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Long-Term Care in the Republic of Serbia



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LONG-TERM CARE IN THE REPUBLIC OF SERBIA

Natalija Perišić*

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1. COUNTRY OVERVIEW



- » Sub-Region: Southern Europe
- » Capital: Belgrade
- » Official Language: Serbian
- » Population size: 6,945,235 (WB 2021; 2019 value)
- » Share of rural population: 44% (WB 2021; 2019 value)
- » GDP: 51.475 billion current US\$ (WB 2021; 2019 value)
- » Income group: Upper middle income (WB 2021)
- » Gini Index: 36.2 (WB 2021; 2017 value)
- » Colonial period and Independence: N/A

Source: <https://ontheworldmap.com/serbia/> (Accessed: April 30, 2021)

Note on Kosovo: This designation is without prejudice to positions on status and is in line with UNSCR 1244 and the ICJ opinion on the Kosovo declaration of independence.

2. LONG-TERM CARE DEPENDENCY

a. Population statistics

Table 1. Older population in Serbia

	Total number	Share of total population
Population 60+	867,858	12.1%
Population 70+	652,754	9.1%
Population 80+	258,118	3.6%

Source: Data derived from the latest Census of 2011 (Republički zavod za statistiku, 2018).

Table 2. Long-term care dependent population in Serbia

	Total number	Share of total population
Self-reported inability to live without caregiver support for daily activities	Approx. 88,000	1.2%
Population with disabilities	691,262	9.6%

Source: Data derived from the latest Census of 2011 (Republički zavod za statistiku, 2018).

b. National definition and measurement of long-term care dependency

The term 'long-term care' (LTC) is not consistently used in the Serbian context. The most commonly found terms are *dugotrajna nega* (Matković, 2012; Matković, Stanić, 2014) and *dugotrajna zaštita* (Perišić, 2013), while *dugotrajna nega i pomoć* is commonly used by the Team for Social Inclusion and Poverty Reduction of the Government of the Republic of Serbia, the most active stakeholder in this field.

There is no country-specific definition of LTC. Authors in the field in the national context start from the LTC definitions given by the EU and OECD. Therefore, LTC is taken to mean in general cash benefits as well as services provided by the health and social protection systems, either in one's home or in a residential setting, to persons in need of support in order to be able to perform everyday activities during longer periods of time (Tim za socijalno uključivanje i smanjenje siromaštva Vlade Republike Srbije, 2017: 59). Specifically, benefits and services from the health care system (long-term medical care services, in-home and in health care facilities and palliative care services), the social protection systems (residential care services and in-home support services, foster care, allowance for support and care by informal caregiver) and the old-age and disability insurance system (allowance for support and care by informal caregiver) are included in LTC considerations (Matković, 2012; Perišić, 2013; Arandarenko, Perišić, 2014).

Eligibility criteria for LTC services are based on medical, and not functional criteria.

3. FIRST PUBLIC SCHEME ON LONG-TERM CARE

a. Legal introduction

Name and type of law	Law on Social Protection and Social Protection Service of 1966
Date the law was passed	January 31 st 1966 ¹
Date of <i>de jure</i> implementation	January 8 th 1967
Brief summary of content	The Law prescribed rights to 1) social work services, which included, among other, in-home care and support services (Article 29), as well as residential care of adults with disabilities and the elderly (Article 69) and of adults with complete and permanent incapacity to work (article 74); and 2) social welfare benefits in cash in general; however, in case a social welfare beneficiary is paralyzed, chronically ill or blind, he/she or a member of his/her family is eligible to a special allowance (Article 39).
Socio-political context of introduction	Main drivers for the concept were to effectuate the social security of citizens in compliance with the principles of socialist humanism and solidarity, especially by providing the necessary funds to those incapable of work (Article 3). The actors involved were social-political and local communities, labour and other organizations.

b. Characteristics of the long-term care scheme at introduction

The population groups covered by the introductory scheme comprised the elderly (without specifying the age) and adults with disabilities.

The service provision was organized solely through the public sector, i.e. the state. The services were organized both in residential care and in care recipients' homes. However, due to their factual under-development, care was for the most part provided by families, i.e. the informal sector.

Since the scheme under development pertained to the social protection system, there were no qualifying criteria regarding employment or payment of social insurance contributions. All citizens were eligible for ben-

1 From the end of World War II up to the beginning of the 1990s, socialist Serbia was one of the Republics of ex-Yugoslavia. During that period, federal norms which regulated the fields of social protection and health care, among other fields, provided a framework for the Republic regulations. Therefore, Serbia's Law on Social Protection and Social Protection Service of 1966 (as with other laws that followed) was in compliance with the federal regulation in this area, but also specific compared to the regulation of social protection in other Republics that made up ex-Yugoslavia.

efits, subject to means testing. All citizens with a certified medical condition had the right to receive services. The benefits and services described here were funded through the state and municipal budgets. The beneficiaries of the services did not have to contribute to the cost of services.

The public organization in charge of benefits and services were municipal Centres for Social Work (CSWs). CSWs disbursed social welfare benefits in cash and were in charge of supervising residential care facilities and the provision of other services described here. No provisions were made in the Law for quality standards or licensing of providers.

4. SUBSEQUENT MAJOR REFORMS IN LONG-TERM CARE

a. Major reform I

Name and type of law	Law on Social Protection of 1974
Date the law was passed	December 5 th 1974
Date of <i>de jure</i> implementation	December 6 th 1974
Brief summary of content	Like the Law of 1966, the Law on Social Protection of 1974 prescribed rights to benefits and services. The novelty of this Law was, however, that for the first time in Serbia, social welfare benefits in cash for severely disabled persons were denoted as cash allowances for assistance by caregivers (Article 22). Additionally, the rights to social services specified in the Law included 1) residential care for elderly or severely chronically ill people in need of continuous care and health supervision (Article 25), and 2) in-home care and support services to provide necessary care and performance of domestic tasks, cleaning, nutrition, shopping etc. to the elderly, chronically ill and other persons not able to take care of themselves (Article 26).
Socio-political context of introduction	Again, the main drivers behind the concept were to effectuate the social security of citizens in compliance with the principles of socialist humanism and solidarity, and especially the provision of necessary funds to those incapable of working (Article 3). The objective of benefits and services was to provide social care, support and assistance to citizens who cannot provide it on their own. The actors involved included organised workers and their associations, workers and citizens involved in societal-political organizations, self-interest communities and local communities, as well as social-humanitarian organizations.

b. Major reform II

Name and type of law	Law on Social Protection of 1986
Date the law was passed	May 3 rd 1986
Date of <i>de jure</i> implementation	May 11 th 1986
Brief summary of content	The Law continued with the provision of rights to benefits and services. The novelty of this Law was the introduction of additional medical conditions to eligibility criteria, encompassing beneficiaries who are paralyzed, have dystrophia, are severely mentally or developmentally disabled, chronically ill or blind (Article 33).
Socio-political context of introduction	The main drivers and actors remained the same as in the above Law.

c. Major reform III

Name and type of law	Law on Social Protection and Material Provision of Families of 1990
Date the law was passed	January 26 th 1990
Date of <i>de jure</i> implementation	February 4 th 1990
Brief summary of content	The Law provided among other things for the rights to residential care and allowances for assistance and care by an informal caregiver (Article 6). The eligibility criteria for an allowance for assistance and care by an informal caregiver related to adults in need of assistance and care by informal caregivers in order to be able to meet basic life needs due to the nature and severity of their health situation, injury or disease. The right could be claimed provided that a person could not effectuate this right based on any other rules and based on means testing. Eligible adults were classified into two groups, depending on their mobility and capacity for performing activities (Articles 31 and 32). The right to residential care included accommodation in one of three types of facilities (residential homes for pensioners and other elderly, gerontological centres, and facilities for adults with physical and mental disabilities and psychiatric disorders) (Articles 85-88). Finally, the Law stipulated the establishment of centres for providing in-home care services for the diseased, elderly and other adult persons, in terms of nutrition, personal hygiene, home hygiene and other household activities (Article 92).
Socio-political context of introduction	The main drivers for the concept were to effectuate the social security of citizens in compliance with the principles of humanism and social solidarity, with a view to preventing negative consequences of economic and social development on the social security of individuals and families. At the same time, concerns were emerging about the increasing population ratio of the elderly. The Law was the first to be enacted after the breakdown of socialism in Serbia, and with it the network of actors involved started to be widened so as to include non-governmental organizations and private sector stakeholders as well.

d. Major reform IV

Name and type of law	Law on Social Protection and Provision of Social Security to Citizens of 1991
Date the law was passed	June 13 th 1991
Date of <i>de jure</i> implementation	June 26 th 1991
Brief summary of content	The Law provided, among other things, for 1) allowances for assistance and care by informal caregivers, 2) in-home support, and 3) residential care and accommodation in foster families. An in-cash allowance for assistance and care by informal caregivers was the right of beneficiaries of social welfare benefits who needed assistance and care by informal caregivers for the provision of basic human needs, if they could not effectuate that right on any other basis and if they were not in residential care. Means testing was not envisaged for persons with severe disabilities (Article 24). In-home support was the right of elderly and chronically ill and other persons not in a position to take care of themselves (Article 31). Centres for in-home support were set up to provide elderly, ill and other adults with the services in their homes and care in their households (Article 102). Residential care was an entitlement, among others, that could be claimed by adults with disabilities, severely chronically ill persons unable to live independently, and pensioners and elderly in general who due to medical, social, housing and family circumstances could not live with their families or in their households (Article 36). Four types of residential care were listed: residential homes for pensioners and other elderly; gerontological centres; residential homes for adults with disabilities; and residential homes for people with mental disabilities and psychiatric disorders (Articles 89-94). Alternatively, the aforementioned persons could be accommodated in foster families (Article 40).
Socio-political context of introduction	The context is comparable to that of the previous Law

e. Major reform V

Name and type of law	Law on Social Protection of 2011 (currently valid Law)
Date the law was passed	April 4 th 2011
Date of <i>de jure</i> implementation	April 12 th 2011
Brief summary of content	The Law provides, among other things, for 1) allowances for assistance and care by informal caregivers, 2) increased allowances for assistance and care by informal caregivers, 3) daily community services (which include in-home care), and 4) accommodation services – accommodation in foster families and residential care (Article 40). The Law laid the foundation for the establishment of social-health residential care facilities.
Socio-political context of introduction	The need to introduce budgetary savings and enact austerity measures resulted in the withdrawal of the public sector competencies. The guiding principles of the reforms were decentralization and deinstitutionalization. A further motivation was the espousal of many EU concepts in the field of ageing. The concerns of population ageing are very prominent in Serbia. In particular, there are serious concerns about the well-being of the oldest elderly in connection with dementia, but also other conditions. Plans on introducing an LTC contribution scheme were disregarded due to the already high burden on employees with social insurance contributions. The main stakeholder is still the informal sector, i.e. the family. However, the dominance of the public sector in the regulation was changed and the majority of LTC services are meanwhile provided by the private and civil sectors. Nevertheless, the service coverage of the population is still rather low.

5. DESCRIPTION OF CURRENT LONG-TERM CARE SYSTEM

a. Organizational structure

LTC is organized and provided for in three sectors of the social security system: social protection, health care and old-age, and disability insurance.

In the *social protection system*, entitlements to LTC are twofold, i.e. there exist institutional and non-institutional services as well as cash benefits.

The competences for institutional (residential) care lie at state level and it is provided in public residential care homes for adults and the elderly. The establishment of social-health care residential services was provided for by the Law on Social Protection of 2011, but has not been implemented. Non-institutional services are organized in the form of accommodation in foster families in order to enable the elderly to maintain or increase their quality of life, and in-home support and care which is intended for those elderly who are not capable of independent living in their homes.

A further LTC-related benefit in the social protection system is an allowance for support and care by informal caregivers. The allowance for support and care by informal caregivers is conditional on incapacity to perform basic everyday activities. Depending on the level of impairment, the beneficiaries receive a regular or an increased allowance. Centres for Social Work are in charge of making decisions regarding all rights prescribed by the Law on Social Protection.

Under the *health care system*, the right to palliative care is prescribed and its implementation and provision at the primary level is organized through services for in-home treatment and in health care centres. Long-term health care is also provided in so-called long-term treatment and care units, at the secondary (general and special hospitals), and tertiary levels of care (clinics).

Under the *old-age and disability insurance system*, pension contributors incapable of independent living are entitled to a fixed-amount allowance for support and care by informal caregivers.

LTC is part of both the health care system and the social protection policies, but it does not seem to be prioritized in any of the modernization agendas. The period of reforms has “bypassed” LTC, particularly in terms of health care (Arandarenko, Perišić, 2014: 22), while there have been positive developments in the social protection system.

Since LTC is fragmented between three schemes, there are divided political responsibilities:

- 1) the Ministry in charge of social welfare (The Ministry of Labour, Employment, Veteran and Social Affairs) regulates the part of LTC pertaining to *social protection system*,
- 2) the Ministry of Health regulates the part of LTC pertaining to the *health care system*, and
- 3) the Old-Age and Disability Insurance Fund is in charge of the part of LTC pertaining to *old-age and disability insurance system*.

b. Service provision

Residential care services are provided in about 40 public and about 100 private homes for the elderly, accommodating approximately 6,700 and 3,000 persons aged 65 years and over respectively (Vlada Republike Srbije, 2018: 206).² Nationally, therefore, residential care currently covers less than 0.8% of the population over 65 years of age (Vlada Republike Srbije, 2018: 207). There have been no significant changes in the coverage of elderly with residential care in the past in Serbia. Additionally, there are strong regional differences regarding availability of residential care. Some local communities do not have a public home for the elderly, in which case an elderly person has to move to another local community. This testifies to the importance of family care in Serbia, i.e. the family's responsibilities and obligations. Challenges arise from the fact that the majority of the elderly in Serbia live in old-age households, i.e. households with no members below 65 years of age. Women are more affected than men, i.e. they are most frequently faced with making arrangements for LTC since they live longer.

Palliative care services are provided to the elderly in only one hospice in Serbia ("BelHospice") which is run by a civil sector organization (Bogićević, 2020). Due to rather limited capacities of the hospice and insufficient capacities in public hospitals for palliative care, it is clear that consequently families have the responsibility of taking care of their dying older family members in their own homes, too.

In-home support care service is available to those who are not in a position to take care of themselves and who do not have any family members to provide care for them. It comprises indirect care activities provided by home helps, known in Serbia as "geronto-housewives". Geronto-housewives are semi-professionals caring for the elderly and supporting them for a certain number of hours per week in their instrumental and living activities. This service covers 1.24% of people over 65 years of age, i.e. about 15,000 service users. In Serbia, 84% of local communities offer in-home support services. The intensity of the service is not the same throughout the country – only in less than half of local communities is the service provided throughout the year, covering 57% of users (Matković, Stranjaković, 2020: 47). Public sector providers have a slightly higher coverage of service users, since they provide the service to 55% of the covered population. However, the trend of their coverage is decreasing compared to 2012, when the public sector covered 74% of care receivers. By contrast, the voluntary sector has increased its percentage of service users from 26% in 2015 to 34% in 2018. Also, after the adoption of the 2011 Law on Social Protection, private sector providers started offering their services for the first time. They currently cover 9% of care users (Matković, Stranjaković, 2020: 53). The majority of service users are from urban areas, but the difference is not huge – 52.5% of users are from urban areas, and the rest are from rural areas. A noticeable difference is observed regarding gender – 71% of care receivers are women (Matković, Stranjaković, 2020: 18).

As regards *foster care* of the elderly there is anecdotal evidence on its extremely rare usage in the national context (Kolin, 2011: 162-163), but the available data cannot be segregated by age.

c. Financing

The *social protection system* is tax funded, i.e. it is funded from the state and municipal budgets and by the city of Belgrade. Its LTC benefits are dependent on means testing and services are free of charge as a rule, though with notable exceptions. Public residential care is means-tested; depending on the funds of a beneficiary, it can be free of charge or has to be paid partially or in full by them. The co-payments of public residential care depend on numerous variables. Private residential care is provided on an individually funded basis, and their prices are

2 Data on the number of private residential facilities are extremely unreliable and depend on the source.

market-driven. Contracting with the public sector has been on the scene since 2018, when about 20% of the total number of private homes signed framework agreements with the Ministry in charge of the welfare sector. When the Ministry started contracting with private residential care providers, the costs of care started to be co-funded by the state budget.

The *health care system* is insurance contribution-based. The health care services are offered to 96% of the population. Elderly patients are exempt from paying fees for health care treatment. The palliative care services provided by the „BelHospice“ are free of charge.

Finally, the *old-age and disability insurance* is contribution-based and only pensioners can effectuate the right to allowances for support and care by informal caregivers under this system. Subject to means-testing, non-pensioners can effectuate this right in the social protection system, as already mentioned.

There are no segregated data on the costs for LTC. The only available data refer to two LTC-related benefits in the social protection system which consume 0.33% of GDP (Vlada Republike Srbije, 2018: 242).

d. Regulation

In practice, choice of public providers is rather limited, while the choice of private providers is extensive. Quality standards have a long-standing history in health care systems and they have been monitored and measured over a long period of time. Thus, although the standards for social protection services have only recently been finalised, significant progress has been made in terms of their monitoring. Reports point to a rather modest quality of residential care services for the elderly, in contrast to in-home support and care. Licensing of service providers in both health care and social protection is required as a means of providing quality standards.

Generally, eligibility for LTC services is based on medical criteria, while eligibility for LTC benefits are based on medical criteria and means testing / retirement status respectively.

The right to allowances under the social protection system can be effectuated regardless of a person's previous status of employment, while the right to allowance in the old-age and disability insurance system is dependent on their retirement status. The social protection system acknowledges the right to a regular or an increased allowance, depending on the level of an applicant's impairments (Vlada Republike Srbije, 2018: 215). The old-age and disability allowance is a flat-rate amount.

The number of elderly receiving allowances from the social protection system is rather low. In 2019, 5,632 and 13,751 elderly received regular and increased allowances respectively. Over the past five years, the number of elderly receiving regular allowances dropped by 17.2% while the number of elderly receiving increased allowances rose by 7.5% (Republički zavod za socijalnu zaštitu, 2020: 37). On the other hand, the number of beneficiaries of an allowance in the old-age and disability system is high, both when compared with the number of beneficiaries under the social welfare system and when compared to the estimated number of those in need of LTC,³ increasing as it did from 74,795 in 2010 to 79,949 in 2019 (RFPIO, 2020: 34).

The regular allowance under the social protection system amounted to approx. half of the minimum wage level, while the increased allowance under the social welfare system amounted to 1.4 times the minimum wage. The allowance in the old-age and disability system amounted to $\frac{3}{4}$ of the minimum wage. This signifies a considerable burden on the elderly themselves and on their family members to cover the needs for care.

In terms of responsibilities for the field of LTC, the Ministries in charge of social welfare and health care are in charge of regulation in the field. However, to a certain extent, non-governmental organizations have been consulted on and thus actively involved in the development of LTC policy.

6. LIST OF ADDITIONAL RELEVANT LAWS/DOCUMENTS

See list of regulations in the reference section.

3 There are estimations that around 80,000 elderly persons are in need of LTC (Crveni krst Srbije, 2020: 1).

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