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POVERTY BENEATH THE BURDEN OF CARE:

The Impact of Long-Term Care on the Poverty of Older Persons in Serbia

Federal Ministry
Republic of Austria
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POVERTY BENEATH THE BURDEN OF CARE: The Impact of Long-Term Care on the Poverty of Older Persons in Serbia

Belgrade, 2025

ABBREVIATIONS

CATI	Computer-assisted telephone interviewing
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
RC	Red Cross
EHIS	European Health Interview Survey
EU	European Union
FZO	Health Insurance Fund
LGU	Local Government Unit
MIPAA	Madrid International Plan of Action on Ageing
OOP	Out-Of-Pocket
RFZO	National Health Insurance Fund of the Republic of Serbia
SORS	Statistical Office of the Republic of Serbia
RZSZ	Republic Institute for Social Protection
WHO	World Health Organization
UN	United Nations
VIPAA	Vienna International Plan of Action on Ageing

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1. INTRODUCTION

The research titled "Poverty Beneath the Burden of Care: The Impact of Long-Term Care on the Poverty of Older Persons in Serbia", the results of which are detailed in this report, is a component of a broader regional project funded by the Federal Ministry of Labor, Social Affairs, Health, Care, and Consumer Protection of the Republic of Austria. The project is being implemented during the 2024–2026 period under the title *"Strengthening Health, Access, Participation, and Social Equity in Western Balkan Countries"*. The project is coordinated by a leading partner Austrian Red Cross, and implemented in Serbia in cooperation SeConS Development Initiative Group and the Red Cross of Serbia.

This initiative was launched in Serbia, North Macedonia, and Albania to address the societal impacts of the COVID-19 pandemic. The crisis further deepened existing inequalities and exacerbated multidimensional poverty, especially affecting the most at-risk populations—the homeless, persons with disabilities, and older persons. In this context, the project aims to mitigate the negative effects of these multiple crises and enhance the quality of life for those most affected. Special emphasis is placed on strengthening their social and economic inclusion, as well as improving access to health and social services.

The research conducted in Serbia aims to examine the risk of poverty among older persons (aged 65 and over). This risk stems from the costs associated with accessing support services, the challenges faced by their carers, and the extent to which this demographic can secure the assistance required to meet their care-related needs within the context of poverty. The research findings are crucial for devising specific recommendations that can facilitate the creation of new measures and services intended to enhance the quality of life for older persons.

1.1 Research purpose and objectives

The purpose of the research is to evaluate the impact of care- and nursing-related costs on older persons nearing the poverty line and to examine the extent to which poverty—broadly defined as a scarcity of resources—contributes to difficulties with meeting care- and nursing-related needs. The objective is to provide a foundation for advocacy efforts and policy proposals aimed at improving social services for older persons and their carers. These proposals, grounded in the research findings, seek to reduce poverty risks associated with care- and nursing-related costs, enhance the quality of support provided, and ultimately improve the quality of life for both groups.

The specific objectives of the research are as follows:

- To identify gaps in care and opportunities for improving existing support systems for older persons and their carers;
- To identify coping strategies employed by older persons and their carers in responding to care-related challenges;
- To develop recommendations for improving policies at both national and local levels—including those related to social protection, health care, and poverty reduction, as well as policies aimed at enhancing the availability and quality of services for older persons—with the goal of promoting their well-being and reducing vulnerability;
- To develop recommendations for introducing new services at the local level, to be piloted and implemented by the Red Cross of the Republic of Serbia, in cooperation with local authorities (in three local government units: Zaječar, Niš, and Sombor), with the aim of strengthening support for older persons and their carers who are at risk of poverty.

This research is of great significance, as it provides new insights and expands existing knowledge about the older population (aged 65 and over) in Serbia, particularly in the context of the relationship between meeting support needs and the risk of poverty. The present research is the first to directly examine the impact of financial expenditures on various types of care—including health and social services—on the living standards and poverty risk of older persons, although numerous prior studies have explored their social inclusion, the availability of long-term care services, and experiences of violence (particularly among older women). To date, no research in Serbia has offered a comprehensive analysis of this phenomenon.

This research is also significant because it provides essential data for the development of national and local policies in the field of social and health care, with the potential to reduce the risk of poverty among older persons. Comprehending the influence of elevated care expenditures on this population's living standard facilitates the formulation of specific social protection and health care policies designed to mitigate these expenses or offer alternative solutions. The importance of this research also lies in its potential to inform the improvement of existing services and the development of new ones, specifically tailored to the needs of older persons and their carers, with the aim of enhancing their social inclusion and quality of life.

2. THE SOCIAL CONTEXT OF THE OLDER POPULATION'S STATUS

2.1 Definition of the older population and demographic data in Serbia

The older population represents one of the key demographic groups whose social position and needs are increasingly acknowledged in modern societies, particularly those marked by pronounced population aging. According to definitions provided by international organizations, the older population is generally defined as individuals aged 60 or 65 and over, depending on the social, economic, and cultural context.[1] This age cohort is not a homogeneous segment of the population but rather a highly heterogeneous group, characterized by physiological, psychological, and social differences. The aging process entails significant alterations in physical health, cognitive abilities, social roles, and life experiences, all of which affect the daily needs and capabilities of older persons. Due to these differences, older persons are frequently classified into age-specific subgroups to enhance understanding of the challenges and unique needs associated with each group. For example, some research classifies older adults into three age groups: individuals aged 65 to 74 are considered the "younger-old" and are generally still physically and mentally capable of engaging in various activities; those aged 75 to 84 are referred to as the "middle-old", often experiencing the onset of more serious health issues and a gradual decline in physical functioning; while individuals aged 85 and over are categorized as the "oldest-old", typically requiring increased care and assistance due to more advanced health problems and reduced independence.[2] This classification facilitates more efficient planning of social and health services customized to the specific phases of aging and older persons' varied needs.

In the Republic of Serbia, the older population is defined as individuals aged 65 and over.[3] This demographic group represents an increasingly significant portion of the total population, with its share steadily rising as a result of various demographic trends, including increased life expectancy, declining birth rates, and migration patterns. The 2022 population census indicates that those aged 65 and over constitute 22.1% of Serbia's total population[4], just exceeding the older population percentage in the European Union, which stands at 21.6%.[5] Serbia is among the European countries with the highest proportion of the older population, behind Italy (23.8%), Portugal (23.7%), Greece (22.7%), and Croatia (22.5%).[6]

1 https://www.migrationdataportal.org/themes/older-persons-and-migration.
2 Alterovitz SS, Mendelsohn GA. (2013).
3 "Official Gazette of RS", Nos. 24/2011, 42/2013, 106/2015, 50/2018, and 95/2018.
4 https://popis2022.stat.gov.rs/sr-latn/5-vestisaopstenja/news-events/20230525-starost-i-pol/.
5 https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Population_structure_and_ageing#:~:text=On%201%20January%202024%2C%20the,EU's%20population%20reached%2044.7%20years.
6 SORS (2024a).

Among the older persons in Serbia, the majority are aged between 65 and 74, accounting for 63.8% of the total older population. This group is commonly referred to as the "younger-old" and is generally in better health, more physically active, and less dependent on assistance compared to older age groups.[7] The "middle-old" age group accounts for a smaller share—28.2% of the older population—while individuals aged 85 and over, classified as the "oldest-old", represent 8% of the older population and just 1.7% of Serbia's total population. This proportion is below the European Union average, where the "oldest-old" constitute approximately 2.9% of the total population.[8]

Women make up the majority of older persons in Serbia, accounting for 56.9% of the older population. To better understand this demographic pattern, it is useful to compare these figures with the share of women in the total population, where they constitute 51.4%, and in the population under 65, where their proportion is about the same. This comparison highlights that the gender composition of the population shifts significantly with age in favor of women, particularly in the oldest age groups. The gender gap becomes more pronounced within subgroups of older persons: women make up the majority (54.9%) of the "younger-old" group (aged 65–74), and this proportion rises to 60.5% in older groups (aged 75 and over).[9] This gap is primarily the result of women's longer life expectancy, which leads to their predominance in the older age groups. In 2022, life expectancy for women in Serbia was 78.1 years, compared to 73 years for men.[10] Women's longer life expectancy also has its disadvantages—they often spend more years coping with health problems, and as a result of gender inequalities experienced earlier in life, they are more likely to face adverse living conditions in old age, particularly when living alone.[11]

Chart 1: The share of the older population (aged 65 and over) in the total population of Serbia, 2022

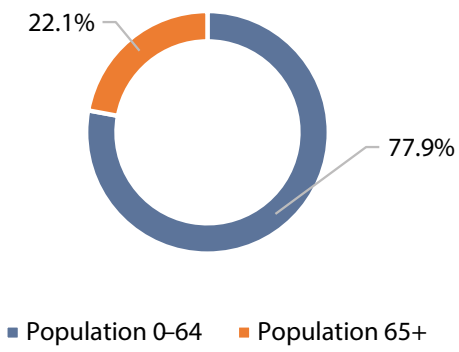
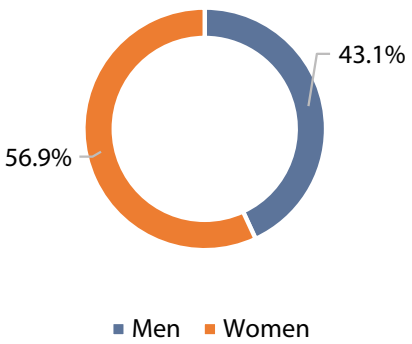


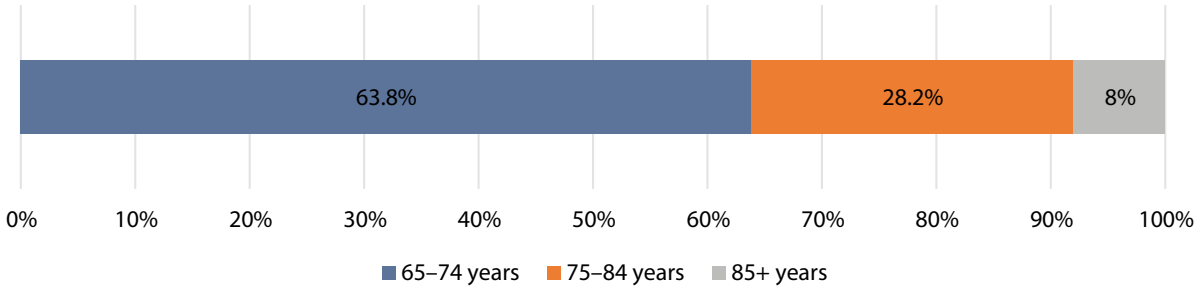
Chart 2: Gender composition of the older population in Serbia, 2022



Source: SORS (2023a)

7 Ibid.
8 https://www.bruegel.org/analysis/beyond-retirement-closer-look-very-old.
9 SORS (2024a).
10 SORS (2024b).
11 Babović, M., Veličković, K., Stefanović, S., Todorović, N., & Vračević, M. (2018).

Chart 3: Representation of age-specific groups within the older population, 2022



Source: SORS (2023a)

Demographic trends also point to significant changes in household composition, particularly among the older population. Data from the latest census indicate that households of older persons now make up 21.6% of all households in Serbia, while single-person older-person households account for 13.4%.[12] Nearly two-thirds of these households are composed of women (69%), with this proportion being even higher in urban areas compared to other types of settlements.[13]

2.2 Poverty and social exclusion of the older population

The older population in Serbia faces increasing risks of poverty and social exclusion. While the at-risk-of-poverty rate has gradually declined among other age groups in recent years[14], it has remained stagnant or slightly increased for the older population. In 2023, the older population recorded an above-average at-risk-of-poverty rate for the third consecutive year, reaching 23.5%—the highest among all age groups (Chart 4).[15] The 2023 Report on Progress in Achieving the Sustainable Development Goals in the Republic of Serbia also warns of growing poverty risks among the older population. According to the report, while progress in reducing the risk of poverty has been recorded across all other age groups, the older population group is increasingly falling behind and moving further away from the established targets.[16]

12 SORS (2024c).

13 Ibid.

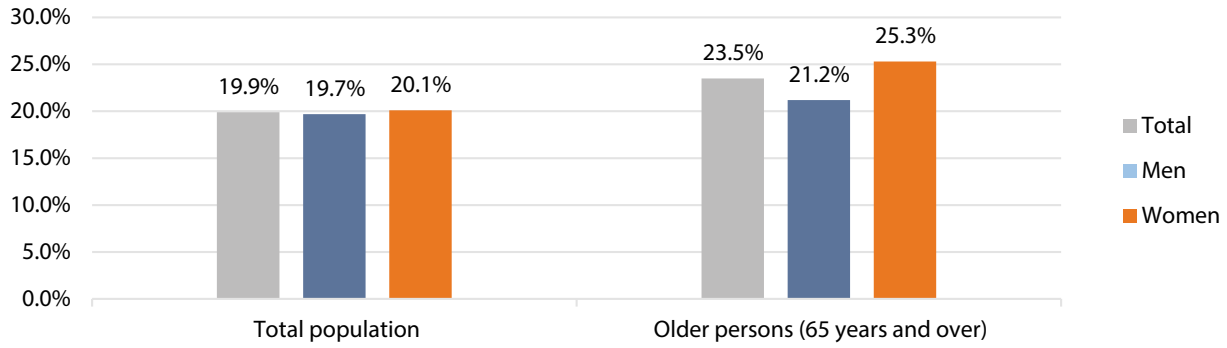
14 The at-risk-of-poverty rate indicates the proportion of individuals whose disposable equivalized income falls below the at-risk-of-poverty threshold. This indicator does not reflect the absolute number of people living in poverty, but rather the share of the population whose income is below the at-risk-of-poverty threshold. Equivalized income refers to the total disposable income of a household, equally distributed among the household members using the modified OECD equivalence scale (Organisation for Economic Co-operation and Development). Under this scale, the first adult in the household is assigned a weight of 1, each additional household member aged 14 and over a weight of 0.5, and each child under the age of 14 a weight of 0.3. Income in kind is excluded from the calculation of household income. The at-risk-of-poverty threshold—also referred to as the relative poverty line—is set at 60% of the national median equivalized income and is expressed in dinars. For more information, see: https://sdg.indikatori.rs/sr-cyrl/area/no-poverty/?subarea=SDGUN010201&indicator=01020501IND01.

15 SORS (2024d).

16 Sustainable Development Goal 1: End poverty in all its forms everywhere; Babović, M. (2024).

Although there is virtually no gender gap regarding poverty risk at the level of the population as a whole, a significant gender disparity exists among the older population: older women face a higher risk of poverty (25.3%) compared to older men (21.2%).

Chart 4: At-risk-of-poverty rate by sex in the total and older populations, 2023



Source: SORS (2024d).

According to 2023 data, single-person households consisting of individuals aged 65 and over faced an above-average risk of poverty, with the at-risk-of-poverty rate reaching 34.2%. These households represent one of the most vulnerable household categories in Serbia—second only to multi-person households with three or more dependent children, whose at-risk-of-poverty rate stood at 34.7%. In other words, more than one-third of single-person households in Serbia, in which older persons reside, are at risk of poverty—meaning their monthly income is below 29,100 dinars.

Pensions play a vital role in ensuring financial well-being in old age and in establishing the prerequisites for a dignified life. The importance of pensions for older persons is underscored by data from the 2022 Survey on Income and Living Conditions (SILC), which indicate that, in the absence of pensions and social transfers, the at-risk-of-poverty rate among individuals aged 65 and over would rise to 74.7%.[17] However, pensions cannot provide adequate protection against poverty unless they are regularly adjusted to keep pace with inflation, which has been notably high in Serbia in recent years.[18] For instance, in July 2024, an individual receiving a pension equivalent to the average pension in Serbia was unable to cover the cost of the minimum consumer basket. Specifically, in July 2024, 1.2 average pensions were needed to cover the cost of the minimum consumer basket, while 2.3 average pensions were required to cover the cost of the average consumer basket.[19] This disparity between consumer prices and pension levels highlights the financial vulnerability of

17 Eurostat, online data code: ilc_li09.

18 More information on monthly and annual inflation rates, including consumer price indices, can be found at: https://publikacije.stat.gov.rs/G2025/HtmlL/G20251010.html.

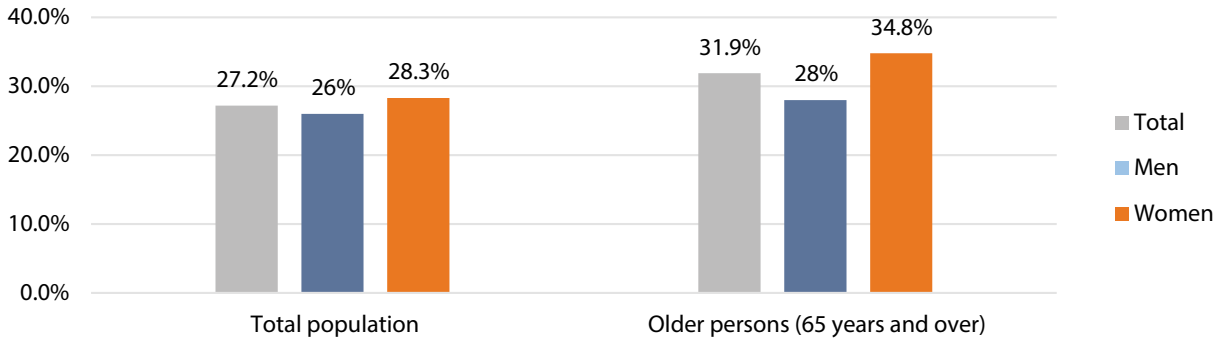
19 Data on the average pension, as well as the minimum and average consumer baskets, refer to July 2024, when the average pension amounted to 45,709 dinars, the minimum consumer basket to 53,654.85 dinars, and the average consumer basket to 103,722.13 dinars (PIO Fund, 2024); Ministry of Internal and Foreign Trade (2024).

the older population. The most vulnerable older persons are those who have not exercised their right to a pension or who receive very modest pensions, such as agricultural or family pensions.[20]

The social inclusion of the older population is a key factor in preserving their quality of life. It implies that older persons have equal opportunities to participate in community life without discrimination or marginalization and that they are able to maintain interpersonal relationships, engage in various social, cultural, and political activities, and access resources—such as health care and social protection—that enable them to live a dignified life. While poverty refers to financial and material deprivation, social inclusion—and by extension, social exclusion—is a more complex and multidimensional concept. Methodologically, the at-risk-of-poverty or social exclusion rate is an indicator that reflects the proportion of individuals in a society who are at risk of financial poverty, experience severe material or social deprivation, or live in households with very low work intensity.[21] Social exclusion has been defined as "a process whereby certain individuals are pushed to the edge of society and prevented from participating fully by virtue of their poverty, or lack of basic competencies and lifelong learning opportunities, or as a result of discrimination. This distances them from employment, income and education and training opportunities, as well as social and community networks and activities".[22]

In 2023, the at-risk-of-poverty or social exclusion rate for the older population was 31.9%, which is higher than the rate for the total population, recorded at 27.2%. Older women are more exposed to the risk of poverty or social exclusion than older men—34.8% compared to 28%. Although women across all age groups are more exposed to these risks, the gender gap is most pronounced among the older population. While the at-risk-of-poverty or social exclusion rate for the total population has been gradually declining in recent years, it has been increasing for the older population since 2022.

Chart 5: At-risk-of-poverty or social exclusion rate by sex in the total and older populations, 2023



Source: SORS (2024d).

20 Babović, M., & Stević, M. (2024).
21 Eurostat (n.d).
22 European Commission (2024:10).

2.3 Long-term care needs

Demographic changes in Serbia—primarily population aging and the shrinking share of the working-age population—represent one of the key challenges for the health and social systems. According to demographic projections, the share of older persons in the total population is set to continue rising, together with life expectancy.[23] Between the two most recent censuses (2011 to 2022), the share of older persons aged 65 and over increased by 4.7 percentage points, from 17.4% in 2011 to 22.1% in 2022. The 2022 census revealed that the most unfavorable demographic structure was observed in the South and East Serbia Region, where nearly one in four individuals (23.7%) were aged 64 or over.[24] Projections suggest that by 2052, this share will rise to 28.5% of the total population. In addition, the share of the oldest persons (aged 80 and over) is projected to increase from 4.4% in 2022 to 7.3% by 2052.[25]

The older population is significantly more likely to suffer from chronic illnesses than individuals under the age of 65, with the risk of illness increasing with age.[26] In addition, due to functional limitations—commonly present among older persons—their ability to perform activities of daily living may be significantly reduced, while the costs associated with medications, assistive devices, and support services may substantially increase. According to self-assessment of their health status, the older population is much less likely to rate their health as good or very good compared to individuals under the age of 65.[27] In addition, there are notable differences among older persons themselves, both by age group and by sex. Persons aged 75 and over are less likely to consider their health to be good compared to those aged 65–74. The gender difference is particularly pronounced among the oldest age group, with twice as many women as men reporting their health as good or very good.[28] Compared to their peers in European Union countries, older persons in Serbia are significantly less likely to rate their health as good or very good.[29]

Research on the health of the population in Serbia has shown that nearly half of the older population experience functional limitations in walking (44.8%), hearing (45.9%), and vision (40.7%).[30] Approximately one third (31.5%) reported having severe difficulties in performing instrumental activities of daily living, such as preparing food, doing housework, and shopping, while nearly one in ten individuals (9.5%) reported difficulties with personal care activities, including dressing, toileting, and bathing.[31] These limitations are significantly more prevalent among women, persons aged 75 and over, residents of non-urban areas, those with the lowest levels of education, and the poorest segments of the older population.[32] Compared to their counterparts in

23 https://popis2022.stat.gov.rs/sr-latn/5-vestisaopstenja/news-events/20241018-projekcijestanovnistva-rs-2022-2025/?utm_source=chatgpt.com.
24 https://popis2022.stat.gov.rs/sr-latn/5-vestisaopstenja/news-events/20230525-starost-i-pol/.
25 SORS (2024e).
26 Babović, M., Veličković, K., Stefanović, S., Todorović, N., & Vračević, M. (2018).
27 Ibid.
28 SORS (2024a).
29 Eurostat (2025), online data code: hlth_silc_02.
30 SORS (2021).
31 Babović, M., Veličković, K., Stefanović, S., Todorović, N., & Vračević, M. (2018).
32 Ibid.

European Union countries, a significantly higher proportion of older persons in Serbia experience limitations in performing activities of daily living, including both self-care and household activities.[33]

Population aging, accompanied by health and functional difficulties, contributes to the growing need for the development of long-term care services that can provide adequate assistance to the older population. The need for care depends on multiple factors—including health status, social support, living conditions, and individual capacities—all of which may change over time. For instance, some individuals of the so-called 'third age' may not require additional care, while others may experience serious health issues or physical impairments that hinder daily living, potentially requiring long-term assistance or even institutional care. Moreover, a person's health may deteriorate over time, leading to an increased need for more intensive care.[34]

2.4 Availability of long-term care services

In Serbia, long-term care is not recognized as an explicit right of citizens but is delivered through various components of the health care and social protection systems.[35] For example, the social protection system allows persons over the age of 65 to access community-based day services—such as home help, day care, and respite stay—as well as residential care services in institutional or family-based settings. In contrast to this, home-based and inpatient treatment, including palliative care, is delivered within the health care system. The absence of clear coordination and integration into a unified and functional system poses a significant challenge, as these components fall under the jurisdiction of various institutions and levels of government.[36] Central and local authorities share responsibilities, which leads to uneven availability of services across the country (Figure 1). Health care services are primarily regulated at the national level, whereas the regulation of rights to social protection services is shared between central and local authorities, depending on the type of service provided. At the same time, the regulation of access to social protection services varies significantly across different local government units.

Although social protection services are accessible in nearly all municipalities and cities, the majority of local governments provide only a limited number of services. The majority of local government units (LGUs) provide only two to three services, and one-fifth offer only one.[37] The most commonly provided service is **home help**, which was available in 134 local government units in 2023. Data from the Republic Institute for Social Protection indicate that persons aged 65 to 79 represented the largest share of recipients of this service (45.8%), followed by those aged 80 and over, who accounted for 42.8%.[38]

Other services within the social protection system, such as day care, respite stay, and residential accommodation, are less widely available. Some of these services are insufficiently promoted, resulting

33 Eurostat (2022), online data code: hlth_ehis_tadle.
34 Tiago Cravo Oliveira Hashiguchi & Ana Llena-Nozal (2020).
35 Babović, M., et al. (2022).
36 Matković, G. (2012).
37 Matković, G., Šunderić, Ž., & Muždalo, L. (2024).
38 Report on local social protection services provided by licensed service providers in 2023, available at: www.zavodsz.gov.rs/извештаји-из-система/извештаји-из-система-2023.

in limited public awareness of their benefits.[39] For example, according to the 2023 data from the Republic Institute for Social Protection, 118 persons over the age of 65 used the **respite stay** service, which was available in only three cities in Serbia—Belgrade, Niš, and Šabac.[40] Similarly, the **daycare** service for adults and older persons, despite its importance, was poorly utilized, with only 11 recipients in 2023, and was available exclusively in Belgrade.[41] In addition, coverage of **residential accommodation** services (both institutional and family-based) for older persons is low, amounting to only about 1%, with nearly half of the recipients residing in private old people's homes that they finance independently.[42] In Serbia, this service is most often used only when health care is unavailable or as a last resort, when no other support options are accessible to the recipient.[43] Conversely, in European Union countries, the share of older persons residing in residential long-term care institutions (excluding hospitals) is significantly higher, averaging 3.8%.[44]

The majority of recipients of health care services require assistance that can be provided at home, while a smaller proportion need more extensive assistance or relocation from their homes to receive care. **Home treatment** services are mainly used by citizens with severe functional difficulties,[45] while older persons aged 75 and over use **inpatient** (hospital) treatment services significantly more often.[46]

However, older persons in Serbia have traditionally relied on family as their primary source of assistance. **Informal carers**—including family members, friends, and neighbors—continue to provide the majority of long-term care, primarily due to deeply rooted cultural norms that promote caring for older and infirm community members, as well as the underdevelopment of public services, which often cannot meet the growing needs of recipients.[47] Professional services are often used only as supplementary assistance or in situations where the family is unable to provide adequate care.[48] Additionally, financial barriers frequently limit access to professional services, further reinforcing the critical role of family and loved ones in the long-term care process. However, it is important to recognize that informal care, which is often unpaid, imposes significant costs on carers themselves. The physical and psychological strain on families can lead to serious consequences, including leaving work or reducing working hours, which directly impacts household income.[49]

Although the aforementioned services formally exist within the social protection and health care systems, their actual availability largely depends on the financial capacity of recipients and their families. The level of household income has a major impact on whether an older person will be able to access care services, as well as on their quality and scope.[50] Since difficulties in performing activities of daily living often persist for years, care costs can become very high and accumulate rapidly. In many cases, the only source of

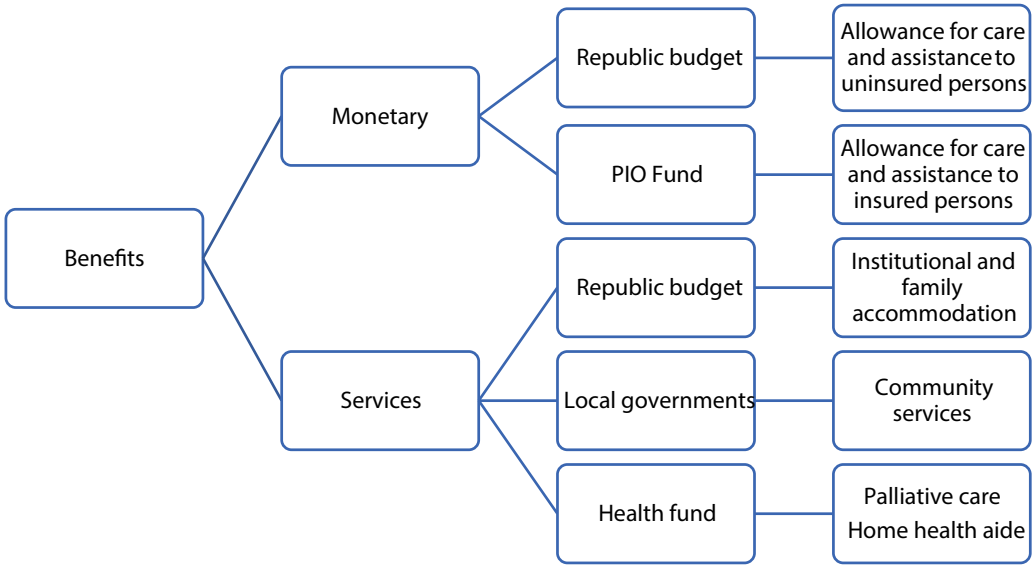
39 Babović, M., et al. (2022).
40 Ibid.
41 www.zavodsz.gov.rs/извештаји-из-система/извештаји-из-система-2023.
42 MRZBSP (2025).
43 Babović, M., et al. (2022).
44 MRZBSP (2025).
45 Ibid.
46 SORS (2021).
47 Babović, M., et al. (2022).
48 Ibid.
49 Tiago Cravo Oliveira Hashiguchi & Ana Llena-Nozal (2020).
50 Dakić, B., et al. (2023).

funding for these services is the personal funds of recipients or their family members who provide care. For older persons with low incomes, these costs can become a significant burden, leading to serious financial problems and even the complete inability to secure necessary care.[51]

To alleviate this financial burden—that is, to reduce the costs of formal care services and provide financial support to informal carers—the state has established a mechanism for monetary compensation (Figure 1).[52] Financial support, in the form of **attendance allowance**, is regulated within the social protection system. The right to this allowance is exercised by insured persons, including beneficiaries of pension and disability insurance, social protection, and veteran and disability protection.[53] This monetary compensation is intended as support for individuals who, due to illness or disability, are unable to independently perform basic activities of daily living—such as feeding, dressing, personal hygiene, and mobility.[54]

An **attendance allowance** is also allocated from the central budget to older persons who are unable to exercise a right to this benefit (uninsured persons) but have a determined need for care, analogous to PIO Fund–insured persons.[55] Persons with the highest degree of disability—i.e., 100% based on a single criterion or more than 70% across multiple criteria—are entitled to an **increased allowance**. If they meet the above condition regarding the degree of disability, recipients of the PIO Fund's attendance allowance may also be entitled to an additional payment, up to the amount of the increased allowance.[56]

Figure 1. Long-term care benefit, jurisdiction and funding



Source: Matković, G. (2012:3).

51 Tiago Cravo Oliveira Hashiguchi & Ana Llena-Nozal (2020).
52 Babović, M., et al. (2022); Matković, G. (2012).
53 "Official Gazette of RS", Nos. 24/2011, 42/2013, 106/2015, 50/2018, and 95/2018.
54 Matković, G., & Stanić, K. (2014).
55 Babović, M., et al. (2022).
56 Article 94, "Official Gazette of RS", Nos. 24/2011, 42/2013, 106/2015, 50/2018, and 95/2018.

2.5 Policies to improve the status of the older population

International framework

The international legal and strategic framework plays a crucial role in establishing standards and guidelines aimed at improving the position of older persons, promoting active aging, and ensuring greater social inclusion. Legal documents adopted at the international level serve as the foundation for the development of national and local policies that address the specific needs of the older population.

The key planning documents that provide a framework for aging policies are **the Vienna International Plan of Action on Aging (VIPAA, 1982)**[57] and **the Madrid International Plan of Action on Aging (MIPAA, 2002)**[58]**.** These documents emphasize the importance of protecting the rights of older persons and ensuring their full inclusion in society across various domains, including health care, social protection, housing, security, and related areas.

The European Social Charter (1961, revised in 1996)[59], adopted by the Council of Europe, is a unique human rights instrument that guarantees older persons access to social protection. The signatory states of this instrument are committed to implementing measures that enable older persons to remain active members of society for as long as possible, including the provision of adequate resources and access to information about available services.

Some significant international documents that establish standards and recommendations for enhancing the rights, social protection, and quality of life of older persons prioritize issues of gender equality and human rights. In this context, **the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW, 1979)**[60] holds particular importance for older women, who frequently face multiple forms of discrimination based on both sex and age. This convention advocates for equality in all aspects of life, including access to health care, economic rights, social security, and protection from violence. Furthermore, **General Recommendation No. 27 on older women and protection of their human rights (2010)**[61] identifies various forms of discrimination that women experience as they age.

Although primarily intended for persons with disabilities, **the Convention on the Rights of Persons with Disabilities (2006)**[62] also indirectly addresses older persons who frequently experience physical, sensory, or cognitive difficulties in performing activities of daily living.

In addition to numerous international conventions, various strategies have been adopted and initiatives launched with the aim of improving the lives of older persons, promoting social inclusion, increasing the availability of health services, and enhancing living conditions. Examples include **the United Nations**

57 https://social.desa.un.org/issues/ageing/resources/ageing-resources/vienna-international-plan-of-action.
58 https://www.un.org/esa/socdev/documents/ageing/MIPAA/political-declaration-en.pdf.
59 https://ravnopravnost.gov.rs/wp-content/uploads/2012/11/images_files_Revidirana%20Evropska%20socijalna%20povelja%20SE.pdf.
60 https://arhiva.minljmpdd.gov.rs/lat/medjunarodni-ugovori-konvencija-CEDAW.php.
61 https://www.refworld.org/legal/general/cedaw/2010/en/27430.
62 https://ravnopravnost.gov.rs/wp-content/uploads/2012/11/images_files_UN_Medjunarodna%20konvencija%20o%20pravima%20osoba%20sa%20invaliditetom.pdf.

Principles for Older Persons,[63] then **the Sustainable Development Goals (Agenda 2030, United Nations)**[64], and **the Decade of Healthy Aging (2021–2030, World Health Organization)**[65]. These documents collectively promote health, gender equality, the reduction of inequality, the transformation of social perceptions of aging, and the development of supportive environments for older persons, thereby contributing to their integration into society and improving their quality of life.

The Republic of Serbia has ratified all the aforementioned conventions and harmonized its legislation with the priorities outlined in Agenda 2030 and the Decade of Healthy Aging 2021–2030.[66]

National framework

In the Republic of Serbia, the rights of older citizens are regulated by a comprehensive legislative framework that guarantees their safety, protection, and dignity, either directly or indirectly. **The Law on Pension and Disability Insurance**[67]**, the Law on Social Protection**[68]**, the Law on Health Care**[69]**, the Law on Health Insurance**[70]**, the Labor Law**[71]**, the Law on Prohibition of Discrimination**[72]**, and the Law on Social Housing**[73] **are among the most significant laws in this field.**

In addition to legal provisions, the Republic of Serbia has adopted several **strategic documents** that outline goals and measures aimed at improving the quality of life of older persons. One of the key strategic documents is the **Strategy for Active and Healthy Aging in the Republic of Serbia for the period 2024–2030.**[74] This strategic document is founded on the principles of social inclusion, gender equality, intergenerational solidarity, lifelong learning, digital competencies, education on health, psychological and social aspects of aging, and the active participation of older persons in all facets of social life. The objectives of the strategy align with international frameworks that promote the empowerment of older persons, including the Madrid International Plan of Action on Aging (MIPAA), the Regional Implementation Strategy (RIS), and the World Health Organization's Strategic Framework on Healthy Aging (Decade of Healthy Aging 2020–2030). The specific goals of the strategy include the following:

- Greater awareness among the general population of the needs and potentials of persons over the age of 65,
- Enhanced accessibility to public services for older persons, particularly in rural areas,
- Availability of lifelong learning programs as well as recreational and cultural activities for older persons,

63 https://www.ohchr.org/en/instruments-mechanisms/instruments/united-nations-principles-older-persons.
64 https://serbia.un.org/sr/sdgs.
65 https://www.decadeofhealthyageing.org/.
66 https://www.mei.gov.rs/srp/vesti/2686/detaljnije/w/0/miscevic-agenda-2030-je-nacionalni-prioritet-srbije/?utm_source=chatgpt.com.
67 "Official Gazette of RS", No. 142/2014.
68 "Official Gazette of RS", Nos. 24/2011, 42/2013, 106/2015, 50/2018, and 95/2018.
69 "Official Gazette of RS", Nos. 25/2019, 92/2023—authentic interpretation).
70 "Official Gazette of RS", No. 10/2016.
71 "Official Gazette of RS", No. 113/2017.
72 "Official Gazette of RS", Nos. 22/2009 and 52/2021.
73 "Official Gazette of RS", No. 72/2009.
74 "Official Gazette of RS", No. 84/2023.

- Strengthened volunteer engagement among older persons, especially within local government units, and
- Improved institutional and non-institutional protection for older persons, including health care, social protection and security, and violence prevention.

The Action Plan for the period 2024–2026[75] serves as a companion document to the strategy. It sets out five specific objectives and 17 corresponding measures to achieve them. The aim is to promote the active and healthy engagement of persons aged 65 and over across all social domains identified in the strategy. The Ministry of Family Welfare and Demography is responsible for coordinating and reporting on the implementation of the Action Plan, in cooperation with the Council for Old Age and Aging Affairs, which was established by the Government of the Republic of Serbia in 2023.[76]

The Strategy for Deinstitutionalization and Development of Community-Based Social Protection Services for 2022–2026[77] is also of particular importance for older persons. This strategy focuses on transitioning from institutional care to community-based social protection services that enable older persons to remain in their homes longer and have their needs met in a familiar environment. The goal of the strategy is to develop a support network that includes home help and day care services, family and intergenerational support, as well as innovative forms of supported housing. The Action Plan for implementing this strategy for the 2025-2026 period is currently under development.

Moreover, operational guidelines defined in the **Strategy for Prevention and Protection Against Discrimination for the 2022–2030 period**[78], as well as in the **Strategy for Gender Equality for the 2021–2030 period**[79], contribute to improving the position of older persons. These strategic documents include measures to combat discrimination against older persons, particularly women aged 65 and over, who frequently experience multiple forms of discrimination based on sex and age. However, the action plans for implementing these strategies expired in 2023.

It is crucial to underscore that certain critical strategic documents that establish the course of development in the areas of social protection and the quality of life for older citizens have not yet been updated. For example, the **Social Protection Strategy** expired in 2009, the **Poverty Reduction Strategy** in 2010, the **Social Housing Development Strategy** expired in 2022, and the **Palliative Care Strategy** expired in 2015. These documents serve as the foundation for shaping public policies aimed at improving the living conditions of older persons.

75 https://www.minbpd.gov.rs/wp-content/uploads/2023/12/Akcioni-plan.pdf.
76 "Official Gazette of RS", No. 29/23.
77 "Official Gazette of RS", No. 12/2022.
78 "Official Gazette of RS", No. 12/2022-58.
79 "Official Gazette od RS", No. 103/2021-3.

3. RESEARCH METHODOLOGY

3.1 Analytical framework and examined dimensions

The research methodology was designed to facilitate understanding of how receiving support affects the risk of poverty among older persons. In the context of this research, older persons are defined as individuals aged 65 and over who are not employed and require assistance in performing activities of daily living. The need for assistance is determined by the type of difficulty and the level of dependence on support from others. The methodology is grounded in the definition proposed by the European Commission and the Committee for Social Protection:

Figure 2: Examined dimensions

"Long-term care is defined as a range of services and forms of assistance to people who, as a result of mental and/or physical frailty and/or disability over an extended period of time, depend on help with daily living activities and/or are in need of some permanent nursing care. Activities of daily living requiring support may include personal care activities necessary on a daily basis—activities of daily living such as bathing, dressing, eating, getting up from bed or chair, going to bed, moving, toileting, managing continence—as well as activities related to independent living, such as meal preparation, managing finances, shopping, housekeeping, and using the telephone (European Commission, 2014)."[80]

The survey covered key aspects of older persons' lives, including access to social and health services and factors associated with poverty, thereby providing a clearer picture of the need to improve care and support services for this group (Figure 2).

80 European Commission (2014).

3.2 Research methods and sample description

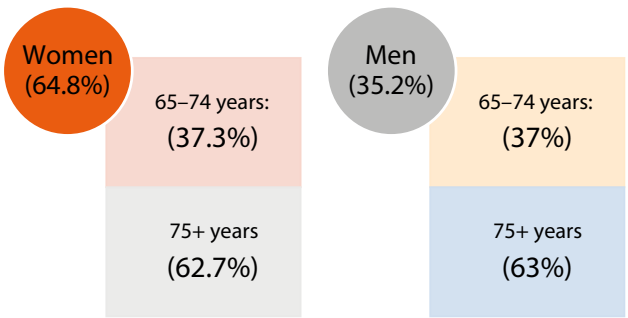
The analysis is based on data collected in several stages, using various methods:

1. **Desk analysis** involved reviewing relevant publications, research, and publicly available data on poverty and social exclusion among people aged 65 and over, their long-term care needs, and the availability of these services in Serbia. It also included an overview of legislation relevant to improving the status of older persons. The goal of the desk analysis is to use secondary data sources to provide a comprehensive description of the context in which this research is conducted, offer insights into the status of older persons, and identify key challenges within the support system for this social group.
2. **Quantitative research** was conducted with persons aged 65 and over who live in Serbia and require assistance with activities of daily living. Data was collected using a structured questionnaire administered using the CATI (Computer Assisted Telephone Interview) method. This method ensured accurate and detailed information about respondents' experiences and needs.

   To ensure the sample included only older persons in need of assistance, respondents were first asked questions designed to identify difficulties that require support—such as problems with vision, hearing, or mobility—and whether they needed help from others with activities of daily living, regardless of these difficulties. For respondents unable to answer survey questions due to illness or physical limitations, the questionnaire was completed via telephone conversations with their carers (full questionnaire available in Annex 1).

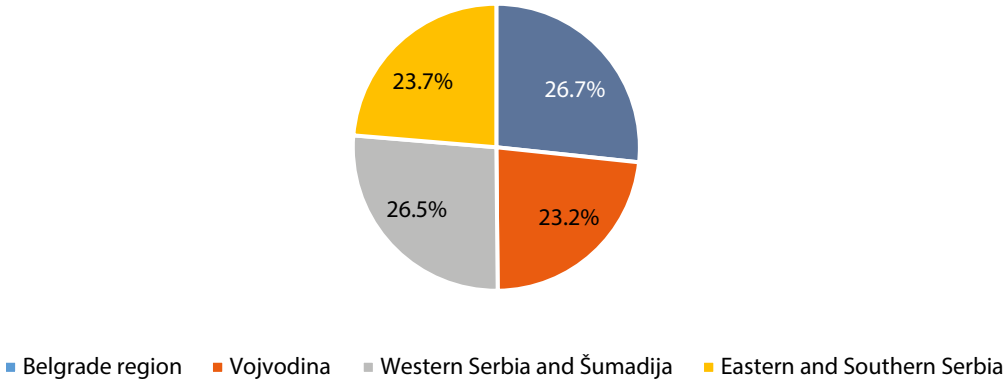
   A total of 600 persons aged 65 and over participated in the quantitative research, with the majority (62.8%) aged 75 and over and 37.2% belonging to the younger-old age group (65–74). By gender composition, women constituted the majority of respondents both in the overall sample and within each age group (Chart 6).

Chart 6: Sample composition by sex and age



Regarding regional sample composition, respondents were almost evenly distributed across four regions (Chart 7). The sample also included older persons living in both urban and rural areas, with the majority residing in smaller towns (37.7%) and villages (38.8%), and only 23.5% living in major urban centers such as Belgrade, Novi Sad, Niš, and Kragujevac. The data suggests that respondents predominantly live in environments where family networks play a crucial role in providing care and support.

Chart 7: Sample composition by region



3. **Qualitative research** was conducted as a case study, which provided a more profound understanding of the specific personal experiences and resources of older persons. This understanding was crucial for identifying the challenges and strategies that older persons employ in order to receive the necessary support services, which may increase their risk of poverty.

   The qualitative research aimed to analyze in detail how household members secure health and social assistance for persons aged 65 and over, including the provision of services, associated costs, daily care practices, and the allocation of resources. The study examined the effects of service availability on the emotional and psychological well-being of recipients, as well as on the dynamics of daily living, from the perspective of older persons.

   The research employed in-depth interviews with members of three households from two local government units in which the development of services is envisaged, in accordance with the project plan. An in-depth interview enables the researcher to gain a deeper understanding of respondents' daily challenges, needs, and experiences, as well as the specifics of their strategies for securing necessary support. The interview was designed to facilitate open-ended responses, allowing respondents to articulate their experiences, perspectives, and opinions (interview guides are available in Annex 1).

3.3 Ethical aspects of research

The research adhered to high ethical standards to ensure the protection of participants throughout all stages of data collection and processing. All respondents were guaranteed complete anonymity as well as full confidentiality of all information shared with the researchers. At the outset of the survey, respondents received clear information about the purpose of data collection. It was explained that the data would be used exclusively for research purposes, stored securely, analyzed appropriately, and would not be misused.[81] It was also emphasized that participation was voluntary, respondents were not obliged to answer any questions they preferred to skip, and they could withdraw from the survey at any time if they felt uncomfortable. At the beginning of each survey, obtaining informed consent from every respondent was mandatory (consent form is available in Annex 1).

The research team paid special attention to ensuring that the language was comprehensible, the questions clearly defined, unambiguous expressions used, and clear definitions provided for any terms requiring further explanation. Additionally, special care was taken to formulate questions in a culturally sensitive way to avoid causing discomfort and to ensure they were not perceived as inappropriate or offensive by respondents.

It is important to emphasize that the research was conducted with full adherence to the principles of human rights and gender sensitivity. The research team ensured that every aspect of the study aligned with the Gender Equality and Women's Empowerment Policy[82], respecting the rights of all individuals and duly considering their specific needs and experiences. This approach ensured that the research was conducted not only in accordance with ethical standards but also contributed to advancing gender equality and empowering women in old age.

3.4 Methodological limitations

One of the main methodological limitations of this research is that the assessment of households' economic situations relies solely on the respondents' subjective observations and self-assessments. Although this approach may introduce certain biases—since respondents' answers depend on personal perceptions, current emotional states, and individual values—it is important to note that self-assessment is frequently used as a valid indicator in poverty research. When combined with objective measures, it can offer reliable and valuable insights into the actual risk of poverty by reflecting personal perceptions of needs and living standards.

Additionally, given the sensitivity of the research topic, respondents may have been inclined to provide answers reflecting perceived social norms. Out of shame, fear of stigmatization, or a desire to avoid negative judgment, respondents may underreport their actual circumstances or downplay the severity of their needs. This tendency is particularly pronounced among women, who often claim they can manage everything independently, even when they objectively require assistance. One of the reasons

81 In accordance with the Law on the Protection of Personal Data ("Official Gazette of RS", No. 87/2018).
82 UNECE (2021).

for this attitude lies in the traditional role of women as family carers. Although they are often responsible for managing the household and caring for other family members, they are still expected to remain independent and capable of looking after themselves. The open expression of their genuine needs may be further impeded by the perception that an inability to meet these expectations is a personal failure or a socially intolerable condition. This subjective dynamic can hinder the validity of the data collected and complicate the process of accurately evaluating the situation of older persons and their caregivers. However, research on phenomena that are inherently challenging to quantify, such as the adequacy of support and perceived requirements, frequently depends on the self-assessments of respondents. In this context, subjective data provides advantageous information regarding the perspectives of older persons, even in the absence of objective indicators.

Finally, discrepancies may arise in the assessment of care needs in cases where carers provided responses to the survey questions. Caregivers may possess a unique perspective on the needs of the older persons they support, shaped by their daily caregiving experiences, which may not correspond with the older persons' own perceptions. Such differences can influence the reliability of the data, particularly if carers unintentionally minimize or exaggerate the needs of those they support. However, including carers in the research remains one of the most effective approaches to understanding the condition of the most vulnerable groups, as their perspectives are often essential for capturing a more complete picture.

4. FAMILY CONTEXT AND STANDARD OF LIVING

4.1 Family context of the older population

- Almost one-third (32.5%) of older persons in the sample live alone, indicating both a degree of autonomy and a potential need for additional assistance due to possible loneliness. Multigenerational nuclear households—where older persons live with children or grandchildren but without other extended family members—were the least common, accounting for just 13% of the sample.
- The prevalence of single-person households increases with age: more than a third (36.3%) of persons aged over 75 live alone, compared to a quarter among those under 75.
- Notable gender differences are also observed—older women are more likely to live alone (37.3%) or in households with children or grandchildren but without other extended family members (17.5%), while older men more often live with a partner (46.4%).
- Pensions serve as the primary source of household income for more than half of the respondents (57.5%), highlighting the significant dependence of older persons on the pension system and their potential economic vulnerability.
- Informal financial assistance—primarily from relatives and friends—is more common than formal support mechanisms: 15.7% of respondents receive assistance from informal sources, compared to only 7% who benefit from attendance allowance and approximately 1% who receive financial social assistance.

- Financial assistance, whether from formal or informal sources, is significantly more common among respondents experiencing severe difficulties in performing activities of daily living—over a quarter of them (27.6%) receive such assistance—while this proportion is notably lower among those with minor difficulties (8.4%).
- In general, older persons tend to assess the financial situation of their households as unfavorable; nearly half of the respondents report that they are unable to cover basic living expenses.
- Self-assessment of the financial situation reveals significant differences based on the place of residence. Older persons living in villages and smaller towns more frequently report barely covering or failing to cover basic living expenses (over 50%), whereas such responses are less common among those living in larger cities (37.6%).
- Perceptions of financial status also vary depending on income sources; on average, respondents from households receiving financial assistance tend to rate their financial situation worse compared to those with income from wages or rents.

Family composition and household type significantly influence the quality of life of older persons and their access to assistance with activities of daily living. Analysis of data from a quantitative survey conducted in Serbia, based on a sample of 600 respondents, reveals diverse family living arrangements among older persons aged 65 and over (Chart 8). **The majority of respondents live alone (32.5%), indicating a high degree of independence among this group but also potential loneliness and a need for additional social or institutional support.** A smaller percentage of respondents reported living with a spouse or unmarried partner (28%). Multi-family households[83] continue to play an important role, with 26.5% of older persons living in households comprising multiple family nuclei. The least common household type is the nuclear multigenerational family[84]—defined as a family composition in which older persons live only with their children or grandchildren**,** excluding extended family members—accounting for 13% of the sample. **The average household size in the sample is 2.4 members.** In the overwhelming majority of households (69.8%), there are two or fewer members (including the respondent), while 17.2% have three to four members, and 13% have five or more members.

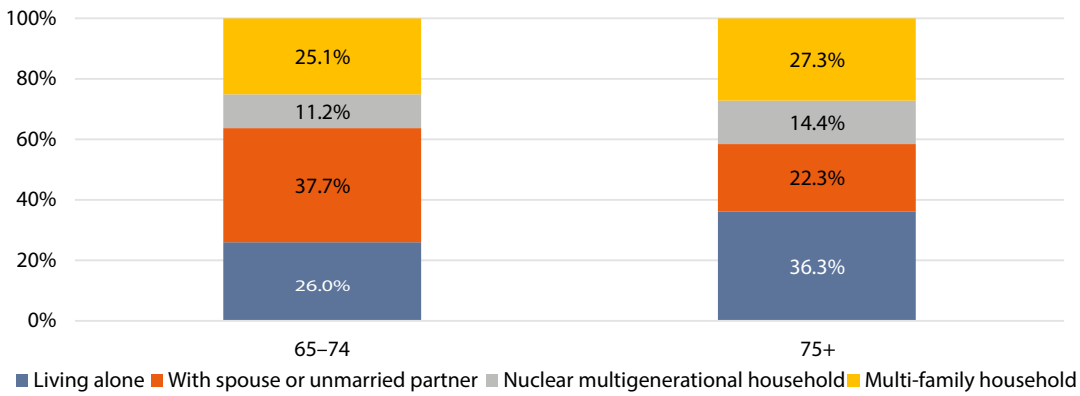
83 Multi-family households refer to family arrangements composed of several nuclear family units, typically households where older persons live with their children and grandchildren.

84 Nuclear multigenerational families are households in which older persons live with their children or grandchildren, without the presence of extended family members.

Chart 8: Type of household in which older persons (65+) live

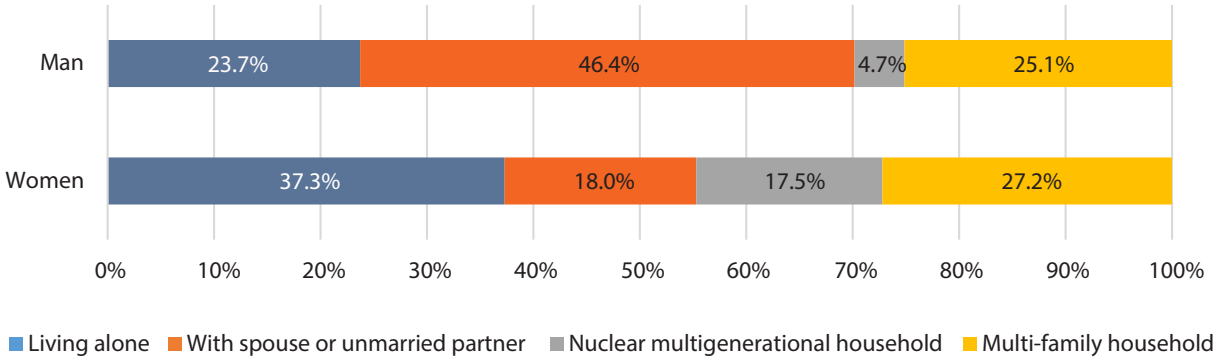
There are notable differences between the household types of younger-old persons (aged 65–74) and those aged 75 and over. **The oldest respondents (75+) most frequently live alone—over one-third (36.3%) of respondents aged 75 and over live in single-person households, compared to one in four among the younger-old.** In contrast, younger-old adults are most likely to live with a spouse or unmarried partner (37.7%), whereas this is the case for only 22.3% of those in the oldest-old group. These findings indicate that the proportion of single-person households increases with age.

Chart 9: Household type by age group



Older women are significantly more likely to live alone than older men (37.3% versus 23.7%), as well as to live with children or grandchildren who do not have families of their own (17.5% versus 4.7%). Nearly half of the men in the sample live with a spouse or unmarried partner (46.4%), whereas only 18% of women in the sample live in this type of household. There is no statistically significant difference in household type based on the respondent's place of residence.

Chart 10: Household type by sex

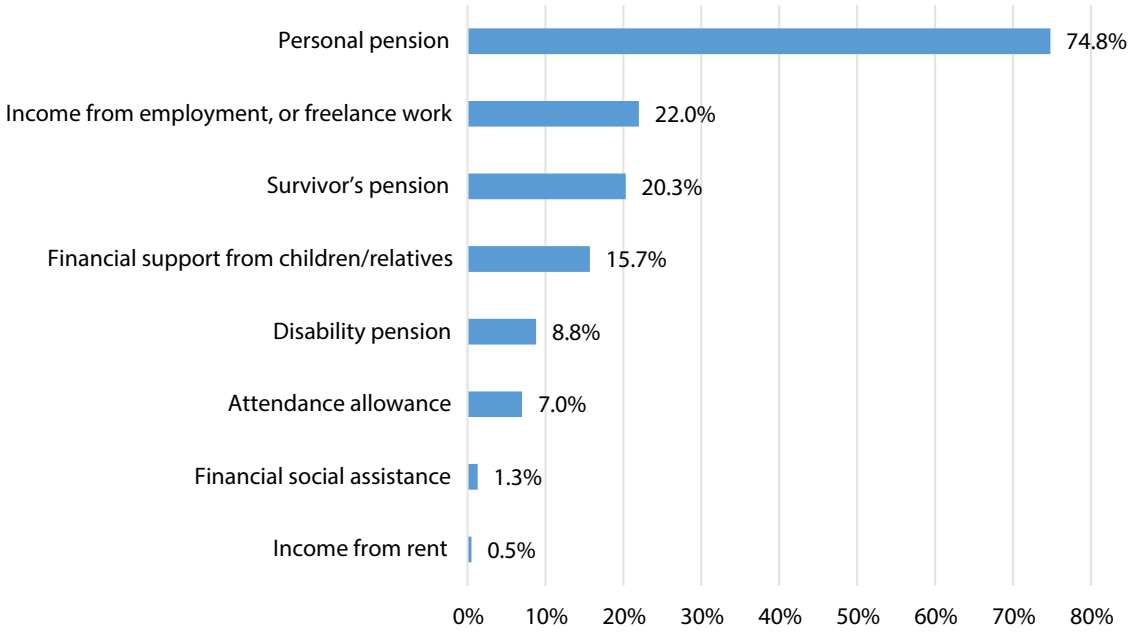


4.2 Older persons' living standards

An important indicator of the living standards of older persons is the income of the households in which they reside. Households may receive income from various sources—such as earnings, pensions, and financial assistance—depending largely on household type and the number of its members. Given that the sample consists of older persons, it is not surprising that **three-quarters of the households (74.8%) receive income from personal pensions (i.e., pensions from prior employment), one in five households (20.3%) receive a survivor's pension, and nearly one in ten households (8.8%) receive a disability pension.** Besides pensions, one in five respondents' households reports income from employment or from freelance work by one or more household members (Chart 11).

In terms of financial assistance, respondents more frequently receive assistance from relatives and friends than from formal support systems—such as attendance allowance (15.7% versus 7%). Only a small percentage of households (just over 1%) receive financial social assistance. **It is important to note that more than half of the respondents (57.5%) live in households where a pension—whether personal, survivor's, or disability—is the sole source of income.**

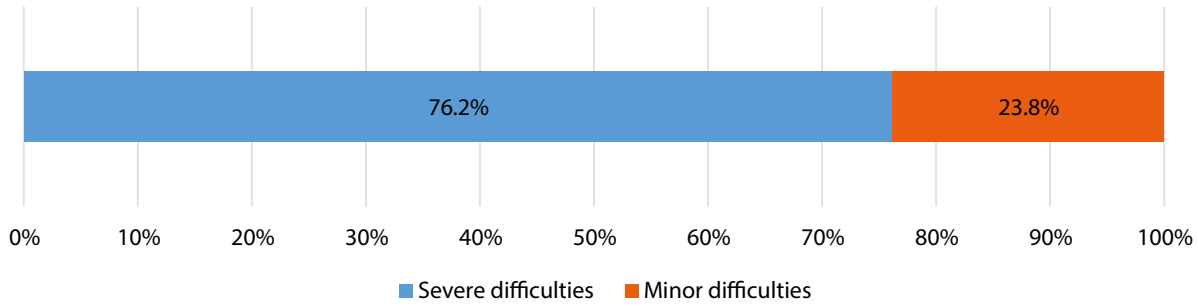
Chart 11: Household income



Different types of financial assistance—provided through both formal and informal support networks[85]—are significantly more prevalent among respondents who experience severe difficulties in performing activities of daily living compared to those who report only minor difficulties. More than one-quarter of respondents with severe difficulties receive some form of financial assistance (27.6%), whereas this is the case for only 8.4% of respondents with minor difficulties. In other words, among respondents whose households receive this type of support, the vast majority (91.3%) are individuals who face severe difficulties in performing activities of daily living. Other respondent characteristics—such as sex, age, and place of residence—were not found to be statistically significant in relation to household income types.

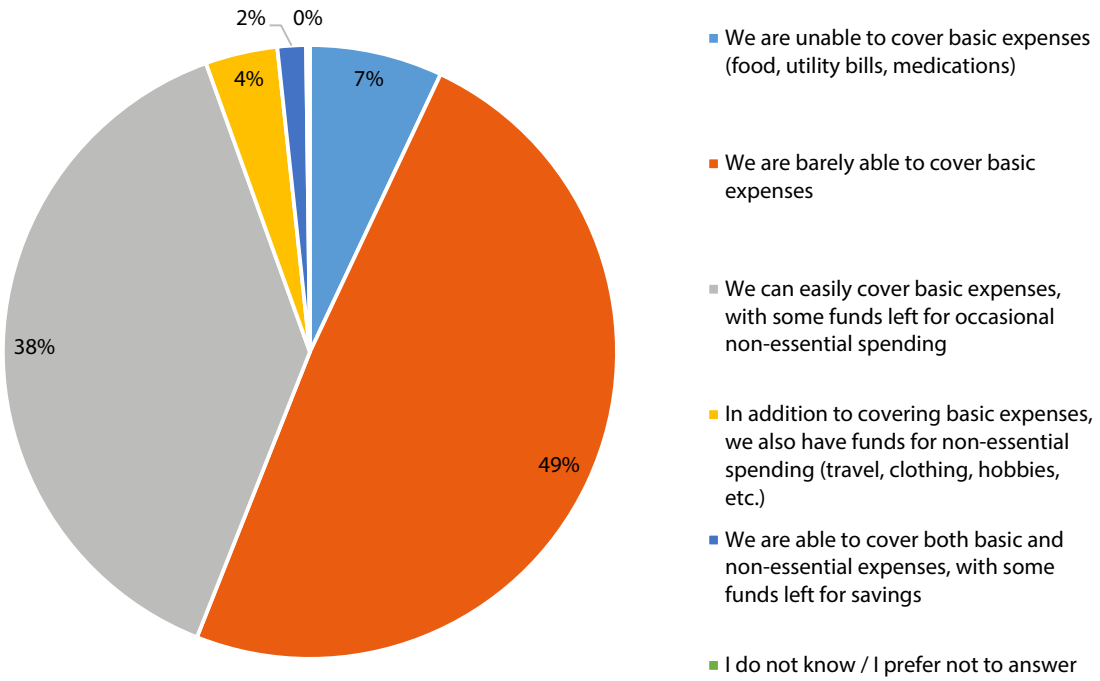
85 In this context, various forms of financial assistance refer to the three categories of income presented in Chart 11: financial social assistance, attendance allowance, and financial support from children or relatives.

Chart 12: Respondents receiving financial assistance, by level of difficulty (N=138)



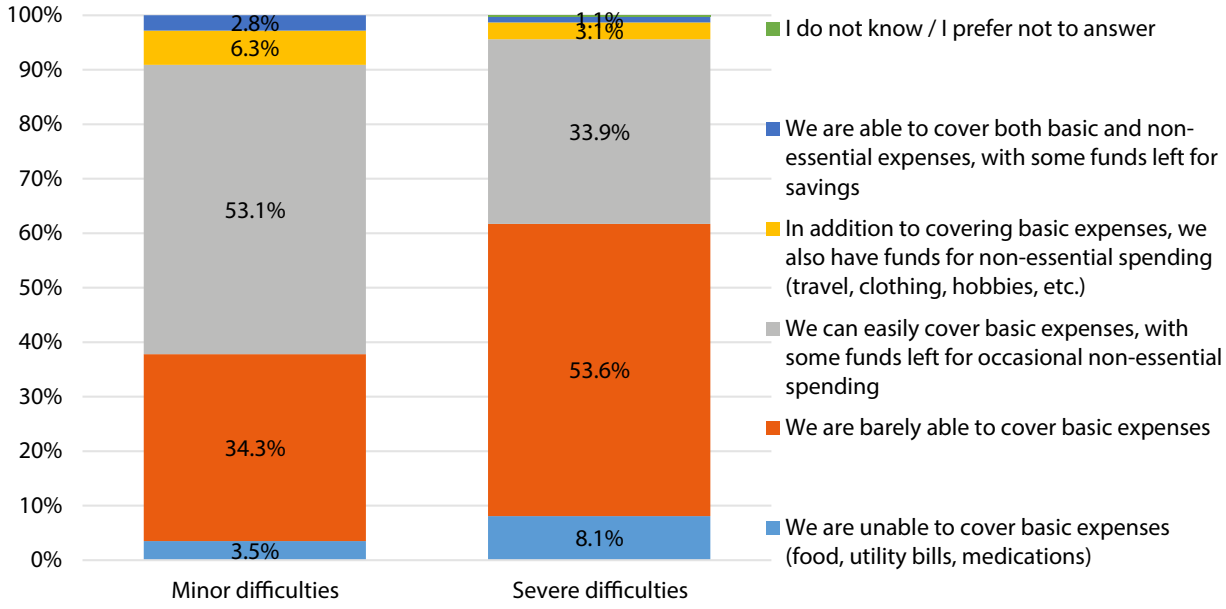
Almost half of the respondents indicated that their total household income is insufficient to adequately cover basic living expenses. A slightly smaller proportion reported that they are able to meet their basic needs with relative ease and can afford some additional expenditures. Nevertheless, a significant share stated that their income does not cover even their basic living expenses. Only a very small percentage report having the financial resources to engage in more "luxurious" activities, such as travel, hobbies, or similar pursuits. (Chart 13).

Chart 13: Self-assessment of the household financial situation



Respondents experiencing severe difficulties in performing activities of daily living rate their financial situation less favorably than those with only minor difficulties in performing such activities (Chart 14).

Chart 14: Self-assessment of financial situation by level of difficulty



Self-assessment of financial situation also varies by the respondent's place of residence. Respondents living in rural areas more frequently report being unable to cover basic expenses (8.2%) compared to those living in larger cities (5%). Additionally, respondents from villages and smaller towns more often report that they can barely cover basic expenses (52.2% and 52.8%, respectively), compared to 37.6% of those living in larger cities. Differences by sex, age, or household type are not statistically significant.

Respondents from households receiving financial assistance tend to rate their financial situation less favorably, whereas those from households with income from wages or rents report the most positive assessments. Among those receiving financial assistance, one in ten respondents (9.7%) report being unable to cover basic living expenses, while the majority (52.8%) state that they can barely cover them. Conversely, among respondents whose household income includes wages or rental income, the majority (51.9%) report that they are able to cover basic expenses with ease and set aside additional funds for other needs.

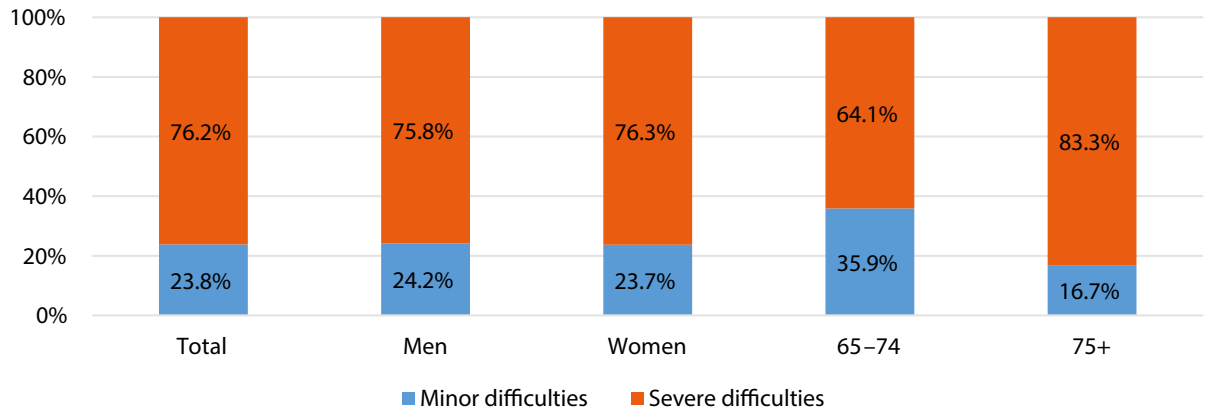
In households where pensions are the sole source of income, the assessment of the financial situation closely reflects that of the whole sample. Nearly half (49.3%) of respondents in households where pensions are the sole source of income report that they can barely cover basic expenses. Over one-third (35.9%) state that they can cover basic expenses and set aside a bit more for other needs, whereas 6.9% report having sufficient income for non-essential spending, while 7.8% indicate that they are unable to cover even basic expenses.

5. NEEDS FOR ASSISTANCE WITH ACTIVITIES OF DAILY LIVING

- The majority of older persons (76.2%) report a need for some form of assistance due to significant difficulties in performing activities of daily living, most commonly caused by disabilities or chronic illnesses.
- The most challenging activities for older persons include going shopping, attending medical appointments (59%), and walking or climbing stairs (58%). Additionally, more than half of the respondents experience difficulties with maintaining household hygiene and preparing food.
- Older respondents are substantially more likely to report challenges in nearly all areas of daily living, with both the need for assistance and difficulties in performing daily activities increasing with age. Memory and recall difficulties are the sole exception, as no substantial differences are observed.
- Older persons living in multi-person households more frequently report a need for assistance, particularly with mobility and personal hygiene activities, whereas those living alone report such difficulties less often, suggesting a higher degree of functional independence.
- More than one-third of older persons rate their health as poor or very poor, whereas only 10% consider themselves in good health. Respondents from older group (75+) report significantly less favorable assessments compared to the younger-old group (42.2% versus 26.9%).

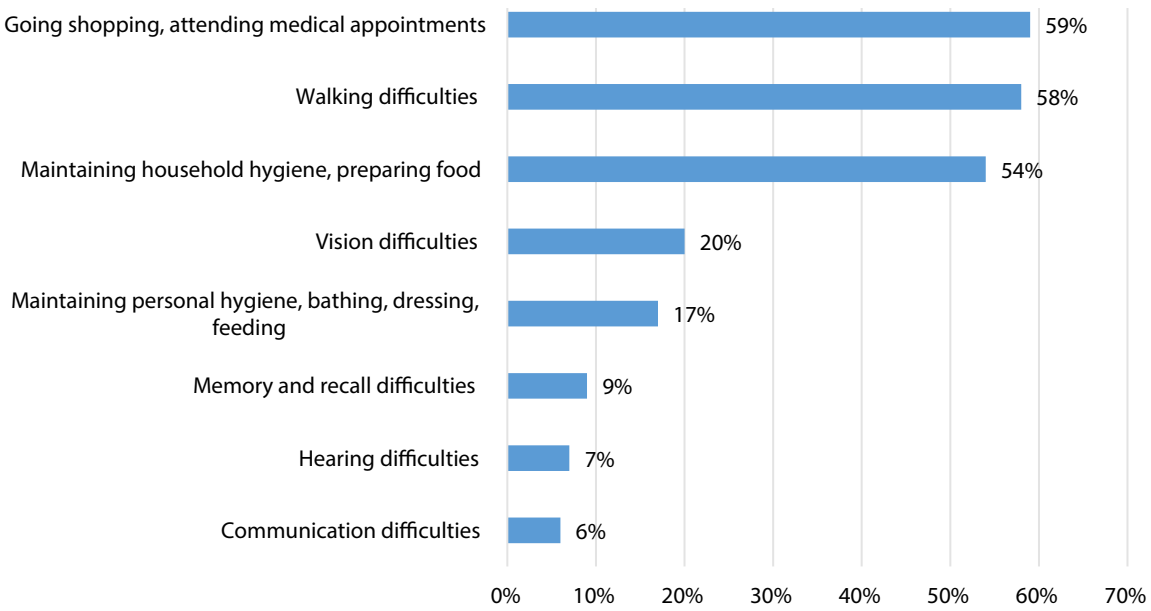
Survey findings reveal that 76.2% of older persons aged 65 and over require some form of assistance due to severe difficulties in performing activities of daily living caused by disability or serious chronic illness. Differences in the share of individuals needing assistance exist between age groups, with a higher percentage of respondents aged 75 and over reporting a need for assistance compared to the younger-old group (65–74).

Chart 15: Share of older persons needing assistance due to varying levels of difficulty in performing activities of daily living



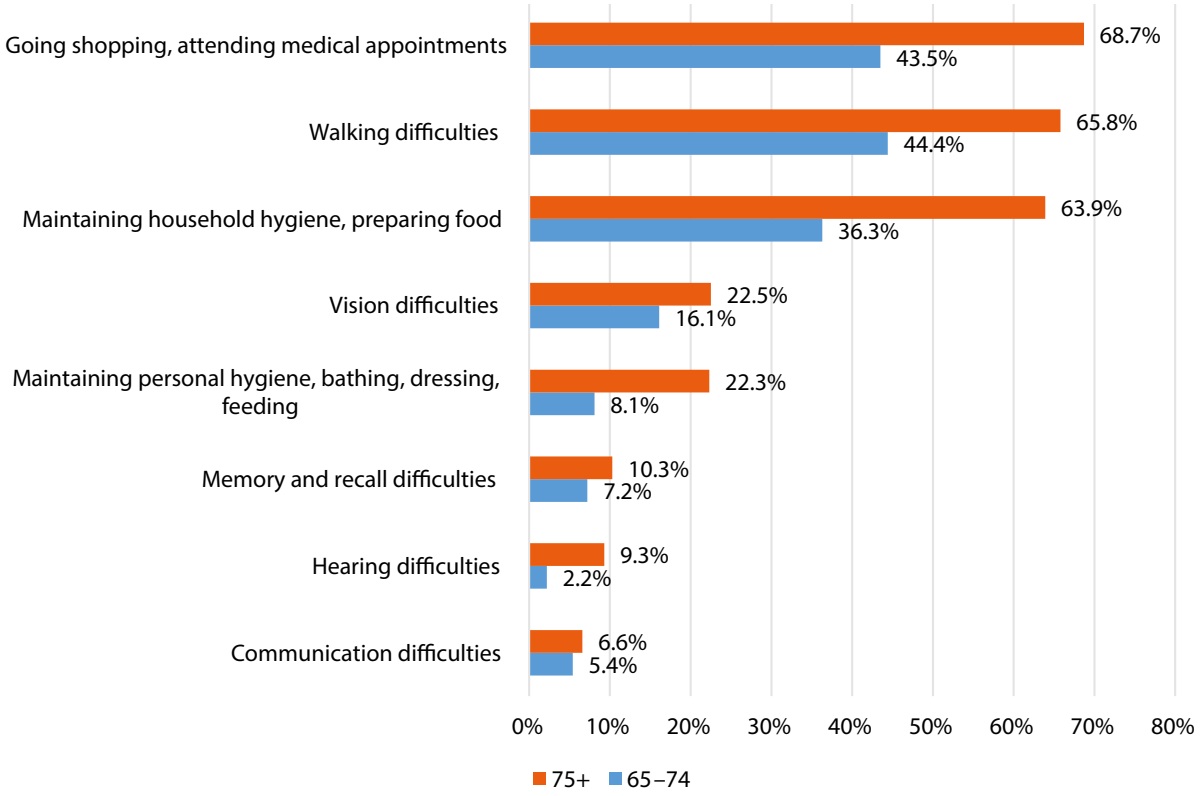
Mobility and movement-related activities are the most common sources of difficulty in performing activities of daily living. Specifically, a large proportion of respondents report difficulties with going shopping, attending medical appointments, walking, and climbing stairs (Chart 16). Apart from mobility, more than half of the respondents report severe difficulties with maintaining household hygiene and preparing food. About a quarter of respondents report having vision difficulties, and 17% report having trouble maintaining personal hygiene. A smaller percentage report difficulties with memory, communication, and hearing.

Chart 16: Share of older persons reporting severe difficulties in performing activities of daily living, by activity type



Research findings indicate that **both the level of difficulty and the need for assistance with almost all activities increase with age**. Statistically significant differences exist between the two age subgroups in almost all activities and difficulties, except for memory and recall. In other words, respondents in both age subgroups report similar levels of difficulty with memory and recall.

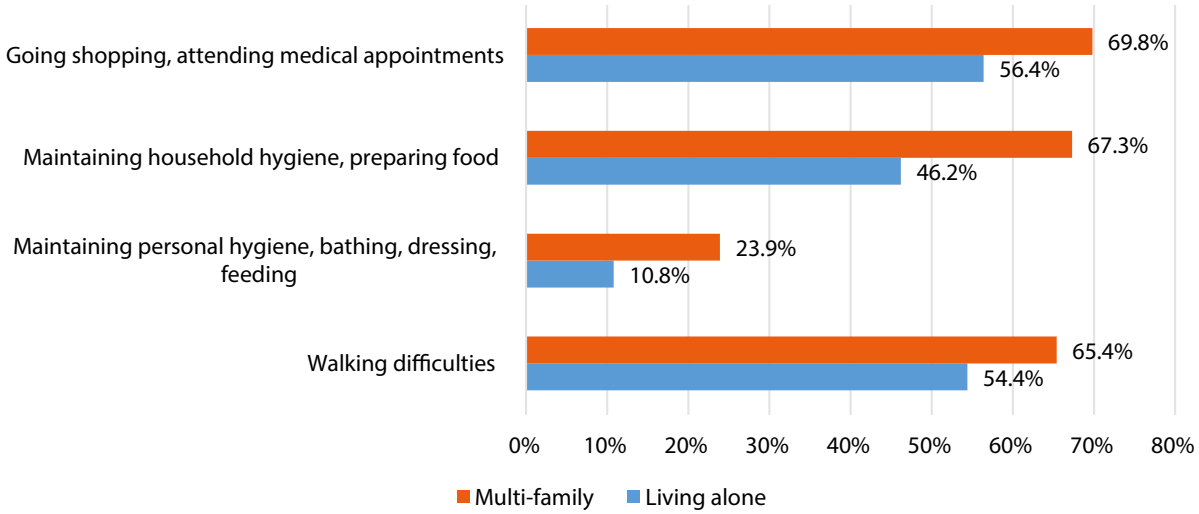
Chart 17: Share of older persons reporting severe difficulties in performing activities of daily living, by activity type and age group



Gender differences are evident in only two activities: walking and communication. Among women, a slightly higher percentage report difficulties with walking and climbing stairs compared to men (59.1% versus 55.5%). Conversely, a slightly higher percentage of men report difficulties with communication and understanding—10.4% of men compared to only 3.9% of women noted these challenges.

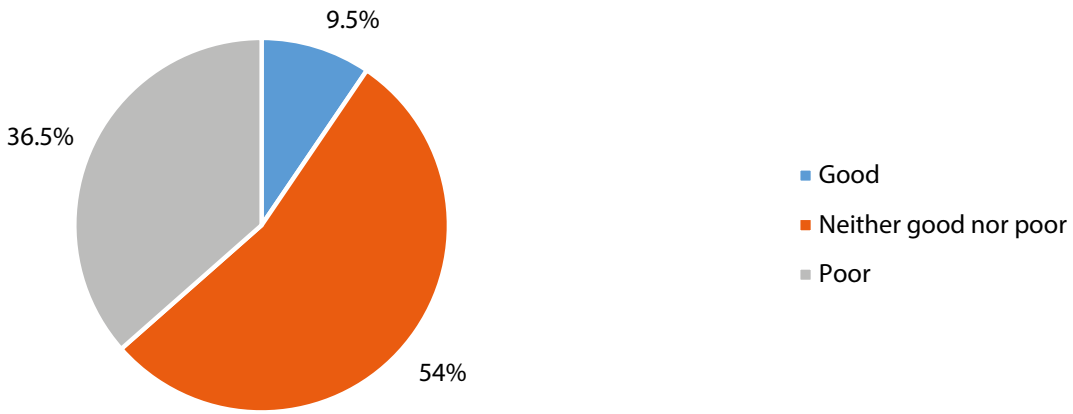
Differences in the assessment of difficulties also vary according to the type of household in which respondents reside. **Respondents living in multi-person households more frequently report needing assistance compared to those living alone.** These differences are most apparent in activities related to mobility and hygiene, including both personal and domestic hygiene. It is presumed that individuals residing in one-person households live alone because they experience minor difficulties in performing activities of daily living.

Chart 18: Share of older persons reporting severe difficulties in performing activities of daily living, by activity type and household type



Indicators of self-assessed health status show that most respondents rate their health as neither good nor poor. More than one-third rate their health as poor or very poor, and only 10% consider their health status good.

Chart 19: Self-assessment of health status



There are notable differences between age groups regarding health status, with respondents from the older group (75+) tending to rate their health less favorably compared to the younger-old. Slightly more than one-quarter (26.9%) of respondents aged 65–74 rate their health as poor, compared to 42.2% of those aged 75 and over. As expected, the level of difficulty in performing activities of daily living is closely associated with respondents' self-assessed health status. In other words, the greater the level of difficulty experienced by respondents, the less favorable their self-assessed health status.

6. MEANS OF MEETING ASSISTANCE NEEDS

The following chapters examine the various means through which older persons meet their assistance needs, with particular emphasis on forms of assistance provided within the scope of long-term care. The findings of each chapter will be presented in detail by the type of assistance provided, including assistance with performing activities of daily living, home health aides and other types of personal and practical assistance.

The analysis covers sources of funding—both formal and informal—as well as models of financing assistance. It includes data on services paid for by recipients themselves, the extent to which free services are accessible, and the impact of out-of-pocket payments for assistance on recipients' financial situation and the overall economic well-being of their households. Special emphasis will be placed on user-perceived differences in the quality of services, depending on whether the assistance is paid or unpaid. The following chapters aim to deepen the understanding of the complexities involved in providing assistance to older persons and to contribute to discussions on enhancing the availability, quality, and sustainability of the long-term care system.

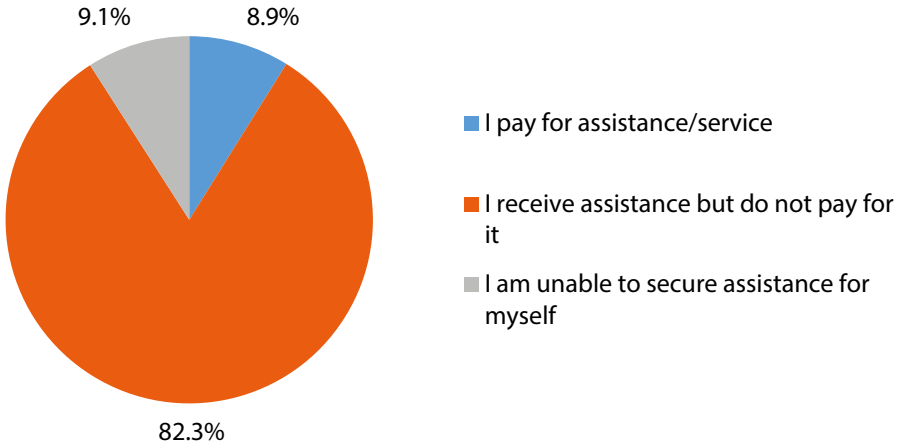
6.1 Assistance with personal care activities

- One in ten respondents is unable to secure the assistance they need for activities such as eating, bathing, or dressing.
- Older persons living alone are significantly more likely to pay for assistance or remain without it, whereas those living in multi-person households most often receive assistance through informal networks. A greater number of household members opens up the possibility of arranging assistance within the family.

- As age increases, informal assistance networks tend to diminish, leading the oldest-old to more often finance the necessary care by themselves. Paid assistance with personal care activities is used exclusively by the older population aged 75 and over—11.3% report paying for assistance, while no cases were reported among older persons aged 65 to 74.
- Older persons who pay for personal care assistance hire carers through personal recommendations or advertisements, whereas those who do not pay typically rely on informal carers from within their social networks.
- During a typical working week, men receive nearly twice as many hours of assistance as women—men receive about 9 hours of assistance per day on average, compared to only 4 hours for women.
- Financial barriers are the primary reason older persons cannot secure or expand assistance with personal care activities. More than half of respondents (52.5%) report that they were unable to secure or expand assistance they needed due to a lack of funds.
- Older persons who are unable to secure assistance remain without adequate help. In most cases, these persons are compelled to rely on themselves or on occasional informal assistance from within their social network.

Slightly more than a third of respondents (34.8%) report needing assistance with personal care activities such as feeding, bathing, or changing. The majority of individuals who report the need for support receive assistance from informal carers, primarily family members, friends, or neighbors. A smaller proportion rely on formal, paid assistance, whereas nearly one in ten respondents report failing to secure the necessary assistance for themselves (Chart 20). Due to the limited number of respondents who report paying for personal care assistance, the analysis will further present primarily descriptive data, except in cases where statistically significant differences are observed.

Chart 20: Securing assistance with personal hygiene activities (N=209)



The means of securing assistance vary depending on the household type. Data indicates that older persons who either pay for or are unable to receive the assistance they need are more likely to live alone. This situation is particularly pronounced among individuals who are unable to secure the necessary care for themselves (Chart 21). Conversely, respondents who receive the assistance they need—particularly through unpaid support—are more likely to live with a spouse or in multi-person households. This suggests that larger household units have greater capacity to arrange assistance within the family, primarily through the involvement of informal carers. **In contrast, individuals living alone are more likely to depend on paid forms of assistance or may completely lack access to necessary support due to financial constraints or the absence of informal caregiving support networks.**

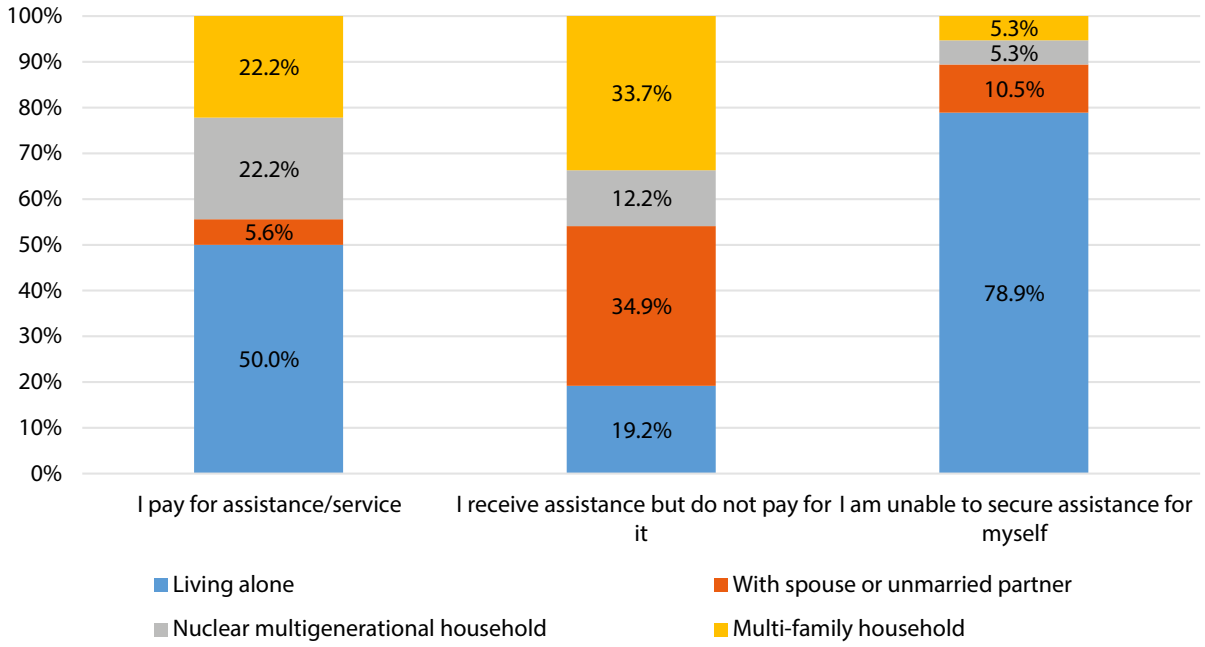
As individuals age, their need for support increases, but the means of securing it tend to change. Individuals who pay for assistance with personal care activities belong exclusively to the 75+ age group. Among the younger-old (65–74), no respondents reported paying for assistance, while 11.3% of those aged 75 and over did. This pattern suggests that informal assistance networks may diminish with age. **Younger-old individuals generally rely on informal and unpaid forms of assistance—most commonly from family or community members—whereas those aged 75 and over are more likely to lack access to such assistance and are therefore compelled to secure it through their own means.**

Assistance provision patterns appear largely similar regardless of whether older persons live in urban or rural areas or their level of difficulty in performing personal care activities.

However, perceived financial status is closely linked to the means by which assistance with personal care activities is secured. Respondents who are unable to secure assistance rate their financial status most unfavorably, whereas those who pay for assistance report a somewhat more favorable perception of their financial status. Although pensions remain the primary source of income, it is noteworthy that social benefits—such as financial social assistance or the attendance allowance—are more frequently reported as income sources by those who pay for assistance compared to those who receive unpaid

assistance or no assistance at all. This may suggest that supplementing income increases the capacity to secure assistance. This is further supported by the fact that among those who pay for assistance, there is a near-equal distribution between individuals who cover the costs themselves and those whose expenses are partially or fully covered by family members. Among those who do not pay for assistance, the most common additional sources of income are wages and rents, which may indicate the presence of other household members with more stable earnings.

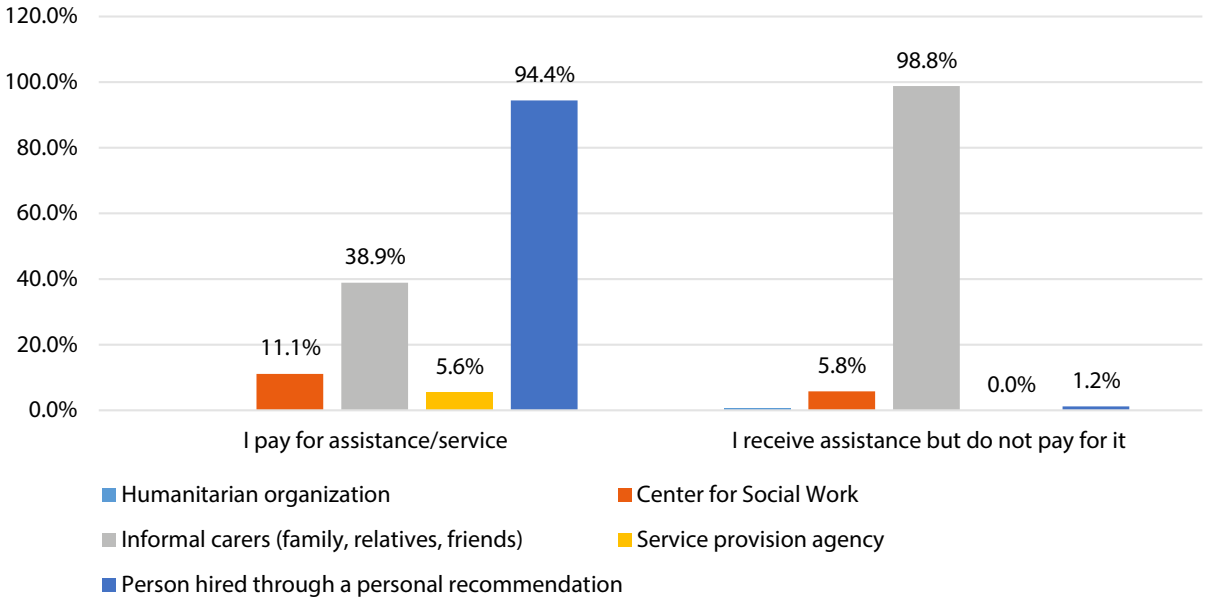
Chart 21: Means of securing assistance for personal hygiene activities, by household type (N=209)



The choice of assistance providers is largely determined by household financial capacity. Respondents who pay for assistance most often hire carers through advertisements or personal recommendations, whereas those who do not pay typically rely on informal carers—usually family members or friends (Chart 22). Importantly, in practice, assistance is often provided through a combination of formal and informal care arrangements. Individuals who pay for support often supplement it with assistance from informal carers, while those receiving unpaid assistance may also access services within the formal social protection system—most commonly through centers for social work. Previous research[86] has shown that the main reason for combining multiple forms of assistance is the limited scope of care—particularly the insufficient number of hours provided—which must be supplemented by other forms of assistance.

86 Babović, et. al (2022.) Access to long-term care services in Serbia. Belgrade: Red Cross of Serbia, available at: https://secons.net/publikacija/pristup-uslugama-dugotrajne-nege-u-srbiji/.

Chart 22: Providers of assistance with personal care activities (N=190)



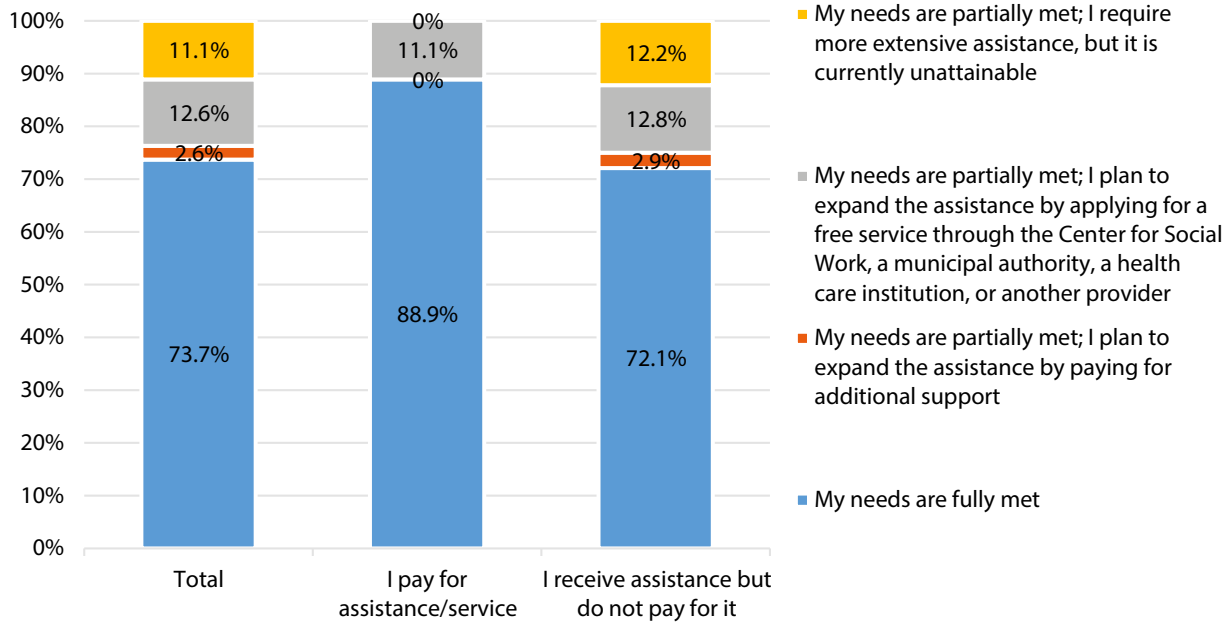
When it comes to the scope of assistance—both in terms of the number of carers and the number of hours provided—no significant differences were observed between older persons who pay for assistance and those who receive it without payment. Regardless of whether the assistance is paid or unpaid, most respondents receive care from one or two persons (the average is 1.5 carers). In particular, 61.5% of respondents receive assistance from a single person, 27.8% from two persons, and 10.7% from more than two persons. The only statistically significant difference relates to the household size: as the number of household members increases, so does the average number of persons providing assistance. This finding confirms that **household members represent an important resource in assistance provision**.

On average, respondents receive 45 hours of assistance per week—just over 6 hours per day. Given that this assistance pertains to personal care and the fulfillment of basic physiological needs, the number of assistance hours reported by respondents is not unexpected. As many as 15.8% of respondents report receiving 24-hour assistance during a typical week. Data also reveals gender differences in the average number of assistance hours received. Specifically, **during an average workweek, men receive almost twice as many hours of assistance as women** (64.6 versus 32.5). In other words, men receive an average of 9 hours of assistance per day, while women receive only 4. **This discrepancy is a direct consequence of traditional gender roles, according to which women are expected to assume primary caregiving responsibilities—resulting in an unequal distribution of care within families.**

The majority of respondents report being satisfied with the assistance they receive, regardless of whether it is paid or unpaid (Chart 23). Those who pay for assistance report slightly higher levels of

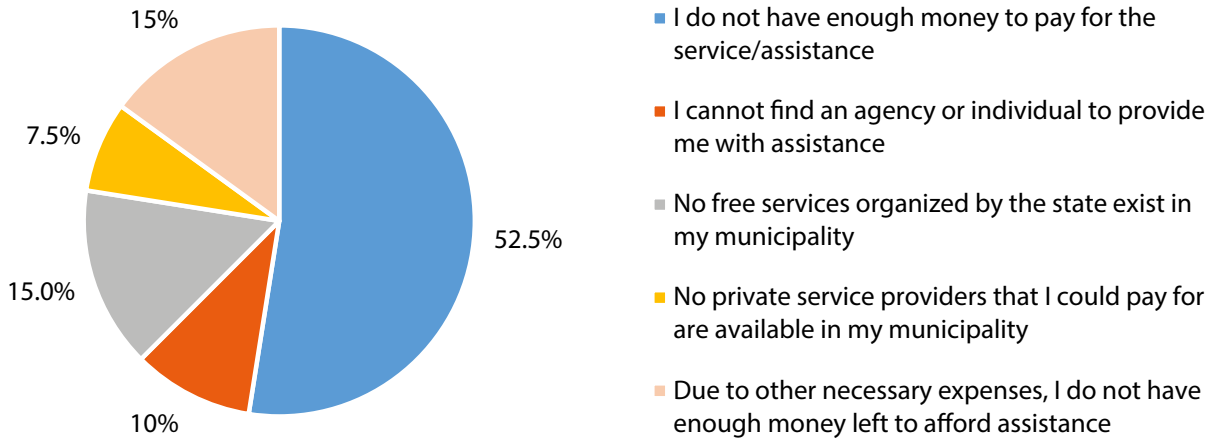
satisfaction than those who receive unpaid assistance, which may indicate a greater degree of control over the choice and quality of paid services. Plans to obtain additional assistance are primarily oriented toward the formal system—most commonly through applications for free services. However, among those currently receiving assistance, as many as 12.2% report that they will not be able to afford additional support to fully meet their needs.

Chart 23: Assessment of satisfaction with assistance received for personal hygiene activities (N=190)



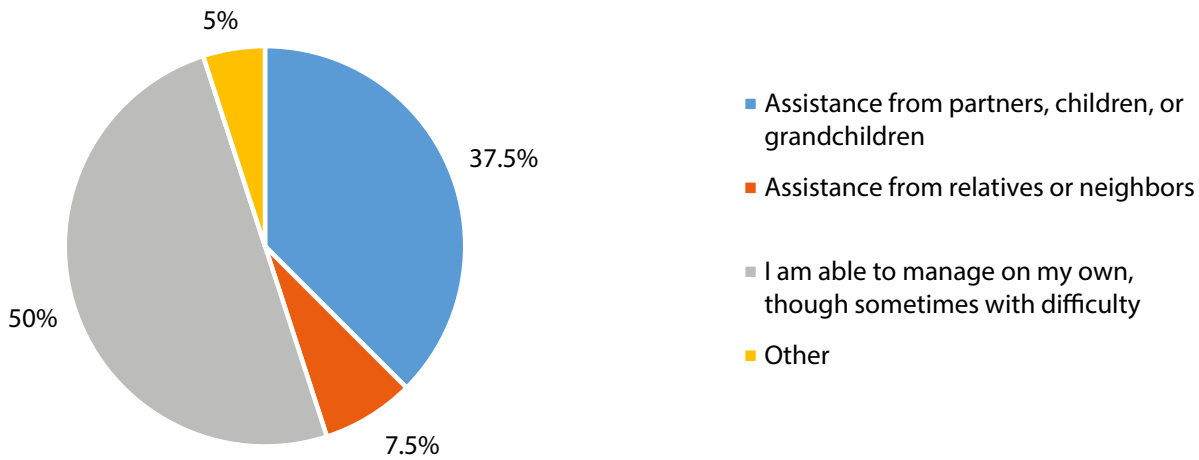
Financial constraints are the most commonly reported reason why respondents are unable to secure or expand the assistance they need (Chart 24). Among those who failed to secure or expand assistance with personal care activities, more than half (52.5%) cited a lack of financial resources as the main reason. In addition, 15% reported having to choose between paying for care and covering other basic living needs. Further illustrating the lack of alternatives, 15% of respondents stated that no free services are available in their municipality. On the other hand, even respondents with sufficient financial means to pay for services were unable to do so due to the absence of private providers in their municipality. These findings point to **pronounced structural deficiencies in the availability and accessibility of services**.

Chart 24: Reasons why respondents are unable to afford assistance with personal hygiene activities (N=40)



The absence of alternatives for providing assistance to older persons who, for various reasons, are unable to secure it themselves—whether through free or paid services—is a particularly concerning finding. In most such cases, respondents who need assistance must manage it on their own or rely on sporadic support from partners, family, neighbors, or friends (Chart 25). The situation is particularly critical, as it concerns personal care activities such as bathing, dressing, feeding, and toileting—needs that are fundamental and directly affect a person's dignity and health. A lack of assistance with these activities undoubtedly compromises the older persons' quality of life.

Chart 25: Means of securing assistance for unmet personal hygiene needs (N=40)



6.2 Assistance with activities relating to independent living

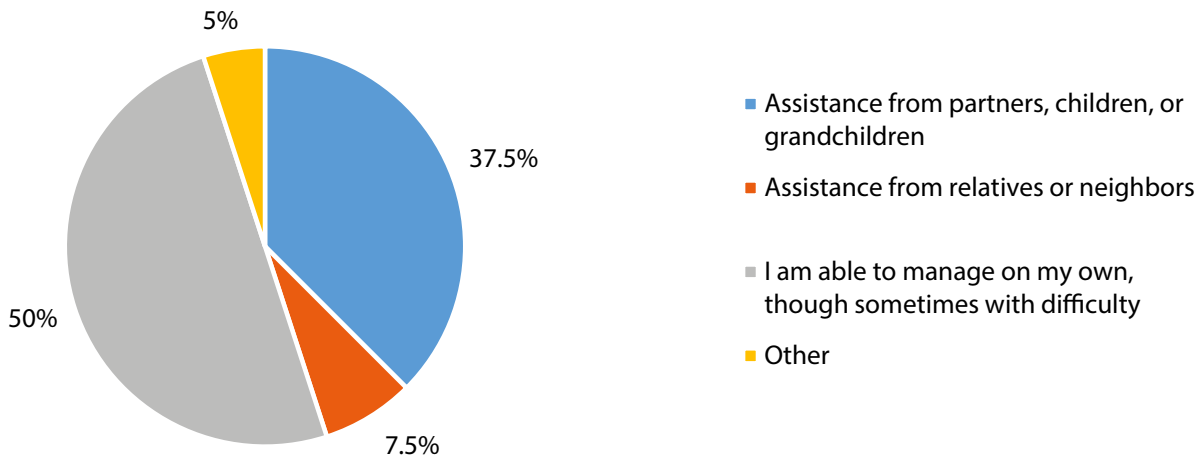
- Nearly all older persons (94.3%) report needing assistance with some activities including household maintenance, shopping, paying bills, or attending medical appointments. Most of the respondents receive such assistance free of charge, primarily via informal carers—most often family members, friends, or neighbors.
- Single-person households are more prevalent among both those who pay for assistance and those who are unable to secure it. In fact, nearly two-thirds of older persons who were unable to receive assistance live alone.

  Among those unable to secure assistance, a significantly higher proportion assess their financial status as poor—one-fifth report barely being able to cover basic expenses. In contrast, an equal share of those who pay for assistance report having sufficient funds left for non-essential spending.
- Social benefits are more commonly cited as part of the income composition of older persons who pay for assistance, suggesting that even limited supplemental income—such as social transfers—can improve access to needed care.
- Respondents who pay for assistance most often hire carers through advertisements or personal recommendations, while those who do not pay rely predominantly on informal carers, particularly family members and friends. In practice, however, the majority of care is provided through a combination of formal and informal assistance. The availability of formal services in rural areas is lower, as rural residents rely more heavily on informal carers (97.7%) than residents of large cities (90%).
- Older persons who do not pay for assistance receive nearly twice as many hours of help per day as those who do pay for this service—resulting in an 11-hour weekly difference. This finding suggests that informal and unpaid assistance enables greater volumes of support than paid services.
- Most older persons report that the available assistance meets their needs, regardless of whether it is paid or not. However, among older persons who currently do not pay for assistance, a greater proportion report that—despite having unmet needs—they have no way of securing additional support.
- Financial constraints are the most frequently reported reason for the absence of assistance with activities related to independent living (60%). An additional concern is that 14.7% of older persons reported having to forgo paid assistance in order to cover other expenses. The absence of free services in certain municipalities further impedes access to care, as confirmed by the same proportion of respondents who report that such services are not available in their municipalities.

As part of the research, in addition to activities related to personal care and hygiene, the needs of older persons to perform activities essential for independent living were also examined. These activities include maintaining the household, purchasing groceries, paying bills, attending medical appointments, and going to the post office.

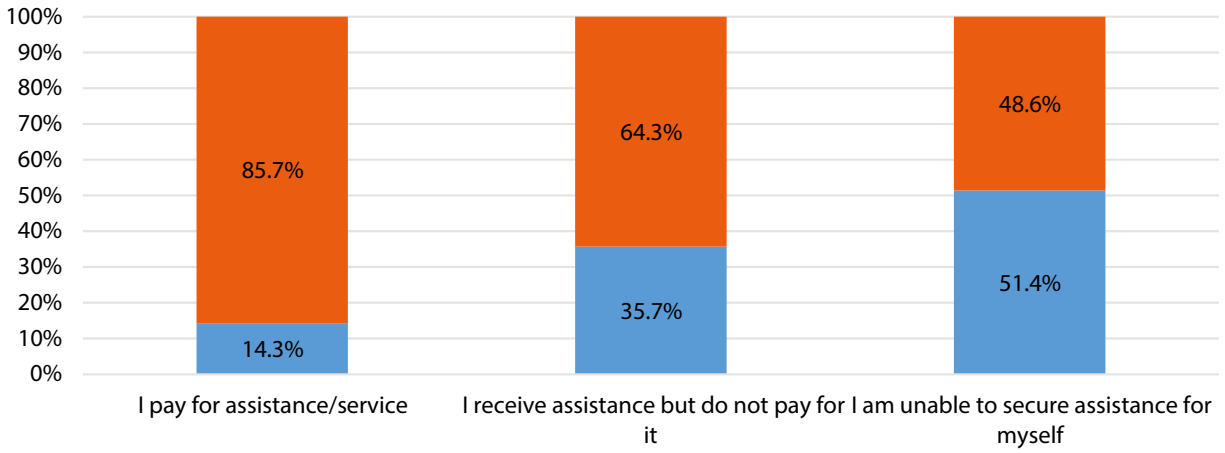
Almost all respondents (94.3%) reported a need for assistance with some of the activities, such as maintaining the household, purchasing groceries and paying bills, attending medical examinations, and going to the post office. As with assistance related to personal care activities, the majority of older persons in this case also receive free assistance (87.6%), while 6.2% receive paid assistance. The same percentage of respondents (6.2%) reported being unable to secure this form of assistance for various reasons.

Chart 26: Means of securing assistance with activities related to independent living (N=566)



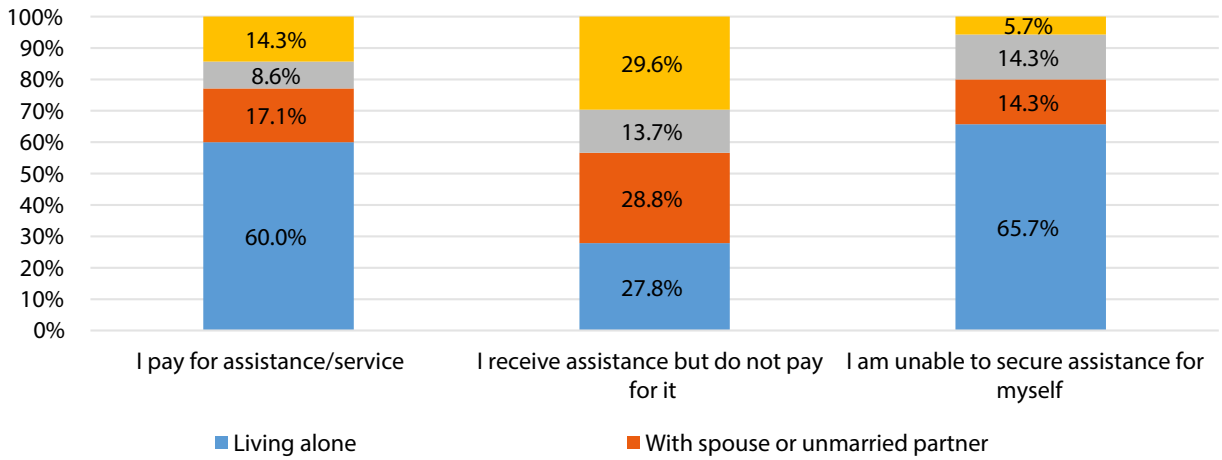
Similar to assistance with personal care, the means of securing assistance with activities related to independent living also vary by age. Older persons aged 75 and over are somewhat more frequently required to pay for this form of assistance, whereas the younger-old—those aged 65 to 74—more often report being unable to secure the necessary support.

Chart 27: Means of securing assistance with activities related to independent living, by age (N=566)



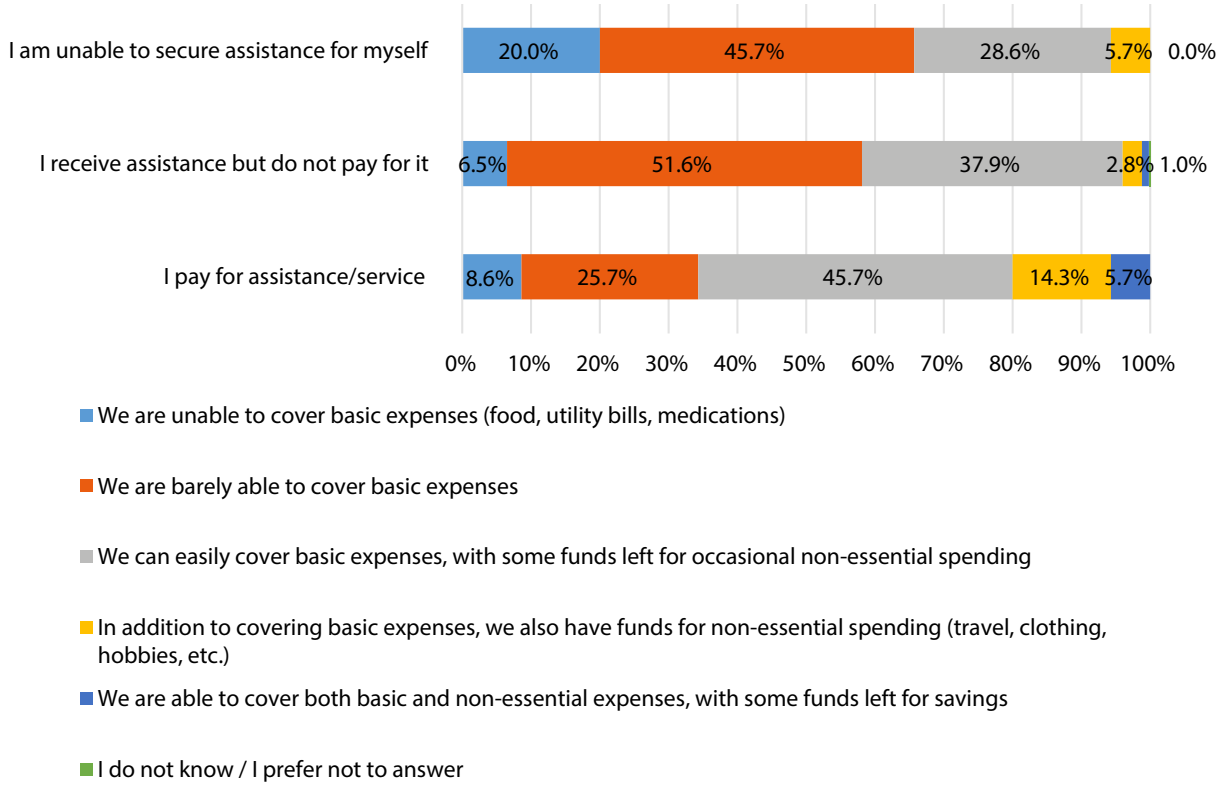
As with personal care and activities of daily living, the means of securing assistance largely depend on household composition. Single-person households are the most represented both among those who pay for assistance and among those who are unable to secure the necessary assistance. **Nearly two-thirds of older persons who were unable to secure assistance live alone (Chart 28).** In contrast, older persons who receive assistance generally live in multi-person households. These findings suggest that, in multi-person households, the responsibility for care is assumed by family members through informal caregiving arrangements. Conversely, older persons living alone are more likely to rely on paid forms of assistance due to their inability to arrange assistance.

Chart 28: Means of securing assistance with activities related to independent living, by household type (N=566)



Access to assistance also depends on the household's perceived financial situation. Respondents who are unable to secure assistance rate their financial status most unfavorably, whereas those who pay for assistance report a somewhat more favorable perception of their financial status. One fifth of those unable to secure assistance for themselves state that they can barely cover basic living expenses, while one fifth of those who pay for assistance report having sufficient income not only for basic needs but also for non-essential spending (Chart 29).

Chart 29: Means of securing assistance with activities related to independent living, by self-assessed financial status (N=566)



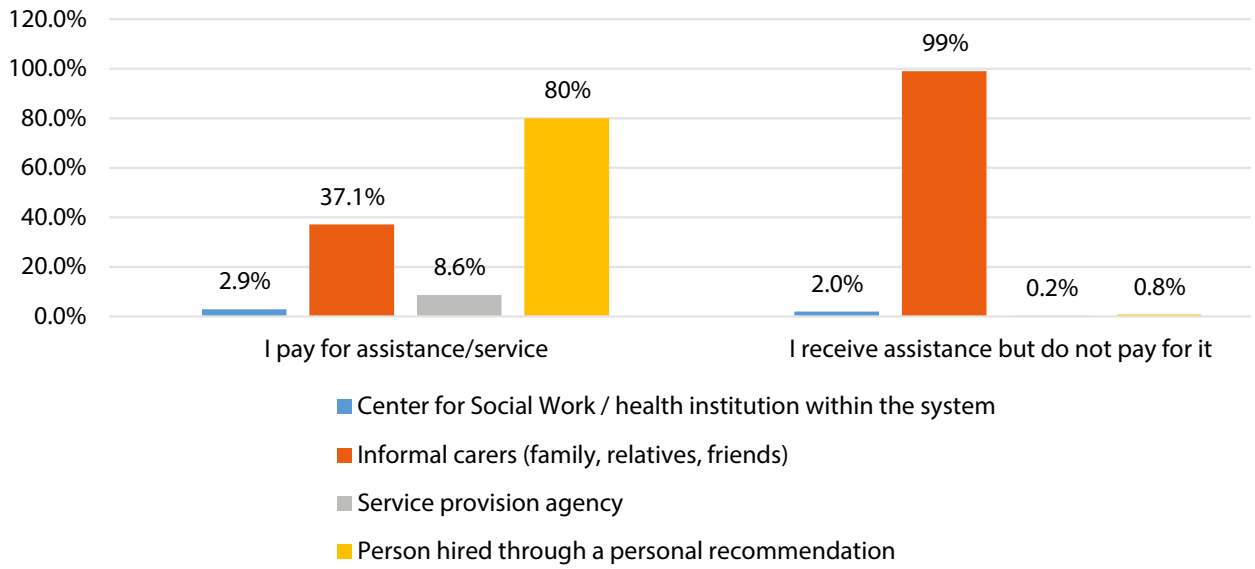
Pensions are the most common source of income for older persons. However, social benefits are more frequently found in the income composition of respondents who pay for assistance (34.3%), compared with respondents who receive unpaid assistance (23.8%) or do not receive assistance at all (17.1%). These findings suggest that supplementary income sources—even including social transfers—can enhance the ability of older persons to obtain necessary assistance. The data shows that most individuals who pay for assistance cover the expenses themselves using personal income, while a smaller proportion either co-finance the costs or have them fully covered by another party. Respondents' perspectives on the financial burden of such expenditures vary. It is most frequently cited that paying for assistance leaves just enough

income to cover basic needs. However, some respondents report that the cost of support has only a limited or negligible impact on the household budget.

For individuals who do not pay for assistance, wages and rental income represent the primary supplementary sources of household income. This suggests a higher likelihood of co-residing with household members who have stable earnings, enabling assistance to be arranged within the family without additional financial costs.

Among older persons who are able to secure assistance, the type of provider varies significantly depending on whether the assistance is paid or unpaid. **Respondents who pay for assistance most often hire individual carers through advertisements or personal recommendations, whereas those who receive unpaid assistance rely predominantly on informal carers—typically family members, friends, or neighbors** (Chart 30). Nonetheless, in practice, formal and informal assistance are often combined. Even among those who pay for assistance, it is common for formal care to be supplemented by support from family members or the broader social network, underscoring the continued importance of informal sources of assistance—even when financial resources are available to engage paid services.

Chart 30: Providers of assistance with activities related to independent living (N=531)



Significant differences in service providers are also observed across age groups. The oldest respondents (aged 75 and over) rely on formal assistance services more frequently than those in the younger-old group (3.2% versus 0%). They are also more likely to hire carers through advertisements or personal recommendations (8% versus 2.2%). Place of residence similarly affects both access to assistance and the means by which it is secured. **Rural residents are more frequently compelled to rely on informal carers (97.7%) than those in urban areas (94.8%), with the lowest reliance observed among residents of**

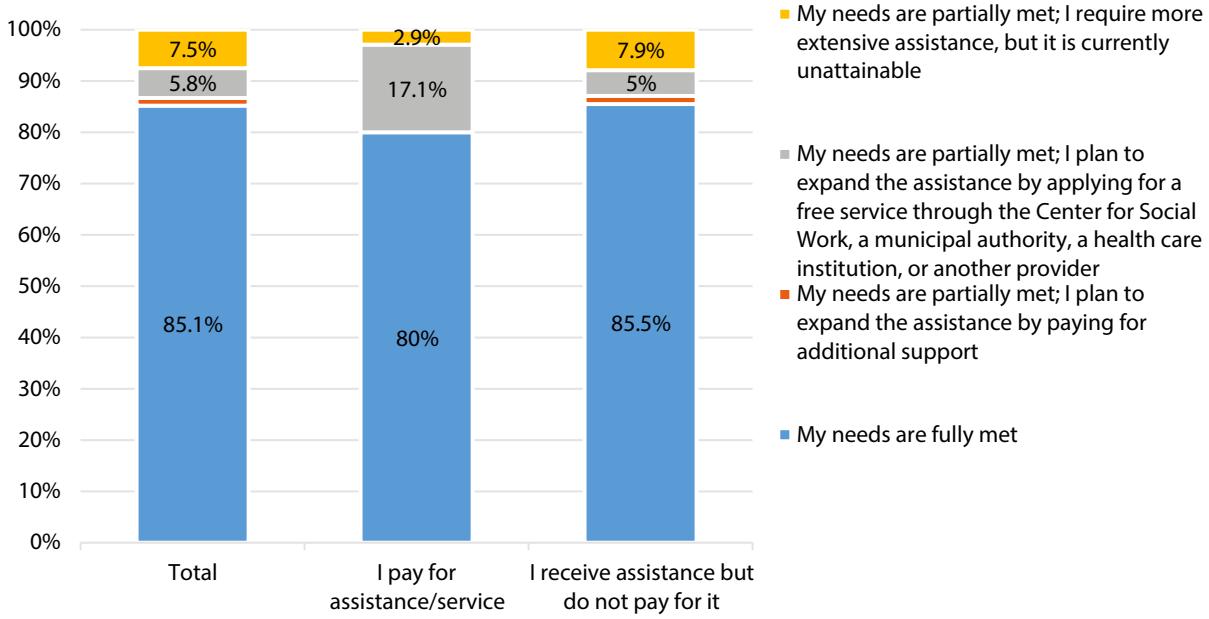
large cities (90%). Therefore, in villages—where formal services are also less available—the family more frequently serves as a key resource for providing care.

Regardless of whether the assistance is paid or unpaid, older persons typically receive it from one or two individuals. In the majority of cases, the burden of care and nursing is carried by a single individual (55.7%); one-third of respondents receive assistance from two individuals (33.9%), and 10.4% are assisted by three or more individuals during a typical working week.

Non-paying older persons receive far more hours of assistance weekly compared to those who pay. Specifically, respondents who pay for assistance receive an average of two hours of assistance per day, while those who do not pay for it receive nearly four hours per day—resulting in a difference of up to 11 hours on a weekly basis. It is not surprising that the scope of assistance received in such cases is considerably greater, given that older persons who do not pay for assistance most often arrange it within the family. In contrast, older persons who pay for assistance are often constrained by financial resources, which is reflected by the limited number of hours of assistance they are able to afford. Compared to women, men receive up to nine additional hours of assistance during a typical week. On average, men receive 32 hours of assistance with these activities per week, while women receive 23 hours.

The assistance provided to older persons, whether paid or unpaid, generally meets their needs (Chart 31). Nevertheless, a greater proportion of individuals who pay for assistance express an intention to expand its scope—most commonly by applying for free services. In contrast, a slightly higher proportion of individuals who do not pay for assistance are unable to expand its scope, although their needs are not fully met. The level of satisfaction does not vary significantly by level of difficulty, sex, age, or place of residence.

Chart 31: Assessment of satisfaction with assistance received for activities related to independent living (N=531)



As with assistance aimed at personal care, **the most common reason for the absence of assistance is financial hardship, as reported by 60% of respondents**. **It is of great concern that 14.7% of older persons were compelled to discontinue paid assistance in order to allocate their limited financial resources to other expenses**. Furthermore, in specific municipalities, the absence of free services prevents older persons from accessing adequate alternatives, as corroborated by 14.7% of respondents who reported that no such options are available in their municipality. Even those who can afford to pay for assistance often face additional challenges, such as the unavailability of service providers or agencies that offer this form of assistance (Chart 32).

Chart 32: Reasons why respondents cannot afford assistance with activities related to independent living (N=75)

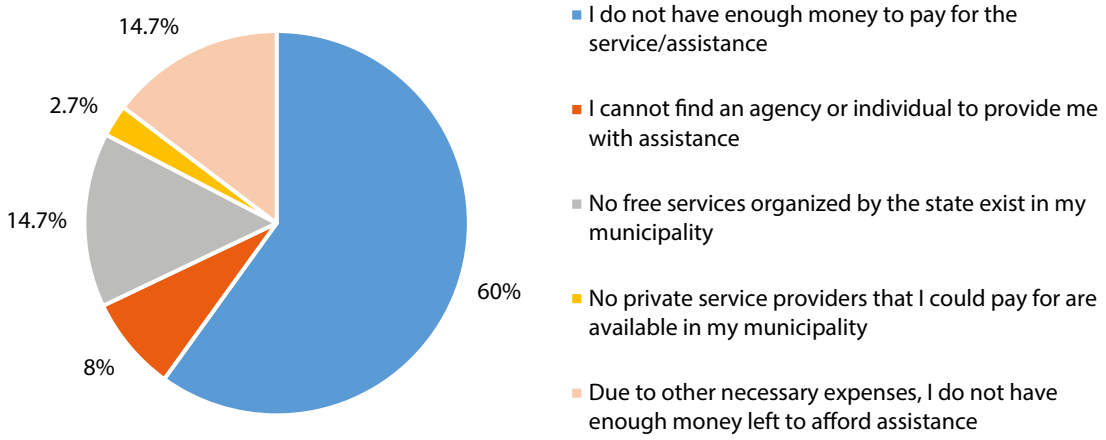
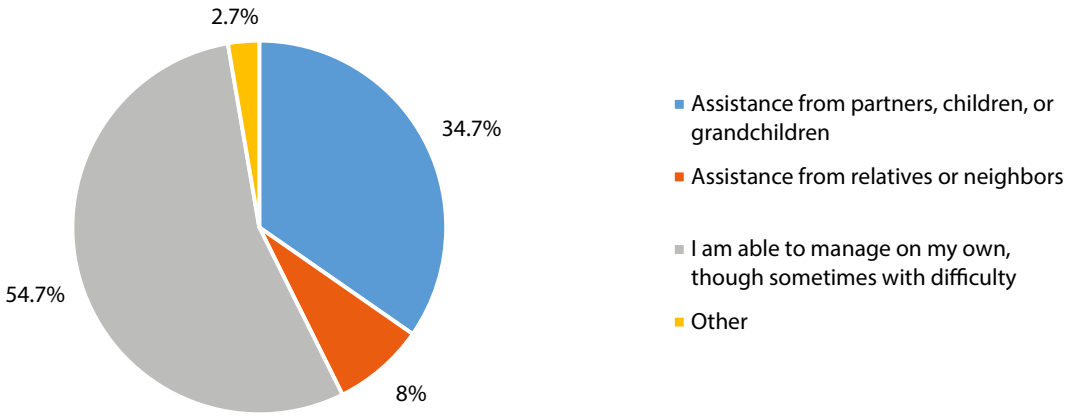


Chart 33 shows that older persons who are unable to secure assistance are largely left to cope on their own or rely on irregular assistance from family members, neighbors, or friends. **A key concern is the temporary and uncertain nature of available assistance.** Although most respondents receive some form of assistance from within their immediate or extended social network, it is often incomplete and depends on whether family members or neighbors are available at a given moment and whether they have the time, financial resources, and capacity to provide assistance.

Chart 33: Means of securing assistance for unmet needs with activities related to independent living (N=75)



Statistically significant differences are observed based on place of residence. Specifically, **older persons living in rural areas rely more heavily on immediate family and community networks for assistance compared to those in large cities** (15 respondents versus 1). This reflects deeper structural and cultural differences between settlement types. Smaller settlements maintain a stronger sense of community, solidarity, and intergenerational ties, whereas urban areas are more distinctly characterized by individualistic lifestyles. As a result, older persons living in large cities are more frequently compelled to cope independently compared to their rural counterparts (8 respondents versus 15).

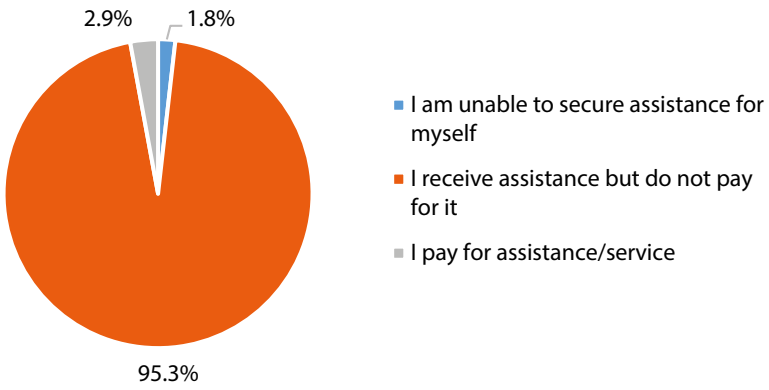
6.3 Medical care

- Almost all respondents (95.3%) who reported a need for medical care—such as blood pressure or blood sugar monitoring, wound dressing, or administration of therapy—have these needs fulfilled through informal carers.
- Older persons living in multi-person households are more likely to receive assistance through informal care, whereas those living alone are far more frequently left without the necessary assistance.
- Those who pay for assistance more often hire carers through advertisements or recommendations, while non-paying individuals predominantly rely on informal carers from within their community.
- Respondents with minor functional difficulties use formal assistance provided by health institutions more frequently (37.5%) than those with severe difficulties (22.6%).

- Regarding the number of hours of medical care received, respondents report an average of 11.7 hours per week, with no significant differences between those who pay for assistance and those who receive it free of charge.
- On average, men receive significantly more hours of health-related assistance than women, with a weekly difference of approximately six hours.
- A total of 8.9% of respondents reported a need for additional health care, which they believed they were currently unable to access. The majority of those who provided an explanation cited financial obstacles as the primary reason, while a smaller number pointed to the lack of free services in their municipality.
- The most common strategies for obtaining additional health care include relying on personal capacities, as well as assistance provided by family members, neighbors, and friends.

The need for specific types of health care—such as blood pressure and blood sugar monitoring, wound dressing, and administering therapy—was reported by 46% of respondents. The results indicate that as many as 95.3% of respondents rely on informal, unpaid assistance to meet their needs. Only eight respondents (2.9%) finance such assistance independently, while five (1.8%) reported being unable to access any form of health-related assistance (Chart 34).

Chart 34: Means of securing health care services (N=276)



The following analysis will provide a descriptive account of the distinctions between the groups as a result of the limited number of respondents who reported paying for assistance with blood pressure and blood sugar monitoring, dressing wounds, or therapy administration.

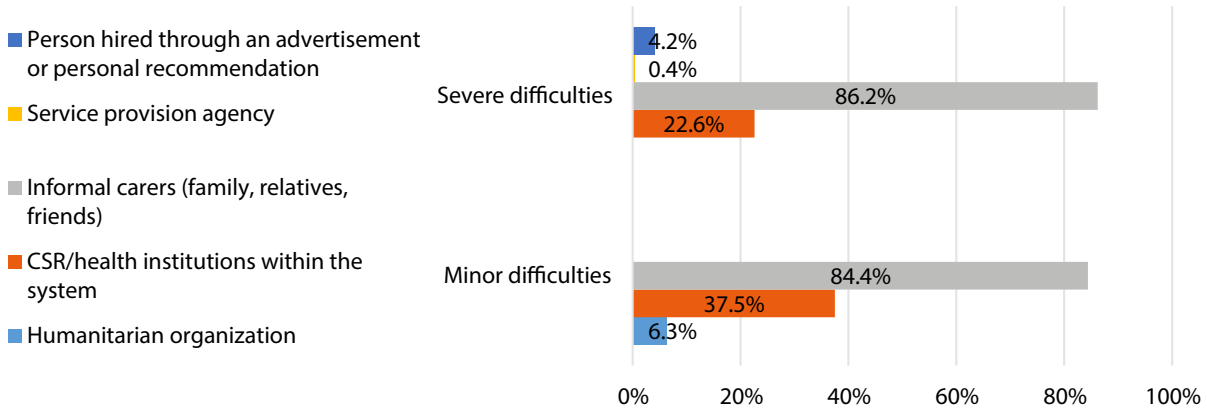
The findings suggest that variations in securing assistance are primarily linked to the type of household in which respondents reside. **Living with a partner or with members of either the immediate or extended family significantly increases the likelihood that an older person will receive necessary health care, primarily through informal caregiving arrangements.** Those who do not pay for assistance generally reside in multi-person households, whereas those who are unable to secure any assistance for themselves typically live alone.

As with other forms of assistance, older persons who pay for it tend to assess their financial situation more favorably than those who either do not pay or receive no assistance. Of the respondents who pay for assistance, four do so independently, and two pay while concurrently receiving partial assistance from family members or friends. Due to the small sample size, a more detailed statistical analysis was not possible.

The findings also indicate that access to health-related assistance often involves relying on multiple providers, reflecting the diverse coping strategies employed by older persons in order to have their needs met. Older persons who pay for assistance are more likely to hire carers through advertisements or personal recommendations, whereas those who do not pay typically receive care from informal carers.

Regardless of whether respondents experience minor or severe difficulties in performing activities of daily living, informal carers are by far the most common providers of assistance in both subgroups (Figure 35). However, some differences between the two subgroups are observed in the types of supplementary assistance providers. **Respondents with minor difficulties were more likely to use formal assistance provided by health institutions (37.5%) than those with severe difficulties (22.6%).** Carers hired through advertisements and service agencies were reported exclusively by individuals with severe difficulties, albeit representing a very small percentage. In contrast, assistance from humanitarian organizations was used by only two respondents experiencing minor difficulties. No statistically significant differences were observed in the type of assistance provider based on sex, age, or place of residence.

Chart 35: Health care providers, by level of difficulty (N=312)

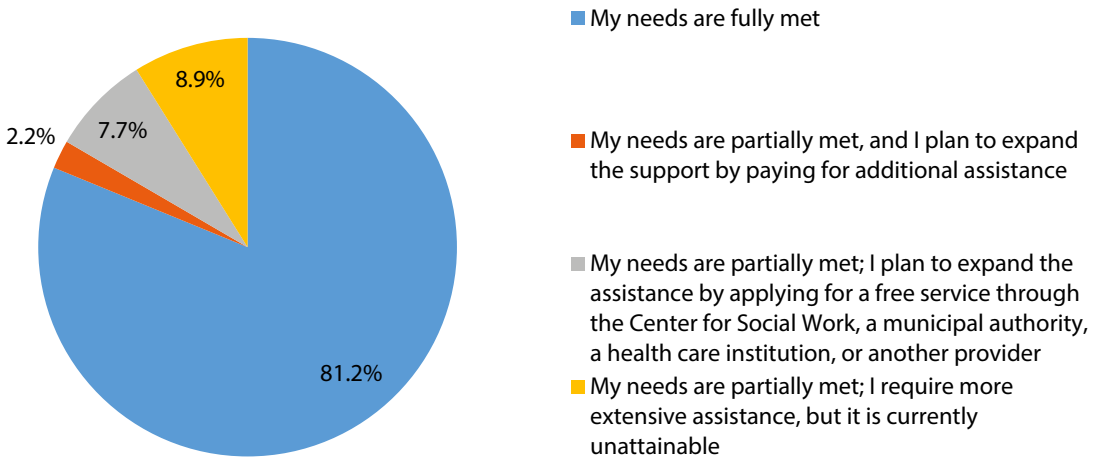


On average, one to two individuals provide health care to each older person, regardless of whether this assistance is paid for or received free of charge. There are no statistically significant differences in the number of carers between men and women, younger-old individuals (65–74 years) and older-old individuals (75+), or between respondents with minor and severe difficulties in performing activities of daily living.

In terms of time, respondents receive an average of approximately 1.6 hours of health-related assistance or care per day—or 11.7 hours per week—with no significant differences between those who pay for assistance and those who receive it free of charge. Further analysis of the results reveals a statistically significant difference between men and women in the number of hours of assistance received. Specifically, on average, men receive significantly more hours of health-related assistance than women. On a weekly basis, men receive approximately six more hours of health-related assistance than women (15.47 hours for men compared to 9.27 hours for women), which amounts to nearly 50 additional minutes of assistance per day. This disparity may be partially explained by traditional gender roles in caregiving, which continue to shape how men and women engage in the provision of care.

The majority of respondents (81.2%) report that their health-related assistance needs are fully met, regardless of whether the assistance is paid for or received free of charge. Among those whose needs are only partially met, some intend to expand the assistance they receive either by paying for additional services (2.2%) or by applying for free services through the Center for Social Work or local health institutions (7.7%). Additionally, 8.9% of respondents stated that they need more assistance, believing it was not currently attainable. The explanation for such responses was provided by only 29 respondents. **Of these, more than half (17 individuals) stated that they did not have sufficient financial resources to pay for additional services**, while four respondents reported no free public services organized in their municipality. The analysis did not reveal statistically significant differences in the level of satisfaction with existing assistance in relation to sex, age, place of residence, or level of difficulty in performing activities of daily living.

Chart 36: Assessment of satisfaction with existing health care (N=271)



Respondents were also asked to describe the strategies they employed when faced with situations in which they were unable to access the support they required. **The most frequently reported strategies were as anticipated: relying on personal capacities (11 respondents), receiving informal assistance from family members (8 respondents), and from neighbors or friends (7 respondents).** However, given the limited number of respondents who answered this question, the findings do not allow for reliable statistical conclusions.

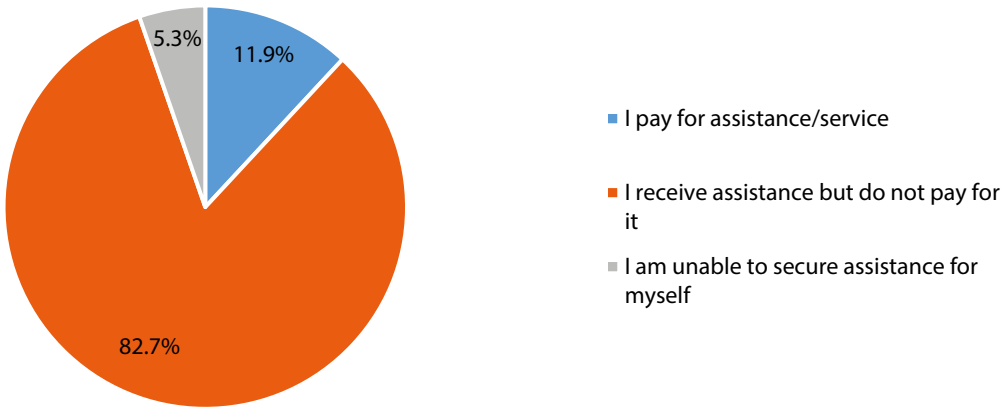
6.4 Assistance with home treatment activities

- More than one-third of respondents (37.7%) reported needing assistance with securing health care at home, particularly with services such as administering therapy, wound dressing, and physical therapy.
- Paid assistance is received by 11.9% of respondents, while 5.3% are unable to secure this form of assistance.
- Two-thirds of older persons who are unable to secure the necessary assistance live in rural areas, indicating substantial disparities in service availability between rural and urban areas.
- Access to health care for older persons is strongly influenced by their financial situation. Individuals who are unable to secure the needed assistance generally assess their financial status as unfavorable, while individuals who pay for services tend to report more stable financial circumstances.
- The majority of older persons (71.5%), regardless of whether they receive paid or unpaid assistance, access home treatment services through the formal system, most commonly through healthcare institutions.
- Paid assistance for older persons is provided on a significantly larger scale—on average, ten hours more per week compared to unpaid assistance.
- The majority of respondents (79%) believe that the assistance they currently receive fully meets their needs. Nonetheless, disparities in satisfaction levels are apparent: beneficiaries of unpaid assistance express more satisfaction than those who pay for services.

- Older persons who pay for assistance, when dissatisfied, typically consider either supplementing it with additional paid services or applying for free public services. Conversely, those who receive unpaid assistance tend to view alternative free sources of support as their only available option.
- When asked about the reasons for not being able to access necessary health-related assistance, the majority of respondents identified insufficient financial resources as the primary barrier, highlighting that economic constraints constitute a major obstacle to securing this type of support.

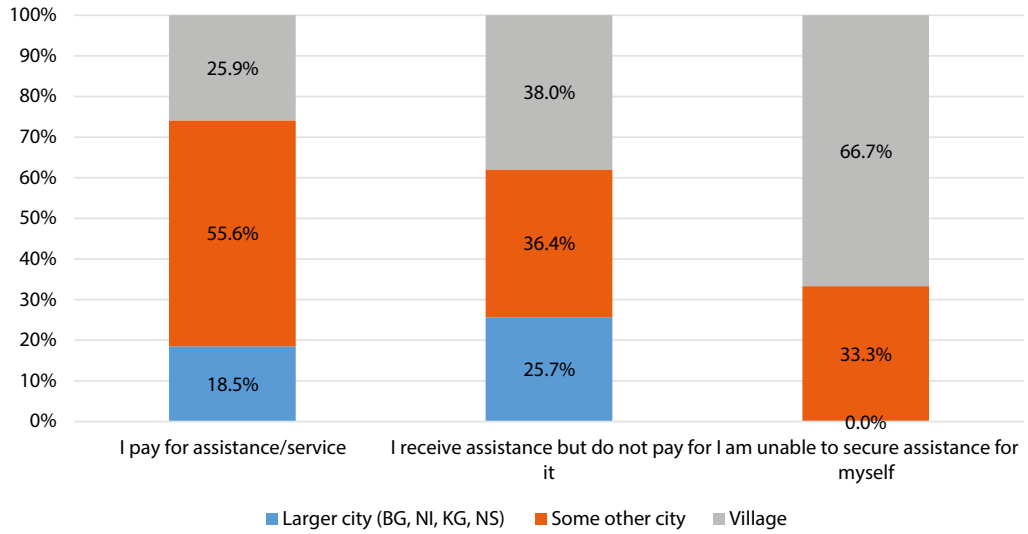
More than one-third of respondents (37.7%) reported needing health-related assistance that falls within the scope of formal home treatment service—such as administering infusions or injections, dressing pressure ulcers, and providing physical therapy. Among respondents in need of such specific health care, the majority (82.7%) receive assistance, while only one in ten respondents (11.9%) pay for it. On the other hand, 5.3% of respondents are unable to secure this form of assistance.

Chart 37: Means of securing assistance with home treatment activities (N=226)



More significant differences in how health-related assistance needs are met are observed exclusively in relation to respondents' place of residence. **As many as two-thirds of older persons who are unable to secure necessary assistance live in rural areas, highlighting a marked inequality in service availability between rural and urban areas.** Conversely, among those who pay for assistance, the largest share lives in smaller towns.

Chart 38: Means of securing assistance with home treatment activities, by place of residence (N=226)



Access to health care for older persons is largely determined by their self-assessed financial situation. **The majority of respondents who were unable to secure necessary assistance, or who rely on free care, generally assess their financial situation as extremely unfavorable**. In contrast, older persons who pay for assistance tend to assess their financial situation more favorably. One in five report having sufficient funds remaining for non-essential spending after covering the costs of assistance. These findings indicate a strong correlation between financial security and the ability to access formal or paid care, with those in the most precarious financial circumstances being particularly vulnerable.

Older persons who pay for assistance most commonly rely on pensions, often combined with social benefits. In contrast, those who receive free assistance are more likely to derive income from a combination of pensions and wages. This difference in income composition may indicate that **older persons who rely on free assistance more often live in multi-person households, where additional income is provided by employed family members.**

Among the 27 respondents who finance home treatment services, nine bear the full cost independently, another nine share expenses with family members, friends, or relatives, and seven contribute partially, with the remaining amount subsidized by the state. The largest number of respondents who pay for home treatment services (9 out of 27) report that paying for such services places a moderate burden on their household budget—that is, after covering the cost of assistance, they are only able to afford basic expenses such as food, utility bills, and medications.

Assistance with home treatment activities is most commonly provided through the formal system of support, primarily through health institutions (71.5%). Older persons who pay for such services predominantly hire care agencies, followed by the use of services provided by health care institutions

or by hiring individuals based on personal recommendations. Reliance on informal carers is the least common. Conversely, those who receive assistance free of charge most frequently rely on the public health system, followed by informal carers such as family members or neighbors. Given that home treatment activities require specialized knowledge and skills, it is not surprising that older persons with financial means rarely opt for assistance from informal carers. On the other hand, those with limited resources are often compelled—due to a lack of alternatives—to rely on informal forms of assistance.

No statistically significant differences in the means of securing home treatment services were observed across respondent characteristics, with the exception of the level of difficulty they experience. Among those with severe difficulties in performing activities of daily living, a significantly higher proportion receive assistance from informal carers, whereas among respondents with minor difficulties, a greater share receive assistance from a care agency.

In most cases (74.8%), respondents receive assistance from a single individual. However, differences emerge depending on the means by which assistance is secured. **Paid assistance is typically provided by two individuals on average, whereas unpaid assistance is generally provided by one.** It may be assumed that the available resources for securing unpaid assistance have been exhausted in advance, rendering it unfeasible to complement the service with informal caregiving arrangements.

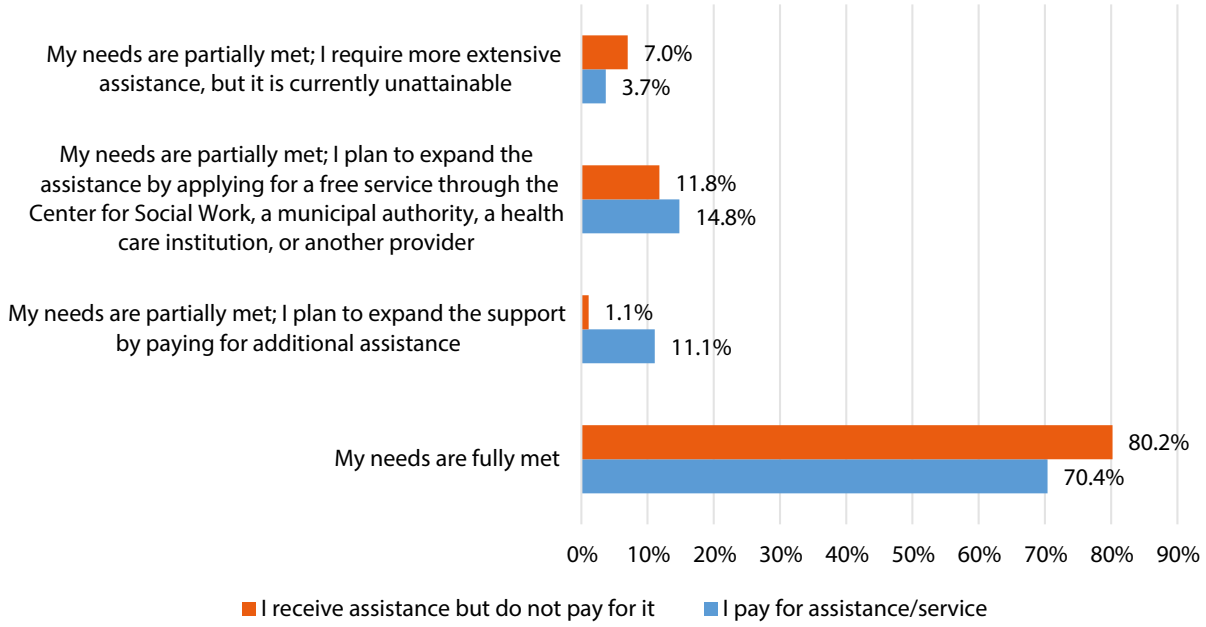
Existing differences in the means of securing assistance are also reflected in the scope of assistance received. **Paid assistance is provided, on average, ten hours more per week than unpaid assistance.** Older persons who pay for assistance receive, on average, 2.5 hours of care per day, whereas those relying on unpaid assistance receive approximately one hour per day—about an hour and a half less. These differences indicate the significant impact of financial capacity on both the availability and scope of care.

In addition, the results of the analysis show a statistically significant difference in the number of hours of assistance the respondents receive during a typical week, depending on sex. Men receive an average of 13.9 hours of assistance per week, while women receive significantly less—an average of 6.3 hours per week.

The majority of respondents believe that the assistance they currently receive adequately meets their needs—with as many as 79% stating that their needs are fully met by the existing arrangement. However, there are differences in satisfaction levels between recipients of paid and free assistance. Those receiving free assistance report higher satisfaction levels, while those who pay for services are somewhat less satisfied (Chart 39).

Respondents who pay for assistance and are dissatisfied with their existing arrangement typically either apply for free services to meet their needs or acquire additional paid assistance. **Conversely, for the recipients of unpaid assistance, applying for free services generally remains their only available option.** These patterns indicate that individuals with greater financial capacity have more options for securing assistance, whereas those with limited resources often lack viable alternatives for having their needs met when dissatisfied with the existing arrangement.

Chart 39: Assessment of satisfaction with assistance received for home treatment activities (N=214)



Only 26 respondents provided an answer to the question regarding the reasons for their inability to secure the necessary assistance. **Lack of financial resources to pay for assistance services was cited as the most common reason (20 respondents).** Other respondents cited the unavailability of free services in their municipality of residence and additional financial burdens as key reasons. These findings indicate that economic barriers remain a key obstacle in accessing assistance for this subgroup of the population.

Among respondents who were unable to secure the necessary assistance, the majority (14 respondents) stated that they were left without a solution due to a lack of financial resources to pay for services. Only a small number of respondents were able to rely on family members, relatives, or neighbors (five respondents) or to manage independently (four respondents). These findings further underscore the severity of the situation for some respondents and confirm that financial barriers are a key obstacle, while alternative forms of assistance remain limited or insufficient.

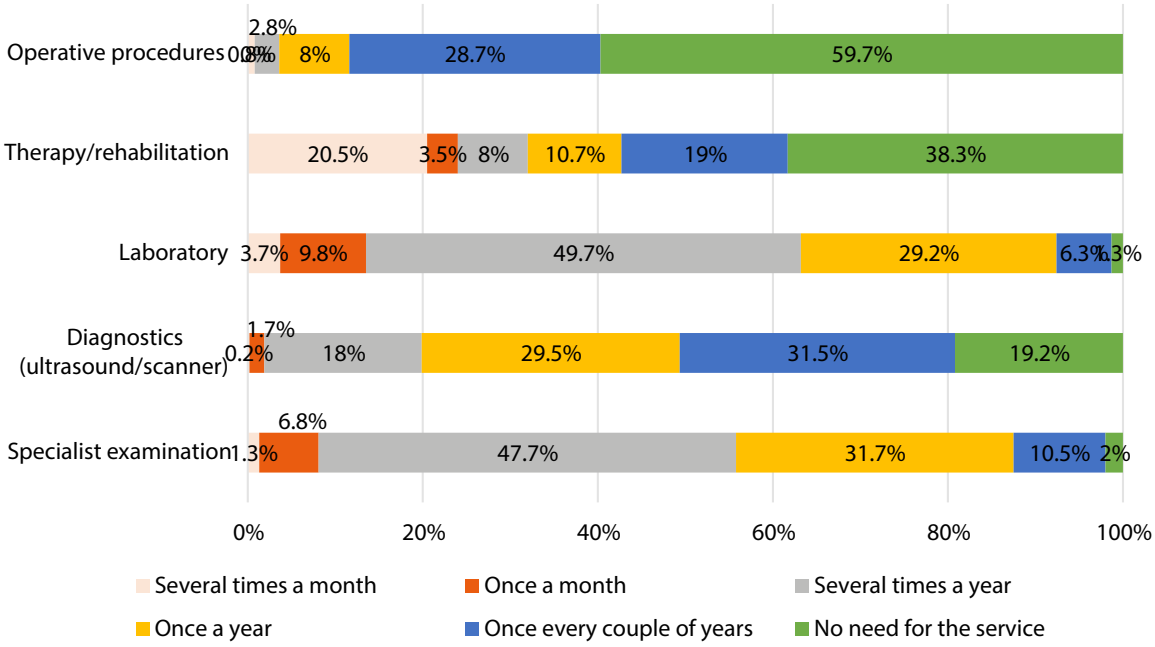
The analysis of the relationship between the means by which respondents sought to overcome the lack of access to necessary support and their financial situations did not reveal a statistically significant correlation. It can be observed that the most economically vulnerable individuals tend to rely on informal assistance—when available—from family members or neighbors; however, in most cases, they remain without access to any viable solutions. Even respondents with slightly more favorable financial circumstances are often unable to secure the necessary assistance, either due to the prioritization of other expenses or the unavailability of services.

7. HEALTH CARE SERVICES

- Laboratory analyses and specialist examinations are the predominant health care services utilized by older persons, whereas more complex procedures are used significantly less frequently, depending on the specific needs of respondents.
- In most cases, services are accessed through the public health system without imposing additional costs on the respondent.
- Older persons who cannot access necessary services through the public health system typically cover the costs themselves, with specialist examinations (16.7%) and diagnostic services (15.9%) representing the greatest financial burden.
- Older persons from rural areas access services within the public health system more frequently, while recipients who pay for services come mostly from smaller towns—suggesting disparities in access to health care based on place of residence.
- The costs of specialist examinations and diagnostic procedures place a significant burden on the household budgets of nearly two-fifths of respondents. Many are compelled to reduce spending on basic needs or rely on financial support from relatives outside the household, indicating a broader familial burden associated with health-related expenditures.
- There is a serious lack of alternative solutions in situations where health care services are unavailable. In most cases, older persons who are unable to access the necessary service remain without assistance and do not pursue further options, instead coping on their own and waiting.

The frequency of health care use varies depending on the type and complexity of the service. The most frequently utilized services are laboratory analyses and specialist examinations, which often form part of preventive care, particularly for older persons. Nearly half of the respondents reported using laboratory services several times per year (49.7%) and undergoing specialist examinations regularly (47.7%). By contrast, more complex health care services, such as operative procedures, are rarely utilized, whereas diagnostic, therapeutic, and rehabilitative services are accessed based on individual needs. At the time

of conducting the research, as many as a quarter of respondents pointed out that they use therapy/

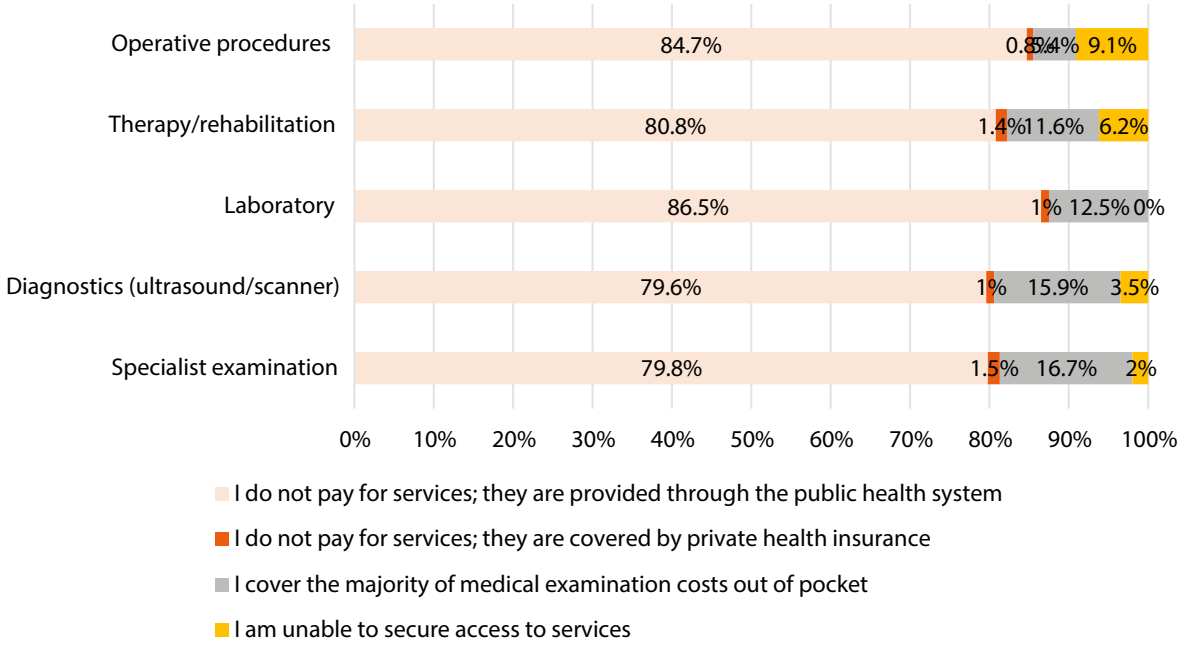


rehabilitation services several times a month.

Chart 40: Prevalence of health care needs

In most cases, health care services are delivered through the public health system, wherein recipients generally do not bear any expenses (Chart 41). Few respondents have private health insurance, and those who are unable to access the necessary services through the public system usually cover the costs themselves. The most frequently incurred out-of-pocket expenses relate to specialist examinations (16.7%) and diagnostic procedures (15.9%), whereas operative procedures are least commonly financed by respondents. This disparity likely stems from the high costs associated with operative procedures and extended waiting periods within the public health system, most often resulting in a higher prevalence of unmet need for operative procedures compared to other types of health care services.

Chart 41: Means of securing health care services



Access to health care services through the public health system is somewhat more prevalent among residents of rural areas compared to those who rely on out-of-pocket payments. For instance, 40.8% of older persons living in rural areas access laboratory services through the public health system, compared to 28.4% who pay for the same services out-of-pocket. In contrast, **among those who pay for health care, older persons from smaller settlements—referred to as "other cities"—are predominant, indicating territorial disparities in the modalities of accessing health care**.

Age also plays an important role in shaping access to health care. Older persons aged 75 and over are more often entitled to free health services, while individuals aged 65–74 are more likely to pay for health care. In particular, specialist examinations within the public health system are accessed by slightly more than one-third (34.5%) of older persons aged 65–74, while as many as half of the respondents in the same age group pay for these services out of pocket.

Older persons who are required to pay for certain health services were asked to assess the extent to which these expenditures impact their household budgets[87]. Overall, out-of-pocket payments for health care services constitute a significant financial burden on household budgets. **The majority of respondents indicated that, after covering the costs of some health services, they have enough resources left to cover only their basic living expenses** (Chart 42).

87 Due to the small number of respondents, the assessment of payments for operative procedures was excluded from further analysis.

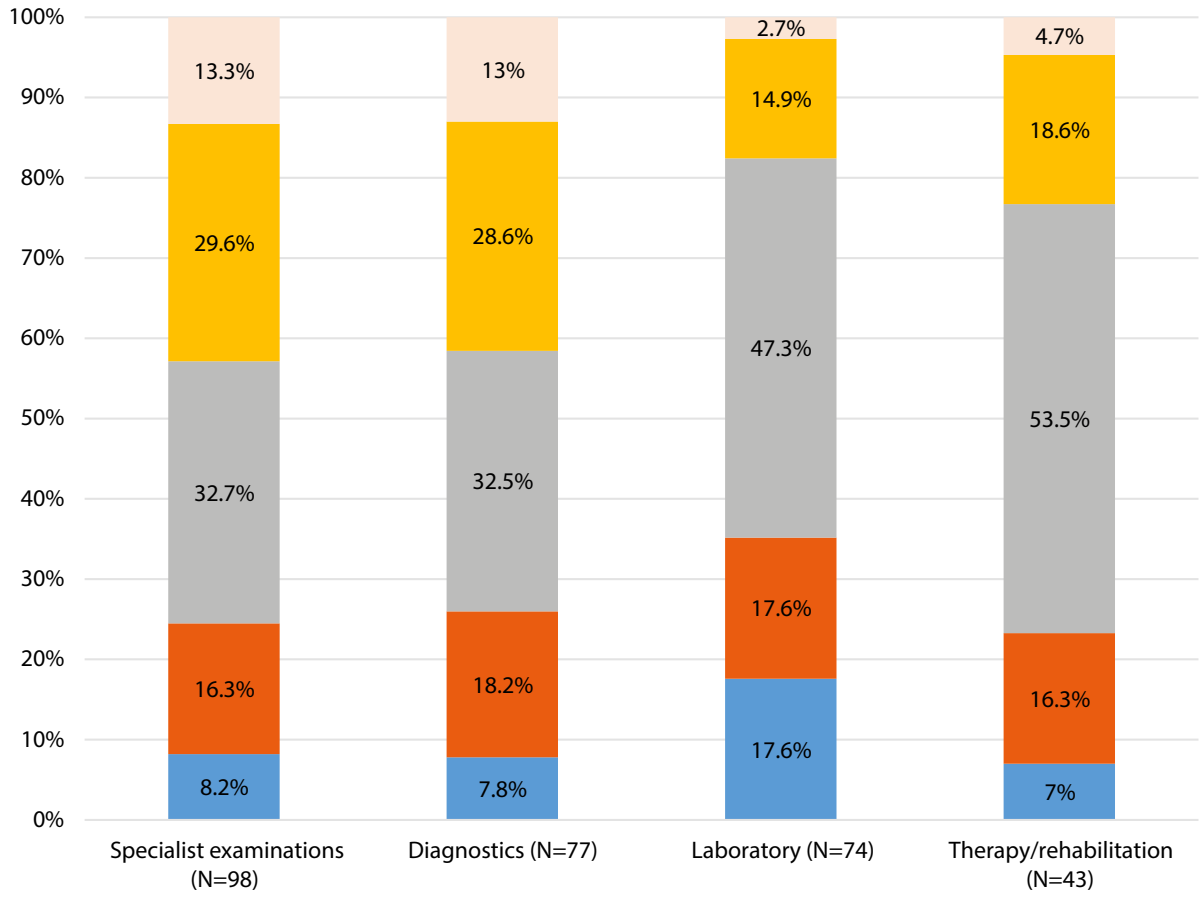
The research findings indicate that the high costs of health care services pose a serious financial challenge for older persons. **Out-of-pocket payments for specialist examinations and diagnostic services place the greatest burden on household budgets, with an average score of 3.2.** In contrast, laboratory services constitute a relatively minor financial burden, with an average rating of 2.6. These differences suggest that more complex and specialized services—typically associated with higher costs—constitute a significantly greater financial burden compared to simpler and less expensive procedures, such as laboratory tests. Approximately two-fifths of respondents report that the costs of specialist examinations and diagnostic services have a large or very large impact on their household budgets. To offset these expenses, many are compelled to reduce or forgo certain basic living expenses, including food, utility bills, or even medications. **Furthermore, 13% of individuals who consider these costs a significant burden report that the financial strain extends to relatives living outside their household, reflecting a broader pattern of inter-household financial pressure**. Therapy and rehabilitation services pose a high burden for nearly one-quarter of respondents (23.3%), while 17.6% report that laboratory services also represent a considerable financial strain.

Older persons who reported a need for health care services were also asked about the reasons they were unable to obtain the care they needed. The reasons vary by type of service: for therapy and rehabilitation services, as well as for specialist examinations, the most frequently cited reason is insufficient financial resources. For operative procedures and diagnostic examinations, the most commonly reported barrier are long waiting lists, whereas service unavailability or geographic distance is consistently cited as the least significant reason across all types of health care services. These findings point to multiple obstacles in the realization of the right to health care, stemming not only from personal financial capacities but also from inefficiencies in the public health system. However, due to the relatively small number of respondents, it was not possible to conduct a more detailed analysis using sociodemographic characteristics such as sex, age group, or place of residence.

The research findings highlight a concerning reality: in the absence of accessible health care, the majority of older persons are left without viable alternative options. In other words, when older persons are unable to secure the needed health care, their needs remain unmet.

For each service type, the largest number of respondents reported taking no active steps to have their needs met, either managing on their own or waiting for an appointment for an examination, surgery, or therapy. Only a small number of respondents were able to access the necessary services—six paid out-of-pocket for specialist examinations and diagnostic services, while three did so for therapy or rehabilitation. Importantly, not a single respondent reported being able to secure the need for the most complex type of care—operative procedures—through out-of-pocket payments in a private institution. These findings suggest the existence of considerable disparities in access to health care and further support the conclusion that the right to health care remains unattainable for a significant number of older persons—particularly those with more severe health conditions—when services are not accessible within the public health system.

Chart 42: Financial burden on the household budget due to out-of-pocket payments for health care services[88]



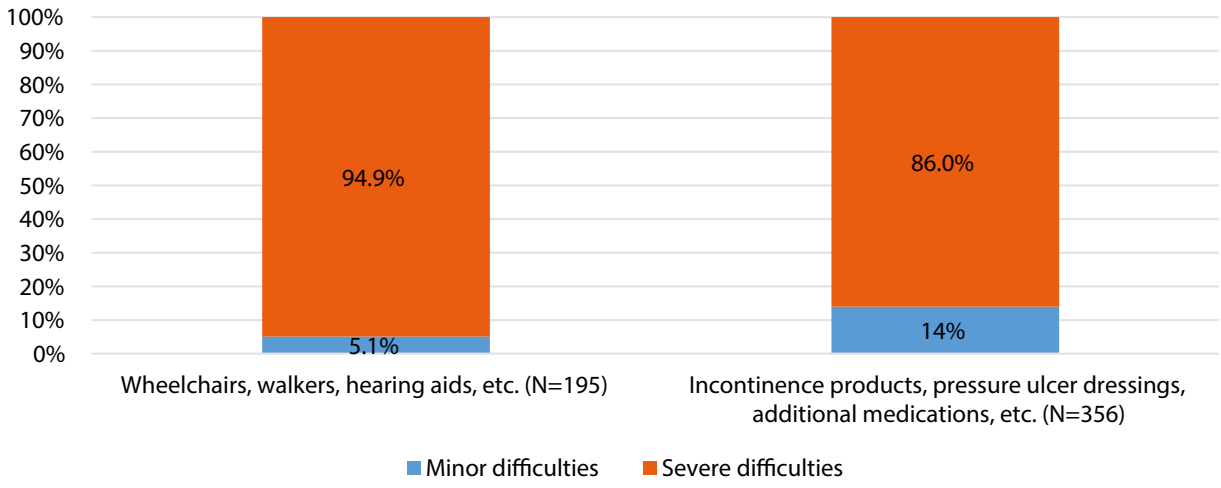
88 Chart 42 does not provide a burden assessment for operative procedures, as the percentage distribution is not considered statistically reliable due to the limited number of respondents (N=6).

7.1 Assistive devices and consumables

- Almost all respondents (97.2%) bear either full or partial costs for consumable medical supplies, while only 2.8% receive them free of charge.
- Assistive devices are predominantly financed out of pocket, either fully or partially, by two-thirds of respondents (65.6%), while 12.3% of them fail to secure these devices by any means.
- Expenses for consumables (15%) and assistive devices (16.4%) are perceived by older persons not only as a burden on their personal budgets but also on the budgets of family members living outside the household, reflecting a broader pattern of intergenerational financial strain.
- Older persons who could not afford appropriate assistive devices—such as wheelchairs or hearing aids—due to high costs are often compelled to rely on less adequate and temporary alternatives that do not fully meet their needs.

A need for medical consumables—such as incontinence products, pressure ulcer dressings, additional medications, and other medical consumables—is reported by 59.3% of respondents, while one-third (32.5%) indicate a need for assistive devices such as wheelchairs, walkers, or hearing aids. **Among those who need such aids, a higher proportion report severe difficulties in performing activities of daily living**, presumably due to poorer health status (Chart 43).

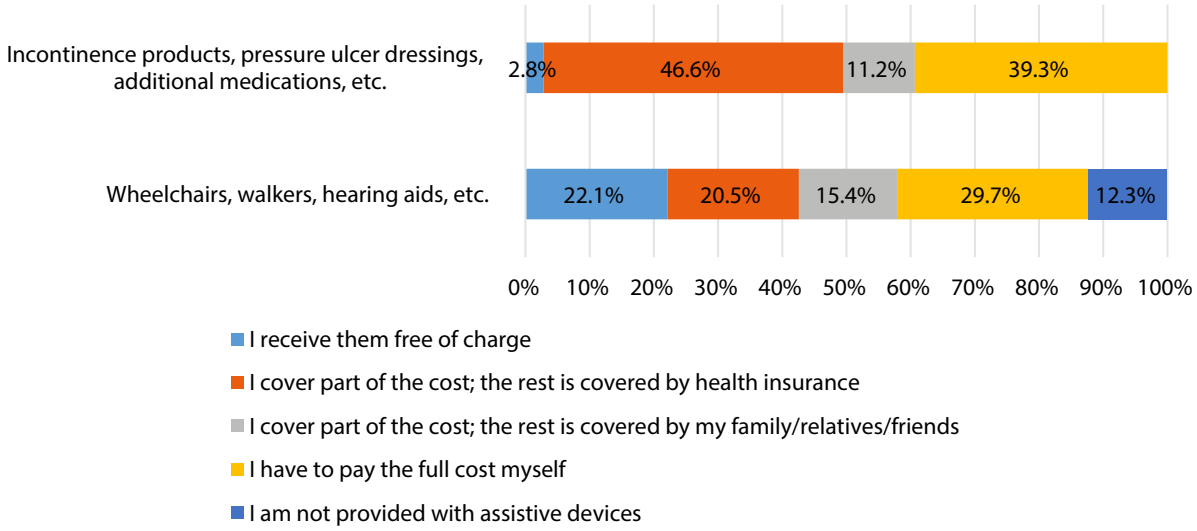
Chart 43: Need for assistive devices, by level of difficulty



Almost all respondents (97.2%) are compelled to cover, either fully or partially, the costs of medical consumables (Chart 44). Only 2.8% reported receiving the consumables entirely free of charge. Two-thirds

of respondents (65.6%) are required to cover some or all of the costs of assistive devices out-of-pocket, while 12.3% report being unable to secure these devices through any available means.

Chart 44: Means of securing assistive devices



Most respondents report that, after covering the costs of medical supplies or assistive devices, they are left with only minimal resources to meet basic living needs such as food, medications, and other expenses. More than one-fifth of the respondents believe that such expenses put a significant burden on their household budget, forcing them to choose between paying for necessary assistive devices and having their existential needs met (Chart 45). It is particularly concerning that 15% of respondents report that the purchase of consumables negatively affects not only their budget but also the budgets of family members living outside their household, while 16.4% report the same in relation to assistive devices.

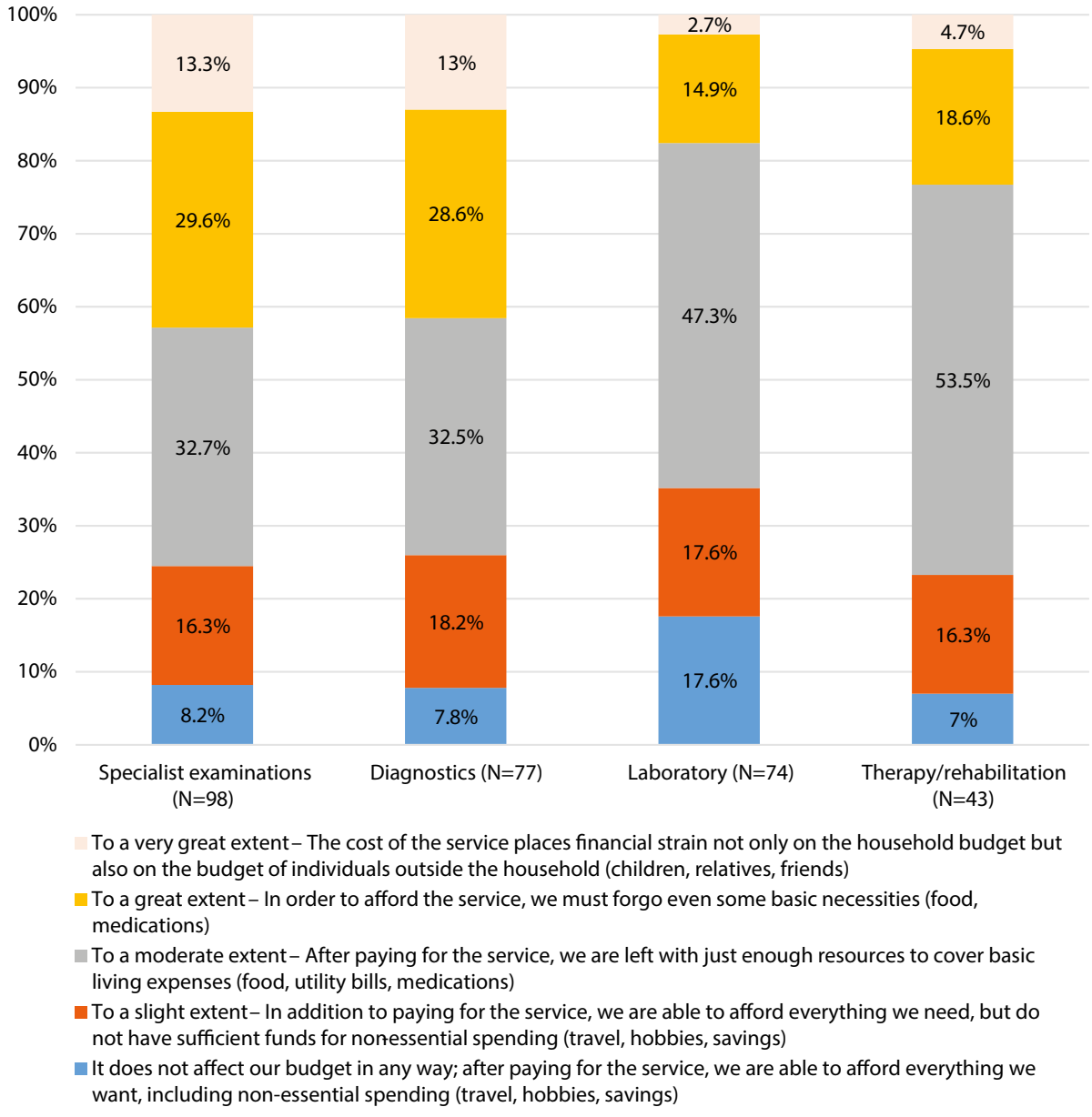
Whether referring to assistive devices or consumables, it is evident that respondents who rate their financial situation as unfavorable also report a greater impact of health-related expenses on their household budgets.

Notably, there are significant differences in the perceived impact of these costs depending on place of residence. Almost one-quarter of respondents living in rural areas (23.5%) report that the cost of purchasing incontinence products, pressure ulcer dressings, and other medical consumables places a burden not only on their budget but also on the budgets of family members who do not live in the same household. By contrast, this view is shared by only 4.7% of respondents from large cities and 12.8% from other urban areas.

Respondents who were unable to secure appropriate assistive devices—such as wheelchairs, hearing aids, or similar devices—due to high costs are often compelled to rely on less suitable and temporary solutions that do not fully meet their needs. Among the 24 respondents whose need for assistive devices remained unmet, 17 reported relying on alternative, less functional solutions that provide only minimal support in performing activities of daily living. Two respondents stated that these

improvised assistive devices were insufficient and failed to meet their needs, while one individual reported being unable to discover any substitute at all. These findings illustrate how limited financial resources can significantly compromise the quality of life of older persons.

Chart 45: Self-assessment of the financial impact of out-of-pocket payments for assistive devices and consumables on household budget



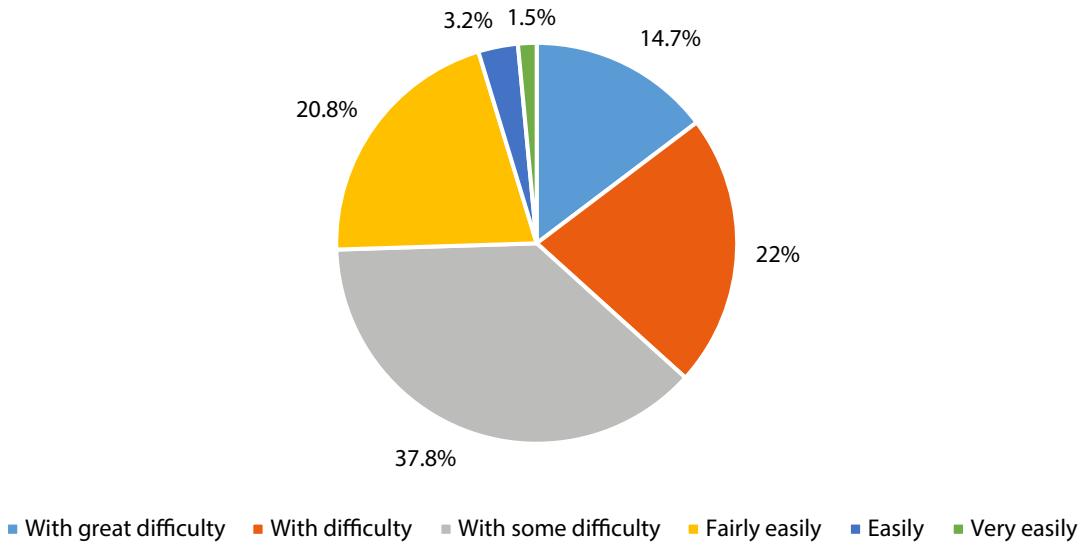
8. CARE COSTS AND POVERTY AMONG OLDER PERSONS

- The majority of older persons in Serbia live with limited financial resources, lacking the ability to save money or cover unexpected expenses. In addition, more than one-third (36.7%) report that meeting their basic needs is difficult or very difficult.
- Individuals with more pronounced functional limitations face considerable economic hardship in meeting basic living expenses. Slightly more than two-fifths (41.2%) of older persons with severe difficulties in performing activities of daily living face major economic challenges in covering basic living expenses, compared to 22.5% of those with only minor difficulties.
- One-third of respondents reported having to forgo essential needs in order to afford necessary care, while 7.3% regularly rely on this economic strategy.
- The financial burden related to securing necessary assistance is most commonly borne by older persons living alone or in two-person households, with one in ten respondents in this group frequently compelled to forgo essential needs in order to secure necessary support. In contrast, older persons living in extended family households encounter such trade-offs less frequently.
- Nearly two-thirds of respondents (65.2%) expressed concerns about having enough resources to cover the cost of services in the future, including health care, medical treatments, and other forms of care.
- Older persons from rural areas, women, those experiencing severe difficulties in performing activities of daily living, and individuals whose income composition includes social benefits express a greater concern about their ability to cover future care-related costs.
- Among recipients of financial social assistance, 86% believe that current benefits are insufficient to cover the costs of services needed. This discrepancy between assistance amounts and real-life expenses contributes to heightened feelings of insecurity and concern among the most vulnerable segments of the population.

Most households face serious economic challenges in meeting long-term care needs of their members. According to research findings, 74.5% of respondents report difficulties in covering monthly household expenses. Specifically, 14.7% consider it very difficult to make ends meet, 22% assess their situation as unfavorable, and 37.8% manage to cover basic expenses with some difficulty.

These findings underscore that most households struggle to meet their basic needs, which leaves them without the capacity to save, invest, or cover unexpected expenses. **It is particularly alarming that more than one-third (36.7%) of older persons report that covering essential expenses is difficult or very difficult, a situation that further exacerbates their vulnerability.** Only 25.5% of respondents stated that covering necessary living expenses was not a significant problem. This disproportion clearly illustrates the lack of financial stability in most households, as the number of those living without financial concerns is significantly lower than the number of those facing financial difficulties on a daily basis.

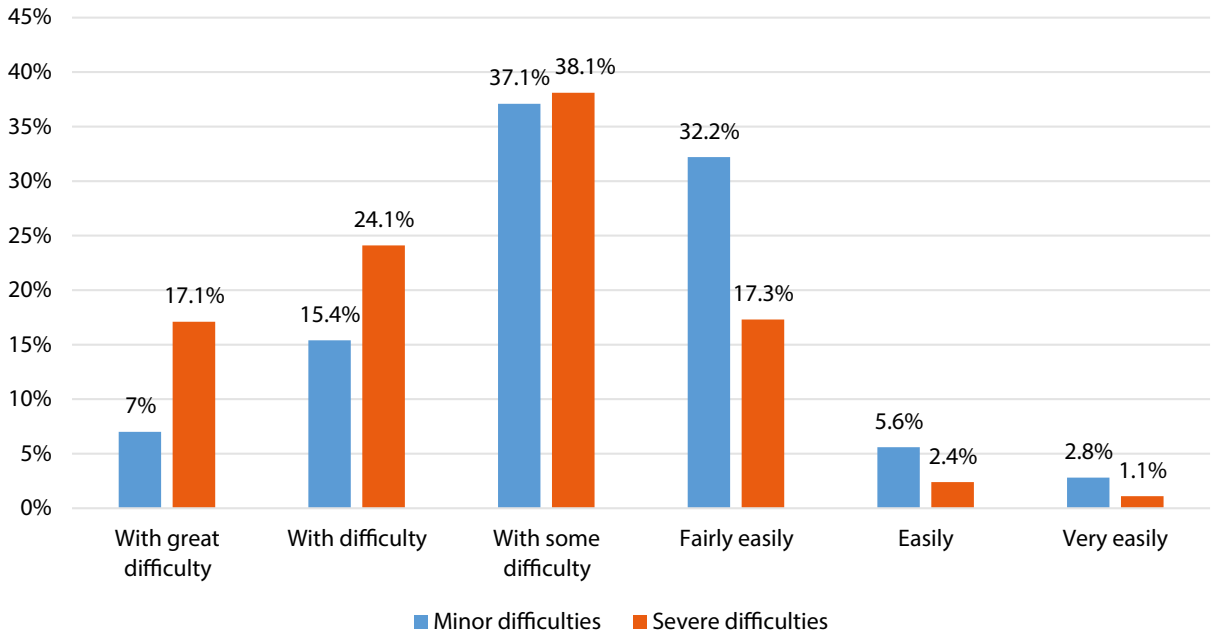
Chart 46: Covering basic living expenses



Covering essential expenses is more difficult for older persons with severe difficulties in performing activities of daily living, compared to those with minor difficulties in performing such activities (Chart 47). Almost a quarter of respondents (24.1%) with severe difficulties report that it is challenging to cover necessary expenses, while only 15.4% of those with minor difficulties report the same. An even more pronounced difference is observed among respondents facing significant economic challenges in meeting their long-term care needs. Among older persons with severe difficulties in performing activities of daily living, 17.1% face major challenges in financing assistance, whereas only 7% of those with minor difficulties experience the same problem. These differences suggest that individuals with severe difficulties in performing activities of daily living face a broader spectrum of basic needs—including medical expenses, assistive devices, and other forms of support—which further exacerbates their economic vulnerability.

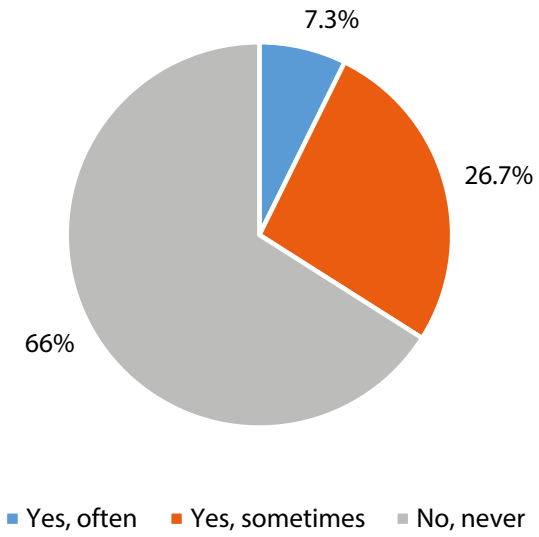
Therefore, essential expenses for this group encompass not only standard living costs but also additional resources required to maintain health and functional independence.

Chart 47: Assessment of the financial situation, by level of difficulty



The research findings point to a high level of economic vulnerability among older persons. Data show that **34% of respondents faced situations in which they had to forgo meeting basic living needs—such as food, hygiene, or other essentials—to secure necessary support services, including health care**. More than a quarter (26.7%) of older persons report occasionally relying on this strategy, while for 7.3% it constitutes a regular budgeting practice. This finding underscores the persistent financial hardship experienced by some of the respondents. The regular deprivation of essential needs significantly increases the risks of poverty and social exclusion, with potentially long-term consequences for both physical and mental health.

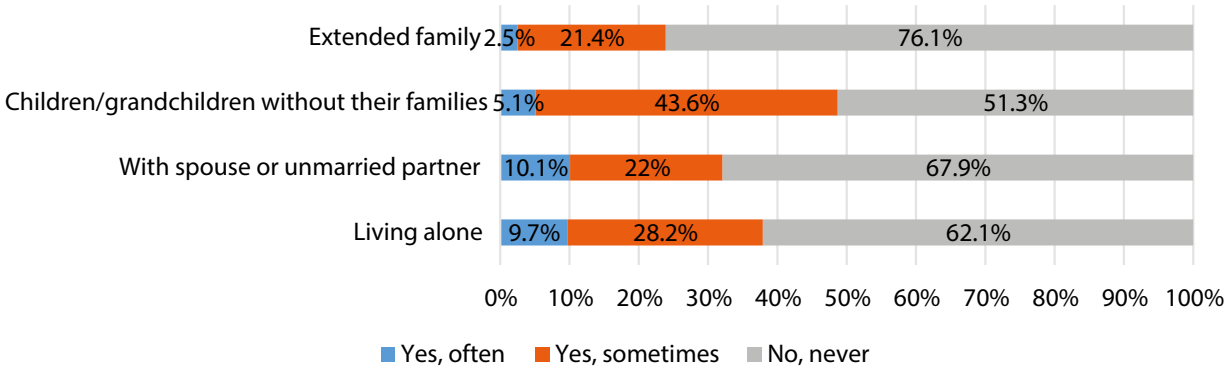
Chart 48: Share of respondents who reduced or forwent basic living expenses to afford care



Older persons who experience severe difficulties in performing activities of daily living often have to prioritize among their needs—choosing between covering basic living expenses and securing the health and social support services they need. The data indicate that as many as 36.7% of older persons with severe difficulties in performing activities of daily living reported being occasionally or frequently compelled to secure necessary assistance at the expense of essentials such as food, medication, or utility bills. In contrast, among older persons with minor difficulties in performing activities of daily living, this trade-off was reported by 25.5% of respondents.

The greatest financial burden in securing necessary assistance falls on older persons living in single- or two-person households. Data indicates that one in ten respondents from these households is frequently compelled to forgo basic living expenses to have their care-related needs met (Chart 49). Conversely, older persons living in extended families are less likely to face such choices. This may be ascribed to the presence of additional household members, which facilitates the sharing of financial responsibilities and enhances household budget stability through multiple income sources, thereby reducing the financial burden on the individual.

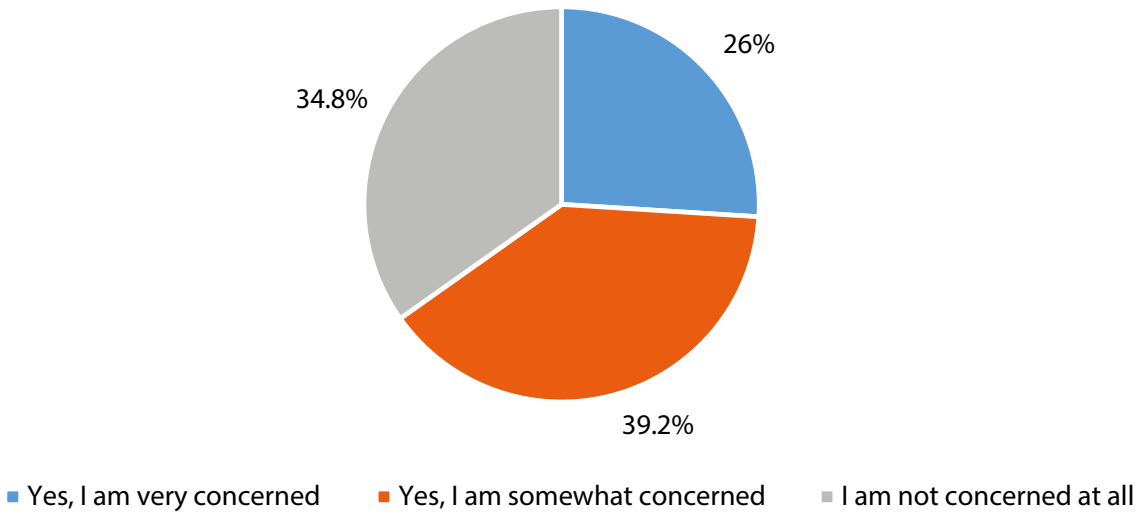
Chart 49: Share of respondents who reduced or forwent basic living expenses to afford care, by household type



8.1 Concerns about the cost of future assistance

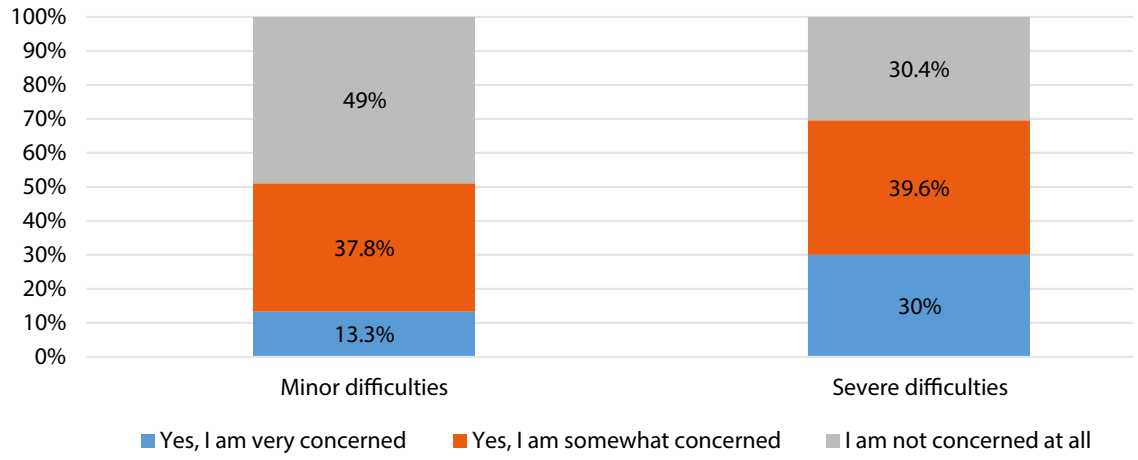
The survey reveals that a substantial proportion of older persons express concerns about their future financial status. **Nearly two-thirds of respondents (65.2%) express concerns that they may lack the financial resources to cover needed services such as health care, medical treatment, and various forms of care and nursing.** Among them, 26% report experiencing persistent anxiety due to financial insecurity, while 39.2% report experiencing such concerns on an occasional basis.

Chart 50: Concerns about the future



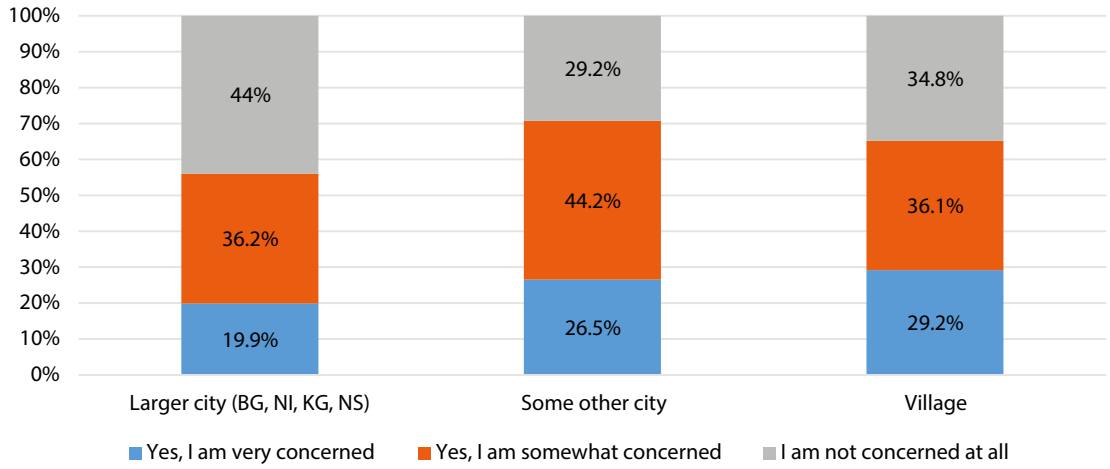
Older persons with severe difficulties in performing activities of daily living express significantly greater concerns about their future. This appears closely tied to their present experience of having to make difficult trade-offs between covering basic living expenses and securing the assistance services they need. Specifically, 30% of respondents with severe difficulties in performing activities of daily living report being very concerned about their future. In contrast, this level of concern is expressed by only 13.3% of those with minor difficulties. These findings suggest that additional health and functional challenges are closely accompanied by heightened economic vulnerability.

Chart 51: Concerns about the future, by level of difficulty



There are significant differences in the level of economic concern among older persons, depending on their place of residence. **Residents of large cities report the lowest levels of concern, while those living in small towns express the highest levels—surpassing even their rural counterparts in this regard** (Chart 52). These differences may stem from the broader availability of formal services—such as public institutions, private care providers, and more developed health infrastructure—in large cities, while rural areas may benefit from well-established informal support networks. Together, these factors contribute to a greater overall sense of security. Small towns, however, are in the least favorable position, as they lack the service infrastructure typical of large cities while also exhibiting family compositions more characteristic of cities—such as a lower prevalence of multigenerational households. This combination makes their residents particularly vulnerable and concerned about the future.

Chart 52: Concerns about the future, by place of residence

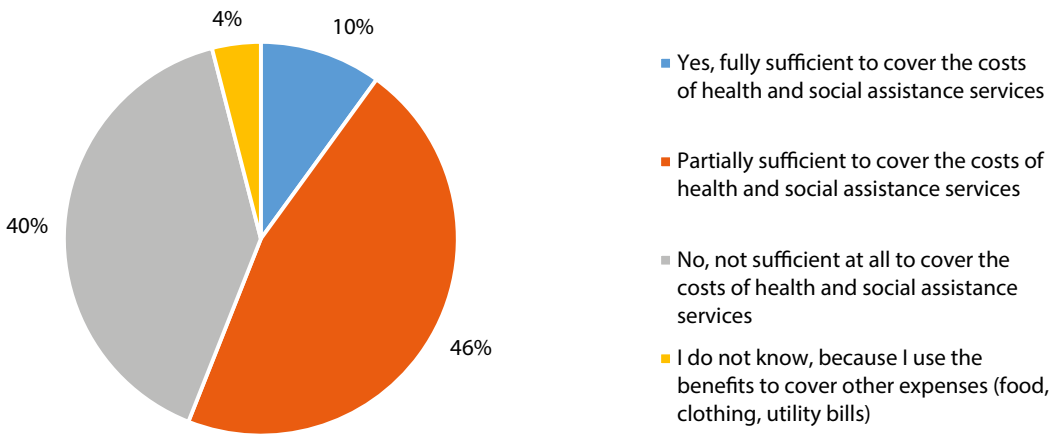


Women express greater concerns about their future financial stability than men. Specifically, 68.1% of women express concerns about their future economic security, while the corresponding share among men is lower, at 59.8%. Potential explanations for the existing gender gap lie in the long-term economic inequalities that women experience throughout the life cycle. During their working lives, women are more likely to experience career interruptions due to unpaid domestic work and caregiving responsibilities, in addition to the gender wage gap—all of which have a direct impact on the level of their pension income. The issue is further compounded by the fact that existing pension systems fail to adequately acknowledge periods of unpaid work performed by women throughout their lives. Such an institutional framework perpetuates and reproduces economic inequalities, resulting in a vicious cycle of gender inequality that becomes particularly evident in later life.

The highest levels of concern about the future are expressed by older persons who, among other sources of income, report receiving financial social assistance. Specifically, 71.5% of those receiving such financial social assistance report great concern about their future. A slightly lower, yet still substantial, level of concern is observed among individuals whose income is derived from wages (65.1%) or pensions (64.6%).

Respondents receiving financial social assistance were also asked to assess whether these benefits are sufficient to cover the costs of assistance and services they need. **The results reveal that nearly half of respondents (46%) believe that the benefits only partially cover the costs of services, while as many as 40% report that the financial assistance is entirely insufficient to cover the costs of services needed to perform activities of daily living.** These findings clearly highlight the gap between existing benefits and the actual needs of recipients, further deepening their sense of insecurity and concern about the future.

Chart 53: Self-assessment of the adequacy of financial social assistance (N=50)



9. REAL-LIFE STORIES

The following real-life stories offer qualitative insights into the daily realities faced by older persons and their caregivers as they navigate complex social, financial, and health-related challenges. Based on in-depth interviews conducted with older individuals and their informal caregivers, these narratives illuminate lived experiences that are often overlooked in formal professional assessments and rarely reflected in policy discussions.

While each case is unique, they reveal some common patterns: caregiving duties fall predominantly on female informal caregivers; functional and cognitive impairments substantially increase dependence in everyday activities; chronic health conditions further diminish independence; healthcare access is primarily reliant on the public system, with private services largely inaccessible due to financial constraints; limited formal professional support places significant emotional strain on families. Together, these narratives illustrate the multifaceted needs of older people and highlight the resilience of individuals and families navigating limited support systems.

Additionally, all these stories reveal how vulnerable older people are when they rely exclusively on informal (family) resources, highlighting the limitations of such caregiving arrangements and emphasizing the urgent need for more integrated, proactive care planning for aging populations.

Story 1: Holding It All Together: One Woman, Four Generations, No Support

Background:

Snežana is 50 years old and lives in a small, bustling apartment in the city centre, which she shares with nine other family members across four generations. She is married and has three children, the eldest of whom has two small children of her own. Snežana works in retail and also carries the primary responsibility of caring for her 79-year-old mother, who has begun showing signs of dementia. Her mother, Radmila, is retired and lives with Snežana's family. She rarely leaves the apartment and has minimal social interaction outside the household.

Functional and Health Status:

The family has never used professional caregiving services nor applied for any form of formal support, as they did not need such assistance beforehand. Snežana is the main caregiver, managing her mother's daily needs alongside her own job and family obligations. Other adult household members help occasionally, but in an inconsistent manner.

Although still able to handle basic hygiene and light household chores, such as dishwashing, Radmila's cognitive decline has affected her ability to perform more complex tasks. For safety reasons, the family has restricted her from using the stove after a few incidents of forgetfulness that could have posed a serious risk. While she sometimes goes to the store alone, this too has become challenging due to memory issues.

"Once she tried to heat something up and forgot about it… Thank God someone noticed in time."

Symptoms of dementia began showing about a year ago. Snežana recalls a poignant moment during her mother's neurological exam when the diagnosis was confirmed. After a long wait for an appointment, a brain scan was performed at a public healthcare facility, revealing early-stage dementia. Further cognitive testing is scheduled for July this year as part of ongoing evaluation.

"The scan showed a textbook example of the onset of dementia... It was terrifying for me when we were at the neurologist's, and they had these quick questions. The doctor asked her, 'What year is it now?' And without hesitation, she said "79.' Of all the years, where did she get '79' from?! The doctor asked, 'Did something happen then?' I said, as far as I know, nothing happened, nothing significant... 'What month is it?' she said 'November—no, no, October...' The doctor said, 'It's cold, but it's March...' I stood there, and couldn't believe it. I said, 'Mom, your birthday was yesterday...' And then she said, 'Oh, today is March 10th.'"

Her mother's physical health is equally fragile – frail legs, painful feet with ingrown toenails, blisters, corns and twisted toes. Snežana lacks the skills to provide adequate care for these issues herself, so she desperately wishes she could afford a regular medical pedicure for her mother.

"It's not expensive compared to other things, but when you add up all the bills, it becomes a luxury. So we keep saying – maybe next month..."

Health-wise, her mother suffers from chronic conditions, including obstructive pulmonary disease, likely linked to long-term smoking. Although prescribed an inhaler, she cannot use it independently and relies on Snežana for assistance. Additionally, neurological symptoms affect her balance, making her prone to falls. She experiences hand tremors, which led to noticeable changes in handwriting followed by the loss of the ability to write, among other challenges. Snežana believes that the biggest part of the problem is her mother's refusal to accept that she has a condition.

"The hardest part for me is arguing with her. I told you — you didn't tell me... but that's just how this illness is."

"It's a struggle, because she doesn't accept there's a problem... And getting her to the doctor? Almost impossible."

However, getting her mother to see a doctor is very difficult. Despite working from 12:30 p.m. to 7 p.m., Snežana arranges and accompanies her mother to every medical appointment. Caring for her mother is a job in itself: Snežana is the only one who takes her to appointments, helps with her inhaler, and manages her confusion. The rest of the family – her husband, her adult children – help "sporadically". However, it's mostly a solo juggling act on Snežana's part.

Because of financial constraints, all medical checkups are conducted through the public healthcare system, often involving waiting times of several months—for instance, they waited over three months to get an appointment for a Holter monitor. Additionally, they mostly rely on prescriptions to obtain medications, as purchasing them regularly out-of-pocket is not affordable.

Financial Burden:

The family's finances are a constant worry, burdened by debts and loan repayments. Snežana works full-time, but her income is modest. Her husband's pension barely covers the essentials. Her mother's small pension pays for minor expenses, sometimes her own medication — although she refuses to visit the doctor, so her list of treatments remains limited.

"I got only 50,000 dinars last month, and it all went on the loan repayment."

"What kind of cost coverage? You're always borrowing money and then paying it back, and you end up in a vicious circle—there's no way out of it."

To ease the financial strain, her teenage son plans to work through a student job program during the summer, and Snežana is considering taking on an additional job herself, as financial insecurity is her biggest concern. She hopes she will never have to quit her job to care for her mother, although that possibility is always on her mind.

"I'm thinking that I'll take on another job when I get back from vacation, because this just isn't working..."

Caregiver's unmet needs:

What Snežana craves most as her mother's caregiver is time – time for herself and time to rest. Her constant worry about the entire family leaves her feeling exhausted, with little space or opportunity to attend to her own needs and recharge.

"Everyone in this house depends on me somehow."

Snežana worries constantly about her mother's safety, particularly when she considers taking a break. She is planning a two-week annual break this summer. But the thought of leaving her mother is unsettling. As this is their first experience with such a situation, Snežana candidly shares the profound emotional weight that comes with caregiving, along with a clear need for support.

"My biggest concern now is how to go on a vacation for two weeks and be away from Belgrade in order to reset. She wants to be alone, but I won't be at peace."

Future:

Looking ahead, Snežana tries not to dwell too much on the future. Yet, in quiet moments, she worries about what will happen when her mother's condition worsens to the point she no longer recognizes her. Placing her in a nursing home is out of the question, both because Snežana struggles emotionally with the idea of being separated from her mother, and because the family's financial situation makes such care impossible. Still, caring for her at home if her condition declines significantly would be overwhelming, especially since four generations live under one roof, which brings its own tensions. The younger family members often struggle to understand the changes in their grandmother's behaviour, adding another layer of emotional complexity.

"What if she doesn't recognize me anymore? That's what scares me the most. But okay, let's not think that far ahead just yet."

"I can't put her in a nursing home — emotionally, and financially it's just not an option."

"Even though the kids are grown up and smart, they just can't process some things about her condition."

Despite all the challenges, Snežana maintains a sense of humour and humility. She regularly visits the local Red Cross, where she is both a beneficiary and a volunteer. Speaking about her hectic life, she smiles and says, ***"There's never a dull moment in our house."*** or ***"Future... I'll think about that tomorrow."***

Story 2: Aging with Severe Disability: A Care System Built on the Backs of Daughters

Background:

Milena is 73 years old and lives alone in a modest apartment in the city. She is a retired factory worker and now receives her late husband's pension along with a modest state allowance for those requiring constant care. She has three children – two daughters living nearby and a son who now lives abroad. While she used to be active and independent, her health has significantly declined in recent years, especially after developing Parkinson's disease and severe rheumatism.

Looking back, Milena is certain that the years she spent as an informal caregiver to her late husband took a heavy toll on her own health – both physically and emotionally.

"Taking care of my husband, I ruined myself."

Health and Functional Status:

Today, Milena struggles with nearly every aspect of daily life. Parkinson's disease has progressed to the point where she has lost control over much of her body. She is unable to get out of bed without help and can barely maintain a seated position. Her hands shake, her memory lapses more frequently, and she is often confused. Bathing is particularly difficult and distressing for her, as she cannot manage it without assistance.

"Bathing? I can't do that by myself at all. I need help."

She also suffers from severe rheumatic pain, which limits her mobility even further. Her condition makes her dependent on others for nearly every task – eating, dressing, moving, and hygiene. Although she owns a walker with wheels (a gift from her sister), it remains unused. Not only is it ill-suited for her condition, but her apartment building has no elevator, and she cannot manoeuvre it up and down the stairs. She only moves around when someone physically supports her – typically one of her daughters.

Daily Care and Emotional Support:

Milena is not completely alone. Her two daughters have taken on the responsibility of her care, splitting the daily activities between them – one visits in the morning, the other in the afternoon. They cook, clean, bathe her, and handle other essential tasks. But they have their own responsibilities and can only stay for short periods.

"They cook for me every day, or bring food if it's already prepared."

Milena's most consistent companion is her neighbour, a woman who also lives alone. She visits several times a day – not only to help Milena take her medications (since memory lapses are frequent), but to

keep her company. Together they watch television and share coffee, offering each other comfort in the face of growing isolation.

"We watch our show and drink coffee together every day."

Though informal, this relationship serves as one of Milena's most valuable sources of social support. For both women, these small shared rituals help alleviate the weight of loneliness.

Financial Burden and Daily Struggles:

Milena receives no paid care – not because she doesn't need it, but because she simply cannot afford it. Her entire budget comes from her pension and the allowance for people needing care. This barely covers her essentials. Once she pays for electricity, medication, and other essential costs, there is often almost nothing left – sometimes not even enough for adequate food, let alone for hiring professional caregivers or paying for private medical services.

"First I pay the bills and buy the medicine. Whatever is left, I use for food."

She emphasizes that her daughters are also struggling financially and are unable to contribute to her care in this way. As a result, all of her needs (food, hygiene items, medications) must be managed using her own limited income. Private healthcare is completely out of reach.

Healthcare Access and Limitations:

Milena relies entirely on the public healthcare system. When her condition requires medical intervention, doctors and nurses make house calls. Fortunately, this service is free of charge. However, like many older adults, she avoids hospitals and clinics unless absolutely necessary, due to long waiting times, transportation difficulties, and her physical challenges. She has never used private healthcare services.

"They're too expensive. I've never even thought about it."

Future:

Milena looks to the future with quiet worry rather than concrete plans, reflecting how older people cope with worsening health when they lack structured support. While she seldom verbalizes her concerns, there is evidence of underlying anxiety related to the potential loss of mobility, further dependence, and the uncertain availability of informal caregiving. The absence of a formal support network increases her vulnerability to disruptions, whether due to her own health deterioration or changes in her daughters' capacity to provide daily assistance. This ongoing uncertainty spanning physical, emotional, and financial dimensions, contributes to a persistent sense of instability.

„ I get by… for now. But it's hard to think about what comes next."

Story 3: Independent Aging in Contexts of Limited Support

Background:

Marija is a 75-year-old widow living alone in a modest apartment. Her husband passed away many years ago, and she has no children or close family members to rely on for daily support. With only an elementary school education and a typing course behind her, Marija built a lifelong career in the textile industry. She worked for decades as a pattern designer in a local garment factory. After retiring, she continued to work occasionally as a seamstress, taking on small jobs to supplement her income. However, in recent years, due to declining health and energy, she has limited herself to minor clothing alterations. Her primary – and only – source of income is her pension, which she manages carefully to cover basic needs. Despite her solitary life and modest means, Marija remains self-reliant and takes pride in her independence.

"I've worked hard all my life… Now I sew just enough to buy cigarettes."

Functional Capacity and Support Needs:

Marija insists that she has never needed household help and takes great pride in managing everything on her own. The only support she consistently accepts is from her neighbor's daughter, who kindly helps her pay the utility bills each month – a task Marija delegates more out of convenience than necessity. For physically demanding chores, such as hanging curtains or lifting heavy carpets for washing, she tries to handle them herself and only reluctantly accepts assistance when absolutely necessary.

"I do everything myself, as much as I can. Even when I am supposed to hang curtains, I climb slowly onto a chair and do it myself."

She cooks, monitors her blood pressure and blood sugar levels, and self-administers insulin. Despite living with multiple chronic conditions, her independence is something she fiercely protects.

"You get used to doing things on your own… I don't like people meddling in my house. I'm not used to it."

Marija continues to do her grocery shopping alone, using a wheeled cart for support. She makes a point of leaving the house every day, whether for errands, a short walk, or a brief visit with her neighbor. These daily outings are part of how she sustains her autonomy and sense of normalcy. Her life is modest and disciplined, but deeply rooted in self-sufficiency and personal dignity.

"No, brother, I have my cart—I get what I need. Everything's nearby. That's my therapy."

Health Status and Needs:

Marija is managing several serious health conditions, including diabetes and two coronary stents. Her diabetes requires her to take insulin-like medication, which has led to significant weight loss – she has lost 18 kilograms since starting the treatment. Due to financial constraints, Marija receives care exclusively

through the public healthcare system. She has regular check-ups with her physician, but only schedules appointments during his shifts at public clinics, carefully coordinating her visits to avoid any out-of-pocket costs. In addition, a nurse from the local community health center visits her home once a week to monitor her blood sugar levels, helping to ensure that her condition remains stable.

"I went privately once – it cost 3,500 dinars. Never again!"

Financial Burden:

Marija describes her financial situation as precarious but manageable – ***"I scrape by somehow"***. Her pension is just enough to cover the essentials (food, utilities, and medications) but leaves no room for unplanned expenses or small luxuries like spa treatments or social outings. She budgets with care, knowing there's no safety net. Health-related costs take top priority – she spends around 5,000 dinars each month on medications and has developed strategies to stretch every dinar. For example, she reuses her insulin needles multiple times to save money.

"I always set aside money for medicines and bills first. The rest is for whatever's left. Also, I use one needle two or three times… that's why it's not too expensive."

Although facing financial insecurity, Marija expresses a notably calm and accepting attitude toward her lack of savings, with no explicit signs of distress or worry. ***"I have no savings—not for spas, nor anything else."***

Social Support:

After years of caring for her late husband, Marija has naturally stepped into a new caregiving role—this time for her longtime neighbour, a mostly homebound 80-year-old woman. Their friendship, which spans over four decades, has become one of the most stable and meaningful parts of Marija's life. The two women spend their mornings watching TV series, chatting, and simply being present for one another.

"Every morning, I fetch her groceries, give her medication, and we drink coffee together. It's our routine."

Future:

Marija faces the future with quiet acceptance rather than active planning. While she remains deeply independent and resilient, her advancing age, increasing health needs, and lack of close family support place her in a precarious and potentially vulnerable position. The stability of her daily life depends largely on her own physical ability, with limited capacity to adjust should her condition deteriorate. Her reluctance to seek help is not only personal but also shaped by cultural norms that frame aging as a family matter—best handled privately and outside of formal systems of care. This intersection of personal strength, cultural expectations, and vulnerability is poignantly captured in her simple reflection: ***"Whatever happens up there [points skyward], will happen."***

10. CONCLUSIONS AND RECOMMENDATIONS

Older persons in Serbia, as well as globally, are encountering escalating challenges in preserving their health and accessing care. These challenges arise from three significant transitions that are affecting their lives and require an immediate change in the approach to health care and the long-term care system.

The first is the demographic transition—the number of older persons is rapidly increasing. By 2030, as many as 1.4 billion people worldwide will be aged 60 and over, with the majority living in low- and middle-income countries. Although people are living longer—particularly women, who on average live 5.4 years longer than men—a longer life does not necessarily translate into a higher-quality life, especially in settings where support systems are underdeveloped. [89]

The second challenge is the epidemiological transition—an increasing number of people are living with chronic non-communicable diseases, which have become the leading cause of disability and death globally. These diseases disproportionately affect the older population. Available data shows that, already in 2011, as many as three-quarters of deaths from aforementioned diseases in low-income countries occurred among persons aged 60 and over. [90]

The third challenge is the transition in health and care systems—existing systems are not adapted to the evolving needs of the older population. Care and health services are often unavailable, unaffordable, or insufficiently tailored to the needs of older persons, leaving many without adequate support in their activities of daily living. [91]

In this context, research on the impact of out-of-pocket payments for long-term care on poverty among older persons in Serbia reveals that the current support system not only fails to meet their basic needs but also exacerbates their poverty and social exclusion. Regardless of the type of need—whether personal care, medical assistance, rehabilitation, or home treatment—the lack of a comprehensive and accessible system leaves older persons to cope with everyday challenges on their own.

89 https://www.ageinternational.org.uk/siteassets/documents/reports/2023/universal-health-coverage-for-all-ages---an-agenda-for-action.pdf

90 https://www.who.int/publications/i/item/9789240047761

91 https://www.helpage.org/wp-content/uploads/2022/12/Achieving-Universal-Health-Coverage-fit-for-an-ageing-world_2024-revision.pdf

In general, older persons are less likely to use paid health services compared to social care services, largely due to their high cost. Health services often represent a significant burden on the household budget, leading older persons to primarily rely on the public health system.

Paid care is used mainly by persons with higher incomes, but even they are often unable to cover the full range of personal needs and must therefore rely on a combination of paid and unpaid assistance. The greatest burden is borne by older persons living alone or in two-person households. One in ten respondents in this group must forgo basic living expenses—such as food, medications, or utility bills—in order to secure the necessary care. On the other hand, older persons living in extended families are in a somewhat better financial position. However, the financial burden is often shifted to family members who live outside the household—particularly when more costly services, such as medical care, are required.

Older persons who are unable to pay for support mostly rely on unpaid assistance, which usually comes from informal sources—family members, neighbors, friends, or others from within their immediate social network. This form of support serves as the primary—and often the only—source of assistance for a large number of older persons who lack access to formal services or are unable to afford them. Although informal assistance holds important emotional value, its capacity is limited. In many cases, family members are unable to provide continuous and adequate care due to work obligations, time constraints, physical distance, or simply because they are not trained to meet the specific health and functional needs of older persons. Assistance provided in such circumstances is often irregular, uncoordinated, and lacks the intensity required to address all aspects of activities of daily living, particularly for persons with severe difficulties.

Nonetheless, the informal network—although often unacknowledged and insufficiently recognized by the system—actually covers a substantial portion of older people's needs. This is reflected in the fact that older people who do not pay for care receive nearly twice as many hours of assistance with activities of daily living as those who rely on paid services. However, it is important to emphasize that this form of assistance has clear limitations—in terms of capacity, availability, and expertise—and cannot serve as a substitute for a structured long-term care system. Informal assistance may mitigate some of the consequences of institutional gaps, but it cannot compensate for the underlying structural deficiencies.

Individuals who are unable to afford assistance often receive no support at all, relying solely on themselves or on sporadic assistance from members of their social network. In other words, older people who cannot secure the necessary care by any means are left to fend for themselves. This is particularly concerning in situations where assistance is required with personal hygiene or home treatment, as the lack of such support can have serious implications for an individual's health and dignity.

The situation is further complicated by the highly uneven access to free care services. Older people living in rural areas face more limited opportunities, and the available services are often inadequate, irregular, or insufficiently known to potential recipients. Even when formally free of charge, limited physical accessibility and administrative barriers often prevent effective access to services. Gender disparities further exacerbate the issue. Women—who make up the majority of the older population and are more likely to live alone—receive assistance less frequently than men.

Even when older people have clearly identified functional limitations, this does not ensure access to adequate care. Systemic responses remain insufficient, and access to services is often determined not by the assessed need but by an individual's financial situation, household composition, or place of residence. The most vulnerable group comprises individuals aged 75 and over who face serious health challenges and are most likely to experience multiple forms of deprivation—ranging from inadequate care and lack of assistive devices to limited access to specialist services and social exclusion.

Concerns about the future further exacerbate this vulnerability. Nearly two-thirds of respondents expressed concern that they may not have sufficient resources to access the care they need in the coming years. This concern is not evenly distributed. It is particularly pronounced among women (who are more likely to live alone and have lower incomes), persons with disabilities (who face higher care-related costs and reduced access to services), recipients of financial social assistance (whose income does not correspond to their actual needs), and residents of rural areas (where service availability is limited and local support systems are often underdeveloped or nonexistent).

The current model of long-term care in Serbia does not adequately address the needs of those who require assistance the most. On the contrary, it increases the exposure of the most vulnerable older persons to heightened risks of poverty, health-related neglect, and social exclusion. Rather than serving as a safety net, the existing system often operates as a mechanism that reinforces vulnerability—where care and assistance are not allocated based on assessed needs but rather according to recipients' financial capacities and the availability of services in their immediate environment.

10.1 Recommendations

Addressing the identified challenges requires a comprehensive, cross-sectoral reform that encompasses legislative changes, the development of community-based services, financial assistance for recipients and their families, and a transformation in societal attitudes toward aging and care. This can be achieved by:

- **Improving the collection and analysis of data on older women and men.** Existing health, social, and demographic data systems often fail to adequately capture the experiences and specific needs of older persons. It is necessary to systematically collect age-sensitive data, disaggregated by sex and disability, with particular attention paid to the oldest age cohorts. Discriminatory age limits should be eliminated when setting targets and indicators for chronic conditions and other health issues. Research focused on older persons' health and the barriers they face must be encouraged, ensuring their active participation in the research process.
- **Developing mechanisms for identifying care recipients who are at risk of poverty**. Needs assessments should not be based solely on health and functional criteria but must also consider the financial capacity of households. Older persons who live alone, rely on social assistance, and experience functional dependency should be prioritized within the support system. The introduction of systematic poverty assessments and early warning mechanisms can improve the allocation of resources. It is particularly important to engage communities in identifying older persons at risk of neglect and poverty.

- **Establishing a system for monitoring the financial situation of older persons**. It is necessary to develop tools and indicators that enable local service providers to continuously track changes in the financial status of older persons, particularly those already receiving some form of assistance. A sudden onset of vulnerability may result from a loss of income (e.g., following the death of a spouse), rising treatment costs, or a reduction in informal assistance. Regular updates of social registries, in combination with their integration with other databases (such as pension, health, and social assistance records), can enable the timely identification of individuals with newly emerging needs and the activation of appropriate responses—such as expanding service coverage, waiving co-payments, or providing emergency financial assistance.
- **Redefining eligibility criteria and benefit amounts based on the type and intensity of long-term care needs.** Cash benefits should be adjusted in accordance with the degree of functional dependency and the nature of required services—for example, by distinguishing between individuals who require daily assistance and those for whom occasional assistance is sufficient. A differentiated approach to financial support should be adopted, combining means-testing with assessments of the health and social needs of the recipient. Such a system would help mitigate the long-term risk of poverty among older persons, particularly those with severe difficulties in performing activities of daily living.
- **Adapting primary health care, as the cornerstone of a universal and accessible health care system,** to respond to the needs of individuals across all age groups. Health care systems must be made accessible and responsive to the needs of older persons, including through the provision of age-friendly infrastructure, accessible assistive devices, clear information and awareness-raising initiatives, dedicated spaces for older persons, free or affordable essential medications, and mobile health teams, particularly in rural areas. This approach enables even the most vulnerable older persons to exercise their right to accessible and dignified health care.
- **Aligning the development of services with local capacities and cost structures**. In many areas, particularly in rural settings, the cost of private care services remains unaffordable for the majority of recipients. It is thus necessary to develop publicly funded models of care based on actual service delivery costs, accompanied by regionally defined pricing standards. This would facilitate a more rational budgeting and promote equitable and high-quality service provision for all recipients.
- **Promoting lifelong preventative health care**, **including regular preventative check-ups, systematic screenings, vaccination, and the use of telemedicine**. Chronic non-communicable diseases constitute the greatest burden on health systems globally and disproportionately affect older persons. Therefore, it is crucial to promote the prevention and early detection of non-communicable diseases over the course of life. Healthy lifestyles should be encouraged, including balanced nutrition, regular physical activity, and mental well-being. Equal priority must be given to ensuring access to essential medications for the treatment and control of chronic diseases. People should be empowered to take care of their physical and mental health. Chronic non-communicable diseases must be integrated into health insurance

benefit packages and fully covered under primary health care services. Regular seasonal influenza vaccination should be actively promoted to reduce pressure on health systems. In parallel, the expansion of telemedicine should be supported to improve service provision, particularly in rural areas.

- **Integrating a gender-sensitive approach into the planning of assistance services.** Evidence shows that older women are more likely to live alone, have lower incomes, and receive assistance less frequently than older men. Policies must be developed to address the specific needs of older women and other vulnerable groups, including persons with disabilities and recipients of social assistance. A gender-sensitive approach must become an integral part of service planning.
- **Strengthening the capacity of professionals working with older persons**. To ensure that health and social care systems can adequately respond to the needs of an aging population, sustained investment in the workforce is essential. This encompasses continuous training, adequate working conditions, and sufficient resources—including financial ones—for all professionals working with older persons, such as doctors, nurses, social workers, and home care aides. Only motivated and well-trained professionals can deliver high-quality services to older women and men.
- **Taking the specific needs of older persons into account when planning humanitarian and climate responses**. Due to chronic illnesses, disabilities, and often limited access to support, older persons are particularly vulnerable during emergencies and crises caused by climate change. Older persons must have access to humanitarian assistance, which must encompass essential medications, assistive devices, adequate hygiene conditions, and secure spaces. Public policies on climate change and emergency response must recognize both the needs and the contributions of older persons. It is imperative to conduct additional research and systematic data collection on the health impacts of climate change on older persons in order to ensure that this evidence is integrated into emergency preparedness plans and risk assessments. The active involvement of older persons in the planning and implementation of these measures strengthens community resilience and promotes equitable access to assistance.

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12. ANNEX 1 – RESEARCH INSTRUMENTS

*The terminology applied in the research instruments refers to the designation of the ministry that was valid at the time of the funding call. During the course of the study, the ministerial portfolio was adjusted in the context of the new government formation. Irrespective of the terminological change, the reference consistently pertains to the same ministry.

Questionnaire

Poverty and Support for Older Persons

Good afternoon, my name is _____ [first and last name]. I work as an interviewer for the research agency _____ [agency name]. Your phone number was selected using a random number generator. We kindly ask you to allow me a moment to explain the purpose of the research, after which you can decide on your participation.

This is research conducted as part of the project titled **"Strengthening Health, Access, Participation, and Social Equity in Western Balkan Countries (SHAPE)".** The project is funded by the Federal Ministry for Social Affairs, Health, Care, and Consumer Protection of the Republic of Austria. It aims to improve the status of at-risk groups, mainly older persons, with a specific emphasis on older women.

We are primarily interested in speaking with a member of your household who is 65 and over and needs support in performing activities of daily living. For that reason, we kindly ask you to begin by answering the following questions:

SCREENING QUESTIONS			
No.		**ANSWER**	
R1	IS THERE ANYONE AGED 65 AND OVER LIVING IN YOUR HOUSEHOLD?	Yes	1
		No	2
R2	DOES THE PERSON AGED 65 AND OVER NEED ASSISTANCE FROM OTHERS IN PERFORMING ACTIVITIES OF DAILY LIVING, SUCH AS MEAL PREPARATION AND EATING, PERSONAL HYGIENE, BATHING, DRESSING, HOUSEKEEPING, GOING SHOPPING, PAYING BILLS, ATTENDING MEDICAL APPOINTMENTS, ETC.?	Yes	1
		No	2
R3	**DOES THE PERSON AGED 65 AND OVER HAVE ANY DIFFICULTIES THAT REQUIRE ASSISTANCE FROM OTHERS WITH ACTIVITIES OF DAILY LIVING—SUCH AS DIFFICULTIES WITH VISION, HEARING, MEMORY, COMMUNICATION, OR SIMILAR?**	Yes	1
		No	2
R4	(If such a person exists) May we conduct a short survey with them, or with their primary carer who is most familiar with their situation?	Yes, I am that person and I would like to participate	1
		Yes, I am that person but I do not wish to participate	2
		Yes, we have such a person and they will answer the questions themselves	3
		Yes, we have such a person who wishes to participate, but I will respond on their behalf	4
		Yes, we have such a person but they do not wish to participate	5

Continue: We would like to emphasize that participation in this research is entirely voluntary, and all responses you provide will be treated with strict confidentiality and anonymity. Your data will be stored

in accordance with the highest ethical research standards and data protection regulations[92]. It will not be misused or used for any purposes other than this research.

We would like to assure you that participation in this research involves no risk. If at any point during the interview you feel uncomfortable and wish to discontinue your participation, you are free to do so without any consequences. In that case, your responses will not be stored.

Once again, having heard all the relevant information, do you agree to participate in the research and allow us to proceed with the questions?

NO, I do not agree => Thank you for your time! Goodbye!

YES, I agree => Thank you for your time and cooperation! Shall we begin?

MODULE A. BASIC INFORMATION ABOUT THE RESPONDENT

A1. Is the interview being conducted with a career?

1) Yes
2) No

A2. Sex of the respondent:

1) Male
2) Female

A3. How old are you?

1) 65 – 74
2) 75+

A4. Place of residence:

1) Belgrade
2) Novi Sad, Niš, Kragujevac
3) Some other city
4) Village

A5. Who lives with you in your household?

1) I live alone
2) Spouse/unmarried partner
3) Child/children without their own family
4) Child/children with their partner or own family

92 In accordance with the Law on Personal Data Protection ("Official Gazette of RS", No. 87/2018.

5) Grandchildren—alone, without their own family
6) Grandchildren with their own family
7) Other relatives
8) Non-relatives

A6. How many people live in your household, including yourself? _____

A7. Which of the following sources of income does your household have:

1) Personal pension based on length of employment
2) Survivor's pension
3) Disability pension
4) Financial social assistance
5) Attendance allowance
6) Financial assistance from children/relatives
7) Income from rent
8) Earnings from employment or freelance work
9) I do not know

A8. How would you assess the financial situation of your household?

1) We are unable to cover basic expenses (food, utility bills, medications)
2) We are barely able to cover basic expenses
3) We can easily cover basic expenses, with some funds left for occasional non-essential spending
4) In addition to covering basic expenses, we also have funds for non-essential spending (travel, clothing, hobbies, etc.)
5) We are able to cover both basic and non-essential expenses, with some funds left for savings
6) I do not know / I prefer not to answer **(INTERVIEWER: DO NOT READ THIS OPTION ALOUD)**

MODULE B. NS AND MEANS OF SECURING THEM

B1. People may experience various types of difficulties that affect their ability to perform activities of daily living. Please indicate the level of difficulty you experience with each of the following activities:

		No difficulties	Minor difficulties	Severe difficulties	Unable to do it at all
1.	Do you have difficulty with vision, even when wearing glasses?	1	2	3	4
2.	Do you have difficulty hearing, even when using a hearing aid?	1	2	3	4
3.	Do you have difficulty walking or climbing stairs?	1	2	3	4
4.	Do you have difficulty remembering or concentrating?	1	2	3	4
5.	Do you have difficulty communicating with others, understanding what they say, or being understood by them?	1	2	3	4
6.	Do you have difficulty maintaining your personal hygiene independently, such as bathing, dressing, or eating?	1	2	3	4
7.	Do you have difficulty performing household tasks such as cleaning or preparing meals?	1	2	3	4
8.	Do you have difficulty going shopping, attending medical appointments, going to the post office, or performing similar activities?	1	2	3	4
9.	Do you have any other difficulties that limit your ability to perform activities of daily living? Please specify _____	1	2	3	4

B2. How would you assess your current health status?

1) Very good
2) Good
3) Neither good nor poor
4) Poor
5) Very poor

B3. How do you secure assistance with activities such as eating, personal hygiene, bathing, dressing, or toileting?

1) I pay for the assistance/service
2) I receive assistance but do not pay for it
3) I am unable to secure assistance for myself
4) I do not need any support/assistance

B3.1 Who pays for the assistance/care you receive?

1) I pay for it myself
2) I pay part of the cost, and the rest is covered by the state
3) I pay part of the cost, and the rest is covered by my family/friends/relatives
4) The full cost is covered by the state
5) The full cost is covered by someone else – children, friends, relatives

B3.2 To what extent does the cost of this service affect your household budget?

1) Not at all – It does not affect our budget in any way; after paying for the service, we are able to afford everything we want, including non-essential spending (travel, hobbies, savings)
2) To a slight extent – In addition to paying for the service, we are able to afford everything we need, but do not have sufficient funds for non-essential spending (travel, hobbies, savings)
3) To a moderate extent – After paying for the service, we are left with just enough resources to cover basic living expenses (food, utility bills, medications)
4) To a great extent – In order to afford the service, we must forgo even some basic necessities (food, medications)

5) To a very great extent – The cost of the service places financial strain not only on the household budget but also on the budget of individuals outside the household (children, relatives, friends)

B3.3 Who provides the assistance/care?

1) Humanitarian organization
2) Center for Social Work / health institution within the system
3) Informal carers (family, relatives, friends)
4) Service provision agency
5) Person I hired through an advertisement or personal recommendation

B3.4 Overall, how many different individuals assist you with these activities during a typical week?

_____

B3.5 Approximately how many total hours of assistance do you receive for these activities during a typical week? _____

B3.6 Which of the following statements best describes your satisfaction with the current arrangement:

1) My needs are fully met
2) My needs are partially met; I plan to expand the assistance by paying for additional support
3) My needs are partially met; I plan to expand the assistance by applying for a free service through the Centre for Social Work, a municipal authority, a health care institution, or another provider
4) My needs are partially met; I require more extensive assistance, but it is currently unattainable

B3.7 Why is it not possible?

1) I do not have enough money to pay for the service/assistance
2) I cannot find an agency or individual to provide the assistance I need
3) No free services organized by the state exist in my municipality
4) No private service providers that I could pay for are available in my municipality
5) Due to other necessary expenses, I do not have enough money left to afford assistance

B3.8 Please describe how you managed to cope with the situation when you were unable to secure the service you needed.

B4. How do you secure assistance with household cleaning, shopping, paying bills, attending medical appointments, going to the post office?

1) I pay for assistance/service
2) I receive assistance but do not pay for it
3) I am unable to secure assistance for myself
4) I do not need support/assistance

B4.1 Who pays for the assistance/care you receive?

1) I pay for it myself
2) I cover part of the cost; the rest is covered by the state
3) I cover part of the cost; the rest is covered by my family/friends/relatives
4) The cost is fully covered by the state
5) The cost is fully covered by someone else – children, friends, relatives

B4.2 To what extent does the cost of this service affect your household budget?

1) Not at all – It does not affect our budget in any way; after paying for the service, we are able to afford everything we want, including non-essential spending (travel, hobbies, savings)
2) To a slight extent – In addition to paying for the service, we are able to afford everything we need, but do not have sufficient funds for non-essential spending (travel, hobbies, savings)
3) To a moderate extent – After paying for the service, we are left with just enough resources to cover basic living expenses (food, utility bills, medications)
4) To a great extent – In order to afford the service, we must forgo even some basic necessities (food, medications)
5) To a very great extent – The cost of the service places financial strain not only on the household budget but also on the budget of individuals outside the household (children, relatives, friends)

B4.3 Who provides the assistance/care?

1) Humanitarian organization
2) I receive it as a service provided through the Centre for Social Work / health institutions within the system
3) Informal carers (family, relatives, friends)
4) Service provision agency
5) Person I hired through an advertisement or personal recommendation

B4.4 Overall, how many different individuals assist you with these activities during a typical week?

_____

B4.5 Approximately how many total hours of assistance do you receive for these activities during a typical week? _____

B4.6 Which of the following statements best describes your satisfaction with the current arrangement:

1) My needs are fully met
2) My needs are partially met; I plan to expand the support by paying for additional assistance
3) My needs are partially met; I plan to expand the assistance by applying for a free service through the Centre for Social Work, a municipal authority, a health care institution, or another provider
4) My needs are partially met; I require more extensive assistance, but it is currently unattainable

B4.7 Why is it not possible?

1) I do not have enough money to pay for the service/assistance
2) I cannot find an agency or individual to provide the assistance I need
3) No free services organized by the state exist in my municipality
4) No private service providers that I could pay for are available in my municipality
5) Due to other necessary expenses, I do not have enough money left to afford assistance

B4.8 Please describe how you managed to cope with the situation when you were unable to secure the service you needed.

_____

B5. How do you receive health care support such as wound dressing, blood pressure or blood sugar monitoring, or the administration of therapy?

1) I pay for assistance/service
2) I receive assistance but do not pay for it
3) I am unable to secure assistance for myself
4) I do not need support/assistance

B5.1 Who pays for the assistance/care you receive?

1) I pay for it myself
2) I cover part of the cost; the rest is covered by the state
3) I cover part of the cost; the rest is covered by my family/friends/relatives
4) The cost is fully covered by the state
5) The cost is fully covered by someone else – children, friends, relatives

B5.2 To what extent does the cost of this service affect your household budget?

1) Not at all – It does not affect our budget in any way; after paying for the service, we are able to afford everything we want, including non-essential spending (travel, hobbies, savings)
2) To a slight extent – In addition to paying for the service, we are able to afford everything we need, but do not have sufficient funds for non-essential spending (travel, hobbies, savings)
3) To a moderate extent – After paying for the service, we are left with just enough resources to cover basic living expenses (food, utility bills, medications)
4) To a great extent – In order to afford the service, we must forgo even some basic necessities (food, medications)
5) To a very great extent – The cost of the service places financial strain not only on the household budget but also on the budget of individuals outside the household (children, relatives, friends)

B5.3 Who provides the assistance/care?

1) Humanitarian organization
2) I receive it as a service provided through Center for Social Work / health institution within the system
3) Informal carers (family, relatives, friends)

4) Service provision agency

5) Person I hired through an advertisement or personal recommendation

B5.4 Overall, how many different individuals assist you with these activities during a typical week?

_____

B5.5 Approximately how many total hours of assistance do you receive for these activities during a typical week? _____

B5.6 Which of the following statements best describes your satisfaction with the current arrangement:

1) My needs are fully met

2) My needs are partially met; I plan to expand the support by paying for additional assistance

3) My needs are partially met; I plan to expand the assistance by applying for a free service through the Centre for Social Work, a municipal authority, a health care institution, or another provider

4) My needs are partially met; I require more extensive assistance, but it is currently unattainable

B5.7 Why is it not possible?

1) I do not have enough money to pay for the service/assistance

2) I cannot find an agency or individual to provide the assistance I need

3) No free services organized by the state exist in my municipality

4) No private service providers that I could pay for are available in my municipality

5) Due to other necessary expenses, I do not have enough money left to afford assistance

B5.8 Please describe how you managed to cope with the situation when you were unable to secure the service you needed.

B6. How do you secure health care assistance such as IV infusions, pressure ulcers dressing, injections, or physical therapy?

1) I pay for assistance/service
2) I receive assistance but do not pay for it
3) I am unable to secure assistance for myself
4) I do not need support/assistance

B6.1 Who pays for the assistance/care you receive?

1) I pay for it myself
2) I cover part of the cost; the rest is covered by the state
3) I cover part of the cost; the rest is covered by my family/friends/relatives
4) The cost is fully covered by the state
5) The cost is fully covered by someone else – children, friends, relatives

B6.2 To what extent does the cost of this service affect your household budget?

1) Not at all – It does not affect our budget in any way; after paying for the service, we are able to afford everything we want, including non-essential spending (travel, hobbies, savings)
2) To a slight extent – In addition to paying for the service, we are able to afford everything we need, but do not have sufficient funds for non-essential spending (travel, hobbies, savings)
3) To a moderate extent – After paying for the service, we are left with just enough resources to cover basic living expenses (food, utility bills, medications)
4) To a great extent – In order to afford the service, we must forgo even some basic necessities (food, medications)
5) To a very great extent – The cost of the service places financial strain not only on the household budget but also on the budget of individuals outside the household (children, relatives, friends)

B6.3 Who provides the assistance/care? Humanitarian organization

1) I receive it as a service provided through the Centre for Social Work / health institution within the system
2) Informal carers (family, relatives, friends)
3) Service provision agency

4) Person I hired through an advertisement or personal recommendation

B6.4 Overall, how many different individuals assist you with these activities during a typical week?
_____

B6.5 Approximately how many total hours of assistance do you receive for these activities during a typical week? _____

B6.6 Which of the following statements best describes your satisfaction with the current arrangement:

1) My needs are fully met
2) My needs are partially met; I plan to expand the support by paying for additional assistance
3) My needs are partially met; I plan to expand the assistance by applying for a free service through the Centre for Social Work, a municipal authority, a health care institution, or another provider
4) My needs are partially met; I require more extensive assistance, but it is currently unattainable

B6.7 Why is it not possible?

1) I do not have enough money to pay for the service/assistance
2) I cannot find an agency or individual to provide the assistance I need
3) No free services organized by the state exist in my municipality
4) No private service providers that I could pay for are available in my municipality
5) Due to other necessary expenses, I do not have enough money left to afford assistance

B6.8 Please describe how you managed to cope with the situation when you were unable to secure the service you needed.

MODULE C. SERVICES WITHIN THE HEALTH CARE SYSTEM

C1. Let us now turn to some questions about the health care services. Please think about specific types of health care services and indicate how you secure the care you need.

	C1.1 How frequently do you need the following health care services…? 1) Several times a month 2) Once a month 3) Several times a year 4) Once a year 5) Once every couple of years 6) I have no need for the service	**C1.2 How do you secure the following health care services?** 1) I do not pay for services; they are provided through the public health system 2) I do not pay for services; they are covered by private health insurance 3) I cover the majority of medical examination costs out of pocket 4) I am unable to secure access to services	**C1.3 To what extent does the cost of this service affect your household budget?** 1) Not at all – It does not affect our budget in any way; after paying for the service, we are able to afford everything we want, including non-essential spending (travel, hobbies, savings) 2) To a slight extent – In addition to paying for the service, we are able to afford everything we need, but do not have sufficient funds for non-essential spending (travel, hobbies, savings) 3) To a moderate extent – After paying for the service, we are left with just enough resources to cover basic living expenses (food, utility bills, medications) 4) To a great extent – In order to afford the service, we must forgo even some basic necessities (food, medications) 5) To a very great extent – The cost of the service places financial strain not only on the household budget but also on the budget of individuals outside the household (children, relatives, friends)	**C1.4 Please indicate the reason why you were unable to secure the health care service you needed:** 1) There was a long waiting list 2) The service was not available in my area / it was too far away 3) The service was not available through the public health care system, and I could not afford to pay for it 4) Something else – please specify.	**C1.5 Please describe how you managed to cope with the situation when you were unable to secure the service you needed.**

C1.A. Specialist examination					
C1.B. Diagnostics (ultrasound/ scanner)					
C1.C. Laboratory					
C1.D. Therapy/ rehabilitation					
C1.E. Operative procedures (cataract surgery, hip or knee surgery, or similar interventions)					

C2. Let us now turn to some questions about assistive devices that may be part of your health care—for example, wheelchairs, walkers, hearing aids, incontinence products, and similar aids. How do you obtain the assistive devices you need?

MODULE F: FINANCIAL BURDEN

F1. Considering the overall income of your household, would you say that your household is able to make ends meet, specifically with regard to covering essential expenses?

1) With great difficulty
2) With difficulty
3) With some difficulty
4) Fairly easily
5) Easily
6) Very easily

F2. F2—Have you ever been in a situation where you had to reduce or forgo basic living expenses—such as food, utility bills, or other essential items—in order to afford the health care or social support services you needed?

1) Yes, often
2) Yes, sometimes
3) No, never

F3. When contemplating the future, are you concerned that you may not have sufficient financial resources or support from others to secure services to meet your health, care, or nursing needs?

1) Yes, I am very concerned
2) Yes, I am somewhat concerned
3) I am not concerned at all

F4. Are the financial social benefits you receive (welfare benefits, attendance allowance) sufficient to cover the costs of the health and social assistance services?

1) Yes, fully sufficient to cover the costs of health and social assistance services
2) Partially sufficient to cover the costs of health and social assistance services
3) No, not sufficient at all to cover the costs of health and social assistance services
4) I do not know, because I use the benefits to cover other expenses (food, clothing, utility bills)
5) I am not entitled to any social benefits / I do not receive any material assistance or support

DEBRIEFING

Thank you very much for taking the time to participate in this research!

Your participation offers important insights into the support required by older persons in performing activities of daily living. The findings enable more effective responses to key challenges in health care, social protection, and economic inclusion, directly contributing to an improved quality of life for vulnerable groups—particularly older persons.

If you have any additional questions regarding this research, please contact _____ [name of the organization] at the following email address: _____. Your inquiry will be forwarded to the client's research team, and you will receive a response as soon as possible.

Interview guides

INTERVIEW GUIDE FOR INTERVIEWS WITH OLDER PERSONS (AGED 65 AND OVER) WITH DIFFICULTIES IN ADL

The project titled **"Strengthening Health, Access, Participation, and Social Equity in Western Balkan Countries (SHAPE)"**, funded by the Federal Ministry of Social Affairs, Health, Care and Consumer Protection of the Republic of Austria, is currently being implemented. This is a regional project implemented in Serbia, North Macedonia, and Albania. The general objective of the project is to improve the position of at-risk groups, with a particular focus on older persons (aged 65 and over).

One of the project components, implemented by the SeConS Development Initiative Group, aims to develop recommendations for enhancing long-term care services so that older persons in need have better access to higher-quality care. As part of this project component, qualitative research will be conducted with individuals aged 65 and over who experience difficulties in performing activities of daily living and require long-term care services.

The interview will be anonymous and confidential. You are under no obligation to disclose the opinions you express during the interview, and none of the information you provide will be attributed to you personally in any way. The information you provide during the interview will be used in the report without including your name or any other personal information that could identify you. Furthermore, all personal data collected will be processed in accordance with the highest ethical standards and the Law on Personal Data Protection.[93]

Please note that participation is entirely voluntary, and choosing not to participate will have no negative consequences for you. In this regard, you are not obligated to answer any questions that make you feel uncomfortable, and you may choose to end the interview at any time.

This conversation will be audio-recorded solely for the purpose of ensuring the most accurate data analysis possible.

Are you comfortable with that? Yes/No.

Are you willing to participate in the interview? Yes/No.

We appreciate your interest and willingness to participate in this research. If you have any questions, please feel free to ask them before we begin the interview.

93 The Law on Personal Data Protection ("Official Gazette of RS", No. 87/2018.

MODULE A: General information

To begin, please briefly introduce yourself—your name, age, occupation, current employment status, and the people you live with in your household.

MODULE B: Needs and access to support

In this part of the interview, we would like to better understand your daily needs and the support you receive—whether it involves assistance with feeding, personal hygiene (bathing, dressing, toileting), housekeeping, shopping, paying bills, attending medical appointments, or receiving health care (such as domiciliary care—wounds dressing, blood pressure or blood sugar measuring, therapy administration, IV therapy, injections, etc.).

1. How would you describe your current health status? Do you experience any difficulties that make it challenging to perform activities of daily living—for example,
   - Do you have difficulties with hearing, vision, mobility, remembering, communication, or similar?
   - Are you able to perform the following activities independently: bathing, dressing, preparing meals, maintaining household hygiene, shopping, and similar activities?

2. Which daily tasks are the most difficult for you? What do you find to be the greatest challenge you face? What are you unable to do on your own? Which activities do you need assistance with?
3. When you need assistance, is there someone who helps you? Please describe the assistance you currently receive.
   - Which activities do you receive assistance with? Who provides the assistance you need (family members, neighbors, friends, a paid carer – either through a service agency or someone hired through an advertisement or personal recommendation, a public or private institution, a humanitarian or non-governmental organization)?
   - Is the assistance you receive provided by one person or by several people (for example, a paid carer along with a family member, a neighbor, etc.)? If multiple people are involved, who provides assistance most frequently? Whose assistance is the most important to you?
   - How often do you receive assistance (how many hours per day or how many times per week)? Do you feel that the assistance you receive is sufficient? Would you like to receive more extensive assistance, or do you feel that you need it?

4. Is there a form of assistance or service that you need but that is currently not accessible to you? Could you describe which activities are affected and why this form of assistance is not currently accessible?
5. What do you do in situations when you are unable to receive or afford the assistance you need (or when the assistance is delayed)? If you can recall a situation when you were unable to secure the assistance you needed, how did you manage that situation?
6. What form of assistance would be most helpful to you in performing activities of daily living? What would make the greatest difference for you?
7. If you are not currently receiving any assistance, what is the main reason (lack of financial resources, lack of available carers, or lack of information)? How does this situation affect your daily life and emotional well-being? How do you cope with these challenges and meet your need for assistance?

MODULE C: Services within the health care system

We would now like to learn more about your experiences with using health care services. These may include specialist examinations, diagnostic procedures (ultrasound or CT scans), laboratory tests, therapy or rehabilitation, operative procedures, and the use of assistive devices (wheelchairs, walkers, hearing aids, incontinence products, and similar devices).

1. Who most often provides health care services to you—public or private health care institutions? How do you decide whether to use public or private services (based on waiting times, quality, or availability)?
2. How often do you use services such as specialist examinations, diagnostic procedures (ultrasound, CT scans), laboratory tests, therapy or rehabilitation, or operative procedures? Is the frequency of using these services sufficient to meet your needs, or would you require more frequent access?
3. Are you satisfied with the quality of these services—particularly in terms of how you are received, treated, and informed within these institutions, regardless of whether the services are paid or free of charge? Do you trust the health care professionals you come into contact with? Do you receive clear explanations about your therapy, diagnosis, and any additional examinations that may be required?
4. Are there any services that you need but are currently unable to access in practice? Which services are these, and what are the reasons you are unable to access them?
5. What happens when you are unable to access or afford the health care service you need? How do you manage in those situations? If you can recall a specific instance when you were unable to access a needed service, how did you respond or cope with the situation?

6. Which health care service would be most helpful to you at this time?
7. If you are currently not using any health care services, what is the main reason (lack of financial resources, lack of available carers, lack of services, or lack of information)? How does this situation affect your daily life and emotional well-being? How do you cope with these challenges and meet your need for assistance?

ASSISTIVE DEVICES:

8. Do you have a need for any assistive devices, such as a wheelchair, walker, hearing aid, incontinence products, pressure ulcer dressings, or similar items? If yes, how do you obtain these devices? How do you cover the costs? To what extent does the cost of these devices place a burden on your household budget?
9. If you need assistive devices but are unable to obtain them, how do you manage in that situation?

MODULE F: Financial situation and financial burden

1. What are the sources of income for your household (personal pension, survivor's pension, disability pension, financial social assistance, attendance allowance, financial support from children/relatives, income from rent, income from employment or freelance work, etc.)? If you receive any financial assistance, how frequently do you receive it?
2. How would you assess the financial situation of your household? All things considered, are your household's income sufficient to cover basic expenses such as food, utility bills, medications, and clothing?
3. Who covers the costs of the health and/or social services that you use? Do you pay for them yourself, do family members contribute, or do you receive financial assistance from the state, the municipality, a non-governmental organization, or from another source? Please specify.
4. How does paying for these services affect your monthly household budget? In addition to the services you pay for, are you able to cover other expenses?
5. Have you ever been in a situation where you had to reduce or forgo basic living expenses—such as food, utility bills, medications, or other essentials—in order to afford the health care or social support services you needed? Can you recall a specific situation when this occurred? What did you have to forgo?
6. When contemplating the future, are you concerned that you may not have sufficient financial resources or support from others to secure services to meet your health, care, or nursing needs?

Is there anything else you would like to share about your experience that we haven't asked you about?

Thank you very much for your time!

GUIDE TO CONDUCTING INTERVIEWS WITH INFORMAL CARERS OF OLDER PERSONS (AGED 65 AND OVER) IN NEED

The project titled **"Strengthening Health, Access, Participation, and Social Equity in Western Balkan Countries (SHAPE)",** funded by the Federal Ministry of Social Affairs, Health, Care and Consumer Protection of the Republic of Austria, is currently being implemented. This is a regional project implemented in Serbia, North Macedonia, and Albania. The general objective of the project is to improve the position of at-risk groups, with a particular focus on older persons (aged 65 and over).

One of the project components, implemented by the SeConS Development Initiative Group, aims to develop recommendations for enhancing long-term care services so that older persons in need have better access to higher-quality care. For the purpose of implementing this project component, a qualitative research will be conducted with individuals aged 65 and over who experience difficulties in performing activities of daily living and require long-term care services, as well as with their carers.

The interview will be anonymous and confidential. You are under no obligation to disclose the opinions you express during the interview, and none of the information you provide will be attributed to you personally in any way. The information you provide during the interview will be used in the report without including your name or any other personal information that could identify you. Furthermore, all personal data collected will be processed in accordance with the highest ethical standards and the Law on Personal Data Protection.[94]

Please note that participation is entirely voluntary, and choosing not to participate will have no negative consequences for you or for the older person for whom you provide care. In this regard, you are not obligated to answer any questions that make you feel uncomfortable, and you may choose to end the interview at any time.

This conversation will be audio-recorded solely for the purpose of ensuring the most accurate data analysis possible.

Are you comfortable with that? Yes/No.

Are you willing to participate in the interview? Yes/No.

We appreciate your interest and willingness to participate in this research. If you have any questions, please feel free to ask them before we begin the interview.

94 The Law on Personal Data Protection ("Official Gazette of RS", No. 87/2018.

MODULE A: General information

To begin, please briefly introduce yourself—your name, age, occupation and employment status, place of residence, your relationship to the older person you care for, and how long you have been providing care.

Could you now tell us more about the person you care for (their name, sex, age, place of residence, marital status, and any other relevant information).

MODULE B: Needs and access to support

In this part of the interview, we would like to better understand the daily needs of the older person you care for, as well as the assistance they receive. This may include assistance with feeding, personal hygiene (bathing, dressing, or toileting), housekeeping, shopping, paying bills, attending medical appointments, or receiving health care services (such as domiciliary care—wounds dressing, blood pressure or blood sugar measuring, therapy administration, IV therapy, injections, etc.).

1. How would you describe the current health status of the older person you care for? Do they experience any difficulties that make it challenging to perform activities of daily living—for example,
   - Difficulties with hearing, vision, mobility, remembering, communication, or similar?
   - Are they able to perform the following activities independently:
     bathing, dressing, preparing meals, maintaining household hygiene, shopping, and similar activities?
2. Which daily tasks are the most difficult for them? What do they find to be the greatest challenge they face? Which activities do they need assistance with?
3. What type of assistance do you most frequently provide to them? Could you please describe in more detail what the assistance you provide looks like over the course of a typical day?
   a. Which activities are involved—for example, physical assistance (dressing, bathing, feeding), household tasks (cooking, cleaning, shopping), wounds dressing, blood pressure or blood sugar monitoring, administering therapy, IV therapy or injections, accompanying them to medical appointments, handling administrative matters (going to the post office or bank), communication support, or emotional support?
   b. How often and for how long (per day or per week) do you provide assistance? Is the assistance provided on a daily basis? If so, approximately how many hours per day?
   c. What do you find most difficult in the care you provide to the older person? Which part of the caregiving is the most demanding for you?

4. Do you provide assistance on your own, or is someone else involved as well, even occasionally? If someone else is involved in providing assistance, who are they? Family members, friends, neighbors, paid professional assistance—either a service agency or someone hired through an advertisement or personal recommendation—a public or private institution, or a humanitarian or non-governmental organization?
    a. If you are the only one providing assistance, what is the reason for that (lack of financial resources, lack of available people, services, or information)? Have you ever sought assistance for yourself as a carer (from institutions, organizations, the community, or your family)?
5. Are there any activities where you are unable to provide assistance to the older person? Which activities are these? Why are you unable to assist with those activities?
6. What do you do in situations when you feel that you cannot provide the necessary assistance on your own, but are also unable to secure or afford the needed assistance for the older person? If you can recall a situation when you were unable to secure the assistance/service needed, how did you manage that situation?
7. In your opinion, what would make the greatest difference for the older person if it were available to them? What form of assistance would be most helpful to them in performing activities of daily living?

MODULE C: Services within the health care system

We would now like to learn more about the use of health care services. These may include specialist examinations, diagnostic procedures (ultrasound or CT scans), laboratory tests, therapy or rehabilitation, operative procedures, and the use of assistive devices (wheelchairs, walkers, hearing aids, incontinence products, and similar devices).

1. How often does the older person use services such as specialist examinations, diagnostic procedures (ultrasound, CT scans), laboratory tests, therapy or rehabilitation, or operative procedures? Is the frequency of using these services sufficient to meet their needs, or would they require more frequent access?
2. Are there any services that they need but are currently unable to access in practice? Which services are these, and what are the reasons they are unable to access them? How do you handle those situations?
3. How do you manage to secure the financial resources for the health care services needed by the older person? Do you pay for them yourself, do family members contribute, does the older person pay out of pocket, or do you receive financial assistance from the state, the municipality, a non-governmental organization, or from another source? Please specify.

ASSISTIVE DEVICES:

1. Does the older person have a need for any assistive devices, such as a wheelchair, walker, hearing aid, incontinence products, pressure ulcer dressings, or similar items? If yes, how do you obtain these devices? How do you cover the costs? To what extent does the cost of these devices place a burden on your household budget?
2. If the older person needs assistive devices but you are unable to obtain them, how do you manage in that situation?

MODULE F: Financial situation and financial burden

1. What are the sources of income for your household (personal pension, survivor's pension, disability pension, financial social assistance, attendance allowance, financial support from children/relatives, income from rent, income from employment or freelance work, etc.)?
2. How would you assess the financial situation of your household? Is your household income sufficient to cover basic expenses such as food, utility bills, medications, and clothing?
3. Who covers the costs of the health and/or social services used by the older person? Do you pay for them yourself, do family members contribute, or do you receive financial assistance from the state, the municipality, a non-governmental organization, or from another source? Please specify.
4. Have you ever been in a situation where you had to reduce or forgo basic living expenses—such as food, utility bills, medications, or other essentials—in order to afford the health care or social assistance services needed for the older person? If yes, what did you most often have to forgo—medications, food, clothing, heating, or something else? Have you often found yourself in such a situation?
5. When you think about the future, are you concerned that you may not have sufficient financial resources or support from others to meet all of the older person's health, care, or nursing needs?

ADDITIONAL QUESTIONS:

Have you (or any members of your household) ever been in a situation where you had to take on an additional job in order to cover the costs of health or social care needs?

Have you ever been compelled to leave your job or take extended unpaid leave in order to care for the older person? How did this affect your household's financial situation? How did you manage to cover the costs of these services during that period?

Is there anything else you would like to share about your experience that we haven't asked you about?

Thank you very much for your time!

Consent form

INFORMED CONSENT FORM FOR PARTICIPATION IN A RESEARCH INTERVIEW

Dear Participant,

The project titled "Strengthening Health, Access, Participation, and Social Equity in Western Balkan Countries (SHAPE)", funded by the Federal Ministry of Social Affairs, Health, Care and Consumer Protection of the Republic of Austria, is currently being implemented. This is a regional project implemented in Serbia, North Macedonia, and Albania. The general objective of the project is to improve the position of at-risk groups, with a particular focus on older persons (aged 65 and over).

One of the project components, implemented by the SeConS Development Initiative Group, aims to develop recommendations for enhancing long-term care services, with the goal of ensuring that older persons in need have better access to higher-quality care. For the purpose of implementing this project component, qualitative research is being conducted with individuals aged 65 and over who experience difficulties in performing activities of daily living and require long-term care services, as well as with their careers.

All information you provide during this interview will remain fully anonymous and confidential. In reporting, the information will be used without mentioning your name or any other personal data that could disclose your identity. Please note that you are not required to answer any questions that make you feel uncomfortable and that you may withdraw from the interview at any time.

We appreciate your interest and willingness to participate in this interview.

Before we begin, please confirm that you have:

- Read the information above and understood the purpose of the research;
- Understood that all information collected during the interview will be treated as confidential, in accordance with the Law on Personal Data Protection[95];
- Understood that, should you choose to decline participation or withdraw from the interview, you may inform the researchers, and you will be excluded from the research;
- Understood that your decision not to participate or to withdraw from the interview will not in any way affect your position or access to services available to you;
- Understood that the information collected will be used to compile a report, and your anonymity and confidentiality are fully guaranteed—no individuals will be identifiable in the report;

95 "Official Gazette of RS", No. 87/2018.

- Agreed that the interview may be audio-recorded solely for the purpose of systematic data analysis, and that the recording will not be published or made publicly available;
- If you do not consent to audio-recording the interview, you agree that the interviewer may take notes during the interview instead.

If you have any further questions regarding the data collection process, please feel free to ask before we begin the interview.

Signature of interview participant	Signature of interviewer

In _____ (place), _____ (date)