is provided to all Croatian citizens according to the following principles: subsidiarity, social justice, freedom of choice, availability, individualisation, inclusion of welfare beneficiary into the community, timeliness, respect for human rights and integrity of the welfare beneficiary, ban of discrimination, provision of information about social rights and services, participation in decision making, confidentiality and personal data protection, respect for privacy and submission of complaints.

By adopting the definition of 'elderly' or older person as someone aged 65 or over, social welfare is available to individuals who cannot meet their basic needs independently due to their age or condition. Residential LTC is just one of a number of social services available to welfare beneficiaries according to the Act. Social services encompass activities, measures and programmes whose aim it prevent, detect and solve problems and difficulties that individuals and their families face and increase the quality of their lives in the community. 'Housing and accommodation' is a type of social service that refers to provision of care outside the family. In that sense, care providers include a wide range of entities: social care homes, centres for provision of services in the community, care homes or other service providers, as well as foster families or the so-called family nursing homes (non-institutional caregivers). Given the focus of the project, the text below describes how LTC for older persons is regulated in greater detail.

The competent Centre for Social Welfare issues a Decision according to which an eligible beneficiary is entitled to housing and accommodation outside the family if his/her needs cannot be met in the family or local community. Nevertheless, according to the Act on Social Welfare, social services can be granted to a beneficiary who has entered into a contractual arrangement with a service provider of his/her own choice. In that case, the welfare beneficiary will finance the cost of care in full.

Pursuant to the Act, housing and accommodation is a type of social service including housing, provision of food, assistance with personal hygiene and grooming, healthcare, social work,

psychological and social rehabilitation, physical therapy, occupational therapy, work activities, active leisure, education and training, depending on the identified needs and choice of the beneficiary. It can be permanent or temporary.

LTC is available to beneficiaries who are in need of intensive care and whose other basic needs have to be met over a period of time. A functionally dependent older person or a seriously ill person in need of permanent assistance and care due to his/her health condition are deemed eligible for LTC.

The price of social services provided within the Social Services Network² is established according to the methodology prescribed in the rulebook of the line minister. Prices of social services not covered by the Social Services Network are set by service providers. Beneficiary/resident – an adult who uses LTC services on the basis of SWC's Decision is required to finance the cost of care from personal financial resources. In the event the beneficiary's resources do not suffice for LTC cost, or if he/she has no financial resources whatsoever, the cost will be borne by the line Ministry (hereinafter: the Ministry). The line minister issues a rulebook that prescribes the beneficiary's contribution and payment method.

The procedure for recognition of all legally prescribed rights including the right to LTC for older persons is launched at the request of the party or *ex officio*. The procedure is treated as urgent.

A social care home or other service provider has to meet minimum requirements for provision of social services, i.e. it has to be licensed. Minimum requirements are set in the Rulebook on Minimum Requirements for Provision of Social Services that sets minimum requirements in terms of space and equipment for service provision; minimum scope and nature of a structure and duration of direct interaction with beneficiaries; structure and duration of other activities; requirements and minimum number of professional and other staff for a given service. In addition to general minimum requirements, the rulebook stipulates special minimum requirements for the provision of social services per groups of beneficiaries. In terms of older persons, LTC services can be provided at several levels, depending on the intensity: the first-level-service shall be provided to a functionally independent beneficiary who can meet his/her needs independently and whose health condition does not call for engagement of others; the second-level-service shall be provided to a partially dependent beneficiary who needs assistance of others to meet his/her needs fully; the third-level-service shall be provided to a functionally dependent beneficiary who needs assistance of others to meet his/her needs fully; finally, the fourth-level-service shall be provided to a beneficiary who needs assistance and supervision of others to meet his/her needs fully due to Alzheimer's or other types of dementia

² By using the Social Services Network it is possible to identify the number and types of social services that are necessary for the entire territory of the Republic of Croatia (RoC). Social services within the Network are provided by institutions established by the RoC or other legal entities, so-called crafts or natural persons that entered into agreement re. provision of social services unless otherwise provided by law or special regulations. Social services outside the network are provided by legal entities, so-called crafts or natural persons that obtained the Decision on fulfilment of minimum requirements for provision of social services in accordance with the law.

(moderate/moderately severe stage). The rulebook also describes what each segment of housing covers. Last, but not least, it specifies spatial requirements and requirements regarding the equipment and staff.

In addition to public institutions, housing services can be provided by a natural entity on an independent basis or a legal entity according to the relevant legal provisions. If LTC is provided by a natural person, he/she is obliged to keep records and documents regarding beneficiaries, types of services or other issues pertaining to the work. Natural persons are obliged to deliver a relevant report to the Ministry and local/regional (self) government unit or the City of Zagreb. The number of available beds in these institutions may be included within the Social Services Network on the basis of a relevant agreement.

Professional activities in nursing/care homes are carried out by social workers, nurses, physiotherapists and occupational therapists. Individual caregivers are in charge of providing assistance with personal hygiene and grooming. They are obliged to perform these activities in line with professional rules, by respecting personal privacy, dignity and integrity of personal and family lives of beneficiaries and treating the information about their personal and family lives as confidential.

The work carried out by social institutions is supervised by inspectors of the line Ministry. Apart from ministerial and administrative supervision, institutions are obliged to conduct internal supervision.

In accordance with the Act on Healthcare, healthcare covers a whole system of social, collective and individual measures, services and activities for maintenance and improvement of healthcare, disease prevention, early intervention/detection, timely treatment and healthcare and rehabilitation. It relies on the principles of comprehensiveness, continuity, availability and holistic approach in the primary healthcare (PHC) and specialised approach in multidisciplinary and inpatient care. Special healthcare measures targeting the population aged 65 years or over represent one segment of general healthcare measures envisaged by the Act. These measures ensure provision of primary healthcare services, ranging from general practice (GP), dental care and obstetrics and gynaecology. In addition to doctors of medicine, application of specific healthcare measures targeting the population aged 65 years or over requires engagement of psychologists, speech therapists and social workers and/or other experts for specific areas of healthcare.

Rights to healthcare include health equity, free choice of medical and dental practitioner and access to health services that conform to certain standards of quality and equity principles.

The healthcare sector is a type of public service provided within or outside the network of public healthcare providers. The network specifies the desired number of healthcare institutions and private healthcare practitioners for the territory of the Republic of Croatia or local/regional (self) government units. Healthcare providers within the network are obliged to work in one, two or more shifts, work flexible hours and provide practitioners on duty or on

call to ensure continuous healthcare, in line with needs of population and types of healthcare provision.

Work performed by healthcare institutions, private companies providing healthcare, public and private healthcare practitioners are subject to internal supervision, supervision carried out by the Medical Chamber and the line Ministry (inspection-type supervisions).

After obtaining the opinion by the Croatian Institute of Public Health and line chambers, the Minister of Health adopts the national healthcare plan that, among others issues, stipulates roles and goals of healthcare providers, priority development areas, health needs of population that are of specific interest for the Republic of Croatia, specific needs and access to healthcare in certain areas, benchmarks for setting the network of public healthcare providers taking into consideration availability of healthcare by areas. Protection of vulnerable and specific social groups represents one of the priorities set in the Plan. Healthcare for older persons represents a precondition for healthcare development.

Findings 2: Human Rights Situation of Older Persons in LTC in Practice:

Entry into Long-Term Care: Access and Choice

The manner of entry of elderly persons into the system of long-term institutional care depends on the health, financial and other welfare conditions of the potential beneficiary, and on whether the beneficiary wishes to be placed in a care home established by a public law body or one established by another legal or physical person.

In state-run and decentralised homes for the elderly and infirm, as in all other homes and providers of welfare services contracted by the Ministry to provide such services within the Network, placement can be provided based on a decision by the competent Social Welfare Centre (SWC) office granting an elderly person the right to out-of-family care, in the manner and under the conditions defined by the law. As persons with a decision issued by the SWC, as well as those granted the right to permanent accommodation by the Act on the Rights of Croatian Homeland War Veterans and Their Family Members and the Act on the Protection of the Military and Civilian War Invalids, have the priority in placement, they are usually ensured long-term care quickly. Thus, with the notable exception of the City of Zagreb (where demand for such placement considerably exceeds available capacities), there are no waiting lists for such beneficiaries in the social welfare homes that we have visited.

On the other hand, placement can also be provided based on a placement contract concluded between the service provider and the user following a request by the potential beneficiary. Such a request is accompanied by documents stipulated independently by the service provider in their official acts. These documents typically include certificates on the health condition and the pension, along with a statement by the person to pay for the costs of placement. Each care home/service provider establishes a commission for the admission and discharge of

beneficiaries to decide on beneficiaries' placement contracts. As the capacities of care homes established by public law bodies typically cannot meet demand, there were waiting lists in all but one of them at the time of our visits, with the average waiting time for placement standing at 4 to 8 years, depending on the desired quality and standard of accommodation. As there is biggest demand for accommodation in single rooms, their waiting times are the longest. According to available data, there are currently 17,000 persons on the waiting lists for homes for the elderly and infirm in Croatia. However, monitoring the pace of dealing with this issue is hindered by the fact that the same persons can be found on waiting lists for several care homes. Separate lists are sometimes formed for different types of accommodation and levels of service. For instance, there are separate waiting lists for the residential and the infirmary home sections. According to data provided by a Zagreb care home, around 60 persons are admitted annually. Analysing the complaints, we found that decisions on rejecting admission were sometimes passed by applying discriminatory criteria, mostly based on the health status of potential beneficiaries.

While there are private care homes contracted by the Ministry to provide placement to beneficiaries in the Network, such placement in private homes is possible only based on contracts concluded between the beneficiary and the services provider following a submission of a placement request. Admissions are decided on by the commission for the admission and discharge of beneficiaries. The price of accommodation in private care homes is formed based on market principles and is therefore higher than in the homes established by public law bodies. Given all above, the interest for placement in such institutions is on a lower level, and they always have a certain number of vacancies. According to some data, 10% of accommodation capacities of the private homes for the old and infirm are vacant at any time. Accordingly, placement in such institutions is possible without any waiting.

The Right to Life

By respecting human life as an inherent right of every human being, the right to life is one of the fundamental human rights guaranteed by the Croatian Constitution. As such, it is protected by a ban on the death penalty, on euthanasia, and on all other practices threatening it. Threat to human life is sanctioned in the Croatian criminal code. As a criminal offence can be committed by acting or failing to act, the person who has failed to avert the consequences of a criminal offence is criminally responsible, too, provided they were legally obliged to avert such consequences.

Criminal offences against life and limb constitute a separate chapter of the Croatian criminal code. They include: murder, aggravated murder – including murders of persons particularly vulnerable due to their age, physical or mental disability or pregnancy – manslaughter – including killing another person upon their express and earnest request out of compassion due to their difficult health state, causing the death of another person by negligence, participating in suicide, as well as failure to render aid and deserting a helpless person.

With regard to all above, threatening human life is sanctioned by the criminal code, and is as such within the competences of the prosecution and the legal bodies.

Freedom from torture, violence and abuse

No signs of torture were found in any of the care homes we have visited. However, the status of a particularly sensitive social group brings elderly persons in a position of potential danger from various forms of undesirable behaviour that can lead to violence or abuse. The very dependence on the help and care of others brings them in an unequal position in the society and increases the danger of their being subjected to violence or abuse, i.e. undesired procedures.

When talking about violence or abuse of elderly persons, it is low pensions, unfavourable economic conditions and poverty that create particularly aggravating circumstances. Combined with the already mentioned problem of insufficient institutional care capacities and their relatively high price, undeveloped non-institutional care mechanisms and the lack of support for unofficial forms of care for elderly, such circumstances have an additional negative effect, primarily on economic exploitation and abuse of elderly persons.

Although care homes and other providers of long-term care normally do not supervise their beneficiaries' legal affairs and often have no insight into their beneficiaries' contractual relations, it is lifelong support contracts that constitute a special form of economic exploitation of elderly persons. On the basis of such contracts, elderly persons give away their property to the providers of lifelong support, who are supposed to ensure them with the necessary care and support. However, insufficiently informed about the legal effects of such contracts, elderly persons are often left tricked, ripped off their property, with no legal protection or agreed care and support. In such situations, they face the particularly difficult circumstance of having no right to the welfare services of long-term care and in-home assistance, or the financial allowance for assistance and care, and the guaranteed minimum allowance, unless they terminate such contracts, since it is assumed that they can get all the necessary support from the provider of lifelong support. Institutions providing institutional care could therefore ensure their beneficiaries comprehensive information about the effects of such contracts and the possibilities for legal protection in case such contracts are not honoured.

Fortunately, the issue above has been increasingly prominent in the public. In order to avoid fraud against elderly people on the social welfare level, there are initiatives, due to the conflict of interest, to prevent owners of care homes, homes for the elderly and infirm, doctors, lawyers and nurses from entering into such contracts, thus making them ineligible to provide support based on the lifelong support contract. In addition, non-governmental organisations and social welfare institutions have been providing counselling to elderly people with an intention to stop their abuse through such contracts.

Dignity

As a starting point for human rights, dignity insists on respecting the person of every human being, protecting them from all abuses which put them into a position of inequality and instrumentalise them for achieving someone else's goals. When talking about the dignity of elderly people in long-term institutional care, the system's starting point should be empowering this vulnerable group and adapting the services to their not only objective, but also subjective needs. However, faced with mounting costs and a continued decrease of available funds, the system itself, as the most responsible link in the chain, sometimes loses the perspective of the purpose of its existence, setting limits that may threaten the dignity of its beneficiaries.

In modern, neo-capitalist societies, the dignity of elderly people is threatened by their very perception. By treating them as useless members of society that generate numerous, very high costs, the system often loses from its focus the material, empirical and intellectual potential and contribution of older generations in reaching the existing level of social progress. By putting young, active, strong and successful people in the centre, the society isolates its elderly members by robbing them of their social role.

In our visits to care homes, we have identified certain aberrations that can be described as humiliating. They sometimes included actions that, although ingrained in the system, threaten the dignity of beneficiaries. However, sometimes they were merely mistakes made by the persons in charge of beneficiary care or by other service providers, who were often unaware that they infringed the dignity of beneficiaries. As an illustration, a resident in one of the homes stated that 'one loses all their shame coming here'.

Insufficient attention to the privacy and dignity of beneficiaries is one of the challenges of institutional care of elderly people. It is a relatively frequent occurrence for assistance with personal hygiene to immobile and semi-mobile persons to take place with doors wide open, with visitors and passers-by around. Even in those institutions that pay attention to this, we have established that the privacy of persons sharing a room is not respected during such assistance. Generally, the gender of nurses is not taken into account, which is exacerbated by the shortage of trained nurses, especially men. However, as such assistance is traditionally provided by women, male beneficiaries showed no resistance to being assisted by women. Still, there have been opposite cases, with women rejecting assistance provided by male nurses, and such requests were normally fulfilled. We established that the staff do not even realise that not using a screen, or providing assistance with personal hygiene with the door open, amount to infringing the intimacy of beneficiaries and violating their right to dignity. In all, it can be concluded that targeted staff training would ensure protecting the dignity of beneficiaries.

In one of the homes, we noticed that the privacy of less mobile residents was protected during bathing, but in returning one of them to the room, she was spotted sitting in the wheelchair

naked from waist down, which is unacceptable and was immediately brought up. According to the explanation provided, this mistake had been made by trainee nurses who had no experience. One of the residents mentioned the earlier practice of several residents bathing at the same time, to which she objected as she considered it humiliating. The practice was suspended and from then on, each resident took a bath on their own.

Due to ever more rigorous savings by the system, savings are made in the heating, too, which is not turned on despite relatively low outside temperatures. Even though residents did not complain about being cold, a temperature of 19°C was measured in one institution's infirmary unit, which is below the set lower limit. Following our objections, the heating was turned on the next day.

Given the position of authority that the institutions have in relation to their beneficiaries, their dignity is also violated through non-transparent charges for additional costs, and through unwarranted charges for the services that have not even been delivered (e.g. charging the full price of accommodation, including for days the resident did not spend at the institution). To secure payment for their services, some of the decentralised care homes force residents to sign a statement agreeing to have their pensions paid to the institution's bank account. After covering the costs of their services, the institutions then pay out residents the rest of their pensions at the cash desk. Such actions amount to infringing on the assets of residents, but they are justified by common cases of residents or members of their families spending the whole pension and not having enough money to pay for the accommodation costs.

Although they provide housing services, which can include different life situations, accommodation in decentralised care homes is often encumbered with hidden costs that new beneficiaries are not aware of when concluding placement contracts. Such costs vary from one care home to another. While some hardly have any extra costs, some calculate numerous additional costs. For instance, in some homes delivering each meal to the resident's room in the residential unit is charged extra, regardless of whether there is any legitimate health reason for it or it is just the resident's whim. Other extra charges include using the refrigerator, fan, air-conditioner, washing machine. In one of the homes, functionally independent residents are charged HRK 150 for additional services, yet with no cost specification.

In all the institutions we have visited, the staff treats residents with respect. However, there have been isolated cases of treating residents like small children, giving them instructions as to how to respond to questions, and the staff consuming food brought to residents by their visitors.

Choice and autonomy

The right to choice does not only include deciding on entering long-term institutional care, but also on the type and scope of desired care and assistance.

Persons with legal capacity make decisions on entering long-term institutional care themselves. This should mean that each potential beneficiary submits an application for placement and hand-signs it, thus stating their unambiguous consent to being placed in an institution. In practice, however, applications are often submitted by family members, who also sign them instead of the potential beneficiary, and the absence of active resistance to being sent to a care home is interpreted as consent. There are cases when, in line with official acts regulating admission, the contract on care home placement is signed not by the potential beneficiary, who is prevented from doing it due to illness or physical condition, but by a member of the immediate family on their behalf. The competent SWC is not even notified of such cases, as the whole procedure is carried out in an informal manner, the future beneficiary is not assigned a guardian, as stipulated by the law, and the process does not include a public notary to authorise the beneficiary's statement on accepting care home placement.

In some of the homes we have visited, we found that family members who have committed to paying care home costs were also allowed to sign an application for placement instead of the beneficiary. Applications submitted in this way are inserted into the beneficiaries' files. Such beneficiaries, despite having been in a good psycho-physical state at the time of admission, did not express their unambiguous consent to being placed in the institution. They said they did not oppose home placement, but at the time of admission they did not express their unambiguous consent, and their silence was interpreted as consent. We therefore warned that each beneficiary must hand-sign the application and the contract on placement. In situations where this is not possible due to seriously deteriorated health, the SWC must be notified to appoint a special guardian.

In some homes, the placement application form addresses a third person – the one submitting the application and signing it, while only a part of it refers to information about 'the person placement is requested for', again to be filled by the submitter. It can be inferred from such an application form that the submitter can contract home placement even in cases of clearly expressed opposition by the future beneficiary.

Persons with the right to the provision of care outside their family are placed following a decision by the competent SWC.

The right to choice (between one's own home or the institution) is also threatened by the lack of a national strategy of reconciling the professional and family life, which forces families, often left to themselves, to place their elderly members in institutions. Insufficient capacities, however, limit the choice of possibilities. In an event of a sudden serious illness, elderly persons whose families cannot care about are placed wherever there are vacancies or where their families can afford the costs. Consequently, as reported by the Ministry, elderly persons are placed in 'illegal' institutions that do not meet minimum conditions for work. As there are no alternatives, the person fatalistically resigns himself or herself to the circumstances, concluding 'what else can I do?'

Though very seldom, during our visits we came across persons who were placed into care homes without their clearly expressed consent. What is more, there was a person placed in one of the private homes who clearly stated her opposition to long-term institutional care, expressing a desire to be sent back home. Although not deprived of her legal capacity, she had a specially appointed guardian who received her mail, including remittances, and was authorised to use it to pay her bills, buy medications and meet her other everyday needs. The special guardian was also authorised to set up monthly standing orders to cover the costs of her accommodation and to undertake all necessary actions at the police station for her to be issued an ID. According to the explanation of the decision to appoint a special guardian, the resident was immobile, incontinent, and dependent on assistance in feeding, assistance and personal care. However, visiting her three months after this decision was issued, we found the resident capable of sitting independently, and even standing with some assistance. She constantly repeated that she wanted to go home, with the staff replying that her house was unfit for living and that she had nowhere to return to, and could not live independently due to her health condition. As the resident was not deprived of legal capacity, we warned that it was impermissible to keep the person without her consent, and that the special guardian was not authorised to sign the application for placement. We notified the competent SWC of the need to regulate her status, as any retainment against her will amounts to a violation of the freedom of movement and constitutes an act of violence.

Freedom of Movement and Restraint

In all homes we have visited, the freedom of movement is guaranteed for beneficiaries in the residential unit. Although the home doors are locked at certain times, residents can go in and out as they wish. Still, for their own safety, going out late in the evening must be announced at the reception, or to the staff on duty.

Some homes that are not located in the vicinity of public transport provide their residents with a shuttle service to town in the morning, with buses departing from and returning to the care home at set times. At other times, resident travel to town on their own.

Residents are free to go on trips or visit their families for several days. Such goings are announced to the staff in advance.

Most homes encourage residents with significant limitation of movement to get out of bed, including those residents who are unable to move on their own. In some homes, we noticed very high thresholds on the door to the balcony, preventing residents who use walking aids or wheelchairs from getting out. Spaces between beds are sometimes too narrow, too, blocking wheelchair passage.

In the homes we have visited, psycho-pharmaceuticals are prescribed by psychiatrists and there was no indication of excessive sedation of residents. No means are used for physical restraint of people. The only such devices used, supervised by the medical staff, are those for

fixing one hand during the infusion and those preventing residents from falling out of the wheelchair, if the person cannot sit independently. In the infirmary unit, for agitated residents, the sides of the bed are raised at night to prevent their falling out.

In homes that have the possibility of accommodating people with Alzheimer's or other types of dementia, such wards are locked for the security of residents. Some of them have balconies specially protected with a high transparent plexiglass fence allowing residents to spend some time in fresh air on their own. Infirmary unit residents suffering from dementia or with walking difficulties can venture outside the building only accompanied by the home staff, which is normally provided regularly.

Homes' common rooms generally feature video-surveillance, which is duly noted.

Visitors usually report at the reception, which is manned at all times. In residential units, visits are normally allowed all day, but infirmary units, due to their residents' specific needs and the organisation of assistance, have fixed visiting times. Visiting times are mainly determined by the times when assistance in personal hygiene and grooming take place, to protect the dignity and privacy of all residents. Still, whenever possible, immediate family members are permitted to visit outside defined times, as well.

Participation and Social Inclusion

Social inclusion and participation of older persons in long-term care is ensured through their active participation in the care home activities, but also through their encouraging to participate in the activities of the wider community.

They are informed about procedures affecting them by the home's social workers or medical staff. It is a common practice, when a new resident moves in, to create his or her individual care plan, drafting of which involves the participation of the social worker, the chief nurse and the work therapist, but also the beneficiary himself or herself.

Residents are generally informed about the activities taking place in the home on the notice board. In addition, meetings of home residents are regularly organised on each floor where they can discuss the issues and topics of common interest, and where the social workers and other home staff inform them about all important issues, and residents bring up their opinions and suggestions and ask questions. However, in large homes, residents stressed that they did not have enough information about the way home life is organised, or even information concerning their own status. For example, one of the residents complained about not knowing who paid the difference between her pension and the price of the infirmary bed, saying that she would like to be explained that. She needed some pocket money and did not know who to talk to about it. She had no idea of what was included in the price of accommodation, and which services were charged extra. She was reluctant to ask for a cup of coffee as she was not aware of whether that was included in the price of accommodation or had to be paid extra.

In keeping with the law, residents have representatives in care homes' governing councils. The one representative of the home's residents is appointed by the administration following a proposal by the home's residents made in the residents' meeting. However, some residents have no idea of who their representative is. The fact was also indicated that those representatives are often selected by the home administration, and that in reality they do not represent all residents but only themselves.

In most care homes, residents located in the infirmary unit pointed at not having enough information about how the home life is organised, or lacking some other important information.

Along with group exercises and birthday parties, most institutions also organise other joint activities for the residents: choirs, dancing, board games. In some homes there are additional facilities such as bowling or bocce courts. There is also a practice of organising theatrical performances and other cultural events on the premises, typically in collaboration with amateur troupes or schoolchildren. According to care home residents, no joint excursions are organised, or visits to the theatre, concerts or other such public events. What activities are organised depends, first and foremost, on the sensibility of the staff. There are homes where spending free time together boils down to playing bingo or handwork resembling the motor games played by pre-school children. On the other hand, there are homes where the staff organises popular music concerts for all residents, dancing, drama groups and various other activities.

In all homes, residents' birthdays and important public and religious holidays are marked. A joint New Year's Eve celebration with staff participation is organised only in the private care home in Bjelovar. Other homes, due to a lack of interest by the residents, organise New Year's Eve celebrations during the day.

Residents can exercise their voting rights in all care homes, with polling stations typically set up on the premises. Since a significant number of residents, for various reasons, mostly personal, do not have official residence in the care home, they exercise their voting right based on the voting certificate. All care homes are therefore urged, in line with the Residence Act, to deal with the issue of their residents' residence, thereby allowing them to obtain new IDs.

Privacy and family life

Mindful of their residents' privacy, care home staff knock before entering rooms, yet there are isolated cases of their entering without knocking and of arrogant behaviour towards residents. All residents in the residential section have their own lockers that can be locked, which is not ensured for all residents of infirmary units. Letters and packages are delivered to their recipients at the reception, and nobody opens them. The privacy of residents in rooms with several beds is ensured by means of then using dayrooms for meeting family members or solving their private issues. This is more problematic in rooms with several beds in the infirmary unit where immobile residents are located, which impedes respecting their privacy.

In most care homes, rooms in the residential section can be locked. In one private home, however, there is hardly any difference between the residential and the infirmary unit, with rooms in the residential unit resembling hospital rooms with doors open at all times, thus eliminating the need for the staff to knock when entering.

The aforementioned practice of residents' pensions being paid to the care home bank account, along with affecting dignity, impinges on the privacy of residents, as well.

The cases of impinging on privacy include providing assistance with personal hygiene and grooming with an open door, i.e. in front of other residents and with no screen.

Residents' medical records are kept at care home surgeries, or at the chief nurse's office. Barring medical staff, nobody else normally has access to information from the medical records. However, we established in one of the homes that copies of referrals and specialist reports are also sent to the accountant, which is an unacceptable practice justified by the need to document payments made when accompanying residents going to specialist examinations.

Personal documents are normally kept by residents themselves, with cases evidenced of them being kept by other family members.

Freedom of expression, freedom of thought, conscience

In all care homes we have visited practicing religion is ensured for residents of Roman Catholic faith. The homes have chapels where masses are celebrated, with frequency varying from once a week to once a month. In one of the homes, immobile residents are provided with live transmission of the mass through the public address system installed in their rooms, while in others their participation in the mass is organised in accordance with their abilities. However, according to reports by care home staff, there is good collaboration with representatives of religious communities, ensuring their presence in the infirmary, as well.

As reported by the staff, as well as residents themselves, there were no requests for holding regular religious ceremonies for other denominations, as they are not organised. However, residents express desire to be given last rites in the event of death. Such wishes are always respected, and residents are buried in line with the desired religious rites provided in collaboration with local religious communities.

Following our express inquiry, we were informed that there had been no requests for religious dietary practices in any of the care homes.

Highest attainable standard of health

All care homes for the elderly organize the provision of health services. Primary health care provided through family medicine clinics in care homes is organised in various ways, depending on the size and the ownership of the home. Although some homes organise occasional dental visits, in most cases dental protection is not appropriately assured in the homes. Dentists who visit homes do not provide full dental services, as was pointed out by the residents of one home where the visiting dentist does not repair teeth, but only removes them. Such practices particularly affect residents in the infirmary unit, who are unable to obtain dental care by going to a dental clinic. Gynaecological check-ups are not available in any of the care homes, despite the fact that women represent the majority of residents. Interviews with residents indicated that no gynaecological check-ups take place.

In the Bjelovar Nova Vita care home, health care is outsourced to doctors who visit the home once per week. If one of the residents is not registered with the designated home doctor, they are driven to their general practitioner. The head nurse visits residents of the residential unit on a weekly basis and discusses their health issues with them. The residents' blood pressure is measured regularly (three times per week), and the care home nurse monitors their blood sugar. The blood pressure and temperature of residents in the infirmary unit are checked every day. Residents can also consult with a psychiatrist. Healthcare is organised in the same way in the private care home in Pula, where a physician visits one per week and services of a psychiatrist are also provided.

In large, decentralised care homes, health care is often provided in the family medicine doctor's office located in the care home itself. In such cases, all residents bring their file and sign an agreement to use the services of the physician who works in the home's clinic upon admission. They are provided with the services of an outside psychiatrist who visits the care home twice per week. The care home's head nurse familiarises the residents with the recommended course of treatment or medical procedure. According to the residents, paternalistic behaviour has been observed when medical staff withhold information, saying 'trust me, I know what is best, there is no need for you to read the medication instructions.' In order to avoid this in the future, we recommended that staff involved in providing health care and nurturing undergo human rights and communication skills training.

Residents in the infirmary units of all the care homes we have visited are provided with medical, hydraulic beds. There is an alarm button next to the beds, enabling residents to call for medical staff if needed. The premises are clean and the personal hygiene of residents is good. Non-mobile residents and those with limited mobility are served meals in their rooms, and when necessary in their beds. Residents of some, primarily decentralised homes complained that the number of diapers was insufficient and that baths were too few. According to residents, there were cases when morning bathing was performed using wet wipes used for cleaning hands at mealtimes, while teeth were brushed only once.

Only the Bjelovar private home provided residents with five meals, while others provided three. Additional medically indicated meals (e.g. in case of diabetes) are charged as

supplemental meals. Our analysis of menus leads to the conclusion that the dietary menus are not sufficiently elaborated and that there are no menus adjusted to the individuals' diagnoses. A light version of the lunch menu is usually provided while other meals remain the same as for all the other residents.

The practice of creating an individualised plan of care for each new resident upon arrival, adopted in all the institutions, contributes to the quality of health protection for persons in long-term institutional care. Besides the resident, the creation of the plan involves the social worker, head nurse and work therapist.

There is a pervasive lack of staff in decentralised homes, such that residents themselves pointed out that lack of nurses, aides and physiotherapists, which renders them hesitant to request help, even when it is necessary. For example, the nurse on night duty takes care of seventy-five residents located in the infirmary unit, while also performing the tasks of the aides. During the day, one nurse per shift works in each of the six infirmary units, which means they take care of fifty residents during the day. A total of forty-two carers work in that home in daily shifts, each caring for fourteen residents. During the visit some residents noted that the insufficient number of nurses, aides and physiotherapists in infirmary unit accommodation, sometimes led them to refrain from asking for necessary assistance while performing certain activities.

The rooms in all the homes we have visited are equipped with a staff alarm system. The alarms can be activated from the beds and bathrooms.

Age discrimination

Since care home residents are always elderly persons, we have not encountered cases of discrimination against them based on age. Nevertheless, although discrimination based on age is prohibited by law, elderly persons are victims of systematic age discrimination in the form of 'ageism' or other behaviour that jeopardizes their equality in society. This report has already underlined certain behaviour that points to potential systematic discrimination based on age. For example, it is true that an elderly person can be placed in long-term institutional care based on another person's request, which is not the case with certain other groups. The practice of not enabling residents of long-term institutional care to decide on their own how to pay for services received, but rather requesting that the pension is transferred straight to the account of the institution providing care, also points to discrimination on the basis of age. Not only does this practice impinge upon ownership rights, but it also puts such persons at a disadvantage in comparison to those living in their own homes, as the former are not able to use their financial resources by using debit cards or purchasing goods in instalments.

Additional charges for certain services as well as pricing policies are left to the founders of decentralised care homes for the elderly and the infirm. As such, they vary greatly, and while some county care homes do charge extra for anything, in others such costs are significant. For

example, a county care home charges more for balconies and a sea view, charges for the use of a personal fan at the same rate as the use of an air-conditioning device, and charges extra for the delivery of each meal to an acutely ill patient (e.g. in case of flu).. Such services do not incur added charges in other care homes, or they are billed at a significantly lower price. In order to avoid such uneven practices, we believe it is necessary to legally define what is encompassed by the price of basic ('standard') accommodation and what services can be charged additionally, as well as how their prices are calculated.

An adequate standard of living

The standard of living in care homes varies between decentralised homes and those in private ownership.

Decentralised care homes are more modestly appointed, using old furniture. Rooms often do not have their own bathroom. Although some of the homes were being renovated at the time of the visit, rooms without bathrooms would still exist after the renovation. Shared bathrooms on each floor would be used. Although there are significantly more women than men in these care homes, there is an equal number of toilets and showers for each of the sexes in the shared bathrooms.

While there is most interest for single rooms, institutions also have rooms with 3, 4 or 5 beds. They are usually occupied by persons who do not know each other. Although the compatibility of residents is taken into consideration, shared residence is often a source of discord among residents. Small kitchens are installed on the floors. The rooms usually have television sets owned by the residents themselves.

Each resident in the rooms in the residential unit has a closet that can be locked. Nightstands are placed next to the beds. Personal furniture is usually not permitted, unless otherwise agreed with the care home staff. There is a lack of storage space for personal objects, so residents come up with various solutions. Telephones are not part of the standard equipment in the rooms, but many residents use personal mobile phones. If there are no telephones in the rooms, the use of a telephone is made available in other ways, such as a telephone booth on the floor or a telephone in the office of one of the care home employees made available to all residents.

All of the premises are very neat and clean. Shared facilities are cleaned on a daily basis. While residents' rooms in decentralised institutions should be cleaned once a week, residents stated that it is performed on a daily basis. The rooms' cleanliness, however, depends on the residents themselves and varies between rooms. All institutions provide the service of washing and ironing the residents' clothes. Given the large number of residents, it sometimes happens that someone's laundry gets lost or misplaced.

Each care home has a joint space for social/daily activities that is equipped with a television. Some also have a smaller, informal library. All institutions have elevators spacious enough for a wheelchair or a transportable bed.

Mobile residents' meals are served in the restaurant. Three basic meals are provided on a daily basis, and one private care home charges additional meals as supplemental meals. Vegetarian menus are not available but vegetarians can arrange for meat to be replaced by vegetables.

While rooms are better equipped in private care homes, the accommodations within them varies significantly. For example, although the Pula care home technically has both residential and infirmary units, they barely differ. Most users of the residential part spend their days in bed, dressed in pyjamas. If they do not want to get up, their meals are served in bed. All rooms look like hospital rooms, containing a bed, a cupboard with a key and a nightstand, while a table and a chair are not made available for every person, making the room inappropriate for healthy persons. Rooms cannot be locked and the doors are wide open during the day, enabling staff to enter and leave at will.

On the other hand, the private care home in Bjelovar has well-equipped rooms that resemble home accommodation both in look and in furnishings. Thanks to the collaboration of the owner and the residents, each room has a personal touch and feels like a 'home'. The use of personal furniture is permitted, which raises the residents' satisfaction. Every room has a bathroom. The care home building can accommodate the residents' visitors for several days. The care home has a swimming pool and a sauna that are open for the residents' use on a daily basis. It is surrounded by large grounds with an orchard, fish ponds and an arbour with a barbecue for socializing outdoors. The care home has a café bar where residents often socialize. While the basic price is higher than in decentralised care homes and depends on the accommodation and care required, there are no hidden additional costs.

Some care homes do not allow residents to use their own items and furniture, while others allow the residents to furnish the whole space with their objects.

The shared space that is available to residents only during certain hours is sometimes locked. It is common for such areas to be unlocked only when staff is present. Rules should therefore be adjusted to meet the residents' real needs, which certainly include a reasonable level of adaptability. Continuous professional training of staff is also necessary.

Education, training and lifelong learning

Cultural and educational needs are met at the individual level, as well as through joint activities, such as choirs, board games, group exercise and visits by theatre groups to the care homes' premises.

According to residents, care homes usually do not organise excursions or visits to cultural events, theatres or concerts. In some homes, however, cultural events, such as theatre plays and concerts are organised at the care home's premises. Daily newspapers are usually available in print form, and modest, informal libraries are organised in care homes.

Redress and Complaints

The Act on Social Welfare provides for lodging a complaint about a social service rendered or the actions of a person performing social service activities. In addition, the Rulebook on Quality Standards of Social Services is applied to public and decentralised care homes and private homes with which the Ministry of Social Policy and Youth concluded accommodation contracts. The Rulebook defines the standards according to which service users, their families and other interested persons may lodge complaints against the decisions of competent bodies or individual staff, and request and obtain answers regarding services rendered, without fear of repercussions and with full certainty that their complaints will be answered. Nevertheless, the institutions we visited usually do not have well-developed protocols for lodging complaints and appeals nor, according to statements by staff, for informing residents about the right to lodge complaints. In both decentralised and private care homes alike, any discontent or problem the residents encounter is orally communicated to the director, who in turn deals with the problem on an ad-hoc basis.

Some care homes introduced complaint boxes, yet residents are not motivated to leave their complaints in them since they never receive answers regarding the way in which a problem they pointed out has been solved.

A book of complaints was created in one of the care homes for residents to write their complaints.

According to the director of one of the care homes we visited, residents prefer to express their complaints orally. Nevertheless, during the visit she did not elaborate on how such complaints are addressed. She also did not elaborate on how and to whom a written complaint may be delivered. On the other hand, users of the same institution were complaining that they were not familiar with the process of making complaints.

Palliative and end-of-life care

None of the institutions visited is registered for palliative care. Nevertheless, they take care of seriously ill persons, including the terminally ill, in their infirmary units and to the best of their ability. A high level of staff commitment to the care and nurturing was observed in the infirmary units.

The issue of death is discussed with all residents upon admission. The conversation usually focuses on the residents' wishes regarding informing their families and religious rites.

All care homes are equipped with a morgue for the short-term accommodation of the deceased.

Conclusion: Implementing a Human-Rights Based Approach in Long-Term Care: Key Challenges

As a universal value of the modern society, respecting human rights cannot be conditioned by any status, including age. Despite this, there are examples when the obligation to respect them is ignored when it comes to elderly people. Sometimes they include minor mistakes, the negative effect of which on respecting human rights is realised by neither those who make them nor those whose rights are threatened. Sometimes those are bigger violations putting elderly people in a far more unfavourable position in relation to any other social group. Such violations include deciding on behalf of elderly persons by neglecting their own will, social exclusion, creating and perpetuating prejudices about elderly people leading to ‘ageism’, unavailability of information and an undeveloped system for filing complaints.

Having visited five homes for the elderly and infirm, we found that most beneficiaries were satisfied with their accommodation and the quality of services provided, with the staff invariably emphasised as the strongest link in the system. However, long-term institutional care is mainly focused on beneficiaries’ medical, rehabilitation or physiological needs, organising which often neglects the human rights aspect. This is also partially caused by policymakers’ lack of awareness of the need for human rights to be in the focus of all public services, including those providing care to the society’s oldest members. Discussions with employees of care homes, but also with beneficiaries of their services, pointed at the need for comprehensive training on human rights and the need to work on the normative framework focused on human rights that would forestall their violation.

Changes in the concept of family and the increasing ageing of population lead to a quicker development of services intended for the elderly population. However, the formal system is much slower than the informal one, as evidenced by the figure of 17,000 people on the waiting lists for placement in care homes established by public law bodies. Such a situation creates opportunities for immoral people with dishonourable intentions, who look for possibilities to make quick profit by providing inadequate care to elderly people. This is made easier by the mentioned lack of policies focusing on reconciliation between the professional and family life.

Institutional care is provided to elderly people by professionals in this area. However, in most decentralised homes there is a notable shortage of trained staff, which directly affects the quality of care provided. The shortage of staff is partly compensated for by dedicated work of the staff, but sometimes that is just not enough. In some homes, there are attempts to counteract the shortage of staff by having functionally independent residents assisting, on a voluntary basis, those in poor health by feeding them, taking them for a walk, reading or talking to them, or providing small services for them.

The economic crisis hits elderly people in Croatia particularly hard, as their pensions are very low. Financially incapable, they often cannot get timely institutional care. In state-owned and decentralised care homes, which provide care services at prices considerably lower than those privately owned, very long waiting lists are created. In some homes, placement is awaited for up to eight years, which hits particularly hard those groups of elderly persons who do not meet the conditions for placement in the Network based on a SWC decision, while at the same time not having enough funds to cover the costs of care in a private home.

Elderly people do not constitute a homogeneous group with the same needs. However, although there are no defined standards or extra standards of services, decentralised homes provide uniform services that sometimes do not follow specific individual needs. These include safeguarding privacy, availability of information, transparent charging for services, type and number of meals, frequency of assistance in personal hygiene and grooming, meeting cultural needs, protecting residents' dignity, and, absolutely, the possibility to lodge complaints. Even though the standards of care and personal assistance are generally higher in private homes, there are differences between them, as well as room for improvement.

Recommendations

To improve the level of protection of the human rights of elderly persons in long-term institutional care, we suggest as follows:

- ensuring the enforcement of the legal provision guaranteeing the participation of elderly persons with legal capacity in deciding on matters related to them, especially in the context of deciding on their placement in homes for the elderly and infirm;
- ensuring monitoring the level of respecting human rights through the monitoring of care homes;
- employing the number of staff providing the care and assistance services as required by the systematisation of jobs in all homes for the elderly and infirm, and by other care providers for elderly persons;
- organising training for all staff working in the long-term institutional care system on the human rights of elderly people and communication skills required to work with them;
- organising public campaigns to raise awareness in elderly people about human rights and the possibilities and instruments for their protection.