ESPN Thematic Report on Challenges in long-term care

Former Yugoslav Republic of Macedonia

2018

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February 2018

EUROPEAN COMMISSION

Directorate-General for Employment, Social Affairs and Inclusion
Directorate C — Social Affairs
Unit C.2 — Modernisation of social protection systems

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European Commission
B-1049 Brussels

European Social Policy Network (ESPN)

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Summary

Though not so substantial as in the EU-28 countries, population ageing, in parallel with lower birth rates and changing family structure, has become a serious challenge in the Former Yugoslav Republic of Macedonia. During the period 2006-2016, the percentage of the younger population (0-14) steadily decreased (from 18.6% in 2006 to 16.6% in 2016) and the percentage of the old age group (65+) increased from 11.2% in 2006 to 13.3% in 2016. In 2015, life expectancy at birth for men was 73.5 and for women 77.4. At the same time, life expectancy at age 65 for men in 2015 was 14.4 and for women 16.2, which is far below the EU-28 average (21.2).

The share of the population aged 80 or over was 2.3% in 2016 and the old-age dependency ratio was 18.5% (compared to the EU-28 average of 29.3%).

Provision of long-term care (LTC) in the Former Yugoslav Republic of Macedonia is based on the principles of insurance for health care and on universal entitlement for social care services and cash benefits. Long-term care is financed primarily from the state budget, contributions, out-of-pocket payments by the beneficiaries or their families and the municipal budget (for certain social care services). The LTC regime provides rights and services mainly to those being cared for. Carers' rights, especially leave and in-kind benefits, are nether well developed nor supportive. The labour market support of carers is still limited, and carer's leave is limited to the parents of children with developmental difficulties or special educational needs. Some specific benefits do exist for informal carers.

In terms of overall support, the long-term care regime consists of a combination of rights related to: (i) financial support; (ii) residential, semi-residential and non-residential services. Professional (formal) social care is provided in people's own homes, social protection institutions, day care centres, hospitals and foster families in the public and private sectors. All providers must have a licence to deliver the care services on a professional basis. Informal care may be provided by spouses/partners, family members or other friends/relatives. The dominant form of support is residential care (which is now largely privatised) and cash benefits. In recent years, some new forms of cash benefits have been introduced. However, labour market support for carers is still very limited, making carers more vulnerable in relation to employment and decent living standards.

The only support for carers and the cared-for are the financial benefits from the social protection system. The possibility of combining these can, in many cases, lead to an income close to the average national salary. Although this support may compensate for the financial costs of the carer and contribute to the well-being of the cared-for person, it certainly does not contribute to the work-life balance of carers. There are no specific in-kind benefits that are provided to support people with dependent relatives. In-kind support is provided only to the persons being cared for.

The increase in the number of the elderly – one of the main challenges facing LTC – is not accompanied by a corresponding increase in service provision (either social or health; public or private; institution based or community/home). The institutional protection of old people is still insufficiently developed, compared with some European states. Estimates indicate that institutional social care services cover approximately 0.33% of all elderly people in Macedonia. Residential care in particular requires more resources (financial and human) than other forms of service provision. Therefore, in the long run, the institutionalisation of long-term care needs to be placed on an adequate and sustainable financial footing, which has to include the state budget and the budgets of local self-governments, resources from different government funds, funds from non-governmental organisations, donation programmes and other international financial institutions. Moreover, the need to develop supplementary forms of service provision has to be taken into account. The issue of weak quality of service provision remains, mainly because of inadequate numbers of specialised professionals to look after elderly patients, a lack of multifunctional teams and approaches to treatment, a lack of adequate and appropriately equipped facilities, and long waiting lists. In addition, there is a need not

only to improve the quality of services, but also to widen the scope and range of provision. Needs-assessment research studies and the availability of data and information to measure LTC should be improved. A long-term proactive approach to dependency should be emphasised more and sought through the assessment of need for social and public health prevention and rehabilitation policies at both the central and the local level.

1 Description of the main features of the country's long-term care system(s)

1.1 Governance and financing

Long-term care (LTC) in the Former Yugoslav Republic of Macedonia is not covered by a single system, but is provided partly under the social protection and pension insurance system run by the Ministry of Labour and Social Policy (MLSP) and partly under the healthcare system run by the Ministry of Health. Both of these systems have their own legal regulations, their own criteria governing accessibility and quality, and their own funding methods. A basic legal foundation is offered by the Social Protection Law, Regulations on the manner of acquiring the right to financial reimbursement for assistance and care, the Healthcare Law, the Law on Health Insurance, the Law on Employment and Insurance in Case of Unemployment and the Law on Pension and Disability Insurance.

The provision of long-term care is based on the principles of insurance for health care and on universal entitlement for social care services and cash benefits. Some cash benefits also depend on a person's financial means. Long-term care is financed primarily from the state budget (tax funded), contributions, out-of-pocket payments by beneficiaries or their families and the municipal budget (for certain social care services). Some specific benefits exist for informal carers.

Risks covered by social protection refer to all permanent residents who are not capable of looking after themselves and who are dependent on assistance and care from others (elderly people over 65, persons with physical and/or mental disability/illness, or persons who cannot perform basic living functions without orthopaedic devices due to temporary changes in their medical condition).

In terms of overall support, the long-term care regime for the elderly in the Former Yugoslav Republic of Macedonia consists of a combination of rights related to: (i) financial support and (ii) residential and non-residential services. In addition, informal caregiving forms a substantial part of care for dependent people.

1.2 Residential and non-residential services

In accordance with the Family Law, children are obliged to take care of their parents and cover the costs of care if the dependent person is unable to pay.

The residential and semi-residential part of formal long-term care in the country is provided in people's own homes, social protection institutions, day care centres and hospitals, in both the public and the private sector. All providers must have a licence to deliver the care services on a professional basis.

Non-residential forms include social services for those eligible, the services of foster families, temporary care for the victims of any kind of violence or abuse, and some home-based services provided at the community level. Informal care may be provided by spouses/partners, family members or other friends/relatives.

The residential forms of LTC are provided through social and healthcare institutions. Residential institutions provide accommodation, full-time care, nutrition, rehabilitation and health care, as well as work and occupational therapy in accordance with each person's abilities and state of health. There are only five public homes for the elderly, with a total of 640 beds. One of these – the Gerontology Institute – operates under the healthcare system. This institute is a specialised hospital for geriatric and palliative care; it has 340 hospital beds and 10 beds for residential care. The uniqueness of this institute lies in the way it integrates geriatric, long-term and palliative care, providing 24-hour medical care, palliative care for those in need and residential care for healthy people who

predominantly need support and social care in their everyday lives (WHO, 2017). Here, the healthcare services (interventions and treatment) are fully covered by the Health Insurance Fund. Meanwhile, the accommodation, nursing care and food are paid for by the patients or their family members. For patients who are unable to pay, the costs are covered by the social protection services, in accordance with the regulations and benefits governing socially deprived persons. The other four homes for the elderly are under local government auspices.

Persons with physical and mental impairment, as well as the elderly (or members of their families, who are obliged to support them under the Family Law), contribute to the cost of accommodation in social protection institutions and with foster families. The amount varies from case to case and is determined on the basis of the income of the beneficiary and the members of his/her family. Placement in a social protection institution is covered by the state (through tax) if the beneficiary is accommodated after a decision has been taken by the competent social work centre and if total income (of the family and the beneficiary) is below 25% of the previous year's national average (net) wage.

Thanks to financial benefits introduced by the government to encourage private homes to open, the number of these is increasing: there are currently 25 licensed private homes for old people in the country (22 of which are in the capital Skopje), with a total of 777 beds. The cost of these facilities is high, and involves out-of-pocket expenditure in the region of EUR 400-600 per month. In recent times, 12 day care centres have opened in the country. In addition, the Pension Fund has 28 homes for retired persons (Ministry of Health, 2017). These are used to accommodate retired individuals who have difficulty with housing. The daily costs are paid out of the pockets of the residents (or their families). Most of those homes are operated by the Association of Retired Persons.

There are special criteria for selecting foster families, and these are applied by the social work centre (e.g. age, education, marital and family status of the members). Foster families are reimbursed by the state for the accommodation they provide (MKD 5,000/EUR 85 per month per person) and they receive an additional MKD 1,500/EUR 25 per month for taking care of elderly people. Training and educational activities are organised by the social work centre, within the scope of the continued professional development of professionals – especially those employed in the newly established residential or semi-residential institutions. In cooperation with the Employment Agency, special informative workshops involving long-term unemployed women over the age of 40 were organised in April 2017. The aim was to include a group of these women in the training and education programme for home carers for the elderly. To this end, a special curriculum with practical and theoretical modules was drawn up. Furthermore, in cooperation with the Red Cross and foreign donors, a special training course for home carers has been introduced; after completing this course, carers receive a special certificate and – if requested – may visit the elderly in their homes and provide services such as personal hygiene, food preparation, etc.

Estimates indicate that residential social care services cover approximately 0.33% of all elderly people in Macedonia.

1.3 Cash vs in-kind benefits

1.3.1 Benefits in cash

Cash benefits include permanent financial assistance for people (over 65) who are unfit for work and do not have sufficient means, assistance or care from another person; an allowance for blindness; an allowance for mobility impairment; an allowance for deafness; one-off financial assistance and assistance in kind in special circumstances of social risk (assessed by the social work centre) and healthcare Cash benefits are organised at the central level. As of 2017, all of them (except permanent financial assistance) do not have an income threshold. Permanent financial assistance is provided if the total household income does not exceed 5500 MKD (EUR 89). The current amount

of permanent financial assistance is MKD 4,247 (EUR 70), and it is constantly adjusted to the inflation rate for the previous year. Of all the rights mentioned above, the most frequently used is financial reimbursement for assistance and care. People in home care settings can apply for a means-tested cash benefit to receive care from a third party. Persons with a higher level of dependency are entitled to financial reimbursement amounting to MKD 4,348 (EUR 72) or 43% of the minimum wage, while those with a lower level of dependence are entitled to MKD 3,846 (EUR 63) or 38% of the minimum wage (adjusted to the previous year's inflation rate). There are no specific benefits for carers: the cash benefit is payable to the dependent person (beneficiary), who can then pay the carer.

The deficit in health protection (as well as programmes that provide health protection to persons who are not insured) is covered by the state budget (CoE, 2016). No co-payment is required either for a medical check-up performed by the patient's registered general practitioner or for emergency care delivered to recipients of continuous financial assistance or persons accommodated in social protection institutions/foster families. For hospitalisation, there is total exemption for pensioners receiving less than the average pension in the country (MKD 12,600/EUR 210); and for specific diseases that are treated under the special programmes arranged by the government (dialysis, diabetes, cytostatic), the patient's treatment is covered.

1.3.2 In-kind benefits

In the Former Yugoslav Republic of Macedonia there are no specific in-kind benefits that are provided to support people with dependent relatives (ESPN, 2016). For dependent persons, there is home care and assistance – mainly for elderly, infirm and disabled people. Individuals may provide such services if they are issued with a licence by the Ministry of Labour and Social Policy and have signed a contract with a social work centre. The law does not specify whether family members can provide home care and assistance. Article 167 of the Law on Social Protection only specifies the criteria for physical persons, who need to have completed at least secondary education; for the purposes of providing home care and assistance, they can employ up to three persons. The social protection system offers access to day care centres, small group homes and accommodation with a foster family. Day care centres for disabled people, run by the state or non-governmental organisations (NGOs), offer stays of a day or half a day, nutrition and personal hygiene, as well as working, cultural, entertainment and other activities. Residential care is still the dominant form of social care; other forms of non-residential care are less utilised (home care and assistance, foster family care). In addition, elderly people can use the services offered by the healthcare system, such as specialised day healthcare centres and centres for palliative care, community mental health centres that provide services through sheltered homes, social clubs and mobile teams that provide home treatment. The main beneficiaries of these services are dependent persons (Annex 2, Table 1 and Table 2). Pensioners in need of long-term care are entitled to rehabilitation and spa treatments, provided they have an established diagnosis and a referral from their personal doctor and a medical committee. In-kind benefits are organised both centrally and locally.

1.4 Combination of benefits

Financial transfers for LTC are mainly paid by the Ministry of Labour and Social Policy. In addition, the MLSP pays for spa recreation for pensioners (with pensions no greater than EUR 276 per month). The MLSP budget also pays for non-residential services for those needing long-term care. Also, those on minimum income are provided with free access to public residential services. The Health Insurance Fund or the Ministry of Health provide for other services: salaries and financing of long-term residential care, as well as medical support equipment for long-term care patients (wheelchairs, etc.).

1.4.1 Mixed benefits

Benefits in kind and cash benefits can be combined. The cash benefit of the person who receives it from the Pension and Disability Fund is suspended for as long as he/she is in a home for the elderly. It is possible to combine the benefits provided through different schemes. In principle, there is free choice between cash benefits and benefits in kind.

It is possible to combine these with social cash benefits and pension benefits if the individual's annual net income from all sources (including social cash and pension benefits) does not exceed the total of monthly national average net wages of the previous year.

1.4.2 Benefits for the carer and user charges

There are no specific benefits for carers: cash benefits are payable to the beneficiary, who can then pay the carer. The wage compensation for reduced working hours is used as a basis for the calculation and payment of social security contributions and other commitments. Foster families are reimbursed by the state for taking care of elderly people and persons with physical and mental impairments.

Persons with physical and mental impairments, as well as the elderly (or members of their families, who are obliged to support them under the Family Law), contribute to the cost of accommodation in social protection institutions and foster families. The actual amount varies from case to case, and depends on the income of the beneficiary and the members of his/her family. Placement in a social protection institution or with a foster family is covered by the state if it follows a decision by the relevant social work centre and if the total income of the beneficiary and his/her family is below 25% of the previous year's average national net wage.

1.5 Evaluation of needs and eligibility criteria for the various LTC cash benefits and services

In the case of long-term care services that are provided in social protection institutions (e.g. homes for the elderly), the total income of the beneficiary and his/her family members (from all sources) is calculated and taken into consideration when setting the level of co-payment. The beneficiary and his family members are exempt from co-payment if their total income (from all sources) is below 25% of the average national net monthly wage in the previous year (i.e. is below MKD 5,477/EUR 90, or 54% of the minimum wage) and if they do not own property that could be used for commercial purposes. Financial reimbursement for assistance and care, the allowance for blindness, the allowance for mobility impairment and the allowance for deafness are granted to persons over the age of 26 if the individual's annual net income (from all sources) is lower than the previous year's total of the average national net monthly wage. There is no particular minimum level of dependency, although the level of need of care is evaluated according to the Barthel index of activities of daily living (ADL) before a decision is taken on entitlement.

The degree of disability/level of dependency/incapacity to work is determined by various Expert Committees established within social welfare institutions that deal with mental and physical development problems. The Expert Committees are composed of three medical specialists, who base their evaluation on the opinion of the individual's personal doctor as to the need for care, the opinion of the medical council at a clinic hospital, or the medical documentation and examination of the applicant. Applicants are referred to the Expert Committee by a social worker in the relevant social work centre, following an initiative taken by the personal doctor. Dependency is assessed by means of specific evaluations, in particular on the basis of the International Classification of Functioning, Disability and Health (ICF) of the World Health Organization and the Barthel ADL index.

In the healthcare system, the need for home or semi-inpatient palliative care is established by specialist doctors. The need for long-term nursing medical care in hospitals is determined on the basis of the opinion of a medical council of specialists at a hospital and the opinion of a committee of doctors with the Health Insurance Fund.

There are two categories of care dependency. Persons with the higher level of dependence are those with severe or pronounced mental disabilities, severe and very severe physical disabilities, total blindness and temporary or permanent changes in their state of health, rendering them unable to perform basic living functions. Persons with the lower level of dependence are those suffering from temporary or permanent changes in their state of health and who cannot perform all the basic living functions without help and care from another person (CoE, 2016).

2 Analysis of the main long-term care challenges in the country and the way in which they are tackled

2.1 Challenges in LTC

2.1.1 Access and adequacy challenge

In 2015, life expectancy at birth in the Former Yugoslav Republic of Macedonia for men was 73.5 and for women 77.4. At the same time life expectancy at age 65 for men in 2015 was 14.4 and for women 16.2, which is far below the EU-28 average (21.2). The share of the population aged 80 or over was 2.3% in 2016 and the old-age dependency ratio was 18.5% (compared to the EU-28 average of 29.3%).

This increase in the elderly population is not accompanied by an adequate increase in service provision (either social or health; public or private; institution based or community/home). Despite the existing network of health and social care services in the country, as well as partially systematised special care for the elderly, there are still difficulties in obtaining the services needed, and a proper organisation and appropriate structure are still lacking.

There has been an evident fall in the living standards of the population over recent years, especially among the elderly. Poor health conditions of the elderly have led to the almost complete exclusion of elderly people from society. Elderly people – even those with health insurance – have difficulty in buying drugs and paying for health services. Despite the provision of some of the necessary funding and resources by the state (funds for pension insurance), the majority of services are privately financed and the costs of care in a private home are high and need to be covered by the patients themselves out of pocket. Finally, it is obvious that most often the socially deprived population cannot afford formal care; and if their families cannot support them, then their real LTC needs will not be met. Research into the use of social services has shown that 12.8% claim continuous financial support from the state, 11.3% claim funds for care and assistance for help from third persons and 0.2% use daily or temporary accommodation in institutions or foster homes (Dimitrievska, 2010). According to the Red Cross (2017), 34% of respondents need additional financial assistance. In addition, the barriers to appropriate care include: lack of information for citizens on existing services and on their rights; insufficient materials printed in the languages of the different ethnic communities; and the geographical distance to selected facilities (healthcare centres and institutions), particularly for people in rural areas. In a field survey performed in 2017, only 9.1% of respondents said they had used the social care centre services, and more than 40% had never heard of such services or of the possibility (and right) to use them (Red Cross, 2017). The same survey also shows that 73% of respondents never used home care services. Furthermore, 89% of respondents had never been visited by any institution or NGO. Instead, the majority have regular or frequent visits from their children or family members.

2.1.2 Quality challenge

Due to population ageing, a rapidly growing demand for care will increase the tension between the volume and the quality of care. Ensuring the quality of organised care services is urgent, as more people are likely to become dependent. The country is missing activities (or data) to measure, monitor and ensure the quality of LTC. With regard to institutional care at a national level, a structured approach is lacking. The issue of weak quality of service provision (including home care) remains, mainly because of insufficient numbers of professionals specialising in elderly patients, a lack of multifunctional teams and approaches to treatment, a lack of adequate and appropriately equipped facilities, as well as long waiting lists for the institutions (Dimitrievska, 2010). Unfortunately, there are no available data or information on the quality of jobs, working conditions and types of contract in LTC. As regards training and educational activities, some are organised by the centres for social work, with the goal of the continued professional development of professionals – especially those employed in the newly established residential or semi-residential institutions.

There are no available data on existing measures to support family carers in providing good-quality unpaid care. Deinstitutionalisation, in light of the decentralisation policy, is proceeding both in health care and in social protection services. Some service provision is partially organised at the community level or in the home, mostly through local government. The inter-sectoral cooperation between the NGO sector and local government has deteriorated, due to the mismatch in terms of available facilities of the two sectors. Namely, there is a gap between the NGO sector and local government. On the one hand, civil society is getting stronger and better educated; on the other, local governments have been reduced to having one committee member working in the field of social protection, or else have members of committees making decisions on the basis of little knowledge about social protection.

2.1.3 Employment challenge

In formal care, at the institutional level one of the biggest problems is the lack of sufficient qualified staff: the existing staff can barely meet the increased demand for services. Despite the existing programme of education and training (as well as the licensing system for professionals working in the social care system in general), when LTC employees retire, very often no new staff are taken on (or else less-educated and less well-trained staff come as replacements). In addition, in the health sector there is a high demand for nurses and specialist gerontologists.

Almost all the benefits are aimed at dependent people; there is a clear lack of specific support for carers, such as longer leave or in-kind benefits. The lack of such measures clearly has a negative work-life balance effect on carers. This particularly affects women, as they tend to be the main informal care providers in the family.

The only financial support for carers and the cared-for comes in the form of financial benefits from the social protection system. The possibility of combining these can, in many cases, lead to an income close to the national average salary. Although this may go some way to cover the financial costs of the carer, and may contribute to the well-being of the person being cared for, it certainly does not contribute to the work-life balance of carers.

In informal care, women make up the overwhelming majority of family carers. Some 89% of all those who are either unemployed because they are looking after children and disabled persons or are not looking for a job because they are caring for disabled people are women (Annex 2, Table 3; ESPN, 2016). The very limited provision of support for carers makes it impossible to reach any conclusions as to the effects on employment. Insufficient provision of formal care can hinder female labour market participation. Women are more likely than men to assume care responsibilities for elderly family members with long-term needs. Informal care provided by family members to some extent tackles the issues of accessibility, affordability and quality of LTC care. However,

informal care reduces the opportunities for female labour force participation (particularly for women in middle age) and leads them to opt for part-time work or early withdrawal from the labour market. In cooperation with the Employment Agency, special informative workshops involving long-term unemployed women over the age of 40 were arranged by the Red Cross in April 2017. The aim was to include a group of these women in the training and education programme for home caregivers for the elderly. To this end, a special curriculum with practical and theoretical modules was drawn up by the Centre for the Education of Adults. On completion of the programme, participants receive a certificate; on request, these caregivers visit the elderly in their homes and provide services of personal hygiene, food preparation, etc. – paid for by the beneficiary. This programme will continue and will include other population groups.

2.1.4 Financial sustainability challenge

It is difficult to provide exact figures on LTC spending in the country, mainly due to the lack of an ESSPROS (European System of Integrated Social Protection Statistics) survey and the absence of precise administrative data – a consequence of the responsibilities for LTC being spread between different ministries and also of the mixed profile of beneficiaries of the financial assistance aimed at those who need LTC and those on low incomes (i.e. permanent financial assistance). However, according to MLSP data for 2017, spending on cash benefits related to LTC (disability benefits) amounted to MKD 2,636 million or EUR 42.8 million. In addition, the permanent financial assistance budget for 2017 (used by those needing LTC, but also to a lesser extent by some other categories, such as single parents with children aged up to 3 years) was MKD 406 million or EUR 6.6 million. The sustainability of long-term care needs to be separately projected and reviewed, especially in respect of continuous financing and revenue streams. Despite the provision of some of the necessary funding and resources by the state (funds for pension insurance), the majority of services are privately financed. Thus, the socially deprived population may have limited or no access to those services. Furthermore, the lack of funds and the unfinished process of decentralisation mean local government is unable to place more focus on the planning, organisation and proper financing of LTC at the local level.

2.2 Assessing the recent or planned reforms

The National Strategy for Elderly People 2010-2020, adopted by the Government in June 2010, is the basic strategic document; it is implemented through annual operational plans issued by the MLSP. The document focuses on the elderly population (over 60) and envisages joint activities in support of the ageing population. This strategic document provides a comprehensive approach to defining and implementing social and healthcare services. The overall vision of the strategy emphasises an improvement in the quality of life of the elderly, an improvement in their socio-economic status, access to resources in the living environment and social and community integration, as well as respect for the right of individual choice (MLSP, 2010a). The Government's National Programme for Social Protection (2011-2021) envisages sustainable economic development through good social protection of the most vulnerable strata of the population (MLSP, 2010b). Besides improving the economic status of the elderly, increasing the institutional capacities in order to meet the increased need, supporting the institutionalisation of people on low income, improving the quality of social care services, increasing the number of day care centres (to be established in each municipality), special emphasis is laid on the programmes for the professional development of employees, improving the process of standardisation and licensing of the services, and opening local social services in collaboration with the municipalities and civil society organisations. In that direction, the government adopted a package of benefits with the aim of increasing interest in investing in the construction of social care institutions (such as ensuring low prices for building land, reducing the rates of fixed tax, securing favourable loans, etc). However, the implementation of these measures is still at a very early stage and there has been no

major debate. Some media have reported on extremely poor housing and health conditions among the recipients of social benefits, socially deprived people and homeless people in the community. In the health sector, an Action Plan for Healthy Ageing is in the process of public debate and adoption. The main focus is on disease prevention and promotion of healthy lifestyles among the elderly.

2.3 Policy recommendations to improve the access and adequacy, quality and sustainability of the LTC system(s)

Given the trend of population ageing and the projections made, serious consideration needs to be given to long-term care when planning the state's health and social care budgets. This includes not only how to empower the services, but also how to broaden the scope and range of provision. There is a need for a long-term proactive approach to tackling dependency; this includes reining in the need through prevention and rehabilitation policies at the central and local levels.

Since the elderly consider that finances are the biggest obstacle and limitation to meeting their needs, one solution could be that the Ministry of Labour and Social Policy covers a minimum amount of the service fee for users through the Centres for Social Work. Otherwise, the most vulnerable categories of the elderly would remain unprotected (Red Cross, 2017). Providing as many free services for them as possible is the solution; financing of the non-institutional forms of care could be provided by everyone who has a legal provision to help and to create policies for social protection.

The system should encourage home care as well, to ensure that the benefits and services related to long-term care support the other family members as well (spouses and other family carers).

In order to improve the work-life balance of carers, as well as the well-being of carers and their family members, there is a need for greater emphasis on the provision of services through the social protection, health and labour market schemes. Such services could include counselling, respite support and longer leave for caring duties. Incentives for the employment of carers should not be diminished, and women should not be encouraged to withdraw from the labour market for caring reasons. The employment challenge also covers the need to address informal/undeclared work in LTC and to open upskilling/skills validation to informal learners, in order to assist them in becoming LTC professionals.

In addition, access to the existing support available to carers (such as wage compensation for reduced working hours) should be more transparent and flexible. Social work centres that administer this right should have a greater role in improving access to it.

There is a need to invest in research and needs assessment in LTC, and also in information and communication technology (ICT) as an important source of information, care management and coordination.

Service provision at the institutional level needs more resources (financial and human) than other forms of service provision. Therefore, in the long run, the institutionalisation of long-term care requires adequate and sustainable financial backing, which should include the state budget and the budgets of local government, resources from different government funds, funds from NGOs and donation programmes, and other international financial institutions. Moreover, the need to develop supplementary forms of service provision has to be taken into account.

3 Analysis of the indicators available in the country to be used for measuring long-term care

There is a significant lack of available data, information, surveys and indicators to present and assess the quality of the LTC system in the country. Currently the only available and reliable source is the data and publications of the State Statistical Office (although there is insufficient focus on the major elements of LTC), as well as some regulations, handbooks, surveys and publications by different authors (listed in the reference list). Updated policy and strategy documents, surveys and debates are lacking.

3.1 Definitions

A beneficiary of social welfare is considered to be any physical person who makes use of the rights, measures and services of social welfare provided by social work centres, once or several times in the course of the reporting year.

Data covering the rights, measures and services of social work refer to the number of cases in the reporting period, not the number of persons.

Institutions for adults provide housing, food and health care for adults. Homes for the elderly and sick persons are included here.

Data on social cash benefits refer to those households whose total monthly incomes are lower than the fixed social cash benefits, as a difference between the total average incomes of all members of the household, on all bases, and the amount of social cash benefits.

3.2 Indicators available in the country for measuring LTC administrative data

Area	Name MKD	English translation	Source/web site	Years available	frequency
Demography	*Очекувано траење на живот на 65 г.*	Life expectancy at 65	State Statistical Office (SSO), *Македонија во бројки, 2017* available at: http://www.stat.gov.mk/Publikacii/MakBrojki2017_mk.pdf	2017	annually
	Коефициент на старосна зависност	Age dependency ratio			
Access and adequacy of services	*Основни податоци за установите за социјална заштита - Установи за возрасни лица*	Basic data on institutions for social welfare – Institutions for adults	SSO, Social welfare for children, juveniles and adults available at: http://www.stat.gov.mk/Publikacii/2.4.17.11.pdf	2016	annually
	Корисници во установи за возрасни лица	Recipients in institutions for adults			
	Корисници според причината за прием во домот	Recipients by the reason for reception in home			
	Корисници според плаќањето за престој во домот	Recipients by method of payment for accommodation in home			

	Вработени во установи за возрасни лица	Employees in institutions for adults			
	Вработени според занимањето	Employees according to occupation			
	Вработени според степенот на образование	Employees according to the level of professional education			
	Полнолетни корисници на социјална заштита)	Adult recipients of social welfare			
	Корисници на социјална парична помош.	Recipients of social cash benefits			
Labour force data	*Вработени со скратено работно време, според причините и економскиот статус*	Part-time employees by reasons and employment status	Labour Force Survey *Анкета на работна сила* available at: http://www.stat.gov.mk/Publikacii/2.4.17.02.pdf	2016	annually
	Невработени според причините за напуштање на последната работа, полот и местото на живеење-урбан, рурален дел	Unemployed persons by reasons for leaving last job or business, gender, place of residence – urban, rural			
	Лица кои не бараат работа според наведените причини, полот и местото на живеење-урбан, рурален дел.	Persons not looking for job by reasons, gender, place of residence – urban, rural			

3.3 Missing indicators (available in EU countries)

Administrative data/information or surveys/publications which are not accessible to the author and could have significantly improved particular chapters of the document.

Field	Indicator
Demographic/population data	Limitations in daily activities, population aged 65-74 and 75+
Financial data on spending on LTC	Public expenditure on long-term care as percentage of GDP in 2010, all ages
	Long-term care public expenditure (health and social components), as share of GDP
	Long-term care expenditures by sources of funding
LTC system data	Population aged 65 years and over receiving long-term care (institution-home)

	Long-term care workers as share of population aged 65 and over (institution-home)
	Percentage of population aged 50+ reported to be informal carers
LTC – health system data	Inpatient long-term care (health)
	Day long-term care (health)
	Outpatient long-term care (health)
	Home-based long-term care (health)

3.4 Quality indicators to be introduced

In addition to the above, there is clearly a significant lack of indicators that aim to monitor the quality of LTC. Bearing in mind the existing international database on this issue, the author suggests some quality measurement indicators that will encompass three important dimensions:

- The effectiveness of care in safeguarding – and where possible improving – the health of the person being cared for, and in keeping them safe from adverse incidents;
- User experience (is the care provided attuned to and responsive to the needs and wants of the person being cared for? Is LTC well coordinated with other services uses?);
- The care recipient's quality of life (SPC and EC, 2014).

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Annex 1

Demographic and health trends

Table 1. Life expectancy at birth, in years

	2011		2012		2013		2014		2015	
	male	female	male	female	male	female	male	female	male	female
FYR of Macedonia	73.0	77.1	73.2	77.2	73.3	77.3	73.5	77.4	73.5	77.4
EU-28	77.3	83.1	77.4	83.0	77.7	83.3	78.1	83.6	77.9	83.3
EU-27	77.3	83.1	77.4	83.1	77.7	83.3	78.1	83.7	77.9	83.3

Source: Eurostat, 29 May 2017; SSO (2017).

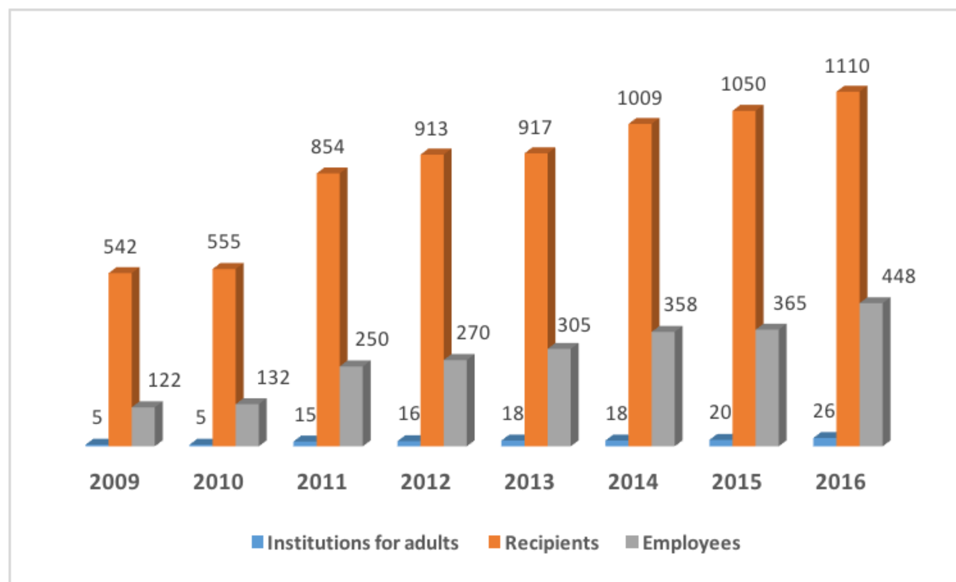
According to the UN population prospects, 2015-2095, the old age dependency ratio in the country will increase to almost 40% (39.3%) by 2055 (UN, 2017).

Besides large-scale emigration, the figures for which are still unknown, the country is experiencing significant internal migration of the population, most of which is occurring towards the region of Skopje. Therefore, the concentration of the majority of the population is in the capital of the country, while depopulation is affecting rural areas. The migrating population is predominantly young, while the elderly people remain behind in the rural areas (MLSP, 2010a).

Mortality and morbidity rates from chronic non-communicable diseases in the country are increasing, especially rates for morbidity and mortality from circulatory diseases. This trend is due to the increased share of the ageing population in the total population, and therefore, an increased proportion of mortality deriving from the ageing population. The highest mortality ratios are after 65-69 years of age. According to data from the State Statistical Office, this trend stems predominantly from the combined factors of decreasing fertility rates and increasing life expectancy (decreased overall mortality rate). The leading cause of death is cardiovascular disease, followed by cancer.

Annex 2

Figure 1. Frequency of bed occupancy in the period 2009-2016



Source: SSO (2016 – Social Welfare for children, juveniles and adults in the Republic of Macedonia).

Table 1. Adult recipients of social welfare rights, 2016

	Total	Socially excluded	Persons with visual impairment	Persons with hearing impairment	Persons with physical disability	Persons with intellectual disabilities	Persons with combined disabilities	Financially unprotected	Elderly persons	Other
Salary compensation for reduced working hours	90	/	/	/	5	3	10	/	/	72
Financial reimbursement for assistance and care	35,406	/	2,023	456	4,876	3,949	11,992	160	3881	8,069
Permanent (continuous) financial assistance	6,679	2	39	56	479	739	1,959	1,080	1,812	513
One-off (occasional) financial assistance	5,244	94	19	14	44	40	130	4,129	157	554
Financial assistance for social housing	80	/	16	22	12	/	/	7	/	23
Allowance for mobility and blindness	10,918	/	3,969	3,462	3,234	19	36	26	69	103

Source: SSO (2016 – Social welfare for children, juveniles and adults in the Republic of Macedonia).

Table 2. Beneficiaries of non-residential and residential social care (2014-2016)

Placement	Juvenile beneficiaries			Adult beneficiaries		
	2014	2015	2016	2014	2015	2016
Small group home	20	16	15	/	/	/
Organised living support	34	32	34	49	46	47
Day care centres	280	291	366	258	265	265
Centre for assistance at home	/	/	/	/	/	/
Social welfare institutions	/	/	/	414	339	363
Adult residential care	/	/	/	1,009	1,050	1,110

Source: SSO (2016 – Social welfare for children, juveniles and adults in the Republic of Macedonia).

Table 3. Part-time employees, unemployed and inactive due to care of children or disabled people in FYR Macedonia, 2011-2016

	Part-time employees by reason - taking care of children, disabled people		Unemployed persons due to care of children, disabled people		Persons not looking for job due to taking care of disabled people	
	All	Women	All	Women	All	Women
2011	1,104	785	918	854	n.a.	n.a.
2012	1,271	1,065	480	480	6,629	6,381
2013	709	620	639	639	3,065	2,868
2014	715	712	838	713	4,723	4,303
2015	769	748	884	835	6,426	5,848
2016	1,445	1,422	1,044	978	4,742	4,260

Source: SSO (Labour Force Survey 2016).