Local Government and Public Service Reform Initiative

WHO CARES?
THE INSTITUTIONAL FRAMEWORK FOR LONG -TERM SOCIAL CARE BENEFITS

National report

SERBIA

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I Demographic Trends

Similar to other European societies, Serbia is also facing serious demographic challenges. At the beginning of the 21st century, Serbia's key demographic trends are negative population growth, continuous fall in fertility and increasingly pronounced population ageing.

The unfavorable demographic trends in Serbia can primarily be attributed to the fact that fertility rate has for decades been below the replacement level. Over the past ten years, economic transition has strengthened the determinants influencing low reproduction norms, while the society and government capacity to respond to these unfavorable trends has been reduced.

Table 1. Selected demographic indicators for Serbia, 2002 and 2009.

Demographic indicators	**2002**	**2009**
Number of inhabitants	7,500,031	7,320,807
Crude birth rate (‰)	10.4	9.6
Crude death rate (‰)	13.7	14.2
Natural increase rate (‰)	-3.3	-4.6
Total fertility rate	1.6	1.44
Life expectancy at birth		
Men	69.7	71.1
Women	75.0	76.4
Average age	40.2	41.2

Source: Statistical Yearbook of Serbia, 2010.
Note: Data for 2002 are based on the census, while the data for 2009 are estimates.

The negative consequences of unfavorable demographic trends are most pronouncedly reflected in population ageing, which has reached alarming proportions.

The Serbian population is in the advanced stage of population ageing. It is estimated that in 2009 more than 1,250,000 persons, or 17 percent of Serbia's total population, were older than 65 (Table 2). The share of elderly is higher only in four EU member states: Germany and Italy (20 percent each), Greece (19 percent) and Sweden (18 percent) (Republic of Serbia 2010). The number of persons reaching a ripe old age is also on the rise. In 2009, the number of persons older than 80 was estimated at 231,000, thus constituting 3 percent of the total population.

The process of population ageing in Serbia is primarily the result of fertility decline. The total fertility rate fell from 3.13 in 1950 to only 1.4 in 2009. The increase in life expectancy also generated an effect on the ageing process, but to a lesser degree than in developed countries. It must be pointed out that the prolongation of life expectancy in the past was due to a decrease in infant mortality rather than the increase of life expectancy among the elderly (Penev, 2006). Migrations have also contributed to ageing, but to a lesser degree. A large number of refugees and displaced persons, who found refuge in Serbia during the 1990s, due to the wars in former Yugoslavia, have not influenced ageing, since the entire population, with the same age structure

and similar reproduction norms, settled in Serbia. Hence, ageing was intensified by emigration. Namely, during the 1990s, more than 320 thousand persons, mostly younger and better educated left the country, thus depleting the country's demographic, educational as well as democratic capacity.

Population ageing both from the base and from the top of the age pyramid has resulted in an almost equal number of persons younger than 15 and older than 65. The old-age dependency ratio, which shows the relationship between the elderly and working-age populations and, in essence, points to the capacity to address the economic consequences of ageing, amounts to over 25 percent.

In Serbia a significant number of the elderly, almost half of them, live in elderly households, out of which over 266 thousand live in single-person households and more than 340 thousand in households with members who are all over 65. The increasing number of elderly households largely reduces the chances for informal care by family members.

The municipality-level data show that the demographic situation in a significant number of local governments (LG) is even more unfavorable than the average for Serbia. According to the 2002 census, over 85 percent of the municipalities are in an advanced stage of population ageing. (Penev 2006). According to the estimates for 2008, the share of persons older than 65 in fifty municipalities and cities[1] accounted for more than 20 percent of the total population (Rašević and Penev 2009).

The population projections warn that the ageing process will be intensified in the future, including the ageing of the elderly population. As shown in Table 2, until 2030, the total number of Serbia's inhabitants will continue to decline, while the number of elderly people will significantly increase. As a result of such trends, the share of elderly will increase to more than 21 percent, while the share of the oldest old will increase from 3.3 percent to 5 percent. The old age dependency ratio will deteriorate considerably.

Table 2. Population ageing, 2009, and the projection for 2020 and 2030, medium variant

	2009	**2020**	**2030**
Number of inhabitants	7,320,807	7,117,038	6,888,888
Number of elderly persons older than 65	1,250,818	1,392,478	1,450,349
Number of elderly people older than 80	244,579	340,539	344,796
Share of 65 +	17.1	19.6	21.1
Share of 80+	3.3	4.8	5.0
Old age dependency ratio	25.2	30.2	33.0

Source: Statistical Yearbook of Serbia 2010.

According to the World Bank study on population ageing in Eastern Europe and the former Soviet Union (World Bank 2007), Serbia has been placed in the category of *aging countries and*

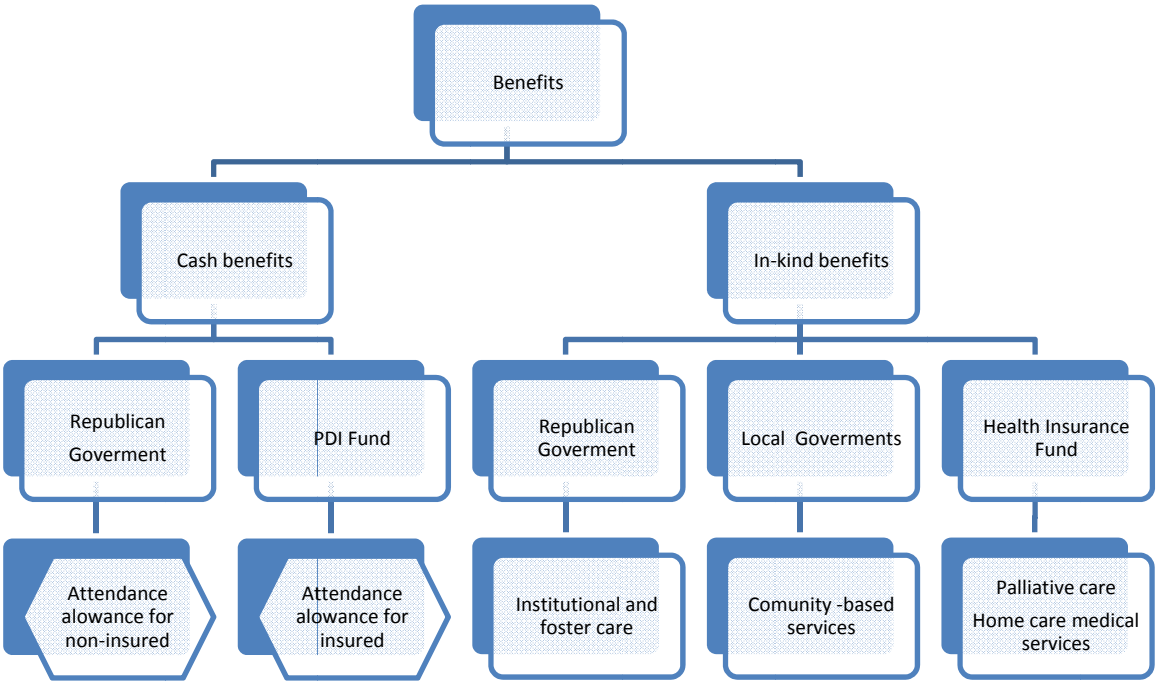
[1] Including two Belgrade municipalities

late reformers, and as such facing the greatest challenges, due to the underdeveloped institutions and pronounced population ageing. It is estimated that these countries will be unable to adequately respond to the consequences of population ageing.

II National Policy Framework and Entitlements at the National Level

In Serbia, long-term care (LTC) benefits comprise of cash and in-kind benefits. The latter are provided primarily through institutional care and community-based services. Cash benefits and institutional care are in the mandate of the republican government and are financed from the republican budget and Pension and Disability Insurance Fund (PDI Fund), while the provision of community-based social services is in the mandate of LGs. Health services are in the mandate of the central level and are financed through the Health Insurance Fund.

Figure 1. Long term care benefits, mandates and financing



1. Cash Benefits for Long-Term Care

1.1 Regulation

In Serbia, the cash benefit for long term care is primarily provided through two systems – the pension and disability insurance system and the social protection system.[2]

Under both systems, the LTC cash benefit i.e. attendance allowance is provided to persons who are unable to perform activities of daily living (ADL) due to illness or disability. During the 1990s, under the regulations in force at that time, the beneficiaries of these two systems were clearly separated. The beneficiaries of the entitlement under the pension and disability insurance were the insured persons and pensioners, while all the other beneficiaries receive the entitlement through the social protection system. Under the more recent legislative changes this division has become less clear-cut.

What is also common to these systems is the so-called categorical targeting, i.e. the benefit entitlement is exclusively dependent on the beneficiary's health status and not on his or her financial status. The assessment procedure is also the same: it is conducted by expert bodies within the PDI Fund, for both the insurance and social protection systems.

Under the *Pension and Disability Insurance Law,* the beneficiaries of attendance allowance can be the insured persons and pensioners. Thus, this entitlement is a benefit under the social insurance scheme and is financed by insurance contributions to the PDI Fund. The contribution rate for this entitlement has not been specifically earmarked. Instead, it is financed from the overall contributions to the pension and disability insurance, which amounts to 22 percent of the gross salary (11 percent is paid by the employed and 11 percent by the employer)[3].

Apart from beneficiaries receiving the regular benefit amount, the pension and disability system also covers so-called pre-existing beneficiaries, whose benefits are lower and who acquired this entitlement under the regulations of the 1990s or even 1980s. The legislative changes eliminated this entitlement and no new beneficiaries could apply, however, according to the Constitution all of the pre-existing beneficiaries are entitled to continue receiving the awarded benefits.

Under the *Law on Social Protection and the Provision of Social Security to Citizens* a person is entitled to attendance allowance if he or she, due to the nature and severity of the injury or illness, needs assistance for performing ADL, provided that this entitlement is not received under any other legal grounds. This entitlement is a right of general interest, in the mandate of the republican government and financed from the republican budget. Consequently, the beneficiaries receive the allowance without paying insurance, that is, contributions.

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[2]Attendance allowance also exists under the veterans-disability care system. Due to the specifics of veterans-disability care, as well as the fact that it is not geared towards elderly care, it will not be the subject of an analysis in this paper. In 2009, the total number of attendance allowance beneficiaries under the veterans-disability care system was 846, of whom 166 were civilian war-disabled. The total expenditures amount to about €4.6 million at the annual level. Monthly attendance allowances under this system are significantly higher and range from €280 to even €600 for persons with the highest degree of disability.

[3] Under the insurance system for self-employed and farmers, the contribution base is taxable income or, more exactly, the amount of income that is the subject of taxation.

Until the legislative changes in 2005, there was only one group of beneficiaries who all had identical allowance amounts. According to the law from 2005, attendance allowance is awarded to three groups of beneficiaries.

The first group is comprised of the beneficiaries of basic allowances, who are entitled to basic care. The second group are those who are entitled to the "augmented attendance allowance", i.e. persons who qualify for a 100 percent disability rating for a single impairement. The third group are beneficiaries from the pension insurance system. These beneficiaries, if eligible, have the possibility to receive the difference in the entitlement amount they receive from the PDI fund and the entitlement amount set by the social protection system.

1.2 Allowance Amounts and Beneficiaries

Under the Pension and Disability Insurance Law, attendance allowance amounts are determined in absolute terms and are indexed in accordance to the same rules as pensions.

In December 2010, this allowance amounted to €130. Under the current Law, the total number of attendance allowance beneficiaries is approximately 65,000. Most of them are beneficiaries of employee insurance, which covers by far the greatest number of beneficiaries. The number of so-called pre-existing beneficiaries is 7,300. Allowances for this group of beneficiaries vary a great deal, depending on the moment when the relevant entitlements were terminated. Hence, the allowances of pre-existing beneficiaries vary from €18 to €78.

The total number of beneficiaries over 65 amounts to 47,434 or over 65% of the total number of beneficiaries. Among the older allowance beneficiaries more than one third are over 80 years old (nearly 18 thousand).

In 2009 and 2010, allowances were frozen, sharing the fate of pension indexation. According to the newest Amendment to the Pension Insurance Law, it is expected that allowances will increase in 2011. In essence, they will increase in real terms only through the October indexation. After this period, with the exception of 2011 and 2012, when the indexation will be based partially on inflation and partially on GDP increase/decrease, both allowances and pensions will be indexed twice a year. The first indexation in April of each year will be based exclusively on CPI, while the second indexation (in October) will also include a certain percentage of the GDP increase, if the increase is higher than 4 percent[4].

[4] Or, to be more precise, "If the gross domestic product in the previous calendar year increases by more than 4 percent in real terms, the pension shall be adjusted as of 1 April of the current year in the percentage that represents the sum of the percentage of the increase/fall in consumer prices in the territory of the Republic of Serbia during the previous sixth months, and the percentage difference between the real rate of increase in the gross domestic product in the previous calendar year and the rate of 4 percent." (Law Amending the Law on Pension and Disability Insurance, Article 33).

Table 3. Beneficiaries and attendance allowances from the PDI Fund, November 2010.

Type of beneficiary	Number of beneficiaries	Allowance amount (in €)
Under the current Law	65,311	130
Pre-existing beneficiaries	7,323	18-78
Total	72,634	

Source: PDI Fund.

Under the Law on social protection, the amount of attendance allowance is determined in absolute terms and is indexed monthly with CPI. According to the new draft law on social protection, this allowance will be adjusted twice a year, on the basis of CPI. In December 2010, the allowance amounted to €70 and more than 19,500 beneficiaries received the entitlement

The amount of augmented attendance allowance is determined in absolute terms and indexed twice a year, with CPI. In November 2010, the augmented attendance allowance was €181 and more than 13,600 persons received the entitlement.

The supplementary payment was paid to nearly 17,500 persons, who were awarded the basic entitlement under the pension and disability insurance.

The share of persons older than 65, who received this entitlement under the social protection system, amounts to somewhat over 40 percent of the total number of beneficiaries.

Table 4. Social Protection Beneficiaries and Attendance Allowances, November 2010.

Entitlements	Amount (in €)	Number of beneficiaries	Number of beneficiaries older than 65	Share of beneficiaries older than 65
Attendance allowance - basic	70	19,585	9,686	49.5
Augmented attendance allowance	181	13,615	3,958	29.1
Supplementary payment to PDI Fund beneficiaries	17.5-160	17,447	7,530	43.2
Total		50,647	21,174	41.8

Source: Ministry of Labor and Social Policy.

Since 2000, the number of attendance allowance beneficiaries under the social protection system has tripled. This increase can partially be explained by the inclusion of the beneficiaries who receive this entitlement under the pension insurance system and who are entitled only to the supplementary payment under the social protection system.

If we analyze only the beneficiaries who receive the entitlement exclusively under the social protection system, it can be observed that the number of beneficiaries doubled, with the largest increase occurring before the adoption of the amendments to the law on social protection in 2006. During the 1990s, the huge arrears and the devalued and low cash benefit amounts resulted

in a great decline in the number of beneficiaries of all social protection entitlements (Matković 2005). At the end of 2000, after the 5th of October changes, attendance allowance payments were in arrears for as much as 32 months. The payment of arrears, regular financing and a significant increase in allowance amounts in real terms encouraged potential beneficiaries to apply for assistance.

Table 5. The average number of attendance allowance social protection beneficiaries, 2000-2010.

		Total
2000		16,925
2005		26,258
2008	From the pension insurance scheme	*13,770*
	From social protection scheme	*31,299*
	Total	45,069
2010	From the pension insurance scheme	*17,447*
	From social protection scheme	*33,200*
	Total	50,647

Source: Ministry of Labor and Social Policy.

The total number of beneficiaries older than 65 under both systems is 68,608 (5.5 percent of the total number of inhabitants older than 65).

1.3 Allowance Expenditures

In 2010, the attendance allowance expenditures under the pension and disability insurance system amounted to €120 million.

During 2010, nearly €62 million were earmarked for attendance allowances under the social protection system, thus accounting for almost 35 percent of the total social protection budget. In the structure of the total expenditures, almost one half accounted for the expenditures for augmented attendance allowances.

The total expenditures for allowances under both systems amounted to €182 million (0.6 percent of GDP), whereby the expenditure for persons older than 65 amounted to €103 million (0.35 percent of GDP).

2. Social Care Services at National Level

Long-term care services for the elderly in Serbia are mostly regulated under the social protection system, through institutional care and community-based services. A very small number of elderly people are placed in foster care for the elderly. Since the provision of community-based services is in the mandate of LGs, this issue will be discussed in more detail in the third section of this paper, while here the emphasis will be on the analysis of institutional care for the elderly.

2.1 Regulation

Institutional care in a social protection institution is provided to the elderly who are unable to live with their families or independently in a single household due to unfavorable health, social, housing or family reasons. An elderly person is entitled to institutional care in a state institution based on the Decision of the Center for Social Work (CSW)[5]. The CSW is legally required to first examine whether an alternative, non-institutional service can be provided for satisfying the elderly person's needs and proposes placement in the institution only as a last resort.

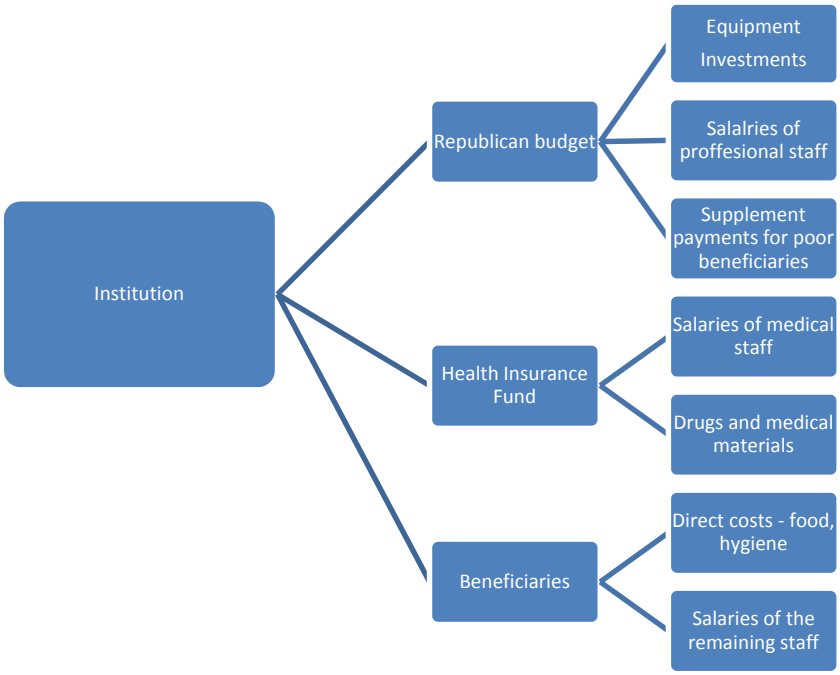
Institutional care is provided by institutions established by the Republic, or the Autonomous Province of Vojvodina. In addition, non-state institutions can also be service providers. The republican/provincial government is responsible for setting the standards and for monitoring and controlling the functioning of residential institutions.

In accordance with the law, elderly care institutions can also provide non-institutional care services for the elderly (home care, day care centers, clubs), which are financed from the local government budgets.

The financing of state elderly care institutions is regulated in the following manner: one portion of the funds – for the procurement of equipment, investments and social care services (salaries of the majority of professional workers) – is provided from the republican budget, one portion from the health care fund (which covers the salaries of medical staff and related material costs), while the portion called "the price of services" (which includes direct material costs and salaries of the remaining staff) is covered by the beneficiaries themselves. In accordance with the law, care recipients pay the full "price of services". If they are unable to pay, the costs will be borne by the persons who are obliged to support them under the Family Law (e.g. adult children for their elderly parents). If these funds are still insufficient or the elderly has no family members, the difference will be covered from the republican budget. The prices of accommodation in state institutions are prescribed by the Ministry.

[5] Centers for Social Work (CSW) are institutions established by local governments. While exercising public authority transferred to them by the republican government, they have the role of de-concentrated units of the Republican Ministry of Labor and Social Policy. Almost all municipalities in Serbia have CSW.

Figure 2. Financing of the state elderly care institutions



Under the Law on Pension and Disability Insurance, which was in force until January 1, 2011, the beneficiaries placed in elderly care institutions were discontinued the entitlement to attendance allowance. However, the latest amendments to this Law once again restored this entitlement. Under the current Law on Social Protection, the beneficiaries retain the attendance allowance even if they are placed in an institution. In private elderly care homes, beneficiaries pay the price in full.

The elderly in need of institutional care may be referred to foster care for the elderly. Within the reform context, this type of care has significantly gained in importance since 2000 and has been widely practiced as a form of care for children without parental care[6]. However, the provision of foster care for the elderly has completely remained outside the focus of the reform. According to the data from the Institute for Social Protection, in 2009 only some 305 elderly persons have been placed in foster care (Institute for Social Protection 2010). Nevertheless, an upward trend does exist, since in 2007, only 180 elderly persons were placed in foster care with other families.

[6] In contrast to 2003, when 1,600 children were placed with foster families and 2,200 in residential care institutions, today there are more than 5,000 children with foster families and only 800 in residential care institutions.

2.2 Network of Institutions and Beneficiaries

In 2010, Serbia had 39 state elderly care insitutions, including 14 elderly homes and 25 gerontology centres, with 8,560 beneficiaries. According to their capacity to live independently, beneficiaries are divided into independent, semi-independent and dependent. According to the data of the Ministry of Labour and Social Policy, the share of semi-dependent and dependent benficiaries (mostly immobile, or in aterminal stage of illness) amounts to 70 percent, so it could be said that in fact in Serbia elderly care institutions to a large extent also have the role of nursing homes.

The number of beneficiaries per elderly care institution ranges from 50 to 220 in smaller towns and municipalities. In larger urban areas, elderly care institutions are usually organised as gerontology centres. Some gerontology centres are comprised of several units. So, for example, the Belgrade Gerontology Centre has 4 units with the number of beneficiaries ranging from 120 to 550 (1,160 beneficiaries altogether). Some of these institutions meet the high residential standards but, on the whole, the quality of services and standards varies.

According to the *Social Welfare Development Strategy,* state elderly care institutions "provide care to a considerable number of beneficiaries with medical indications, psychiatric problems and chronic diseases, and even those in the terminal stage of illness, often without adequate financial support and staff" (Government of the Republic of Serbia 2005, 7).

In Serbia there are no specialized psychogeriatric nursing homes. Thus, the elderly with disabilites and mental health disorders reside either in elderly care institutions or in state institutions for the disabled and mentally ill, where 250 elderly were accommodated in 2010 (Report of the Ministry of Labour and Social Policy 2007).

Over the past years there has been a significant increase in the number of private elderly care institutions operating with an official registration and controlled by the Ministry. In 2010, according to Ministry data, 48 private homes were registered, including as many as 36 in Belgrade.

The accommodation capacities of private institutions are significantly smaller than that of state institutions. In most private institutions, the number of residents ranges from 15 to 35 and in only three of them there are more than 60 residents. In private institutions there are a total of 1,247 residents, although there are also a certain number of private homes operating without the appropriate license.

Consequently, the total number of elderly persons in institutional care in Serbia amounts to nearly 10,000 which accounts for only 0.8 percent of the total population older than 65. In Belgrade and Novi Sad, the existing facilities do not satisfy the needs, while in eastern and western Serbia homes are virtually non-existent. It is estimated that in the remaining parts of Serbia the institutional capacities satisfy the needs of the elderly population

In 2009, according to the data from CSW, there were 500 elderly persons on institutional care waiting lists (Institute for Social Protection 2010). According to the same source, the elderly are often placed in distant institutions, outside their place of residence, either due to the (more favorable) price, or because there is no vacant place in the nearest home. Apart from the development of community-based services for the elderly, which have been prioritized in all the relevant national strategies, the strategies also foresee the establishment of smaller residential homes, either in state ownership or in partnership with the private and NGO sectors, particularly in those parts of Serbia in which there is a lack of this type of facilities (Government of the Republic of Serbia 2006).

2.3 Costs of Institutional Care and Public Expenditures

During 2010, the following funds from the republican budget were allocated to elderly care institutions: €2.2 million for social care services and €1.6 million for equipment and investments, while the share of the state budget in the "price of institutional care" amounted to over €8.5 million. Homes were also financed with €4.9 million from the Health care fund. Thus, the total government expenditures for 8,560 elderly persons amounted to €17.2 million, or 0.06 percent of GDP.

In 2010, the average monthly "price of the service" amounted to €250. The price depends on the beneficiary's disability status and quality of the relevant institution. The lowest price, for independent beneficiaries, is €160, while the highest price for dependent beneficiaries is over €320.

In 2010 the total expenditures of beneficiaries (without the portion paid by the state for beneficiaries who cannot pay the full price) amounted to €17.7 million. This means that their share in the total costs amounted to somewhat over 50 percent and if we exclude the costs of the health care fund, given the nature of health insurance, this share amounted to 57 percent.

Table 6. Annual and monthly expenditures per beneficiary in institutions, 2010

	Annual expenditures (in millions of €)	Structure (in percent)
1. Health care	4.9	14.0
2. Social care services	2.2	6.2
3. Investments and equipment	1.6	4.6
4. Supplementary payment to beneficiaries	8.5	24.6
5. Beneficiaries' expenditures	17.7	50.6
Total	34.9	100.0

Note: The sum of 4 and 5 is the so-called "price for the service"

In private homes, the services and prices are negotiated directly with the home owners and verified through a signed contract. The prices for accommodation in private homes range from €300 to €1,000.

3. Palliative Care and Medical Home Care under the Health Care System

Long-term medical care in Serbia is currently provided at the secondary health care level in 13 health care institutions that have established palliative care units with 140 beds (Republic of Serbia 2010). Specialized health care institutions for palliative care and for the terminally ill do not exist.

At the primary health care level, only 40 percent of primary health care centers in Serbia offer medical home care services for the general population. A specialized institution for medical home care and palliative care of the elderly, the City Institute for Gerontology, is the only one of its kind and is situated in Belgrade. This institution provides health care services at home to the elderly, mostly as part of extended hospital treatment, and in the form of palliative care services. In 2007, according to the City Institute for Gerontology data, 46 percent of the 2,239 elderly persons receiving medical home care were immobile and incontinent patients (Republic of Serbia Ministry of Health 2007). These programmes are financed by the Health Insurance Fund.

In 2009, Serbia prepared and adopted the Palliative Care Strategy which, at the primary health care level, foresees the establishment of palliative care teams in primary health care centres, as part of their medical home care services. At the secondary health care level, the Strategy envisions the setting up of additional specialized palliative care units. By 2015, in line with the Strategy, a number of new palliative care units with 160 beds will be established in hospitals and clinical centres, in addition to the existing 13 units. The Strategy also proposes the establishment of a Centre for the Development of Palliative Care within the Institute for Oncology and Radiology, with the task to monitor, research and propose policies and actions for enhancing palliative care (Government of the Republic of Serbia 2009).

According to the National Health Accounts Estimates, Serbia earmarked only 0.08 percent of its 2008 GDP for long-term care under the health care system (Gajić-Stevanović, Dimitrijević and Vukša 2009).

4. Other relevant health issues

The rise in incidence and prevalence of non-communicable diseases (NCDs) as well as the rise in incidence of Alzheimer's disease and dementia are becoming more prevalent as populations age and influence the demand for health-care and long-term care.

In accordance with data from the Health Statistical Yearbook of the Republic of Serbia 2009[7], "cardiovascular and malignant diseases accounted far more than 2/3 of all deaths in Serbia in 2009". The share of diseases of the circulatory (cardiovascular) system with lethal consequences in 2009 is 54.8%; 20.2% people died of cancer, 3.0% were the victims of diabetes and 2.7% died of lung diseases. The following table shows the total deaths for non-communicable diseases in Serbia from 2002 to 2009.

[7] Serbian Institute for Public Health "Dr Milan Jovanovic Batut" , 2010, Health Statistical Yearbook of the Republic of Serbia 2009

Table 7. Mortality for non-communicable diseases in Serbia in the period 2002 – 2009.

Diseases	2002	2004	2006	2007	2008	2009
Cardiovascular	56,754	56,868	58,925	57,608	57,343	56,951
Malignant	18,548	19,362	20,217	20,417	205,73	21,032
Injuries/poisoning	3,931	3,852	3,869	3,869	3,692	3,739
Diabetes	2,553	2,571	2,541	2,005	3,113	3,068
Lung obstructions	2,279	2,553	2,340	2,598	2,682	2,813
Total	102,785	104,320	102,884	102,805	102,711	104,000

Source: Health Statistical Yearbook of the Republic of Serbia 2009

The overall NCD mortality increased between 2002 and 2009. The highest mortality increase is registered for lung/pulmonary diseases with 23.4%, followed by diabetes with 20.1% and malignant diseases with 13.4%.

Data regarding patients with acute coronary syndrome (ACS) did not exist in Serbia until 2002. By establishing the National Registry for Acute Coronary Syndrome (NRACS), the data collection based on the filled-in "coronary questionnaire" for each patient hospitalized and diagnosed with acute infarction of the myocardium (AIM) and unstable angina pectoris (UAP) was initiated in Serbia (The National Center for Biotechnology Information 2007). According to the National Registry of Acute Coronary Syndrome (NRACS) the incidence rate of acute coronary syndrome (the major health problem amongst ischeaemic heart diseases) in 2008 was 300.1 per 100,000 population (Health Statistical Yearbook of the Republic of Serbia 2009).

Table 8. ACS, incidence and incidence rate per 100,000 population, 2009.

	Total population	Total Male Population	Total Female Population	Population 65+		
				Total	Male	Female
Incidence	23,039	14,020	9,019	13,416	6,319	7,097
Incidence rate	314.7	393.8	239.8	1072.6	873.6	1345.5

Source: Health Statistical Yearbook of Republic of Serbia 2009

Collecting of data on malignant diseases in Serbia has been improved in 1996 when the Population-Based Cancer Register was established (Health Statistical Yearbook of the Republic of Serbia 2009). In the period from 2002 to 2007, an average of 24,500 persons per year was diagnosed with these diseases. The incidence rate in men was 290.0 and 242.2 for women, per 100,000 population.

Table 9. Malignant diseases, incidence and incidence rate (per 100,000), 2008.

	Total	Male	Female	Population 65+		
				Total	Male	Female
Incidence	25,235	13,261	11,974	13,191	7,550	5,641
Incidence rate	469.7	507.7	434.0	1,396.7	1,861.3	1,046.9

Source: Health Statistical Yearbook of Republic of Serbia 2009

Approximately 5.4% of population or 400,000 persons suffer from diabetes in Serbia.

Table 10. Diabetes, incidence and incidence rate (per 100,000 population), 2009.

	Total	Male	Female	Population 65+		
				Total	Male	Female
Incidence	16,363	7,914	8,449	6,701	2,838	3,863
Incidence rate	223.5	222.3	224.7	535.7	538.1	534.0

Source: Health Statistical Yearbook of Republic of Serbia 2009

The highest burden of diseases in Serbia is attributed to non-communicable diseases (NCD) which have been the leading causes of morbidity, disability and mortality for decades. NCDs have common risk factors (smoking, alcohol abuse, unhealthy diet and lack of physical activity) and socio-economic determinants.

The National Health Survey conducted in 2006 showed the following data related to 4 key risk factors: tobacco smoking, unhealthy diet, physical inactivity and alcohol abuse:

- 33% population over 20 smoke,
- smoking rate reduction of 6,9% in comparison with 2000
- growing obesity among adults and children – 54.5% of adults are overweight, while 18% of children (7 to 18) are considered moderately obese or obese,
- 23% of adults were physically active (67% inactive),
- 40% population consume alcohol (Health Statistical Yearbook of the Republic of Serbia 2009)

In order to address these risks, from 2000 to date Serbia implemented several measures. National campaigns against smoking and exposure to tobacco smoke were initiated in 2003 and resulted in a moderate but steady smoking prevalence decrease of 1% per year (World Health Organisation 2011). The law that prohibits smoking in public places was enacted in 2010. The action plan on food and nutrition and action plan for increasing physical activity are being developed. In 2009 the Strategy for Prevention and Control of Non-Communicable and Chronic Diseases and Public Health Strategy, were adopted. The strategies emphasize the significance of prevention, the promotion of health and healthy lifestyles, the need to decrease the inequalities in the health status of certain vulnerable groups due to their socio-economic status, the introduction of a massive screening program for early detection of breast cancer and cervical cancer, focusing on evidence-based and cost-effective interventions and their quality improvement, etc. It is expected that the system of data collection and policy analyses regarding morbidity, incidence and trends in non-communicable diseases will also improved as a result of the implementation of the two strategies.

There are no systematized data or registry on the prevalence of dementia and Alzheimer disease in Serbia. It is estimated that 8% or 160.000 people over 65 suffer from dementia and that the incidence of the disease is higher in women than in men. Around 10% of population over 65 or around 200.000 persons suffer from Alzheimer's disease.

However, some measures have been undertaken. In 2008 the Centre for Dementia at the Belgrade Clinical Centre was established. Within this Centre there is a also a day hospital. This facility treats patients who are diagnosed with both dementia and Alzheimer's. The Centre also offers family support counseling services. The Center will be the focal point for additional education of medical staff dealing with this issue. In Novi Sad (second largest city in Serbia) a daycare centre for Alzheimer patients was set up in 2010 organized by the NGO *Alzheimer*.

III Community-Based Services – Elderly Home Care

Community-based services for the elderly, recognized within the current legal framework as social rights, include: home care, elderly day care centers and clubs. Since elderly day care is an underdeveloped form of care (Republican Social Care Institute 2010), while clubs are not relevant for long-term care, attention will be focused primarily on home care services.

1. Community-Based Services and the Needs of the Elderly

The demand for long-term care services for the elderly can be observed from the results of two surveys conducted in Serbia over the last years.

The findings of the survey, which covered 826 persons older than 70 and was conducted as part of a research on non-institutional care in 2006 (Satarić and Rašević 2007), show that a considerable part of of the elderly need some kind of care and support for ADL or IADL. Apart from a significant number of the elderly who need assistance for visiting a doctor or getting medicines, domestic maintenance and paying household bills (over 33 percent), every fourth person older than 70 in Serbia needs help with preparing and eating meals (26 percent), every seventh person needs assistance for maintaining personal hygiene (15 percent), while every tenth person needs help with moving around the household (10 percent). In absolute terms, it can be estimated that about 280 thousand elderly people aged over 70 needs some type of home care assistance, while it can be estimated that approximately 78 thousand needs combined medical and non-medical home care services.

Table 11. Population older than 70 in need of assistance from another person for ADL or IADL, 2006.

Assistance needed for:	(%)	Number
Domestic maintenance, purchasing medicine, visiting a doctor	36	280,836
Maintaining personal hygiene	15	117,015
Preparing and eating meals	26	202,826

Moving around the household	10	78,010

Source: (Satarić and Rašević 2007) and the author's calculations.

Another relevant research, which is significant for identifying long-term care needs, is the survey conducted in 2006 with the aim of determining the health status of Serbia's population (Republic of Serbia Ministry of Health 2007). The survey covered a representative sample of 6,875 households.

According to the survey findings, 6.6 percent of the elderly over 65, i.e. nearly 83 thousand persons, cannot perform ADL without the help of another person (i.e. they are incapable of independently eating, dressing, going to bed, getting up or maintaining personal hygiene). It can be observed that, in a relative sense, these needs are significantly more pronounced in the population older than 75. Immobile elderly persons – 27 thousand according to estimates – are in the most difficult position, while some kind of help for IADL is needed by more than 315 thousand persons older than 65.

Table 12. Population older than 65 in need of assistance for ADL or IADL, 2006.

	65-74		75+		65+	
Inability to perform ADL	4.7	40,171	10.8	42,780	6.6	82,951
With difficulty or with help of another person	19.3	164,958	38.1	150,920	25.3	315,877
Bedridden	1.5	12,821	3.6	14,260	2.2	27,081

Source: (Republic of Serbia Ministry of Health 2007) and the author's calculations.

Based on the findings of both surveys it could be estimated that over 80 thousand elderly persons need formal and informal medical and non-medical home care for ADL, while more than 315 thousand elderly need assistance for ADL and/or IADL. It should be noted that persons in institutional care were not covered by the surveys.

2. Legislative Framework

Under the current Law on Social Protection and the Provision of Social Security to Citizens, the elderly, frail, chronically ill and other persons incapable of independent self-care are eligible for home care services. Home care services consist of assistance for activities of daily living (ADL) and instrumental activities of daily living (IADL), such as domestic maintenance purchasing food and other supplies, maintaining personal hygiene, etc. (Law Amending the Law on Social Protection and the Provision of Social Security to Citizens 2005).

The provision of these services is completely in the mandate of LGs and they are responsible for service financing, standards, licensing of providers, establishing service prices and criteria for the selection of beneficiaries. The entitlement is approved by the CSW. The Law also provides the possibility of introducing beneficiary co-payments for the service, while the amounts are determined by LGs.

Service providers are organizations that can be established by municipalities, cities and other legal and physical persons.

The most important service-related novelties in the new draft Law on Social Protection are found in the areas concerning institutional and regulatory changes - the establishment of a Chamber for Social Protection, the licensing of professional workers and service providers, the introduction of public procurement of services, redesign of the control functions, expert supervision and inspection... The new provisions in the area of social care services should enable the functioning of a system where it will be possible to clearly identify the minimum standards for service provision, as well as to ensure a more equitable treatment for state and non-state service providers and a shift of the focus from institutional to alternative, non-institutional care.

An important alteration in the new draft Law is the setting of minimum standards for all services, including home care, which will no longer be defined at the local level, but at the central level. The draft minimum standards have already been prepared, setting the minimum structural and functional home care standards, specifying the services, defining the priority beneficiary groups, etc. According to the draft Law, home carers are required to complete training according to accredited programmes. After the adoption of this law in parliament, the by-laws on minimum standards will also be adopted. Local governments will be allowed to prescribe higher standards than the prescribed minimum.

Furthermore, service providers will have to be licensed. Licenses to all service providers will be issued by the Ministry of Labor and Social Policy. In the past, work licenses for community-based service providers were issued by LGs. Once the new Law comes into effect, these licenses will be issued at the central level.

A particularly significant novelty in the new draft Law is the introducing of public procurement procedures for services, thus placing service providers from different sectors – state, private and non-governmental – on an equal footing. The draft Law foresees the obligatory tendering for the provision of those services that are being established for the first time. This is especially significant for community-based services that are in the mandate of LGs since they are still insufficiently developed and unavailable in many communities in Serbia.

Under the draft Law, all control and regulatory functions will also be centralized.

Regarding the funding aspects, the new draft Law introduces the possibility of financing community-based services from the central level - an option that is not provided in the current law. This is proposed through the introduction of three types of earmarked transfers that LGs can use for services that are in their mandate.

The first type of earmarked transfers is intended for municipalities and cities below the republican average, in accordance with the regulations governing the classification of local governments according to their level of development[8]. These transfers will not be available to 38

[8] By the decree of the Serbian Government, all local self-government units have been classified into four groups based on their level of development, considering, above all else, the economic criteria (budgetary revenues per inhabitant, salaries and pensions), adjusted according to the compensation criteria, such a decline in the number of inhabitants over the past 30 years, unemployment rate, share of persons with university and two-year post-secondary education in the economically active population and the like.

of the most developed LGs, mainly cities. More than 75 percent of LGs in Serbia will be able to compete for earmarked transfers.

The second type of earmarked transfers is intended for LGs with residential care institutions in the process of transformation. These LGs face a special challenge of taking over the financing of non-institutional services, developed in residential care institutions now reducing their capacity. Earmarked transfers should help cover the transition costs that are an inevitably part of this process. In the coming period, these earmarked transfers will be primarily channeled into municipalities with residential care institutions for children without parental care, in which the reform-based transformation process has been especially intensive.

The third type of earmarked transfers is for the development of innovative services, whose standards have not yet been defined and which have no clear status within the social protection system. The mentioned funds will also be used for the development of services that are of special interest at the national level, but might not have been identified at the local level. Practically, this type of earmarked transfers will institutionalize best practices from the Social Innovation Fund (SIF) that made a significant contribution to the reform process in Serbia.

The by-laws will govern the amounts of earmarked transfers, the criteria for their distribution to LGs, the criteria for the LG co-financing and the dynamics of transferring funds. The concept is that earmarked transfers will be approved through a competitive process (call for proposals) for services planned in local social welfare strategies. The funds will be approved for a period of several years with compulsory co-financing from LG budgets (complementary grants).

The first type of earmarked transfers is particularly significant for the development of home care services. The Ministry of Labor and Social Policy recently piloted this concept of earmarked transfers through a call for proposals open to LGs. Out of approximately 90 projects that were approved more than 60 requested financing for home care services for elderly and for disabled persons. The remaining approved projects were mostly focused on community-based services for children and young persons with disabilities. A total of €3.88 million have been disbursed to 70 underdeveloped municipalities.

Home care has also been recognized as one of the priority services in almost all local social welfare development strategies. During the past two years, more than 120 LGs prepared local social welfare plans and participated in strategic planning processes at the local level[9]. Hence, it is likely that after the adoption of the new law most LGs will use the earmarked transfers for establishing and developing precisely home care services.

Finally, the new draft law retains the provision that LGs define the levels of beneficiary co-payments for services, but also introduces the requirement that attendance allowance beneficiaries must co-finance the service with at least 20 percent of the allowance amount.

3. Services, Beneficiaries and Service Providers

[9] With donor support from the DFID, Kingdom of Norway and UNDP/EU

Although LGs are required by law to provide non-institutional care services, of which home care, day care center and shelter services are explicitly specified, until the year 2000 in Serbia these services were completely underdeveloped. Some services were present only in large cities, others just in Belgrade.

Until recently, the data on the services in the mandate of LGs were not collected at central level. They were gathered on an ad hoc basis, through surveys and other research (Satarić and Rašević 2007) (Matković 2007).

Since 2008, the Institute for Social Protection has been collecting and analyzing these data based on reports of CSW. Nevertheless, the data cannot be considered as completely reliable since CSW do not have full insight into all home care programmes in their city/municipality. This is especially true for home care programmes financed through NGO –run projects. It should also be noted that data from different sources can vary, depending on the moment when the different analyses were conducted. Namely, due to project-based financing, the number of beneficiaries can vary significantly during the year.

According to various available sources, until 2000, home care services were available on a larger scale only in Belgrade and several larger towns in Vojvodina. In other parts of Serbia, they were virtually non-existent. Over the past few years, the provision of such services has been greatly intensified thanks primarily to special reform mechanisms and donor assistance, which will be presented in greater detail in a later section.

It is estimated that in 2003 home care services were provided in only 35 LGs out of 145[10] (Satarić and Rašević 2007), while in 2009 they were available in 98 LG (Institute for Social Protection 2010).

In 2009, the total number of beneficiaries amounted to 12 thousand, out of which 11 thousand (90.7 percent) were older than 65. Since 2002, the number of beneficiaries increased 5.6 times, with the largest increase of almost 27 times in Central Serbia without Belgrade, and the least increase in Belgrade.

Table 13. Home care beneficiaries across territorial units in Serbia, 2002-2009.

Territorial Units	Number of beneficiaries							Estimated number of beneficiaries older than 65		Share of elderly beneficiaries in 65+ population
	2002	2003	2004	2005	2006	2007	2008	2009	2010	
Central Serbia without Belgrade	195	370	549	673	855	1,698	2,719	5,275	4,784	0.7
Vojvodina	474	577	628	671	971	1,838	3,908	4,275	3,877	1.2
City of	1,465	1,565	1,856	1,829	1,970	2,451	2,446	2,486	2,255	0.8

[10] In 2009, LGs included 23 cities, 122 municipalities and 22 city municipalities (Belgrade and Niš). Since home care services in Belgrade and Niš are organised at the city level, the number of LGs is given as the sum of cities and municipalities, without the city municipalities.

Belgrade										
Total	2,134	2,512	3,033	3,173	3,796	5,987	9,073	12,036	10,917	0.9
Number of LGs	-	35*		-	58*	-	78	98		

Source: (Institute for Social Protection 2010) and the author's calculations, for the number of LGs where home care services were introduced in 2003 and 2006 (Satarić and Rašević 2007).
Note: It has been assumed that the elderly constitute 90.7 percent of beneficiaries in all territorial units.

However, as shown in the Table, the share of elderly people in Serbia who receive home care is still very small – below 0.9 percent. The highest share is recorded in Vojvodina – 1.2 percent. A considerable number of LGs (47), or in other words every third municipality in Serbia, still does not have such services.

The findings of another survey conducted in 2009, with a questionnaire that covered almost 80 percent of CSW, point out that in more than 50 percent of LGs the number of home care recipients was below one hundred and that, apart from Belgrade, a more significant number of elderly recipients was recorded only in a few municipalities/cities[11]. Home care services are provided in more than 80 percent of the more developed LGs, while in the less developed (the third and fourth group) services were only established in every second local government (Vuletić 2009).

According to the same research, it can be estimated that nearly one third of LGs finances these services completely from the local budget, while another 50 percent finance them only partially. In the remaining LGs the funds are extra-budgetary. There is also a pronounced correlation with the LGs' level of development.

In 2009, according to the internal database of the Institute for Social Protection, home care services were provided to over 5,000 elderly persons by units within state elderly care institutions (homes and gerontology centers). Almost one third of these beneficiaries receive combined medical and non-medical home care (Table 10). Service is provided to an additional (approximately) 3.5 thousand elderly people by CSW.

Table 14. Number of home care beneficiaries, as per data of elderly care institutions with home care services, 2009

Beneficiaries	Type of service		Total
	Home care	Medical and non-medical home care	
Elderly	3,311	1,736	5,074
Children with special needs	75		75
Children without parental care	28		28
Total	3,414	1,736	5,177

According to the records of CSW, there are 1,345 persons with approved entitlements on waiting lists (Institute for Social Protection 2010). However, this figure is not a good indicator of the unmet demand for home care. According to the survey data, the number of elderly persons

[11] Such as: Subotica (890), Kragujevac (416), Sremska Mitrovica (250) and Bečej (200).

applying for home care is significantly higher, but the CSW do not register them if there is no prospect for offering them the service in the near future (Satarić and Rašević 2007).

Comparing data collected through an analysis of CSW reports and the data from NGO home care service providers' shows that a significant portion of services in Serbia has not been captured by the previous analysis.

As for non-state organizations, the Red Cross is especially active in providing services to the elderly. Since 2002, the Red Cross has been implementing the *Elderly Care Programme* for 11 thousand beneficiaries, through four types of activities: health prevention activities, home care, psychosocial support and clubs for the elderly.

The Red Cross home care programme is implemented in 54 LGs covering about 6,300 elderly people. Beneficiaries are persons older than 65, poor or with low income and living in single households. In the service provision one thousand volunteers are also included, mostly persons over 55 years old. The programme is supported by the International Federation of the Red Cross and Red Crescent, and Spanish Red Cross (Todorović and Vračević 2009).

For the provision of home care services some local Red Cross organisations received support from the Social Innovation Fund, as well as from funds earmarked for public works. The Red Cross has been the service provider in 8 percent of the projects financed through the Social Innovation Fund (Golicin and Ognjanov 2010).

A very significant role in home care provision is also played by the religious organisation Caritas of Serbia and Montenegro. In Serbia, Caritas became involved in the home care programme as early as 1996. This programme is intended for the elderly, ill and persons with disabilities, and each month provides services to 2,800 beneficiaries in 15 municipalities, mostly in Vojvodina. The programme is mostly donor-funded and is provided to beneficiaries free of charge.

Religious organisations that also implement medical and non-medical home care programmes, albeit on a smaller scale, include the Christian humanitarian society *Hleb života,* which organises home care services for about 500 poor persons in Belgrade, *Čovekoljublje* (Fund of the Serbian Orthodox Church), whose services include primarily medical care, but also home care for about 270 beneficiaries in Belgrade and Kragujevac; Ecumenic Humanitarian Organisation EHO and others (Amity 2007).

Good practice examples also include non-governmental organisations that provide home care and are financed from local budgets on a contract basis, but there are few such organisations (Satarić 2008).

As for private service providers, they virtually operate in the grey zone and there are no credible sources of data on them.

All things considered, it can be estimated that more than 10 thousand elderly persons in Serbia receive some type of home care assistance provided by non-state organisations, for the most part

by the Red Cross and Caritas. These services are provided mainly to exceptionally poor elderly persons, they are usually free of charge and have limited or no access to LG budgetary funding.

By comparing this data and data from the Institute for Social Protection, it can be roughly estimated that 18.5 thousand of the elderly in Serbia receive some kind of support for ADL or IADL, 46 percent within the state sector and 54 percent within the non-state sector.

Significant progress in the inclusion of the non-governmental sector in the regular provision of social care services, insight into their programmes and access to local budgets can be expected only with the adoption of a new Law on Social Protection, that introduces the compulsory licensing of all service providers and tender procedures for the provision of completely new, previously non-existent services, both at the central and local levels.

Home Care Services in Belgrade

The City of Belgrade ranks among LGs having the most developed home care services, which were introduced as early as 1987. The services are organized within a special unit of the Belgrade Gerontology Centre[12] covering 14 Belgrade municipalities (out of 17). Apart from home care, this unit also provides additional services, such as: day care, preparation of meals, home delivery of meals, laundry washing and ironing and the like. The home care entitlement can be provided to elderly and sick persons whose relatives cannot provide them with adequate care. As a rule, home care lasts two hours a day and is organized only on working days. A very small number of the most vulnerable persons receive care 4 hours a day. In 2010, home care was provided to 2,010 beneficiaries of whom only 30 received this care 4 hours a day. Additional services are provided to about 8,000 beneficiaries.

According to the internal data, the majority of home care service beneficiaries in Belgrade are women (over 77 percent), persons older than 70 (84 percent) and those who live alone (about 78 percent). Almost all beneficiaries are pensioners (i.e. recipients of old-age, disability and survivors' pensions) and largely better educated (more than three quarters have secondary or higher education). Only 23 elderly persons (slightly over 1 percent of the total number of beneficiaries) are social cash benefit recipients, or in other words, extremely poor.

There is a great unmet demand for these services in Belgrade, which is also evidenced by the fact that at this moment there are more than 900 persons on the waiting list.

There is no cooperation between the home care unit of the Gerontology Centre, as an institution under the social protection system and the City Institute for Gerontology, as an institution under the health care system for providing medical home care services. Moreover, there is even no exchange of information on beneficiaries.

The data on home care provision in Belgrade point to several conclusions. First of all, such services are underdeveloped, considering the small coverage of the elderly and the great number of persons who have applied for home care services and received approved entitlements from the

[12] The Belgrade Gerontology Centre has 4 residential units, which fall within national competence, and the day care and home care unit, which is in financed from the city budget.

CSW. The share of beneficiaries in Belgrade is slightly below the republican average. Still, it is a fact that in other parts of Serbia there is a significant number of beneficiaries who do not receive home care services under an organized and financially sustainable system like in Belgrade.

An analysis of service beneficiaries in Belgrade confirms the findings of some earlier studies that the services are geared to a great extent towards more educated and better-off population segments (Satarić and Rašević 2007), but also shows that there is a good targeting of beneficiaries with respect to their family status, since almost 80 percent of beneficiaries live alone.

The fact that home care services are provided for equal amounts of time to most beneficiaries, points to the lack of flexibility in organizing the service and failure to respond to the beneficiaries' individual needs.

4. Prices and Expenditures

The fact that there is insufficient knowledge on the types and scope of social care services in Serbia is also true for service prices and expenditures.

In Belgrade, in 2010, the price per beneficiary, which only includes the price of the carer's work, was €110. In small and underdeveloped municipalities, that initiated the services through the implementation of projects, the price per beneficiary was about €41.

As already mentioned, under the current law, LGs establish the criteria for the beneficiaries' co-payment for community-based services. A smaller number of LGs charge the beneficiaries a co-payment calculated as a percentage of the attendance allowance; while in Belgrade all beneficiaries pay a monthly co-payment in the amount of €10 (less than 10 percent). The majority of the underdeveloped municipalities, that have introduced project-based services, have still not introduced co-payments for services.

Among the LGs there is a prevailing opinion that co-payment is not acceptable, due to the difficult financial situation of families caring for the elderly and persons with disabilities, and that shifting a portion of the costs to families would decrease the number of care recipients. There are also some views that co-payment would be completely acceptable for beneficiaries if it were to be introduced at the very beginning of service provision, while it is much more difficult to do so later on, when the service is already being provided with no co-payment (Matkovic 2007).

Very low co-payments that cover only a fraction of the real costs and are much lower than the price formed on the informal market demonstrate the missed opportunity for significantly increasing the number of service beneficiaries through an increase in co-payments and with no additional budgetary expenditures. Research based on focus groups points out that the elderly have more confidence in state services than in those provided on the informal market. Thus, they are ready to pay more for services, especially for services that will last more hours during the

day, as well as during holidays and weekends (Satarić and Rašević 2007). In Belgrade, there is a proposal to introduce differentiated co-payments based on the beneficiary's income.

If we assume that the price of services for all elderly home care beneficiaries registered through the CSW`s reports (approx. 11 thousand persons) is between the ones paid in Belgrade and those paid in smaller and underdeveloped municipalities, a very rough estimate of state expenditures in 2009 for this service would be approximately €9.7 million (0.035 percent of GDP).

5. Extra-budgetary Sources of Financing

Over the last years, the Social Innovation Fund, public works and some donor projects have been of special significance for the development of social care services, particularly for the establishment of home care services.

The Social Innovation Fund was established in 2003 as one of the reform mechanisms for the development of non-institutional social care at the local level. Both governmental and non-governmental organizations competed to take part in the introduction and development of social care services financed through the Fund. Partnership was an important requirement, through which an attempt was made to preserve numerous non-governmental organizations in the social sector formed during the humanitarian crises in 1990s, on one side, and to include the state sector, often omitted from reform/donor projects, on the other (Matković 2005).

Although the Social Innovation Fund was focused to a greater extent on "new" and "innovative" services, it was also conceived to encourage local authorities to introduce the services already in their mandate. The Fund was also expected to "awaken" the needs in the communities, i.e. among the beneficiaries, who would become empowered to "pressure" local governments to continue financing the once established services. In addition, the Fund represented an important mechanism for transferring good practice and advancing the knowledge and capacity of all participants in the reform process (Golicin and Ognjanov, 2010). In a way, the Fund ensured the coordination of donor programmes, partly due to the fact that some donors made significant investments in it and partly because it represented a model for others, who were not prepared to support it directly. By changing its focus from year to year and from one type of service/project to another, the Fund also ensured both support and inputs for reforms at the central level.

Typical projects financed through the Fund are: home care services, day care services for children with special needs, halfway homes, safe houses for victims of violence, etc. During 6 years of its functioning, more than €7 million (Golicin and Ognjanov 2010) were spent on financing nearly 300 local projects[13] in 100 LGs (Golicin and Ognjanov 2010). Of the total number of projects, almost 30 percent were focused on the elderly as a target group (Vuković and Čalošević 2009).

[13] During these 6 years the large number of over 1,300 project applications illustrates not only the interest for obtaining funds but also that through this mechanism a great number of people active in social protection became involved in the reform processes.

On the basis of different sources, it is possible to estimate that, of the total number of projects[14] financed through the Fund, 67 projects, or every fifth, were intended for home care service development. An analysis of the first two calls for proposals between 2003-2005[15] shows that these services were provided to more than 1,560 elderly persons. In most municipalities, home care services were introduced for the first time (Satarić and Rašević 2007) (Social Innovation Fund 2005).

The Government's National Report on the Implementation of the Madrid Plan of Action on Ageing (Government of the Republic of Serbia 2007) highlights the importance of the Social Innovation Fund for home care service development. It is estimated that, from 2002 until now, the Fund provided support for 64 percent of the total number of the newly introduced home care services (Vuković and Čalošević 2009).

The monitoring and evaluation units for SIF projects confirmed that the beneficiaries were properly selected, both according to their family status (they live in single-person households) and according to the actual needs for these services (60 percent of care recipients are immobile or move with difficulty). In addition, most of the beneficiaries are elderly with relatively low income (Satarić and Rašević 2007).

Although project sustainability was supposed to be an important requirement for the approval of a project, the example of financing home care services shows that projects funded under the first three calls for proposals continued to be financed from local budgets in less than half of the municipalities. Following project completion some LGs managed to find other extra-budgetary resources for continuing the services. Different studies, including reports on the Fund's operation, show that projects where NGOs are the service providers are significantly less sustainable.

There are no data on the SIF projects that would enable an analysis of service providers by project type. An analysis of the structure of all service providers financed through the SIF, shows that the share of non-governmental organisations (together with the Red Cross) accounted for approximately 35 percent (Golicin and Ognjanov 2010).

Public works also represented an important source of financing, as well as a motive for introducing home care services into underdeveloped municipalities.

As an active employment measure, public works were introduced into Serbia in 2006. They targeted the long-term unemployed and are primarily carried out in less developed regions. During the period 2007-2009, about 20,000 unemployed persons were engaged in the public works that were financed with more than €21 million. Most of these funds, over €13.9 million, were spent in 2009, when the programme of active employment measures was especially focused

[14] In addition, elderly services were not eligible in the last two SIF calls for proposals since the focus was placed on financing 26 treatments and training projects/programmes for professional providers and day care services for children with disabilities.

[15] During this period, 33 projects out of 178 supported home care services. The share of home care service projects was the largest in the 2006 and 2007 calls for proposals, when 27 out of 59 projects focused on services for the elderly and persons with disabilities.

on public works as a measure for responding to the economic crisis. In 2010, fewer funds were earmarked, and the estimate is that only half of the previous number of unemployed persons will be engaged (Republic of Serbia 2010). The decreased amount of earmarked funds in 2010 is only in part due to the crises and the demand for decreasing public expenditure . An additional reason was that in 2009 the Autonomous Region of Vojvodina budget contributed a larger amount of funds on account of the privatization of the national oil company NIS. Public works are organized in three areas: social humanitarian and cultural activities, maintenance and reconstruction of public infrastructure, and the preservation and protection of the environment (Andjelković and Golicin 2010).

Of 396 public works projects in 2009, every fourth project was in the area of social humanitarian and cultural activities. In agreement with the Ministry for Labour and Social Policy one of the areas where public works were organized was also the establishment and further development of home care services, where representatives of particularly vulnerable groups are engaged as home carers. The local governments that applied for these funds mostly organized public works in partnership with the CSW, while the home carers completed training programs.

According to internal documents of the National Employment Service, in 2009 sixty projects included the component of non-medical and/or medical care in elderly care institutions. During 6 months, about 1,000 persons were engaged in these projects as carers, while every fourth implementing organization was from the NGO sector.

The monitoring and evaluation of public works programmes has not been specifically focused on home care services. However, there are indications from other, indirect sources that, in some municipalities, the programmes enabled the establishment of home care services for the first time and/or the continuation of the service following the ending of project-based service financing from other sources (SIF, donor projects). However, it seems that, when deciding on the disbursement of public works funds, the sustainability of home care services and LGs budget potential for continuing these services were not taken into account. Thus, in some small and underdeveloped municipalities home care services were organized for a very large number of elderly people. Gaps in service provision and "waiting" for the new public works cycle created additional organization problems. Despite all this, it cannot be denied that the introduction of this type of public works did achieve some important positive results – the elderly and vulnerable people in underdeveloped areas received these services; a significant number of carers completed service delivery training, and in the communities awareness has been raised on the need to provide home care services.

In the forthcoming period it will be particularly important to harmonize active employment policies with the introduction of earmarked transfers for the development of community-based social care services so as to avoid program overlap and ineffective use of resources.

Over the past years, the extra-budgetary sources for financing home care services have also been accessible through ***donor programmes***.

The projects *Tools and Mechanisms for Local Development* and *Building Local Mechanisms for Social Inclusion*,[16] financed by the Kingdom of Norway from 2006 until the end of 2010, focused on capacity building of the small and least developed municipalities so that they could adequately respond to the social protection needs of their citizens.

The project results can be identified in terms of very concrete and practical outcomes, ranging from the preparation of local social welfare development strategies and the introduction of specific services (mostly home care and day care for children with disabilities), through the preparation of communication handbook and the handbook for strategic management of integral social protection, to the enhanced capacity of local level stakeholders and recommendations for social policy changes at the central level.

An increasing number of LGs were gradually included in these projects, covering 23 municipalities in the last year of project implementation. If we exclude cities and city municipalities from the total number of LGs, it turns out that almost every fifth municipality in Serbia was covered in the last project phase. It is estimated that in these municipalities, in 2009, there were just over 320 thousand inhabitants, or 4.3 percent of the total population.

Two thirds of the selected municipalities are characterized by distinctly unfavorable economic and demographic indicators and, according to the decree on the classification according to level of development they fall into the group of the least developed municipalities in Serbia (fourth group). The remaining municipalities mostly fall into the third group. Three quarters of the selected municipalities are affected by pronounced population ageing due both to a low natural increase rate and emigration. The share of persons over 65 in these municipalities ranges from approximately 19 percent to over 30 percent.

Poverty and pronounced population ageing are the most important reasons why small and underdeveloped municipalities included in the project have given priority to the establishment of home care services in their local social welfare development plans.

During project implementation, home care services were introduced into 21 municipalities. In 2010, it is estimated that there are 720 care beneficiaries older than 65 (0.9 percent of the population over 65 in these municipalities). However, not all of them received home care throughout the year. Their number varied due to the fact that some municipalities used public works as additional sources of financing.

Some municipalities established the services according to the proper procedures and earmarked the funds for their financing in the local budgets. Financing continued in 2011 on account of the Ministry of Labor and Social Policy's funds assigned for piloting earmarked transfers. With the adoption of the new Law on Social Protection and the introduction of earmarked transfers it is expected that the sustainability of these services will be ensured (Matković 2010).

It is estimated that, under this project, financial support was provided for 23 percent of the total number of newly introduced home care services (Vuković and Čalošević 2009). The external

[16] The project was implemented by the Centre for Liberal Democratic Studies, the Standing Conference of Cities and Municipalities and the International Management Group (IMG).

evaluation of the project (Multiservis 2010) showed that professional and administrative capacities in all municipalities have been significantly improved and that awareness about the need to develop home care services has been raised both among LGs and beneficiaries.

Both the lessons learned from this project, as well as experience of the Social Innovation Fund inspired the introduction of earmarked transfers for financing social care services.

6. The Role of the Family and Volunteers

By tradition, elderly people in Serbia rely primarily on family support. According to the survey findings, elderly people who need assistance in daily functioning, rely mostly on their families – 76 percent. A smaller number of elderly people rely on their relatives, neighbours and friends (15 percent), while paid care is accessible only to a small number (3 percent). Among the elderly living alone reliance on their families is still significant, but is evidently less present (46 percent) (Satarić and Rašević 2007).

However, the abandonment of traditional family models, emigration movements both at the municipal and country levels, and individualism as an increasingly present value system raise the question of the sustainability of elderly care based primarily on family support.

In contrast to developed countries, in which they increasingly contemplate, or introduce various forms of support for family members providing informal care to the elderly, such support is still non-existent in Serbia. At the conceptual level, the need for such support has been recognised in the National Strategy on Ageing (Government of the Republic of Serbia 2006).

The provision of special support to the family carers of their elderly and dependent members has been defined as one of the strategic aims. The steps to be taken should include, inter alia, flexible working time arrangements for family members or relatives – carers; the adaptation of living space and physical environment; the provision of various types of training and education for the family carers of seriously ill, adult or elderly people, as well as the provision of organized psychosocial support, counseling, provision of information about other sources of support and assistance... It is also planned to promote the system of support of relatives, friends or neighbors, as well as coordination and more intensive cooperation among different parts of the care system and family carers.

However, like many other strategic documents in Serbia, this document is more of a "wish list" than a list of realistic solutions and, in essence, has no binding character.

The lack of public support to family members providing informal care to the elderly is partially assuaged only by the fact that they can use the state provided attendance allowance to pay informal carers or to cover oportunity costs of family carers. There are no available data that show for what purposes beneficiaries use the attendance allowance. The studies on the status of persons with disabilities show that half of the families caring for persons with disabilities use attendance allowance to buy medicines and satisfy their basic needs, and that only 14.4 percent of them pay for medical and non-medical care services (Dinkić 2008). Therefore, it is possible

that the same is true for the elderly beneficiaries. In a way, the cash benefit as such is blurring the boundaries between formal and informal LTC, but it also gives wider choice to the family and to the beneficiaries, especially in the environment where LTC services are underdeveloped.

In Serbia volunteering is mostly organized through the work of NGOs that target specific vulnerable groups and implement programs for their protection. According to the 2009 survey findings, out of 42 organizations that describe themselves as volunteer organization, only 2 targeted the elderly population (Mladi istraživači Srbije 2009). The largest numbers of volunteers in LTC services are definitely engaged in the already mentioned Red Cross programs.

Recently the law on volunteering was adopted in Serbia and caused many controversies. Although it is too early to talk about the possible consequences, according to some opinions, the law "over-regulates" this area and it could present more of an obstacle than a stimulus for the development of volunteering

IV Key Policy Issues and Dilemmas

1. Segmentation of the Long-Term Care System and the Need for Its Consolidation

An analysis of the relevant national strategic documents points primarily to the conclusion that Serbia has recognized the need for a social response to the pronounced problems of population ageing today and in the future. The same refers to the need for the development of community-based services for the elderly, health care institutions for long-term care and palliative care, while some documents also emphasize the need for linking health and social care services.

In reality however, long-term care as a system actually does not exist. As shown by the previous analysis, one part of the system is regulated through cash benefits, one part through institutional social care and community-based social services, and one part is just being established under the health care system. However, linkages among these segments are not strong and have not been sufficiently explored. Moreover, there is insufficient awareness of the need to regard the different parts of the system as being interdependent and interconnected, and of the need to provide tailor-made services.

Non-existance of a system and lack of comprehensive approach might lead to a omissions like in the *National Strategy on Ageing* (Government of the Republic of Serbia, 2006) that analyses many important aspects of LTC but fails to even mention attendance allowances, or the fact that the related costs will increase in the future due to population ageing.

In addition the recognition of the need for developing inter-sectoral policies and linkages is sometimes only formal and not substantial. Thus, in the *National Strategy for Palliative Care* (Government of the Republic of Serbia 2009) there is recognition of inter-sectoral cooperation but, in essence, the Strategy is completely focused on health care, so that it is not even aware of the capacity of elderly care institutions within the social protection system, that in today's reality to a significant extent accommodate also the elderly in the terminal phase of illness. Inter-sectoral cooperation can also be found in other strategic documents, but in reality it is at a very low level.

Over the past ten or so transition years, each sector has been concentrated on its own reforms, only beginning to recognize the fact that the problems of vulnerable groups cannot be solved without coordination and joint effort of different sectors. Coordination is additionally complicated by the fact that the level of decentralization in specific sectors varies, as does the sources of financing. It even seems that the local level is more aware of the need for inter-sectoral cooperation and is accordingly better at implementing it. Thus, for example, one report on the level of service development in municipalities and cities states that there is good coordination between health care and social protection institutions in the provision of medical and non-medical care to the elderly (Vuletić 2009). However, as already mentioned, this coordination does not exist in Belgrade that has the most developed services providing both medical and non-medical home care. Local governments recognize the constraints arising not only from inadequate inter-sectoral cooperation, but also from the lack of communication between the central and local levels of government (Antić and Kovačević 2010).

In addition, so far, the health care system has not been adequately present in social protection institutions. However, certain progress can be expected after the adoption of the new Law on Social Protection that regulates the establishment of joint social - health care institutions and social-health care organizational units for beneficiaries who need both social care and permanent health care. It is especially worth mentioning that the two ministries (the Ministry of Health and Ministry of Labor and Social Policy) will jointly set the standards for the provision of services in these institutions. It is also stipulated that the Ministry of Health will carry out inspection in social protection institutions providing health-related services, which has so far not been the case. It is expected that these regulations will also improve conditions for the provision of care in elderly homes. This is especially important for the elderly care institutions providing care to elderly beneficiaries with special needs and in the terminal phase of illness. The draft law also specifically mentions inter-sectoral services and the signing of cooperation protocols.

In the coming period, progress can also be expected within the health care system, as it is increasingly being faced with the need to develop community-based services, cut hospital costs and develop long-term medical care services for the elderly, and recognizing within these reform efforts not only the prescribed but also the real need for establishing strong links with the social protection system (Republic of Serbia 2010).

In the short term it is important to strengthen the inter-sectoral cooperation between the social and healthcare system as regulated in the new Law on Social protection and to formulate all the necessary protocols. Also at least on the analytical and policy level it is necessary to identify and consider LTC as an integrated system.

2. The Adequacy of Benefits, Lack of Linkage with the System of Services and Other Issues Concerning the Cash Benefit System

The number of attendance allowance elderly beneficiaries in Serbia amounts to about 68.8 thousand, constituting 5.5 per cent of the total number of elderly. In 2010, the government expenditure for these purposes amounted to €103 million (0.35 percent of GDP).

In Serbia, there are three amounts of attendance allowance, as shown by the previous analysis. The basic allowance amount in the social care system is low i.e. less than half of the net minimum salary. The attendance allowance in the pension system amounts to 80 percent of the net minimum salary, while an augmented allowance intended for persons with the highest degree of disability is higher than the net minimum salary by about 10 percent[17]. At the same time, these allowances range from 40 percent to 50 percent of the net average salary in Serbia, so that they cannot be considered inadequate in relative terms[18].

However, what can be considered inadequate is the fact that the need for attendance allowance is primarily determined on the basis of medical criteria and not on the basis of the intensity of care needs. In addition, the range between basic and augmented attendance allowances is wide, while the absence of a scale, that would enable the determination of other amounts between these two, cannot realistically reflect individual needs. With this respect, a group that is particularly vulnerable consists of persons who have a high disability rating according to different types of disability, but are not eligible for augmented allowance, since this entitlement is provided only for persons with a 100 percent disability for a single disability. The proposed changes to the new law in this area were not accepted.

In view of the preceding conclusions, changes in the allowance system should include a wider allowance range, linking the allowance amount to the intensity of care need. However, the implementation of these changes must also be adjusted to the budgetary constraints.

It should also be noted that the total contributions to pension and disability insurance[19] are relatively low and that attendance allowance contributions are not specifically earmarked. Regardless of pension reforms, relatively low contribution rates have contributed to a persistently large deficit in the PDI Fund, which is co-financed from the budget. Under such circumstances, the care benefits are only formally an entitlement under the insurance scheme. In addition, if the contributions are relatively low, can the insurance really cover all of the risks, including old age disability, i.e. payments for attendance allowance. Within this context there is the dilemma whether this cash benefit should at all be regulated within the PDI system or should it be completely transferred into the social protection system. Or, perhaps the solution is to introduce earmarked contributions for these purposes? The answers to these dilemmas definitely require specific research.

The elderly are rather well informed about cash benefits compared to some other entitlements. It is estimated, however, that nearly 30 percent of elderly people are not informed about the attendance allowance entitlement (Satarić and Rašević 2007). This evidently points to the need to improve the provision of information about elderly entitlements, as well as to assist elderly people in collecting necessary documents and completing all application procedures.

[17] In November 2010, the average net salary per employee was €334 and the minimum salary €162.

[18] For the sake of comparison, attendance allowance in absolute terms in Slovenia is significantly higher. However, it is maximized at 30 percent of the net average salary per employee.

[19] The Serbian pension system is based on two pillars – PYGO state pension and disability insurance and voluntary private pension insurance. Attendance allowances are paid only on the basis of insurance under the state system.

In essence, cash and in-kind benefits in Serbia are not part of a completely integrated system. Cash benefit recipients are also entitled to institutional care. As already mentioned, they also participate in institutional care costs with their entire income, including attendance allowance. The termination of this allowance and its later reinstating through legislative changes for the elderly placed in institutional care obviously displays the confusion whilst seeking for systemic solutions and the need for their more detailed study.

As for community-based social services, it should be noted that under the current law beneficiary co-payment does not depend on whether a beneficiary receives a cash benefit or not. Some, albeit rare, LGs have linked these two entitlements. Under the new draft Law on Social Protection, cash benefit recipients are obliged to co-finance services amounting to at least 20 percent of attendance allowance. Like in the case of many other issues concerning community-based services that are regulated at the national level, the question remains whether this legal provision will be implemented in practice and whether its implementation will be monitored.

In the short term in this area as a minimum it should be possible to explore some of the listed dilemmas, but also to improve communication with the aim of informing the elderly on their entitlement to attendance allowance. Introducing a wider allowance range could at least prepared if not implemented.

3. The Underdevelopment and Inadequacy of Community-Based Services

Over the last years, Serbia has made significant progress in the development of community-based services, including elderly care services. According to data that do not completely cover non-state services providers, the number of LGs providing home care services has almost tripled over the last seven years, while the number of beneficiaries has increased almost six fold. If we also include the beneficiaries of the services provided by the Red Cross, Caritas and some other NGOs, home care, or at least some kind of support for IADL, is received by 1.5 percent of elderly people in Serbia, either constantly, or periodically and temporarily.

However, in 47 LGs, almost one third of Serbia, such services are not available. It is estimated that somewhat over one third of local governments have established services that are sustainable and completely financed from the local budgets, but the demand for services still exceeds their supply. In the remaining LGs, services are either only partly financed from the local budgets or are completely project-based.

There is not enough evidence on the quality of the delivered services. However, judging by the uniformity of service delivery duration, it can be concluded, at least in that sense, that the services are most likely insufficiently differentiated and individualized according to the beneficiaries' needs. Their inadequacy is also derived from the lack of linkages between health and social services.

The reasons for the underdevelopment of social care services can be found in the historical conception of the system, low level of development and high poverty of many local governments, as well as the lack of local level capacities and the low empowerment among social care beneficiaries.

The lack of community-based services is certainly due to the fact that, in accordance with the regulations still in force and the pre-reform doctrine, institutional care holds the central and most important role in social protection provision. Namely, the system has evidently been conceived in such a way that the state has retained the "most important entitlements" at the central level, leaving at the local level those forms of care which, despite being compulsory, allegedly do not affect recipients, since there is "a way out and solution" at the central level. Institutional care is a "right of general interest" for which the funds are provided at the central level, while the obligation to introduce non-institutional services remains at the local level. If there are no funds, or if these "alternative" social care services are not provided at local level for any reason, there are neither sanctions, nor support for fulfilling this mandate.

Another important reason is certainly the lack of funds, especially in underdeveloped LGs. As shown by the previous analysis, there is a very great difference between more developed and less developed LGs concerning the introduction of home care services. In part, this difference could be a result of different human and professional capacities and not only of the difference in available funds. It is a fact, however, that the some municipalities have very small budgets in absolute terms and that there is great competition among different social needs in those communities. In a way, these municipalities got caught in a vicious circle. Their low level of development causes young people to migrate leading to accelerated population ageing, to diminished opportunities for the elderly to rely on their family, but also to poor development prospects. In this situation there is an increased need to transfer elderly care to LGs, while at the same time there are less opportunities for increasing the local budget revenue.

However the lack of financial capacities is sometimes used as an excuse for not establishing services. The experience of different programmes, implemented in Serbia over the past years, show that even under such circumstances it is still possible to introduce services and allocate at least a small amount of funds for LTC in the local budgets (Matković 2010).

The lack of capacity as well as the lack of interest of LGs for establishing social care services have also been identified in the *Social Welfare Development Strategy,* which underscores the "imbalanced professional capacities and working conditions, insufficient and incomplete awareness and understanding of potential implementers of reforms" and the fact that "the local self-government does not have enough autonomy, and neither is it interested in fulfilling citizens' needs, through the development of a wide range of community based services" (Government of the Republic of Serbia 2005, 10). Some earlier studies show that social protection programmes are not given political significance or, to be more precise are not considered significant for attracting voters (Matković 2006). During the last years, the interest of some local authorities for home care services increased when they realized, owing to special programmes (including public works), that they could both increase employment and respond to social needs.

The underdevelopment of services is also a result of the fact that the elderly are not sufficiently acquainted with their entitlements and nor are they sufficiently empowered to fight for them. According to research on elderly non-institutional care, only 40 percent are acquainted with their entitlement to home care. The elderly who are poorer use these services to a lesser degree, either

due to the lack of information, or because of problems with the application procedure (Satarić and Rašević 2007). Moreover, the potential beneficiaries sometimes hide their need for assitance due to stigmatization. Cases have been reported where the potential beneficiares refused the offered services for this very reason (Matković 2010). Despite the negative evaluation of such projects due to their unsustainability, periodical and temporary home care service projects had a positive impact on informing the elderly on this service. Thus, there were cases that, after project completion, the elderly pressured their LGs into continuing the financing of this service.

It is expected that the new law, with some of its provisions, will succeed in promoting the development of community-based services for the elderly. As already mentioned, apart from an attempt to formally place community-based services in the centre of the care system, the new draft law also anticipates additional funds that should be distributed to LGs in the form of earmarked transfers for financing the services in their mandate. The adoption of minimum standards, establishment of the licensing system, and the accreditation of training programmes and improvement of control mechanisms should also have an impact on service quality. Introducing competition through tendering for services will positively impact the inclusion of non-state providers and the service quality.

The fact that during the last few years over 120 LGs prepared local social welfare plans should also be significant for the further development of services and for strengthening the capacities of professionals and the empowerment of potential beneficiaries. The provision of home care service is one of the principle objectives of all local strategies, but it is equally important to develop mechanisms to ensure that these strategies are implemented.

However, in the short run additional efforts at the central government level are still necessary to ensure the development of professional capacities at the local level, exchange of good practice experiences, systematic gathering and analysis of information on community-based services in order to formulate the appropriate policies. So, for example, the collection of data on elderly services should include not only the number of municipalities and beneficiaries, but also much more specific details on service providers, content and quality of services, beneficiary co-payment modalities, linkages with health sector services, structural indicators of beneficiaries, including the share of the oldest old, completely immobile, poor and the like. The gathering of such information may also be entrusted to the non-governmental sector, especially to the organizations like Amity[20] that already have specialized capacity in this area.

In would also be useful to define the minimum and optimal levels of services at the local level in the coming period. This would especially be important for shifting from the ad hoc development of services through competition and earmarked transfers, to a more systematic response to local level needs. With respect to services for the elderly, it would be important to define the optimal coverage of the elderly at central and local level for Serbia, in line with budgetary constraints, but also with the beneficiaries' needs.

4. Some Issues Concerning Further Decentralization and the Transfer of Mandates

[20] Amity has positioned itself as a focal organization for elderly care and has produced different studies on this topic.

As already mentioned, in Serbia, attendance allowances, elderly care institutions, foster care for the elderly and health care services are in the mandate of the central government, while social care services are in the mandate of LGs.

The further decentralization of the social protection system in Serbia has been defined as one of the main pillars of the reform in the area of service provision (Government of the Republic of Serbia 2005). Namely, with regard to cash benefits, a consensus has been reached – on the basis of experience from other countries and in accordance with principled views that minimum entitlements need to be defined and provided at national level and in line with national criteria, so that they can be accessible to all citizens on equal terms (Matković 2006).

In the area of services, first of all there was a need to promote the development of those services that are already fully in the mandate of LGs. In the short term, and keeping in mind the significant budgetary constraints, as already mentioned, a solution, was found to introduce earmarked transfers for the less developed municipalities

Over a medium term, earmarked transfers could be available to all LGs and formulated so that they are disbursed to municipalities according to a formula that will respect their fiscal capacity and needs for social care services (DfID 2005, 16).The needs could be expressed by indicators such as the share of the population older than 65, share of persons with disabilities, share of the Roma population living in slums, etc. In order to avoid the effects of financial substitution, municipalities could be requested to provide additional funds, so that transfers take the form of complementary grants. In essence, municipalities would receive the funds that must be spent on social care services, but without specifying or imposing the types of services to be financed. This would ensure flexibility and respect for local specifics, as well as the greater responsibility of local authorities.

The decision to opt for earmarked transfers does not have to be a long-term one. The current situation in most local governments in Serbia requires this type of transfer, due to the fact that social protection always loses the battle with health care and education, for example, not only because they really are more significant, but also because both the beneficiaries and the employed in these sectors are more numerous and more influential. However, these arguments may lose significance with further economic and social development.

There are still dilemmas on how the process of decentralization in social care service provision in Serbia should be continued. The most important constraints to the continuation of the decentralization process, that are directly related to social protection,[21] include the absence of the regional level of government in Serbia, and large differences in the size and the level of development of LGs, as well as constraints in the local authorities' capacities and the lack of empowerment of social care beneficiaries (Matković 2006).

[21] In this context, other issues, which are also important for general decentralization processes are not considered, i.e. the general level of democratization of the society, the level of corruption at the central and local levels, transparency in local budget spending, or the possibility for citizens and the NGO sector to influence local authorities...

In contrast to those countries where decentralization was gradual and formed part of a "natural" development process, in the countries in transition it is mostly carried out as a result of emulating more successful systems, and represents a "top-down" process, meaning that the reforms are conducted by the central level. In that context, the question is whether and to what extent should reforms precede the decentralization process in Serbia. In effect, the reform capacities are much larger at the central than at the local level, where there is resistance to reforms.

Still, there is room for the further decentralization of social care services. It can be found in transferring the mandate for elderly care to a lower government level. In view of the reality in Serbia, the responsibility for elderly institutional care should not be either with the central nor the local authorities. Since Serbia has still not defined regions, the transfer of mandates can be carried out only partially, by transferring the functions to the Province of Vojvodina and the City of Belgrade, for elderly homes situated in their territory (asymmetric decentralization). The appropriate funds could be provided by a one-off redefining of the share of these LGs in the state budget. Considering the size of the budget and professional capacities of Vojvodina and Belgrade, there should not be any problems with the provision and management of these funds. The other possibility is to carry out the decentralization through transferring the mandate to cities (a total of 23).

An opportunity has been missed to reach a decision on the decentralization of elderly care institutions and including it into the new draft Law. One possible explanation for this could be that there is an increasing discussion on the need to establish a regional level of government and change the Constitution accordingly. This could open new options in the decentralization of social protection in Serbia as well.

5. *A Gap Between the Needs and Reality*

According to the different surveys, home care is needed for the daily functioning of more than 80,000 elderly people, especially for around 27 thousand of those who are completely immobile. More than 300 thousand elderly persons have indicated that they are in need of some type of self-care support (for ADL or IADL).

Research shows that in Serbia 68,608 (5.5 percent) receive attendance allowance; over 10 thousand elderly are accommodated in institutions (0.8 percent), while 18.5 thousand (1.5 percent) persons received some type of support through home care services. In addition, in Belgrade there are also two thousand elderly who are beneficiaries of medical and palliative care at home. It is not possible to estimate the total number of elderly people receiving some type of cash or in-kind benefits, since there are no data on the number of recipients that receive both cash and in-kind benefits. Under one scenario, although this in not realistic, where all the elderly would be receiving only one kind of benefit, either cash or in-kind, the total number of beneficiaries would amount to 99 thousand or 8 percent of the total number of elderly in Serbia. Provided that these benefits are very well targeted, this would only satisfy the needs of the elderly who require assistance for ADL.

The government expenditures for these purposes in Serbia can be very roughly estimated at 0.5 percent of GDP, largely for cash benefits. These expenditures are significantly lower than in the EU, where they amounted to an average of 0.9 percent of GDP in 2004. Still, there are also large differences between the EU countries themselves, so, in almost one third of the EU countries these expenditures are equal or lower than in Serbia (European Commission 2008).

Table 15. Public expenditures for LTC, 2010

Cash benefits	0.345
Elderly care institutions	0.058
Health care	0.080
Social care services	0.035
Total	**0.518**

Note: healthcare expenditures in 2008

In the analysis of public expenditures for LTC in Serbia it must be noted that unlike for institutional care, almost the complete home care services expenditure burden falls on local governments, i.e. the consolidated state budget. If home care services continue to be free of charge, the advantages arising from the lower prices of non-institutional care will not be fully exploited. As already mentioned, for institutional care the beneficiaries co-finance the costs with a high percentage share, thus making the state expenditures for institutional care in the social protection system only a fraction higher than those for non-institutional care. This is particularly significant if future decentralization results in the transfer of both types of care to the local governments.

Considered over the medium and longer term, the government expenditures on long-term care in Serbia will inevitably increase significantly, primarily due to an increase in the number and share of elderly people and the increase in additional life years spent in ill health or in need of assistance. An increase in the expenditures will also be influenced by a change in the family models and the increasing number of elderly that will be living alone, as well as the diminishing possibilities for reliance on the closest family members, especially due to emigration flows both at local and national levels. Finally, it is important not to neglect the effect of emulating more developed countries, as well as the EU's pressure to adequately respond to the needs of the elderly.

Applying the EU fiscal demographic model for Serbia in this stage is not possible since even gathering data in order to set the baseline expenditure level proved very difficult. Some of the data gathered are not precise, including the data on coverage and the public costs of the LTC services, morbidity, health care expenditure, etc. In addition there are a lot of uncertainties in terms of the immediate and medium term reforms both in social protection and the health care sector and how these reforms will affect public expenditures, the balance between formal and informal care, the balance between home and institutional care within formal care provision, the costs of care units, etc.

According to European Commission estimates, by 2050 public expenditures for LTC in the EU will increase to 1.9 percent of GDP (European Commission 2008). According to World Bank estimates, under the pessimistic scenario, state expenditure for long term care by 2050 in Eastern

European and the former Soviet countries could amount to between 2 and 4 percent of GDP (World Bank 2007). Although nothing precise in terms of future public expenditures can be projected in Serbia there is no doubt that they will increase sharply and that the state and society must promptly prepare a systematic, comprehensive, timely and fiscally responsible response. This response must recognize the capacities of all stakeholders, from family to state and non-state organizations and match the capacities with the appropriate roles in the system of long term care provision.

Annex

SWOT 1 (Inclusion of NGO providers):

Strengths	**Weaknesses**
1. Many different state/donor driven incentives aiming at inclusion of NGOs as service providers 2. Existance of organisations like Red Cross and Caritas with long tradition in providing LTC 3. Lessons learned by the Social Innovation Fund regarding procedures for establishing LTC services	1. Unsustainability of project based development of LTC services provided by NGOs 2. Lack of financial resources and political will at the local level for development of LTC services 3. Distrust and skepticism of LGs towards NGOs as service providers
Opportunities	**Threats**
4. Introduction of obligatory public procurement system for purchasing of social care services in the new Law on Social Protection 5. Introduction of minimum standards, accreditation and licensing procedures under the New Law 6. Introduction of earmarked transfers for services at the local level 1. Potential EU/donor funds for eliminating some weakness	1. Budgetary crisis in Serbia that could pose a threat to allocating sufficient funds for the implementation of the New Law 4. Lack of knowledge in LGs on contracting-out and monitoring of service delivery **5.** Lack of capacities in the NGO sector to fully comply with the requirements in the New Law 6. Non-existence of NGO sector in underdeveloped municipalities

SWOT 2 (Inclusion of private providers):

Strengths	Weaknesses
1. Unmet demand for LTC within the public sector, especially for residential and nursing homes 2. Low quality of service provision in some state homes 7. The state started issuing permits to private homes and monitoring their work resulting in decreasing the mistrust regarding the service quality	3. Non developed private market for LTC services except partially for retirement homes 4. Recipients of attendance allowance use cash to satisfy their basic needs and not for purchasing services 5. Widespread informal economy in home care services is "unfair" competition to the private sector
Opportunities 1. Introduction of obligatory public procurement system for purchasing of social care services in the new Law on Social Protection 2. Introduction of minimum standards, accreditation and licensing procedure under the New Law 3. The return of elderly guest workers who will be able to pay for services due to their relatively high pensions earned abroad	**Threats** 1. Social services market in Serbia is unattractive to the private sector (profit cannot be easily made) 2. Low living standard of a large portion of the population that will increase very slowly 3. The requirements of the New Law could make LTC services even less attractive for the private sector if the standards are set too high 4. Slight chance that in the longer term the state will be able to prevent the informal engagement of home carers

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