EUROPEAN SOCIAL POLICY NETWORK (ESPN)

Long-term care for older people

North Macedonia

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European Social Policy Network (ESPN)

ESPN Thematic Report on long-term care for older people

North Macedonia

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The ESPN is managed by the Luxembourg Institute of Socio-Economic Research (LISER) and APPLICA, together with the European Social Observatory (OSE).

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Highlights

- Long-term care (LTC) in the Republic of North Macedonia is not ensured by a single system, but it is partly provided through the social protection and pension insurance system run by the Ministry of Labour and Social Policy, and partly through the healthcare system under the responsibility of the Ministry of Health.

- The LTC regime for the elderly in the country 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.

- Expenditure on sickness/healthcare in 2017 was 4.2% of GDP, while expenditure on disability was 1.4%. The share of informal carers providing more than 20 hours of care per week in 2016 was 35.6%; a majority were women.

- The increase in the elderly population in the country has not been accompanied by an adequate increase in service provision (either social care or healthcare; public or private; institution-based or community/home-based).
1 Description of main features of the long-term care system(s)

1.1 Demographic trends

Population ageing in the Republic of North Macedonia is becoming a serious challenge, in parallel with lower birth rates and changing family structures. During the period 2008-2018, the share of the younger population (0-14) steadily fell (from 18.1% in 2008 to 16.4% in 2018) and the share of the old age group (65+) increased from 11.5% in 2008 to 14.1% in 2018. Projections indicate that the latter will reach 18.2% in 2030 and 25.4% in 2050, which is significantly alarming for current and future demographic (and other) policies. In 2018 life expectancy at age 65 for men was 14.4 and for women 16.3, which was far below the EU-27 average (20.0).

The share of the population aged 75 or over was 5.2% in 2018 (with predicted levels of 7.2% in 2030 and 11.5% in 2050); and the old-age ratio increased from 16.3 in 2008 to 20.2 in 2019 (compared with the EU-28 average of 30.8%), with a projected level of 27.4 in 2030 and almost 42 in 2050 (Statistical Annex).

Unfortunately, the increase in the elderly population in the country has not been accompanied by an adequate increase in service provision.

1.2 Governance and financial arrangements

LTC in the Republic of North Macedonia is partly provided under the social protection and pension insurance system, and partly under the healthcare system. Each of these systems has its own legal regulations, criteria for accessibility and quality, and method of financing. The basic legal foundation is provided by: the Law on Social Protection; the Law on Social Security for the Elderly; 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 Cases of Unemployment; and the Law on Pension and Disability Insurance.

Apart from the state-guaranteed systems, LTC is traditionally provided by family members and other close persons.

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

The risks covered by social protection include all those cases where permanent residents are not capable of performing basic living tasks, including those who are immobile, completely blind, and suffering from severe and profound mental disabilities and illness. Regarding healthcare, the risks covered include cases where patients are unable to perform basic living tasks due to chronic progressive illness, trauma, dementia, terminal illness, and mental illness.

The beneficiaries of healthcare rights include: social protection beneficiaries; children with disabilities receiving a special allowance; people who cannot be insured on any other ground; children and young people up to the age 18 – 27 if enrolled in education; elderly people; and unemployed women during pregnancy and confinement. Any person who is not insured on any ground can voluntarily join and obtain coverage under the compulsory health insurance scheme for the basic package of services.
According to ESPROSS data, total expenditure on social protection in North Macedonia in 2017 was 14.5% of GDP. Expenditure on sickness/healthcare was 4.2%, while expenditure on disability was 1.4%.

As indicated in the ESPN Thematic Report on financing social protection in North Macedonia (Gerovska Mitev, 2019), the structure of social protection financing changed in the period 2005-2017, mainly reflecting reforms that reduced social insurance contribution rates. Although sources of health revenues include both social contributions and general government spending, other social protection branches – e.g. social welfare and disability protection – are predominantly funded from government tax revenues. Other sources (co-financing, participation, private insurance, etc.) are negligible and do not represent a significant factor in overall social protection revenues.

1.3 Social protection provisions

In terms of overall support, the LTC regime for the elderly in the Republic of North 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.

- Evaluation of needs

In the case of LTC services that are provided in social protection institutions, the total income of the beneficiary and their family members (from all sources) is calculated and taken into consideration when setting the level of co-payment. The beneficiary and their 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 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 people 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. 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.

There are two categories of care dependency. People with the higher level of dependency are those with severe or pronounced mental disabilities, physical disabilities, total blindness and temporary or permanent changes in their state of health, rendering them unable to perform basic living functions. People with the lower level of dependency 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, 2019). The need for care is determined by a medical council in public health institutions, composed of three medical specialists.

In the healthcare system, the need for long-term nursing medical care in hospitals is determined by a medical council of specialists in hospitals and a committee of doctors with the health insurance fund.

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1 ESPPROS = European System of integrated Social PROtection Statistics; Eurostat, 2020, [spr_exp_sum], [spr_exp_fsi], [spr_exp_fdi].
• Related cash or in-kind benefits

Benefits in cash and in kind are provided. Benefits in cash include those for assistance and care by another person, the allowance for blindness and mobility, the allowance for deafness, and salary compensation for the shortened working hours of a parent due to care of a disabled child. Benefits in kind include accommodation and nursing care in social protection institutions or specialised hospitals, day care, home care and assistance, and foster family care. In special circumstances of social risk (assessed by the social work centre), a combination of one-off financial assistance and assistance in kind may be provided. Cash benefits are organised at central level, whereas in-kind benefits are organised both centrally and locally. As of 2017, no benefits (except permanent financial assistance) had an income threshold. Permanent financial assistance is provided if the total household income does not exceed MKD 5,500 (€89). The current amount of permanent financial assistance is MKD 4,247 (€70), and is regularly adjusted according to the inflation rate for the previous year. The most frequently used right is financial reimbursement for assistance and care. People with a higher level of dependency are entitled to financial reimbursement amounting to MKD 4,475 (€73) or 43% of the minimum wage, while those with a lower level of dependency are entitled to MKD 3,959 (€64) or 38% of the minimum wage (adjusted according 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. In healthcare, 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 people 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 14,598/E237); and for some specific diseases that are treated under the special programmes, the patient’s treatment is covered. Foster families are reimbursed by the state for the accommodation they provide (MKD 7,500/€122 per month per person) and they receive an additional MKD 3,075/€50 per month for taking care of elderly people. If the caregiver (in a foster family) is over 62, unemployed, or receives no pension, and has been taking care of an old person more than five years, they receive an additional MKD 8,000 (€130), adjusted according to the previous year’s inflation rate.

1.4 Supply of services

The residential and semi-residential part of formal LTC in the country is provided in 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 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.

There are only five public homes for the elderly, with a total of 624 beds. One of these – the Gerontology Institute – operates under the healthcare system: healthcare services are fully covered by the health insurance fund, whereas accommodation, nursing care and food costs 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 people. In public homes for old people the state financed 40% of the total budget in 2018, and the other 60% was paid for by the users (MLSP, 2018).
There are currently 28 licensed private homes for old people in the country (the vast majority in the capital Skopje), with a total of 1,051 beds. The accommodation cost of these facilities is high, and for healthy residents involves out-of-pocket monthly expenditure averaging €450 (in the range of €350-950). Furthermore, out of 61 day care centres in the country, eight are operating for elderly people.

In addition, the Pension Fund has 28 homes for retired people. These are used to accommodate retired individuals who have difficulty with housing. The daily costs are paid for out of the pockets of the residents (or their families). 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). People 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.

As indicated in the Statistical Annex and in the Section 2.3, the share of the population providing informal care in 2016 was 0.9%. The share of informal carers providing more than 20 hours of care per week in 2016 was 35.6%, a majority of whom were women.

2 Assessment of the long-term care challenges in the country

2.1 Access and affordability

The increase in the elderly population in the country has not been accompanied by an adequate increase in service provision (either social care or healthcare; public or private; institution-based or community/home-based).

Research shows that on average 17% of people aged over 65 are in need of support and services. For the population of 291,921 over 65, it can be deduced that the number of the elderly in need of different types of support and services may be up to 49,626 (MLSP, 2018) (Statistical Annex). Out of them only 1,214 are residents in institutional care. The institutionalisation rate (number of institution residents per capita) is low (0.40) compared with the EU average and with some neighbouring countries. There is an evident regional disparity in institutional care. Another implication of the low institutionalisation rate is that much of the support and assistance is currently undertaken through the informal sector (i.e. family, relatives, the community). The challenge is to find ways to support and improve best practice, and to supplant the worst with the appropriate community (action) response in a way that does not damage existing informal support (MLSP, 2018).

Elderly people – even those with health insurance – also 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; the costs of care in a private home are high and need to be covered by the patients themselves out of their own pockets. 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. There are frequent requests for the state to subsidise accommodation costs, especially for the most deprived residents. In order to enlarge the number of public providers, there is a plan for underused capacity in other public institutions (such as healthcare bodies or local municipalities) to be reassigned for the use of social care services. There is also room for improving and standardising the work of day care centres, as well as for more active promotion of, and support for, the newly introduced mobile (personalised) services for old people in their homes. According to Eurostat data, 63.6% of respondents in the national survey pointed to financial reasons for non-use of the services, and 14.4% stated the care services are not available (Statistical Annex). 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. The EU-SILC\(^2\) indicator on self-reported unmet need in the country for 2016 stood at 2.9\%. The main reason for unmet medical need was that it was ‘too expensive to travel’; this reason was mostly voiced by women (3.2\%), people aged 65+ (6.5\%), the unemployed (4.1\%), retired people (3.8\%), those with lower-secondary education or less (5.1\%), and those in the bottom income quintile (5.2\%) (ESPN 2018b).

### 2.2 Quality\(^3\)

Due to population ageing, a rapidly growing demand for care will increase the tension between the volume and quality of care. The basic regulation adopted in May 2019, besides increasing the number of social care centres at local level and improving their way of working, introduced the case management as well as some new social care services such as personal assistance. Nonetheless, ensuring the quality of care services is an urgent organisational priority, as more people are likely to become dependent. The country does not adequately measure, monitor or ensure the quality of LTC. The issue of the poor quality of service provision (including home care) remains, mainly because of: insufficient numbers of trained and licensed social care workers specialising in elderly patients; a lack of multifunctional teams; a lack of compliance with treatment standards; a lack of adequate and appropriately equipped facilities; and long waiting lists for institutions, especially public ones. There is a need to enhance the capacity of the state social care centres, as well as for proper networking between the various institutional and non-institutional services in the country – with unified quality standards, including mapping existing resources for the support of day care centres, foster families etc. There are no available data on existing measures to support family carers in providing good-quality unpaid care. Deinstitutionalisation, as a matter of policy, is proceeding both in healthcare and in social protection services. Some service provision is partly organised at the community level or in the home, and mostly through local government. Cooperation between the NGO sector and local government has deteriorated, due to the mismatch in terms of the facilities available to the two sectors. On the one hand, civil society is getting stronger and better educated; on the other, local government lacks professionals competent to take decisions regarding social protection policies. Adequate promotion of day care centres or foster families as forms of non-institutional social care is missing.

### 2.3 Employment (workforce and informal carers)\(^4\)

Unfortunately, there are no available data or information on the quality of jobs, working conditions and types of contracts 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 (MLSP, 2019).

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. In 2017, the total number of staff in public and private old-age residential institutions was 442, which made the ratio of residents to staff 2.54:1. The ratio in public institutions (4.79) was extremely inappropriate (MLSP, 2018). 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 high demand for nurses and specialist gerontologists. In regard to informal care, almost all the benefits are aimed at

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\(^2\) European Union statistics on income and living conditions.  
\(^3\) Because the situation in this field has not changed significantly since the description provided in the 2018 report (ESPN 2018a), this section draws very much on that report, with some new data included.
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 effect on the work-life balance of 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. Regarding the people providing informal care, 35.6% were providing services for more than 20 hours per week in 2016, with the figure higher for women (43.9%) than for men (25.5%). (Statistical Annex).

The very limited provision of support for carers makes it impossible to reach any conclusions as to the effects on employment. 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 the 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 information workshops involving long-term unemployed women over the age of 40 used to be arranged by the Red Cross. The aim was to include a group of these women in the training and education programme for home caregivers for the elderly. On completion of the programme, participants received a certificate; on request, these caregivers visited the elderly in their homes and provided services such as in connection with personal hygiene and food preparation, paid for by the beneficiary (ESPN 2018a).

As indicated in the Statistical Annex, the share of the population providing informal care in 2016 was 0.9%. The share of informal carers providing more than 20 hours of care per week in 2016 was 35.6%, a majority of whom were women.

2.4 Financial sustainability

Regretfully ESSPROS disaggregated data on healthcare expenditure by function, which would allow LTC expenditure to be identified, are not available for North Macedonia. One of the reasons for the lack of such data may be that the responsibilities for LTC are spread between different ministries, and another may be 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).

The sustainability of LTC needs to be separately forecasted 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 that local government is unable to place more focus on the planning, organisation and proper financing of LTC at the local level.

2.5 Country-specific challenges regarding LTC for other age groups in need of care

One of the biggest challenges in the country is meeting the real needs of socially deprived groups, especially through the state social services. The number of children with different needs (disability or social difficulties) who are not in contact with social services may be estimated at close to 10% of the total number of children registered with the services. It is also estimated that between 6,400 and 9,600 people with a disability between 18 and 65 years of age are not in contact with the social services (i.e. between 1/3 and 1/2 of the number of registered people). There are no available statistics regarding long-term mental health users. A rough estimate is that there about 3,000 people with long-term mental health difficulties who are in touch with social services. Also, significant number of
population with mental health difficulties are not in contact with social services but are in need of help and support other than purely medical treatment.

3 Reform objective and trends

In the period 2008-2018 there were a few main publicly debated and officially adopted documents/platforms which could be considered as a foundation for ongoing and future reforms in the social care policy in the country, including LTC.

The national strategy for elderly people for 2010-2020 is still the basic strategic document, especially for LTC. The overall vision within 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 (MLSP, 2010).

The national strategy for deinstitutionalisation (adopted by the Parliament in 2018) is one of the most important reforms to be implemented by the current government. The strategy envisages the transformation of large institutions for the social care of children and adults – with children and people with disabilities, orphans and children with educational and social problems in the first phase up to 2022, and adults with long-term mental difficulties and the elderly in the second phase. This means a transition from social care provided in large residential institutions to community care. The plan is for all residents to move to community care settings. The majority will live independently, with support from the staff and professionals of the transformed institution as well as from other social service providers. The staff of care homes would retain their employment and would work in the community, either with former residents or with other users living in the area. However, the community should not merely be a passive recipient of the former home residents, but should also play an active part in creating and providing services by means of micro-community projects or initiatives which establish effective responses to the needs of community members (MLSP, 2018).

In May 2019, the Parliament adopted a package of laws on social reform. With the three laws on social and child protection, and social security for the elderly, the government announced a significant transformation of the current system for social protection. With the reform, a guaranteed minimum income programme is to be introduced, which will provide financial support for all people living below the poverty line. Children’s and educational allowances are being introduced; and in addition to the other beneficiaries, households on the minimum income will also be entitled to these benefits. With the new Law on Social Security for the Elderly (Official Gazette No 104/2019), as part of the social reform which has already entered into force, people over the age of 65 who do not have other sources of livelihood are entitled to a monthly amount of MKD 6,000/€97 (‘social pension’), and the right is expected to be used by about 6,000 citizens. With the social reform, the rights of people with disabilities are promoted by introducing and developing services at the local level, with the main focus on day care centres where people with disabilities receive services according to individual needs, but also contribute to their greater involvement in society. In the new Law on Social Protection (Official Gazette No 104/2019), two kinds of full services for people with disabilities are being introduced – personal assistance and home care as well as a new service, ‘assistance in the home’, which will have to provide support to the elderly at home and support for living in the place of residence. In addition, the right to disability support is to be extended to people with intellectual disabilities, while the allowance for loss of pay by a parent caring for a disabled child is being increased to 50% of the average net salary. A home care service is also being introduced to provide short-term care for dependent family members, allowing for other family members to receive time off and look after their personal and professional needs (MLSP, 2019).
With all these policy interventions, some of the challenges in the area of LTC are also starting to be addressed, as follows.

Access and affordability

- Institutional capacities are being increased in order to meet increased need; financial and technical support has been given to the local municipalities and civil society organisations for providing social services; and packages of benefits are being introduced with the aim of increasing interest in investing in the construction of social care institutions.
- Pilot programmes are being established to improve day care centres, which are key to the socialisation and activation of the elderly population; the aim is to improve the infrastructure in these facilities, and stimulate greater involvement by local government and other social stakeholders in maintaining the centres.
- Mobile services for health and social care are being introduced, to be implemented by two teams of nurses and social workers working in the field. They will visit households in small cities and rural communities on a daily basis, providing preventive services, such as basic social care and healthcare, at home.

Quality

- In order to further improve the quality of social care services, new regulations and procedures are being issued relating to the revocation of permits to work in the social protection field, and to record-keeping by licensed social service providers.
- Intensive training in integrated case management has started as one of the key links in social care reform, which establishes a system of social services in the community that offer services and support tailored to the individual. This means that an expert will handle the case and will be obliged to monitor the family.
- A programme of personal assistance to people with disabilities was introduced in 2018, funded by the state budget. Personal assistants will assist in the performance of daily personal and home activities.

Employment

As part of the social reform package, there will be a 22% increase in the wages of social service providers – it is hoped this will lead to higher skill and education levels among the workforce. Continuous special emphasis is being laid on programmes for the professional development of employees, improving the process of the standardisation and licensing of services.

Financing

- The public call for municipalities to express interest in developing social services in the local communities is underway, for which a total of €10.8 million has been provided from a World Bank loan.
- Special funds within the state budget are being earmarked for the process of implementing the deinstitutionalisation strategy.

4 Main opportunities for addressing LTC challenges

There is still a need for a long-term proactive approach to tackling dependency; this includes reducing the need for services through prevention and rehabilitation policies at central and local levels. Providing as many services as possible on a free or subsidised basis, and an optimal quality of social care services, are still an imperative.

Incentives for the employment of carers should be extended further (besides increasing wages), and women should not be encouraged to withdraw from the labour market in order to provide care. The employment challenge also covers the need to address informal LTC and to open upskilling/skills validation to informal learners, in order to assist them in becoming LTC professionals.
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 LTC 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.

The main risks in the process of deinstitutionalisation are: a decline or loss of political will for deinstitutionalisation; inconsistency in its implementation; and resistance from employees in institutions or from communities. Measures that reduce those risks are: consistent and good management; an effective ongoing monitoring process; a broad coalition of actors for change; dialogue with the community and all stakeholders. Furthermore, deinstitutionalisation of old-age homes cannot be based chiefly on a process of resettlement; it is also necessary to provide tailored and good-quality, community-based social services to old people. In particular, it is necessary to create new services that will allow old people to remain at home and live a dignified and socially integrated life.

Last but not least, there is still a need to: invest in research and needs assessment in LTC; significantly improve data collection and statistics in the area of social care; and make a substantial investment in information and communication technology, as an important tool supporting information-gathering, and the management and coordination of care.
Long-term care for older people

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## Statistical Annex

### Table A.1 Demographics

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>Most recent</th>
<th>2030*</th>
<th>2050*</th>
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<tbody>
<tr>
<td>Population (in millions), 2018</td>
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<td>2.1</td>
<td>2.1</td>
<td>1.9</td>
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<tr>
<td>Old age ratio, 2019</td>
<td>16.3</td>
<td>20.2</td>
<td>27.4</td>
<td>41.9</td>
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<tr>
<td>Population 65+ (in millions), 2018</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>0.2</td>
<td>0.3</td>
<td>0.4</td>
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<tr>
<td>Women</td>
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<td>0.2</td>
<td>0.3</td>
</tr>
<tr>
<td>Men</td>
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<td>0.1</td>
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<td>0.2</td>
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<td>Share of 65+ in population (%), 2018</td>
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<td>14.1</td>
<td>18.2</td>
<td>25.4</td>
</tr>
<tr>
<td>Share of 75+ in population (%), 2018</td>
<td>4.1</td>
<td>5.2</td>
<td>7.2</td>
<td>11.5</td>
</tr>
<tr>
<td>Life expectancy at the age of 65 (in years), 2016</td>
<td>14.6*</td>
<td>15.5*</td>
<td>16.7</td>
<td>18.5</td>
</tr>
<tr>
<td>Total</td>
<td>15.4</td>
<td>16.3</td>
<td>17.7</td>
<td>19.4</td>
</tr>
<tr>
<td>Women</td>
<td>13.6</td>
<td>14.4</td>
<td>15.6</td>
<td>17.5</td>
</tr>
</tbody>
</table>

Population total and 65+ in million, share of 65+, 75+ (m/f for number of 65+). These figures are all based on European demographic statistics. These data can be based either on data from the most recent census adjusted by the components of population change produced since the last census, or on population registers. **Sources:** State Statistical Office. Population Estimation, MakStat Data base, 2018. United Nations, Department of Economic and Social Affairs, Population Division (2019). World Population Prospects 2019, custom data acquired via website. **Old-age ratio** is defined as the ratio between the number of people aged 65+ and the number of working-age people (15-64). **Sources:** State Statistical Office. Population Estimation, MakStat Data base, 2018; proj_18ndbi; United Nations, Department of Economic and Social Affairs, Population Division (2019). World Population Prospects 2019, custom data acquired via website. **Life expectancy at the age of 65 (in years) (m/f)** is the average number of additional years of life that a survivor to age 65 will live beyond the age of 65, if subjected to the assumed mortality conditions. **Sources:** State Statistical Office. MakStat Data base, 2018; United Nations, Department of Economic and Social Affairs, Population Division (2019). World Population Prospects 2019, custom data acquired via website.


### Table A.2 People in need of LTC

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>Most recent</th>
<th>2030</th>
<th>2050</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of potential dependants 65+ (in thousands), total</td>
<td>n.a.</td>
<td>49.6**</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
<tr>
<td>Share of population 65+ in need of LTC, defined as having at least one severe difficulty in personal care and/or household activities (%), 2018</td>
<td>n.a.</td>
<td>17**</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
</tbody>
</table>

**Number and share (in total population) of potential dependants** in thousands (for total population and population 65+) (m/f for 65+): Source: These data are taken from the national strategy for deinstitutionalisation. **Share of population 65+ in need of LTC**, defined as having at least one severe difficulty in personal care activities and/or household activities. Source: These data are taken from the national strategy for deinstitutionalisation.

**Source:** National strategy for deinstitutionalisation.
### Table A.3 Access to LTC

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>Most recent</th>
<th>2030</th>
<th>2050</th>
</tr>
</thead>
<tbody>
<tr>
<td>Share of households in need of LTC not using professional homecare services for financial reasons (%), 2016</td>
<td>n.a.</td>
<td>63.6</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
<tr>
<td>Share of households in need of LTC not using professional homecare services because services not available (%), 2016</td>
<td>n.a.</td>
<td>14.4</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
<tr>
<td>LTC beds per 100,000 inhabitants, 2017</td>
<td>28.5</td>
<td>47.4</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
</tbody>
</table>

*ADL: Activities of Daily Living; IADL: Instrumental Activities of Daily Living*

### Table A.4 LTC Workforce

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>Most recent</th>
<th>2030</th>
<th>2050</th>
</tr>
</thead>
<tbody>
<tr>
<td>Share of population providing informal care (%), 2016</td>
<td>Total</td>
<td>n.a.</td>
<td>0.9</td>
<td>n.a.</td>
</tr>
<tr>
<td></td>
<td>Women</td>
<td>n.a.</td>
<td>0.8</td>
<td>n.a.</td>
</tr>
<tr>
<td></td>
<td>Men</td>
<td>n.a.</td>
<td>0.9</td>
<td>n.a.</td>
</tr>
<tr>
<td>Share of informal carers providing more than 20h care per week, 2016</td>
<td>Total</td>
<td>n.a.</td>
<td>35.6</td>
<td>n.a.</td>
</tr>
<tr>
<td></td>
<td>Women</td>
<td>n.a.</td>
<td>43.9</td>
<td>n.a.</td>
</tr>
<tr>
<td></td>
<td>Men</td>
<td>n.a.</td>
<td>25.5</td>
<td>n.a.</td>
</tr>
</tbody>
</table>

*Source: EU-SILC. ilc_ats17.*

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**Share of households in need of LTC not using professional homecare services for financial reasons or because the services needed are not available.** The indicator shows (%) the reason why professional homecare services are not used by households with at least one member who would need help due to long-term physical or mental ill-health, infirmity or because of old age. The answer categories for the main reason are ‘cannot afford it’, ‘refused by people needing such services’, ‘no such services available’, ‘quality of the services available not satisfactory’, and ‘other’. Source: EU-SILC. ilc_ats15.

**LTC beds per 100,000 inhabitants.** These density rates are calculated by dividing the absolute number of LTC beds in nursing and residential care facilities available in a given period by the respective population in the same period and then multiplying by 100,000. Source EU-SILC hlth_rs_bdsns.

*ADL: Activities of Daily Living; IADL: Instrumental Activities of Daily Living*

**Share of population providing informal care (m/f).** The share of respondents who provide care or assistance to one or more people needing help due to long-term physical or mental health illness, physical weakness or because of old age. There are four answer categories: (1) Yes — only to household members; (2) Yes — only to people who are not household members; (3) Yes — to household members and to people who are not household members; and (4) No. Source: EU-SILC. ilc_ats17.

**Share of informal carers providing more than 20 hours of informal care per week (m/f).** The people who provide care or assistance to one or more people needing help due to long-term physical or mental health illness, physical weakness or because of old age are asked whether they provide less than 10 hours of care per week, between 10 and 20 hours, or more than 20 hours. Source: EU-SILC. ilc_ats17.
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