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Long-term care for older people

Serbia

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European Social Policy Network (ESPN)

ESPN Thematic Report on long-term care for older people

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CONTENTS

HIGHLIGHTS 4
1 DESCRIPTION OF MAIN FEATURES OF THE LONG-TERM CARE SYSTEM(S) 5
1.1 Demographic trends 5
1.2 Governance and financial arrangements 5
1.3 Social protection provisions 6
1.4 Supply of services 7
2 ASSESSMENT OF THE LONG-TERM CARE CHALLENGES IN THE COUNTRY 8
2.1 Access and affordability 8
2.2 Quality 8
2.3 Employment (workforce and informal carers) 9
2.4 Financial sustainability 10
2.5 Country-specific challenges regarding LTC for other age groups in need of care 10
3 REFORM OBJECTIVE AND TRENDS 11
4 MAIN OPPORTUNITIES FOR ADDRESSING LTC CHALLENGES 12
REFERENCES 13
STATISTICAL ANNEX 14

Highlights

- Population ageing in Serbia has been a demographic trend in the past 10 years and will continue in the future. The old-age ratio will reach 39% in 2040, an increase of 13 percentage points (p.p.) compared with 2007 (26%). Presently the ratio is much higher in underdeveloped rural areas, which in the future will create a high level of vulnerability among older people in these regions.
- Serbia does not have a comprehensive long-term care (LTC) policy. Coverage of LTC services and benefits is low; only 1.4% of older people (65+) were covered by residential care in 2018, and only around 1.9% of dependent people received cash benefits. There is a marked uneven regional distribution of residential and day care services.
- In the past 10 years, no reforms have been implemented in this area and there have been no announcements regarding the adoption of new ones. The obligation to provide LTC is commonly placed on the families of dependent people, which imposes a significant burden on their wellbeing. The continuing absence of an adequate LTC policy adversely affects healthy ageing; as a result, the life expectancy of older people (65+) in Serbia did not increase much over the 2010-2017 period, and in 2017 was one of the lowest among European countries, at 15.8 years.
- The main opportunities for addressing future challenges lie in increasing support for preventive services that prolong healthy life years, and in strengthening professional and in-kind capacities for independent living. The provision of home care has been demonstrated to be more effective and efficient than institutional care.

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

1.1 Demographic trends

The population of Serbia has been steadily decreasing since 2007, and this trend will continue up to 2040 (see Statistical Annex, Table 5.1). By 2040 around one quarter of the population (24.1%) will be 65 or older, and the share of this age group in the total population will have increased by 14.2 p.p. compared with 2007. The share of older people aged 75+ will almost double, and will reach 12.2% by 2040. Such demographic trends have had a negative effect on the old-age ratio, which rose from 26% in 2007 to 31% in 2018, while the projections for 2040 show a further increase to 39%.

By 2040, demographic trends will cause different patterns of population growth as between northern and southern Serbia (NUTS1[1]). In 2018 the population distribution was almost the same, with 51% living in the north and 49% in the south. By 2040 the share of the population in the north will increase by 3 p.p., to reach 54%. Similarly, the share of older people (65+) in the population of northern Serbia will rise by 3 p.p., from 19.2% in 2018 to 22.3% in 2040; in southern Serbia it will rise by 4 p.p., from 21% to 25.2%.

Different spatial demographic trends resulted in a discrepancy in the old-age ratio between the NUTS2 regions in 2018. Northern Serbia had lower rates (city of Belgrade – 29%, Vojvodina Province – 28%), whereas those in the south were 31-33%. Another outcome of demographic changes is a significant discrepancy between urban and rural areas. In 2018 the old-age ratio in urban areas was much lower, at 28%, than in rural areas, at 35% (RSO, 2019a). In some sub-regions (NUTS3 level) in southern and eastern Serbia the ratio was above 62%.

As the number of elderly people increases in the future, it can be expected that the number of people with dependency will rise as well, which will increase demand for LTC services. The areas most affected will be rural areas with a prevalence of older households.

1.2 Governance and financial arrangements

The social protection law of 2011 defines LTC services as: (a) residential care; (b) financial benefits for people who need a carer; and (c) day care services.[2] The funding for the first two benefits is covered by the national budget, while day care services are mainly funded by local government. The state covers most operational and maintenance costs for residential care in public homes for elderly people, while coverage of accommodation costs is subject to means testing. Beneficiaries with minimal or no income are exempted from payments; in other cases, they pay all or part of the cost. People without sufficient income may cover accommodation costs by mortgaging their assets (land, a house or a flat) and the centres for social work (CSWs) may lease these assets in order to cover the costs: however, such a practice is not common. Residential care is also provided in facilities that care for people with moderate to severe functional restrictions, for whom the service is free of charge. Since 2018 the Ministry of Labour, Employment, Veterans and Social Policy (MoLEVSP) has signed a few contracts with private residential care providers, for the accommodation of the older people who were on the waiting lists for placement in residential care; the MoLEVSP meets part of the costs and the beneficiary makes up the difference.

Day care services are provided by the public and private sector, and by civil society organisations. Local communities are responsible for the provision and funding of day care services and home care assistance for their residents. Since the beginning of 2000 these services have been developed with broad support from international donors. Funding of the services is mainly secured from local government budgets, and partially through the public work programmes funded by national budget under the supervision of the national

[1] NUTS = Nomenclature of Territorial Units for Statistics.

[2] RS Official Gazette 24/2011.

employment service. Provision of these services is subject to means testing and is commonly free of charge, although in some cases beneficiaries pay a token element of the full price. Financial assistance for all dependent people covers carer's cash benefits

Serbia has a compulsory healthcare insurance scheme, which in 2017 covered 96.1% of the population.[3] Healthcare is provided mainly through public healthcare institutions, whose employees are public employees. Healthcare protection of the vulnerable population is secured by the Article 22 of the Healthcare Law, which provides for free-of-charge healthcare for a large number of population groups (if not covered by the insurance): infants, children, people aged 65 or older, pregnant women, and unemployed people.

Family law regulates the financial support of the elderly by their adult children. The law defines the right of a parent (who is unable to work and has insufficient financial means) to receive monthly financial support from an adult child or relative, depending on their financial capacity to provide such support.[4] Enforcement of this right is through formal, signed contracts or by court procedures. The latter practice is not common, as parents are reluctant to bring such matters to the court. Care for elderly parents or disabled family members is a social norm and as such is commonly provided. Employed people are entitled to five days of paid leave per year for the care of a sick family member (a child, a spouse or a parent) as defined in labour law.[5] The right to a sick-leave payment, defined in health insurance law, cannot be exercised for the care of a sick parent.[6]

1.3 Social protection provisions

The approval and monitoring of all service provision in the public sector is delegated to the local CSWs, which are the main public institutions for the provision of social protection. Applications for residential care are submitted to the CSWs, which coordinate admission with the residential care facility. The general entitlement criteria for LTC services, defined in social protection law, refer to living conditions in which the well-being of an individual is exposed to risk caused by ageing, disability, illness, family situation and other reasons. Entitlement is means-tested. Public residential care facilities may also provide accommodation services through direct arrangements with beneficiaries, subject to approval by the MoLEVSP. In 2018 10% of contracts concluded came under such arrangements, with full coverage of accommodation costs by the beneficiary.

Cash benefits are paid to a dependent person, or to a parent or guardian, and are not means-tested. The exercise of this right is defined in two laws, and depends on the beneficiary's employment status: (a) pension and invalidity law regulates cash benefits for dependent people who are employed or retired – the benefits are funded and administered by the Pension and Invalidity Fund (PIO Fund); and (b) social protection law regulates cash benefits for dependent children, young people and unemployed people. The benefits are administered by CSWs and funded by the national budget.[7] Two types of cash benefits are defined, subject to disability impairment: (a) the basic cash benefit – eligibility conditions include physical and/or mental impairments that affect the ability to carry out everyday activities, or severe sight and hearing impairments; and (b) the increased basic cash benefit – eligibility conditions refer to 100% physical disability of one organ or to multiple physical and mental impairments with a disability level of 70% or more.

In 2018 the full reimbursement of costs was secured for 11% of beneficiaries, 7 p.p. less than in 2015 (RISP, 2020a). Partial reimbursement was secured for 14% of beneficiaries, a decline of 6 p.p. compared with 2015. Over the same period, the proportion of people who paid the full price (out of pocket) of state residential care increased; in 2018 it reached

[3] HIF, https://www.rfzo.rs/index.php/broj-osiguranika-stat.

[4] RS Official Gazette 72/2011.

[5] RS Official Gazette 75/2014.

[6] RS Official Gazette 106/2015.

[7] RS Official Gazette, 75/2014.

75%, 13 p.p. more than in 2015. Among those who paid the full costs, around 60% received financial support from family members.

The level of cash benefits depends on the source of payment; there is a slight discrepancy between carers' benefits covered by the PIO Fund and by the national budget. In 2019 the average benefit covered by the PIO Fund was €141 (RSD 16,566), whereas the basic benefit covered by the MoLEVSP was €91 (RSD 10,710) and the increased benefit was €246 (RSD 28,882). These benefits can be combined with the other financial and in-kind social benefits.

1.4 Supply of services

The official records on the number of service providers cover only residential care facilities (public and private). There are no official records on the number of day care service providers.

In 2018 249 facilities (public and private) provided residential care for older people, and 16 public institutions covered residential care needs for people with functional restrictions (RISP, 2020a). Over the 2015-2018 period, the number of providers of residential care for elderly people increased rapidly, as the number of private providers grew more than threefold, whereas in the public sector one provider was closed down. The growth trend changed the structure between public and private providers: in 2015 61% of providers were private, whereas by 2018 it had increased by 23 p.p. (to 84%). The accommodation capacity increased by half, and reached 16,444 places; 55% in the public sector and 45% in the private. In the public sector the increase was negligible, whereas in the private sector capacity increased threefold compared with 2015. The majority of public facilities, 72%, accommodated 100 residents or more, whereas 48% of private facilities had capacity for 30 or fewer residents, and only 18% had capacity for 50 or more (RISP, 2020a). The territorial distribution of facilities was uneven: 91.1% of all facilities were located in northern Serbia (52.6% in the city of Belgrade, 28.5% in Vojvodina Province). Public facilities were located in only 40 communities (27% of all communities), whereas the majority of private facilities were concentrated in the largest cities (62% in the city of Belgrade). In 2018 the number of beneficiaries in all facilities (annual cumulative) was 23,415, 60% more than in 2015. The majority of beneficiaries, 87%, were 65 or older, meaning that only around 1.4% of older people in Serbia were covered by residential care, 0.5 p.p. more than in 2015 (see Statistical Annex, Table 5.2). Waiting lists increased over the period; in 2018, 1,163 people were waiting for admission, double the number in 2015. The low coverage by residential care could be attributed to several factors: (a) the uneven geographical accessibility of facilities; (b) low affordability due to the inadequate financial means of dependent people; and (c) ongoing traditional attitudes, according to which residential care is the last resort when there are no other options for home care. The RISP (Republic Institute for Social Protection) report on residential care concludes that families usually choose residential care in the advanced phase of disability, when all other possibilities for home care have been exhausted.

Day care services are also provided by the public and private sectors. The available data record only the number of the licensed providers; in 2018 there were 85. Coverage of old people (65+) by public sector day care services was extremely low, at 0.28%, as only 19 licensed organisations provided services, for 3,934 people. However, this type of care is traditionally provided through undeclared work – the informal economy in Serbia is extensive, with a 19.5% rate in 2018 (RSO, 2020b). There are no data on the number of informal carers in Serbia.

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

2.1 Access and affordability

The affordability of services appears to be the main reason for low take-up. In 2016 49.6% of people needing LTC were not using professional home care services for financial reasons, which was 13.9 p.p. more than the EU27 average (see Statistical Annex, Table 5.2). In the same year, 7.5% of people needing LTC reported that no care services were available, 2.2 p.p. less than the EU27 average.

The accommodation prices in residential care vary depending on the accommodation type. Prices in homes for elderly people depend on the type of apartments and on the assistance required for daily living. In 2019 the highest price in the public sector was in the city of Belgrade, at €514 (RSD 60,391) per month for a single-bedroom apartment and full assistance; the lowest price was €280 (RSD 32,939) for a three-bed apartment and partial assistance.[8] The average prices in the less furnished public facilities, located in smaller communities, were around €230 (RSD 27,000). Prices in the private sector generally ranged from €300 to €1,200.[9] In 2019 the average monthly pension was €215.50 (RSD 25,317), while around 60% of pension beneficiaries received less than the average pension (PIO Fund, 2020). It is evident that majority of older people could not afford to cover the full monthly costs of residential care.

Day care and home care services funded by local budgets are provided in most local communities in Serbia, and they are commonly free of charge. However, their provision is rather limited in scope and is time-bound, depending on the available funding from international sources or transfers from the national budget to less developed regions. In 2015 (the latest available data) their coverage was very low; in 122 local communities in 2015, 15,604 elderly people were covered by these services (about 25% of beneficiaries were from Belgrade); the corresponding coverage rate was 1.1% of the total elderly population in Serbia. In a number of cities there are waiting lists for these services (Team for Social Inclusion and Poverty Reduction (SIPRU), 2018). Provision of day care services by the private sector is very costly, and not affordable for most of those in need.

Financial assistance for carers is conditioned only on the disability status of the dependent person. The coverage of financial benefits is extremely low, compared with the estimated proportion of disabled people in the population. The latest estimates are that around 8-12% of the population have some type of disability (Government RS, 2020). In 2018 only around 1.9% of the total population received carer's financial benefits, and the same proportion was recorded in the first quarter of 2019 (RSO, 2019b). The majority of beneficiaries (60%) received benefits from the PIO Fund, which are financed from social contributions, while benefits for the remaining 40% were funded from the national budget. In the latter group around 37% of beneficiaries were 65 or older. One of the main reasons for low coverage by cash benefits is the rigid eligibility criteria; in 2019, 53% of new applicants were refused by the CSW commissions.

2.2 Quality

Since 2013, all registered providers of social services, in both the public and private sectors, have been required to obtain a licence. The quality of services has been secured by the two lower order pieces of legislation: the regulation on licensing providers of social care services, and the regulation on detailed conditions and standards for the provision of social care services.[10] These came into force in May 2016, after a three-year transition period. Licences are issued for a maximum of six years and then have to be renewed. The

[8] https://www.ugcb.rs/dom-bezanijska-kosa-cenovnik.

[9] https://www.mirandre.com/staracki-domovi-cene-cenovnik.

[10] RS Official Gazette 42/2013.

standards for the provision of all types of services are very comprehensive and define space and staff requirements. All residential care facilities are legally obliged to send annual work reports to the RISP. The MoLEVSP is responsible for licensing and inspecting providers and also for control of illegal providers. The list of all licensed providers is regularly updated on the MoLEVSP website. The Association of Private Facilities for Residential Social Care was established in 2015, and one of its main objectives is the improvement of services. It actively cooperates with the relevant state social and healthcare institutions, and regularly organises education workshops and seminars.

The main challenges in maintaining and improving the quality of services relate to the control and closure of illegal residential care facilities, which operate in a number of communities. In 2018, seven such facilities were closed (MoLEVSP, 2020). Another challenge relates to informal private providers of home care, which is a common practice, as a number of unemployed women engage in the provision of home care for elderly and disabled people. Both of these illegal practices exist because they are less costly, and because very often the potential beneficiaries and their families cannot afford to pay the monthly costs charged in official institutions.

The quality of care is also closely related to the cost of services in licensed residential care facilities. One example is the high quality of services in one of the residential care facilities in Belgrade; this also has the highest monthly fees, and provides a wide range of supportive programmes for its residents (recreational, educational, cultural, etc.). The duration of stay in this facility is much longer (some residents have been living there for 10 years or more) than in other smaller and less costly facilities where on average residents stay less than a year (generally the reason for departure is death) (RISP, 2020a).

2.3 Employment (workforce and informal carers)

In 2018 there were 7,698 people employed in facilities for residential care for older people in Serbia (including public residential care facilities for people with mental and/or physical disorders). Out of that number 65% were employed in state institutions, and 35% in private ones (RISP, 2020a, 2020b). The proportion of permanent employees in the public sector was 85% in 2018, and 77% in the private sector, and was constant over the observed period. Compared with 2015, the number of people employed in public institutions fell by 30%, while in the private sector the number increased fourfold. The ongoing ban on new employment in the public sector, imposed in 2014, has been the main reason for the fall in the number of employees in public facilities. Public facilities employed a higher proportion of professional staff (medical workers and personal carers), 46%, 14 p.p. more than the private sector (32%). Over the period observed (2015-2018) the proportion of younger employees (40 years or less) fell by 19 p.p., to 39%; while the proportion of older workers (51+) went up by 11 p.p., to 31% (RIS, 2020a). The employed workforce was predominantly women, around 85% over the whole 2015-2018 period (see Statistical Annex, Table 5.3). The number of all LTC workers per 100 individuals (in residential care) was low, at 0.54; it was even lower, at 0.22, if only professional staff are considered (RISP, 2020a). In both cases the ratio was much lower than the EU27 average for 2016, at 3.8 (OECD, 2019): the Serbian indicator, however, does not include day care service providers.

There are no data on the total number of employees who provide day care services. Licensed organisations in the public sector that provide day care employed 1,054 staff. In 2019 the gerontology centre in the city of Belgrade, the largest one in Serbia, employed 684 'gerontology housewives' for the provision of day care services, while the same centre in Novi Sad, the second largest city in Serbia, employed 36 professionals for the provision of day care services. A number of humanitarian organisations (Red Cross Serbia, Caritas, etc.) also provide home care assistance to elderly and disabled people. Apart from registered organisations, home care is provided by undeclared workers: however, there are no estimates of the scope of services provided.

The latest estimate of the number of informal carers was based on a 2012 survey, which concluded that around 97% of dependent people relied on assistance by family members,

friends and neighbours (IPSOS, 2012). A survey conducted in 2019 as part of research on improving the status of informal carers (involving interviews with 352 informal carers) provides a detailed profile of informal carers (HELPNET Belgrade, 2019). A majority (67%) of carers were a close relative of the dependent person, with an average age of 55.4; 77% of carers were women. The large majority of carers (73%) were of working age (35-64); 43% were employed, 11% had a temporary work engagement, and 28% were retired. The average duration of care of dependent people was 7.2 years, and 59% of carers had to provide 24-hour care. Around 31% did not live in the same household, but 55% made a regular daily visit. Only 12% received assistance from state institutions, and 11% could engage a paid help. The analysis of the survey's responses shows that informal care places a heavy burden on those carers who are employed, and also prevents a high proportion of unemployed carers from seeking employment. Nonetheless, 85% of respondents stated that they would not consider placing the dependent person in a residential care facility. Most (60%) reported the need to gain more knowledge and skills in relation to the delivery of care, and 73% stated that introducing a telephone helpline could relieve some of their worries, by providing information and support in managing daily tasks.

2.4 Financial sustainability

Only composite data on social financial assistance expenditure (child, parental, and caretaker benefits) are available; over the 2015-2018 period spending fell by 0.8 p.p. to 3.1% of GDP in 2019. Spending on LTC services constituted the lesser part of expenditure, as financial assistance for families with children had the highest share. Spending on healthcare protection as a share of GDP fell by 5.3 p.p. over the 2008-2019 period, to 20.9% (Ministry of Finance, 2020). Household budget survey data show that, on average, households in Serbia spent 4.3% of their budget in 2019 on LTC services, a small increase of 0.3 p.p. compared with 2008 (RSO, 2020a, 2009b).

The low level of LTC expenditure reflects the low coverage of financial and in-kind benefits. Even though the economy has recovered in the last three years, the resources earmarked for social care have not increased accordingly. There is a marked imbalance between formal and informal care provision, with an extremely low coverage by formal in-kind services and a relatively low adequacy of cash benefits. The state is not investing in provision of in-kind services; this area is dominated by the private sector, undeclared work and informal carers.

Expenditure needs will rise in the future as the old-age ratio rises: however, increases in the guaranteed benefits will depend on positive changes of social policy in this area.

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

LTC for children with disabilities has seen some improvements in Serbia, but much still needs to be done in order to secure their full social integration. The process of deinstitutionalising residential care for children and young people with developmental disorders started in 2000, and by 2010 the number of beneficiaries had been halved. In 2018, 532 children and young people were living in residential care institutions; 60% of them were the age group 18-25 and 3.2% were aged five or younger (RISP, 2020d). It is evident that once they are admitted they remain in residential care for a long time; 79% of all beneficiaries remained in an institution for 10 years or more, and 45% for 20 years or more. In 2018 only one child was reunited with their family. Social protection law generally prohibits the placement of children aged three or under in residential care; in exceptional cases placement is allowed, for no longer than two months (for longer periods, authorisation is required by the MoLEVSP). In 2018 there were five children younger than two years in residential care: 45% of children in residential care had been there for seven months or more, and 15% for two years or more.

In 2018 10,857 children were recipients of some type of service from the CSWs (0.8% of the child population, aged 18 or less). One quarter of children, 25%, did not receive the caretaker financial benefits; while among recipients 57% received the increased financial

benefit (RISP, 2020e). According to the RISP report for 2018 (based on the reports of licensed providers of care) services in day care facilities were provided for 281 children, services of personal assistant 877 children and home assistance 110 children. It is evident that the available day care services for children are scarce and depend on donor funding, while they are non-existent in smaller communities. A number of pilot projects for support to families with children with disabilities has been successfully implemented; however, the good practice has not been included in systematic measures.

LTC for children should be addressed through an integrated approach which will include relevant stakeholders in the provision of support to families and children. The state needs to invest more in the provision of day care services and financial support to families.

3 Reform objective and trends

Serbia does not have a comprehensive LTC policy. Measures for the provision of financial and in-kind LTC support are incorporated into broader social policies. Provision of residential care is regulated within the context of institutional care, while caretaker benefits are part of financial support for people with disabilities (under social protection law).

The national ageing strategy for 2006-2015, adopted in 2006, set a number of objectives and goals for addressing the future needs of elderly people. Some of the main objectives were: ensuring equal access to residential care in all communities; introducing social pensions; regular monitoring of the actual and future needs of elderly people; and support for families with dependent older members. None of these objectives has been fully implemented. The strategy has been out of date for five years, but there are no plans for the preparation of a new one. The social protection strategy was adopted in 2005, while the proposal for a new one for the 2019-2025 period was prepared in 2018, and public debate on it ended in 2019. There have been no announcements regarding the adoption of strategy documents.

On 5 March 2020 the Serbian government adopted a new strategy for improving the status of disabled people in Serbia in the period 2020-2024 (Government RS, 2020). The main objective of the strategy is to align national policies with the UN convention on the rights of persons with disabilities.

Population policy is currently under the authority of the government’s Cabinet for Demography and Population Policy.[11] The cabinet is predominantly focused on policies for increasing birth rates, and in 2018 the government adopted a strategy for achieving that.

The licencing of all social care providers and the standardisation of social services provision, which came into force in 2016, represents the main reform in improving and securing the quality of social services (see Section 2.2).

The ban on new employment in the public sector introduced in 2014 as a fiscal consolidation measure had a profound negative impact on employment in public social care institutions. The CSWs lost 16% of their staff, and public residential care facilities 29%, over the 2015-2018 period (RISP, 2020a, 2020c). The report prepared by the RISP states that requests for new employment were denied by the MoLEVSP, and that the quality of care is jeopardised due to the lack of professional staff.

[11] https://www.mdpp.gov.rs/latinica/index.php.

4 Main opportunities for addressing LTC challenges

Pressure on the public financing of LTC will increase in the future. It is necessary to ensure that the most vulnerable people receive the proper care, by reducing demand for residential care. Future LTC policy should support measures which prolong independent living. Home-based solutions are advanced not only for their health, social and emotional benefits but also because of the potential reduction in public expenditure, as home care provision has been demonstrated to be more effective and efficient than institutional care.

The main opportunity for addressing LTC challenges is to increase preventive measures that increase the healthy lifespan of elderly people and reduce the number of dependent people. This approach demands combined working between healthcare and social care partners. The relevant authorities need to educate the general population about healthy life styles and potential health risk factors. These duties should be delegated to primary healthcare workers, who are the first point of contact with elderly people. The government should introduce financial incentives for modernising the healthcare system through the use of new medical information technology for home healthcare, which will reduce in-hospital care and also enable older people to stay at home longer. In the area of social care, local government is the central point which coordinates all activities to support the healthy lifestyles of older people. Investing in a healthy environment and safe cities is one measure to preserve population health. Another measure is support (financially and with know-how) for older people to adapt their homes for safe living. These measures are already implemented in a number of European cities, and local communities in Serbia could benefit by learning from their experiences. There are also good examples in some cities in Serbia that organise regular ‘health fairs’ (preventive check-ups and advice) and provide free access by elderly people to recreational facilities.

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Statistical Annex

Table A.1 Demographics (30 June)

		2007*	2018	2030	2040
Population (in millions)		7.40	6.90	6.82	6.81
Old-age ratio (the ratio between the number of people aged 65+ and the number of working-age people (15-64)		0.26	0.31	0.38	0.39
Population 65+ (in millions)	*Total*	1.27	1.41	1.61	1.64
	Women	0.73	0.81	0.93	0.94
	Men	0.54	0.60	0.68	0.69
Share of 65+ in population (%)		9.86	20.2	23.62	24.10
Share of 75+ in population (%)		6.65	8.30	11.31	12.23
		2010	**2017**		
Life expectancy at the age of 65 (in years), (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)	*Total*	15.2	15.8	n.a.	n.a.
	Women	14.0	14.5	n.a.	n.a.
	Men	14.6	17.0	n.a.	n.a.

**1 January; Data source: RSO, 2019a.*
n.a.: not available.

Table A.2 Access to LTC

	2015	2018
Share of population 65+ receiving care in an institution (%) (1)	0.9	1.4
	2016	
Share of households in need of LTC not using professional homecare services for financial reasons (%) (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) (2)	49.6	n.a.
Share of households in need of LTC not using professional homecare services because services not available (%) (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) (2)	7.5	n.a.

Data sources: (1) RISP, 2020a; (2) Eurostat, EU-SILC. ilc_ats15.

Table A.3 LTC Workforce

		2015	2018
Number of LTC workers in residential care facilities per 100 individuals 65+	*Total*	0.54	0.54
	% Women	85%	85%

Data source: RISP, 2020a.

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