WHY SHOULD WE CARE ABOUT CARE? THE ROLE OF CHILDCARE AND ELDERCARE IN SERBIA

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THE ROLE OF CHILDCARE AND ELDERCARE IN SERBIA

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Executive Summary

Despite a slight increase in female labor participation between 2012 and 2013, employment rates in Serbia stood at 40.1 percent for women in 2013, almost 15 percentage points below employment rates for men (at 54.9 percent). The difference in the employment rates is mainly due to marked higher inactivity of women in the labor market.[1] The conflicting demand on women's time for care and work activities represents a fundamental barrier to economic participation and generates a vicious circle of low labor market attachment and prominence of the care provider role that leads to increased vulnerability and gender-based inequalities.

International evidence shows that support for childcare and eldercare affects women's labor market participation. This note examines the care needs of families with children and/or elderly household members and the provision of formal care services in Serbia with an emphasis on the availability, price, and quality characteristics. Based on the analysis of an independent mixed-methods dataset collected in the Western Balkans region, this note documents the perceptions and barriers in the use of quality formal care in Serbia.

Six main messages emerge from the assessment of supply and demand of formal childcare and eldercare in Serbia:

1. Limited availability of affordable services characterizes the relatively low utilization of formal childcare services in rural areas.

2. There is demand of formal childcare services, and this includes childcare services for young kids.

3. The demand for childcare services is voiced predominantly by parents perceiving benefits for their child's development and working (or willing-to-work) mothers.

4. Due to relatively progressive social norms in relation to the region, the perceptions of formal care services are mostly positive (both for children and elderly).

5. Day-care centers and home-based formats—if available—will be more compatible with prevailing standards of care for the elderly.

6. Quality is important for potential users of formal care services and the main challenges of the existing supply involves human resources (HR).

Given its demographic context, the improvement of accessibility, affordability, and quality of formal care options in Serbia is a crucial element for economic growth. Enhanced formal care options can allow would-be informal caregivers (who are mostly women) to reallocate their time

[1] Labor Force Survey data show almost 17 percentage points difference in female labor force participation for the 15–64 age group, while the gender unemployment gap is 2.9 percentage points.

to formal labor market activities, thereby contributing directly to economic output and providing tax revenues that can ease the fiscal burden commonly associated with aging population. Moreover, a well-regulated childcare sector can imply improvements in the school readiness for children via better coverage of early childhood education, which in turn can translate into higher capital accumulation—vital for sustaining economic growth in the context of high shares of aging population. Finally, quality provision of formal eldercare can potentially improve health outcomes for the elderly through prevention, early detection, and consistent maintenance of chronic diseases, which may imply long-term cost savings in the healthcare sector.

Investing in better staff qualification, training, and certification for both childcare and eldercare provision represents one policy option to boost the development of a formal care industry, which can contribute to the active aging objective by recruiting younger-old to care for older-old, as well as increase female labor force participation, in particular for women with low skills and in the rural areas.

I. Motivation: Why Should We Care about Care?

1. **Within families, the demand for time devoted to informal and at-home care falls disproportionately on women of all ages.** In the Western Balkans countries, as well as in most of the world, it is well documented that childcare duties fall disproportionately on women. For the case of eldercare, while filial obligation on the part of the child might rest equally on daughters and sons, those more likely to act upon it are daughters and daughters-in-law (box 1). In an expanded generational view, as mothers are expected to be the main childcare provider, grandmothers are often expected to provide care for grandchildren when mothers need support.

2. **There is a negative circle of low female labor market attachment and prominence of the care provider role for women that leads to increased vulnerability and gender-based inequalities.** Lower labor market attachment and earning potential of women—caused in part by the prominence of their childcare role—combined with women's higher life expectancy result in a higher propensity to become caregivers at one or another point in the lifecycle. As women spend more time engaging in unpaid, informal care work, they have less opportunity to work in the market. Studies looking at the relationship between caregiving and labor market outcomes show negative effects both on the extensive and intensive margins and reduced human capital accumulation (Becker 1985; Behrman and Wolfe 1984; Jaumotte 2003; Ribar 1995). There is also evidence that caregivers receive lower wages, further discouraging labor force participation (Carmichael and Charles 1998, 2003; Correll, Benard, and Paik 2007; Heitmueller and Inglis 2007). Together, these may contribute to reduced lifetime earnings for caregivers, leading to a disadvantaged position with regard to financial status, lower pension accumulation, and long-term economic vulnerability.

3. **Policy interventions that appropriately address care demands will benefit not only women but the whole society as increasing labor force participation and productivity is vital for sustainable development.** The rising demand for care services provides an opportunity to develop a formal care industry, which can contribute to long-term active aging objectives by recruiting younger-old to care for older-old, as well as increase female labor force participation, in particular for women with low skills. With regard to childcare, given that productive and reproductive years overlap for women, support for working mothers (and fathers) is essential to prevent women from dropping out of the labor force due to childcare demands. This target cannot be attained without improved care services that not only free women to take part in paid work, but also ensure adequate human capital investment in the young generations.

4. **The current demographic situation in Serbia implies the rising care burden.** Without appropriate policies to address the expected rise in the care burden, population aging can reduce women's access to economic opportunities and decelerate future growth, thereby threatening the agenda of poverty reduction and shared prosperity. Moreover, failing to meet the challenge of rising care burden can undermine the achievement of other policy objectives, such as increasing women's investment in human capital, stimulating fertility by promoting mother's

employment, and enabling the combination of family and working life, as well as extending the working life.

5. **This note examines the provision of childcare and eldercare in Serbia with an emphasis on the availability, price, and quality of care, and suggests policy priorities that address the identified challenges.** The analysis in this note is based on a study aimed at exploring childcare and eldercare in the Western Balkans region, drawing primarily from a new mixed-methods dataset, described in the following section, and building on relevant quantitative surveys and data sources specific to the Western Balkans countries. The note is structured as follows: Section II introduces the new, independent mixed-methods dataset that is the basis for the analysis and findings presented. Section III describes the use of formal and informal care arrangements in Serbia. Next, based on the analysis of perspectives both from families with care needs and from care providers and discussing the role of norms and perceptions of childcare and eldercare use, the following sections are dedicated to the description of supply and demand of childcare and eldercare, respectively. Sections IV and V focus on the supply and demand of childcare, and sections VI and VII describe the supply and demand of eldercare. Section VIII concludes by examining what we know with regard to policies that can support families in informal care provision in a sustainable and incentive-compatible manner.

Box 1: Summary of literature review on care and female labor participation

The impact of rising care duties on the time women devote to paid work can take the form of lower labor force participation or lower work intensity. The effect of rising care duties on female labor supply can take on numerous forms. Women can decide not to enter the labor force to attend to care demands, or they can enter and at a later stage withdraw from the labor force altogether, thereby being affected on the extensive margin, or they can reduce working hours (for example, by starting to work part time or by requesting flexible work arrangements) or switch to jobs that are less time-intensive and oftentimes more precarious, implying an intensive margin effect. In central European countries, caregiving has an impact on the number of hours women work but not on their labor force attachment (Bolin, Lindgren, and Lundborg 2008). Spiess and Schneider (2003) demonstrate that a negative effect on working hours for women who start or increase caregiving does not reverse when caregiving is reduced.

There is rich evidence that increased availability of formal childcare options results in improved labor force participation of women in many different contexts—in Brazil (Deutsch 1998, Paes de Barros et al 2011); in rural Colombia (Attanasio and Vera-Hernandez 2004); in urban Argentina (Berlinski and Galiani 2007); in Japan (Asai, Kambayashi, and Yamaguchi 2015); and in Canada (Lefebvre and Merrigan, 2005). Closer to the region, Del Boca and Locatelli (2006) used data from the European Community Household Panel to show that female labor force participation is affected by the availability and, even more importantly, affordability of childcare. Fong and Lokshin (2000) examined the relationship between female labor supply and the cost of paid childcare in Romania between 1989 and 1995 and found that both female labor force participation and the decision to use paid childcare were sensitive to the prbice of childcare. In the Russian Federation, Lokshin (2000) used policy simulations based on household panel survey data to show that providing subsidies for paid childcare increased maternal employment by almost twice as much as comparable wage subsidies. In Turkey, a recent World Bank (2015) study also finds that mothers with low education have a limited willingness to pay and will prefer a more basic provision of childcare—but of

good quality—than a costlier system providing an expanded range of services within the childcare centers. Besides this extensive margin effect, childcare subsidies increased the amount of time working mothers spent at work and were more effective in raising the overall family income than any other policy intervention examined in the study. It is important to note that access to childcare can affect male labor market outcomes as well as female labor supply. Calderon (2014) examined the effects of a Mexican Government–provided childcare program and found that it not only increased female labor employment rates and earnings but also enabled men to spend time searching for better-paid jobs.

As with childcare, intensive eldercare duties can reduce female labor supply during the most productive years. There is substantial evidence, from a variety of contexts, that intensive, time-demanding care, such as that requiring more than 20 hours per week, has significant negative effect on the likelihood of staying in the labor force (Bolin, Lindgren, and Lundborg 2008; Carmichael and Charles 1998; Gabriele, Tanda, Tediosi 2011; Heitmueller and Inglis 2007; Henz 2006; Jacobs et al. 2014; Johnson and Lo Sasso 2000; Lilly, Laporte, and Coyte 2010; OECD 2011; Sarasa 2006). Greater availability of formal eldercare options can be expected to affect female labor force participation, although evidence on this topic is so far limited. Heger (2014) uses Survey of Health, Ageing, and Retirement in Europe (SHARE) data to look at caregivers' employment and finds that caregiving decreases employment rates in countries with low supply of formal care (or family care countries) by 34–60 percentage points depending on the frequency of care but has no impact on caregivers' employment probability in countries with more established care systems. Earlier, Viitanen (2007), using the European Community Household Panel to simulate the effect of greater public expenditure on formal residential care and home-help services for the elderly, found a positive effect on the employment rate of 45–59-year-old women by 9–13 percentage points across Europe. Loken, Lundberg, and Riise (2014) examine a 1998 expansion of local, home-based care for the elderly in Norway, which resulted in a significant reduction of extended absences from work for adult daughters of single elderly. Geyer and Korfhage (2014) examine long-term care support in Germany and conclude that cash benefits discourage care providers from engaging in paid work, while benefits given in kind (and as such better substituting for the specific time commitment of the informal caregiver) provide incentives to already caring household members to increase labor supply. These findings confirm analysis by Todd (2013) showing that there are still few acceptable market-based options for eldercare in developing countries compared with childcare.

II. A New, Independent Mixed-Methods Dataset

6. **The World Bank collected a new, independent mixed-methods dataset to investigate the changing care arrangements—specifically, childcare and eldercare—and its interaction with female labor force participation and productivity.** This contribution sought to bridge a knowledge gap with regard to the interaction between female labor force outcomes and care services in the Europe and Central Asia region, especially in the Western Balkans. In particular, on the demand side, it sought to collect new evidence and document the care needs of families with children and/or elderly household members and the barriers they face in accessing care services. On the supply side, it investigated the cost and quality of care in the region. The study also builds up on relevant quantitative surveys including the Generations and Gender Survey (GGS), (SHARE), and data sources specific to the Western Balkans countries, including the European Social Survey (ESS) and National Time Use Surveys. For the casa of Serbia, European Union (EU) Statistics on

Income and Living Conditions (SILC) data on childcare attendance to formal childcare are used for comparisons with other European countries (see table 1 for a summary of data sources by the Western Balkans countries).

Table 1: Summary of data sources

Western Balkans Countries	Independent Data	ESS	National Time Use Survey	SILC
Albania		X		
Bosnia and Herzegovina	X			
Kosovo	X	X		
Macedonia, FYR	X		X	
Montenegro				
Serbia	X		X	X

7. **The field work, which was conducted between February and May 2014, was divided broadly into two components: (a) a supply assessment of available care services, and (b) a household and demand assessment, including Focus Group Discussions (FGDs) with adults with care needs, and questionnaires completed by participants.** The supply assessment was a census-type study, which investigated the types of childcare and eldercare services available to households, both public and private, and explored their accessibility, affordability, and quality. This included site visits, mixed-methods interviews, and, wherever appropriate, quantitative observational checklists. The demand assessment targeted households with children and/or elders and included an investigation of time use, care needs, perceptions, and preferences about care responsibilities, as well as barriers in access to formal childcare or eldercare services. Whenever possible, the assessment followed the dynamics of care demand and supply at the household level, with women and their labor force engagement at the center. This assessment included quantitative individual-level questionnaires, as well as qualitative FGDs. Both childcare and eldercare providers were clearly defined (table 2).

Table 2: Childcare and eldercare definitions

	Childcare	Eldercare
Definition	Care for children younger than primary school age or care after school for older children	Care for aging adults (no set ages specified)
Providers included	Day-care, kindergarten, and preschool, among others	Day-care, long-term care, permanent care, living facilities, and social clubs which are run by an administrator
Providers excluded	Live-in centers (such as orphanages) and those which are primarily focused on education	Those primarily focused on medical needs, such as hospitals
Results focus on	Children younger than 6 years of age	Live-in facilities

8. **Both demand and supply assessments were conducted in each of seven countries: Kosovo, Bosnia and Herzegovina, former Yugoslav Republic of Macedonia, Serbia, Ukraine, the Kyrgyz Republic, and Armenia.** A total of nine FGDs were held in Serbia with working women, nonworking women, and men. The FGDs were held in three sites: in a rural community, in a small city, and in a middle-class neighborhood in the largest urban center of the country. For the supply assessment, 18 childcare facilities and 8 eldercare facilities were visited (table 3). Participants were between 25 and 65 years of age and were spread across different age groups within the range (both younger and older) and experienced different types and levels of care responsibilities (such as childcare, eldercare, and both). Employed respondents included those with different levels of work intensity (part time and full time) and both those who are self-employed and wage workers. The supply assessment was a census-type study of all childcare and eldercare services available in the sites targeted for the demand assessment. It included public, private, and community-based care providers. Official documentation and snowball sampling were used, and providers mentioned in the FGDs were included.[2]

Table 3: Country-level data collected through independent mixed-methods survey

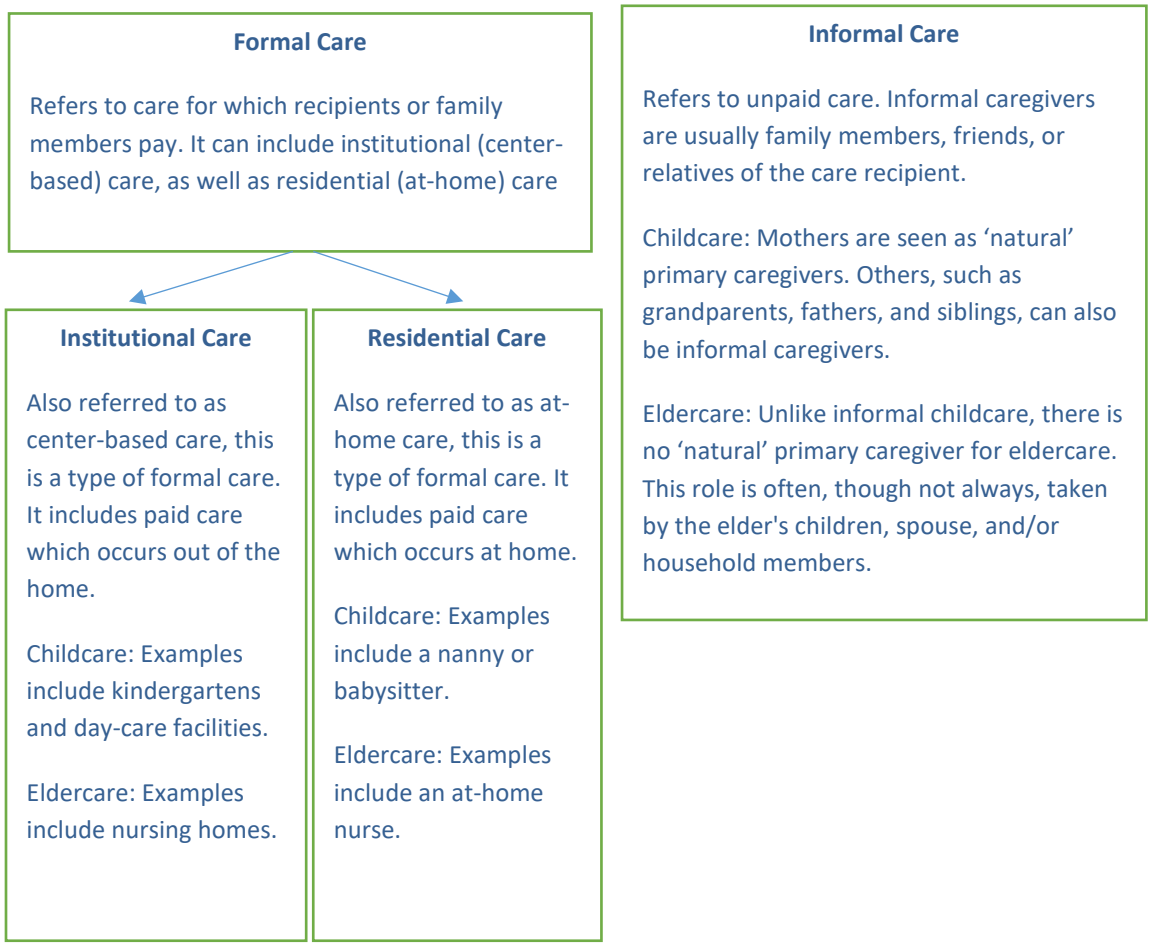
Country	Individuals Interviewed	FGDs Held	Childcare Facilities Assessed	Eldercare Facilities Assessed	Intermediaries Assessed
Kosovo	102	9	9	3	3
Bosnia and Herzegovina	107	12	8	5	0
Macedonia, FYR	103	9	20	5	3
Serbia	108	9	18	8	4
Ukraine	99	9	51	2	10
Kyrgyz Republic	94	9	73	7	0
Armenia	121	9	30	3	1
Total	**734**	**66**	**209**	**33**	**21**

III. Use of Formal and Informal Care

9. **Informal care in this study refers to unpaid and generally unregulated care, usually provided by family members, whereas formal care is defined as care that is paid and is thus regulated by some type of a contractual arrangement (figure 1).** In most countries, formal care tends to emerge as a response to support families in their caregiving role when that role cannot be fulfilled within the family. An interaction between prevailing social norms and institutional environment determines each society's reliance on particular modalities of formal support for caregiving, such as leave arrangements, financial support, and in-kind services.

[2] Snowball sampling, also called chain-referral sampling, refers to the non-probability sampling technique where existing study subjects recruit future subjects from among their acquaintances.

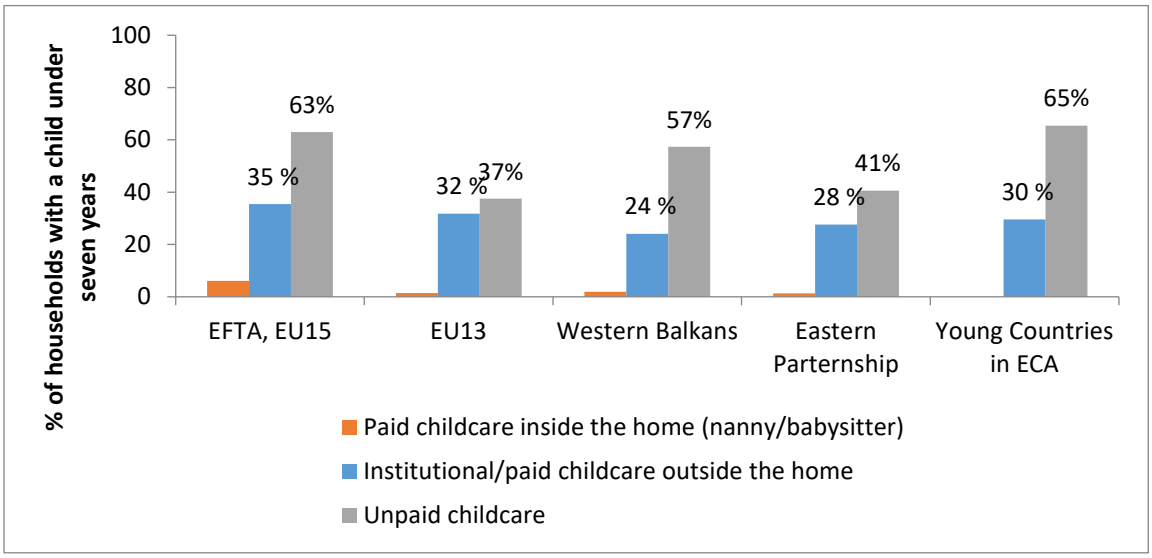
Figure 1: Typologies of care



Source: Based on Krauss et al (2010).

10. **Use of formal childcare in the Western Balkans region is very low.** Data from GGS depicts the prominent care arrangements for children 7 years and younger in Europe by groups of countries (figure 2). Interestingly, the split between unpaid care and formal institutional childcare is most even in EU-13 countries as well as Eastern Partnership countries, suggesting that the two forms of care might be used as complements in these subregions. Individual interviews show that most childcare needs are met by informal care or a combination of formal and informal care (table 4). The analysis of supply and demand in the following sections will show that a combination of service availability and intrahousehold decision-making processes underlies the relatively low utilization of formal childcare services.

Figure 2: Percentage of households with at least one child under 7 years who use institutional, paid at-home care, and unpaid childcare



Source: Authors' calculations based on GGS data (most recent wave for Bulgaria, Russia, Georgia, Romania, Lithuania, Poland, the Czech Republic, Germany, France, the Netherlands, Norway, Austria, and Belgium) and fieldwork data (2014 data for Armenia, Bosnia and Herzegovina, Kosovo, the Kyrgyz Republic, FYR Macedonia, Serbia, and Ukraine).

Table 4: Percentage of women in the study with children of 0–14 years using different child care arrangements

	Formal Care Only	**Informal Care Only**	**Both Informal and Formal Care**	**Only Maternal Care; No Use of Either Formal or Informal Care**
Armenia	4.2	34.7	61.1	0
Bosnia and Herzegovina	13.4	28.4	13.4	38.2
Kosovo	0	0	0	98.4
Kyrgyz Republic	14.6	51.2	13.4	19.5
Macedonia, FYR	0	69.2	21.5	6.2
Serbia	6.4	41	34.6	14.1
Ukraine	9.3	50.7	26.7	9.3
Total	**7**	**39.8**	**26.5**	**24**

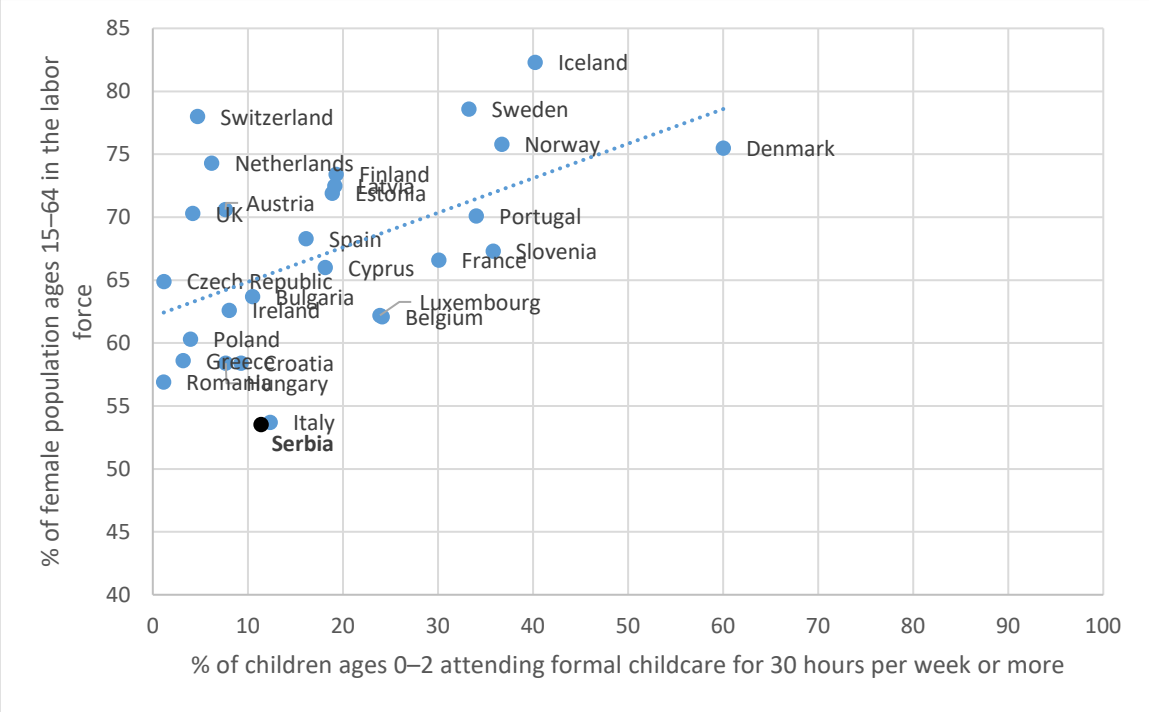
Source: Quantitative individual-level questionnaires, independent field data (2014).

Note: Users of formal care are those reporting to receive regular help from a day-care center, a nursery or preschool, and after-school care center, a school, a self-organized group, a babysitter, or from some other institutional or paid arrangement. Users of informal care are those reporting to receive regular help with childcare from relatives or friends or other people for whom caring for children is not a job.

11. **Attendance to formal childcare is fundamentally related to women's participation in the labor market, particularly for young children. Compared to other European countries, Serbia shows low levels of childcare use.** For European countries, the relationship between use of formal

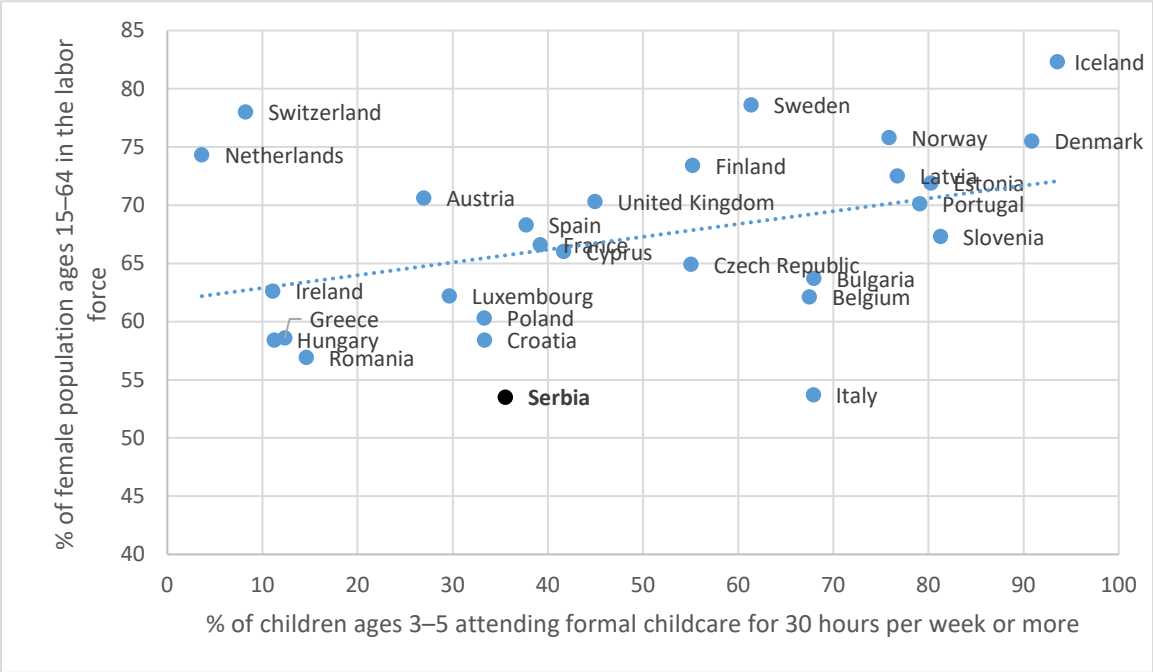
childcare and women's participation in paid work is strong. This is particularly true for infants and young children (figures 3 and 4). In this simple relationship of childcare attendance and female labor participation, Serbia shows low levels of childcare use and low female labor participation. Of course, one has to take into account that there are additional barriers that limit women's access to jobs, for example, access to flexible work arrangements and parental and maternity leave benefits. For older children, preschool attendance increases sharply in the majority of countries and the relationship with female labor participation, although less strong, remains positive (figure 4).

Figure 3: Attendance to formal childcare for the youngest children and female labor force participation in European countries



Source: Authors' estimations based on EU-SILC 2013 for childcare attendance and World Development Indicators for female labor force participation.

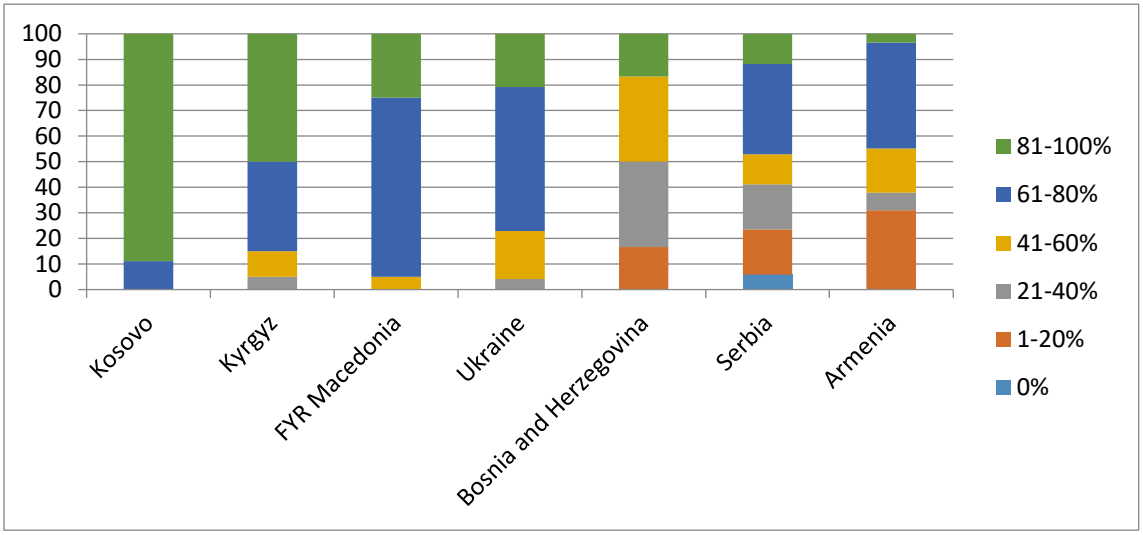
Figure 4: Attendance to formal childcare for older children and female labor force participation in European countries



Source: Authors' estimations based on EU-SILC 2013 for childcare attendance and World Development Indicators for female labor force participation.

12. **In Serbia, interview data show that users of childcare are not necessarily working mothers.** As can be observed in figure 5, there is considerable variation in the percentage of childcare users who are working mothers (full or part time) in the visited facilities. From the supply and demand assessment data, strong differences appear, for example, in Kosovo (where 90 percent of surveyed facilities had at least 80 percent working mother clientele) and Armenia (where very few facilities had a majority of working mothers as clientele).

Figure 5: Percentage of child care facilities with different intensities of working mothers



Source: Independent field data (2014).

Note: The percentages of clients who are working mothers are based on responses from representatives of childcare facilities to the question, "What percentage of mothers (whose children receive care here) are employed ('working mothers')?"

13. **Evidence on the use of eldercare options is thinner, but suggests that most of the eldercare needs in the region are met using only informal care.** In Serbia, interviews suggest that the great majority of needs are covered with informal care or by the household female caregiver (table 5). Overall, qualitative analysis around supply and demand of formal elderly care suggests that social norms and quality considerations dominate general views and decision-making processes. However, changing needs of women and households (both due to changing market and demographic conditions) push for a change of norms and programs around elderly care. Hence, new formats other than (or in addition to) residential care by family are necessary to cater to these needs.

Table 5: Percentage of women in the study who care for an elderly and use eldercare arrangements

	Formal Care Only	Informal Care Only	Both Informal and Formal Care	Only Household Female Caregiver; No Use of Either Formal or Informal Care
Armenia	0	75	1.7	23.3
Bosnia and Herzegovina	2.1	34	4.3	53.2
Kosovo	4.8	14.3	0	78.6
Kyrgyz Republic	28.3	15.2	47.8	0
Macedonia, FYR	0	54.8	0	40.5
Serbia	0	63.5	0	36.5
Ukraine	0	38.1	0	57.1
Total	**4.7**	**44.5**	**7.3**	**39.8**

Source: Quantitative individual-level questionnaires, independent field data (2014).
Note: Users of formal care are those reporting to receive regular help from an institutional or paid arrangement. Users of informal care are those reporting to receive regular help with care for the elderly from relatives or friends or other people for whom caring for an elder person is not a job.

IV. Childcare Supply

Availability is limited in rural areas and year-round service in existing facilities is uncommon

14. **While participants voice challenges with regard to affordability and quality as well, lack of capacity and poor quality due to overcrowding appear to be the most pressing problems with regard to childcare in Serbia.** In FGDs held with urban groups, regardless of country, the two interrelated main problems mentioned by women were lack of sufficient facilities and restricted capacity for children's enrollment. In other words, although there is some recognition of supply of care services that are theoretically accessible to households by location, this is evened out by problems of insufficient supply and low capacity. However, in rural groups, the main problem is a total lack of childcare services; except for part-time compulsory preschooling that was mentioned by some participants, there seems to be no kindergartens or alternate services for childcare in villages where the FGDs were held.

15. **As in other countries in the Western Balkans, provision of childcare services in rural areas is either scarce or nonexistent.** Discussions suggest that one-year part-time preschool education is available; however, childcare for younger children and full-time childcare does not seem to exist. Therefore, rural participants explained that those who are willing to use these services have to commute long distances to nearby villages or towns where formal childcare is available, and this is not always an affordable option. Mentions of participants in rural FGDs reveal that inaccessibility of childcare in rural areas negatively affects those rural women who are willing to participate in the labor force. Hence, demand for formal childcare that fits the needs of rural women was voiced in the rural FGDs, in the belief that this will enable women's participation in the labor force (including agricultural work).

> *"I couldn't work. There was no kindergarten (…) And even if you have money, there is no one to look after your child. You can't hire a woman here to look after your child, since every woman has to work in the field and at home, all day long." (Rural woman, Serbia).*

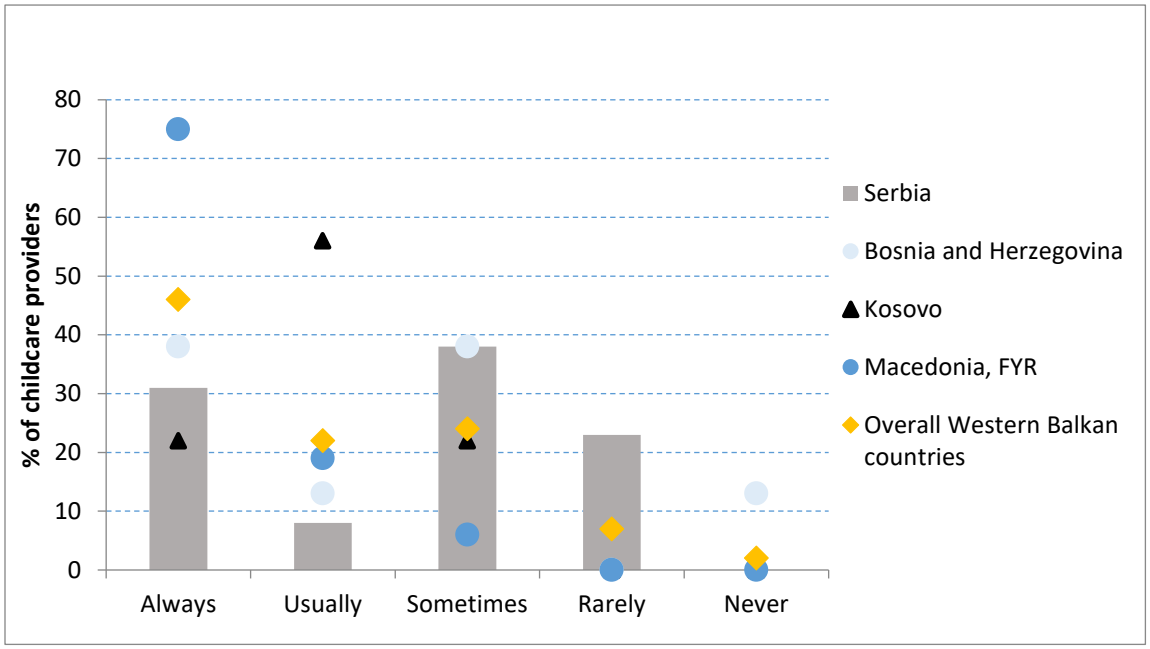
Table 6: Supply of childcare providers in urban and rural areas

	Urban			Small City			Rural		
	Number of Providers	**Total Children Served**	**Average Children Served per Provider**	**Number of Providers**	**Total Children Served**	**Average Children Served per Provider**	**Number of Providers**	**Total Children Served**	**Average Children Served per Provider**
Bosnia and Herzegovina	2	440	220	3	180	60	3	270	90
Kosovo	8	1,040	130	1	80	80	0	0	0
Macedonia, FYR	13	2,375	183	2	345	173	1	120	120
Serbia	6	1,323	221	5	681	136	2	136	68

Note: Total children served = total of capacity of all providers in the location. For example, in Pristina, there were eight providers who could altogether provide care for a total of 1,040 children.

16. **In urban areas, insufficient number of affordable/public childcare centers and high demand from families create a capacity problem and make childcare inaccessible for many.** Regardless of country, FGD participants reported that low capacities of the state-owned kindergartens are an overarching problem that confronts urban families across the Western Balkans. Most childcare providers in the region (67 percent) reported that they are 'always' or 'usually' at capacity. Less than 10 percent reported that they are 'rarely' or 'never' at capacity (figure 6).

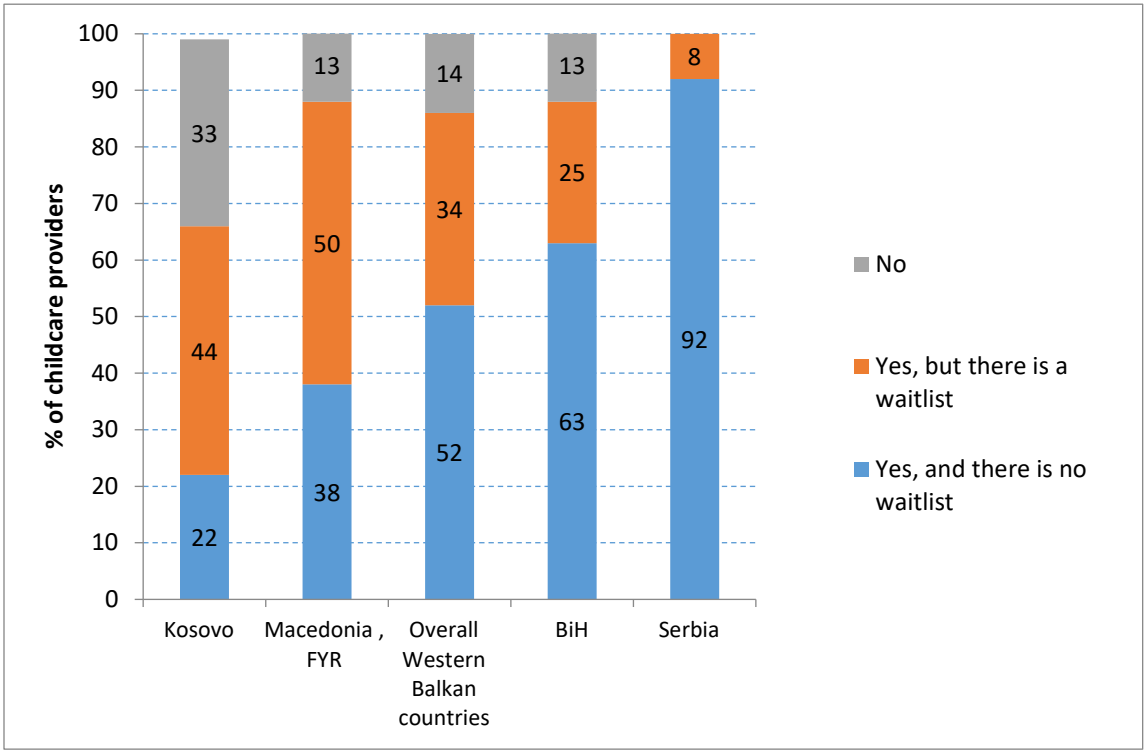
Figure 6: How often is this provider at capacity?



Source: Questionnaires to childcare providers, independent field data (2014).

17. **Though long wait lists are common across the Western Balkans, they are much less pervasive in Serbia.** Supply and demand mismatches are also suggested by the apparent contradiction between perceptions of long queues and actual wait lists. The supply-side data in the independent study shows however that in Serbia the majority of providers declare accepting new clients without putting them in a wait list (figure 6). Heterogeneous quality and location characteristics may explain this apparent lack of correspondence.

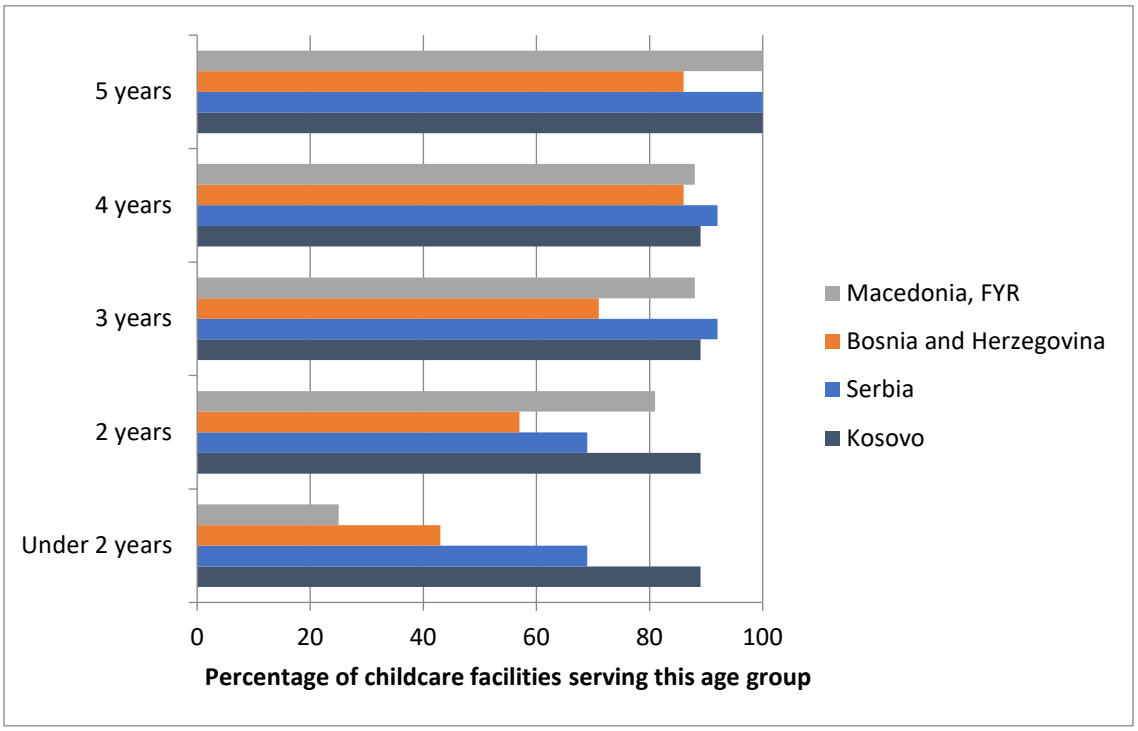
Figure 7: Is this childcare provider currently accepting new clients?



Source: Questionnaire to childcare providers, independent field data (2014).
Note: BiH = Bosnia and Herzegovina.

18. **In Serbia, there is also fair coverage of care for younger children.** Though, across the region, most service providers are focused on older children, in Serbia nearly 70 percent of providers included in the supply-side data cater to children younger than 2 years old (figure 7).

Figure 8: Percentage of childcare facilities by age groups service



Source: Questionnaire to childcare providers, independent field data (2014).

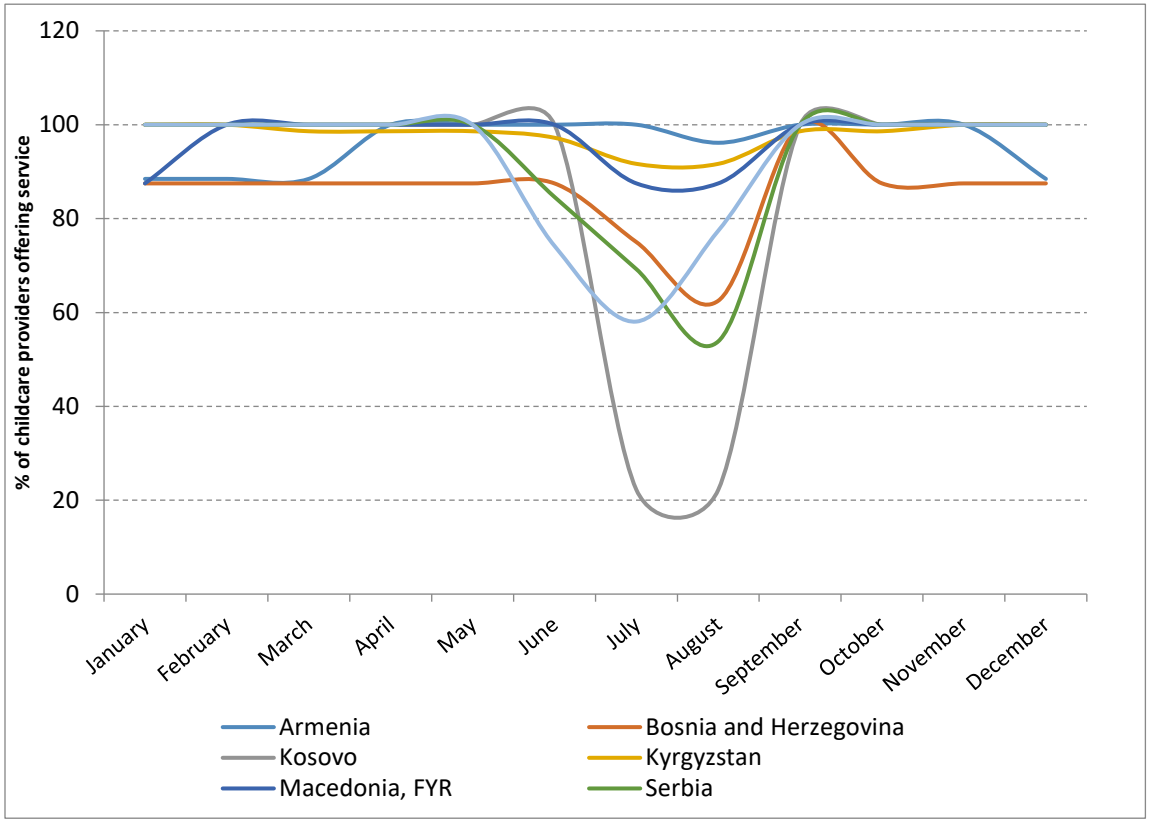
19. **Hours of operation by care centers are closely related to accessibility of these services by families, as well as to whether these services meet care needs of communities.** Similar to Bosnian and Macedonian FGDs, in Serbia, hours of operation was voiced as a concern for working women in particular, since working hours of kindergartens are not always in line with their own or their husbands' professional working hours. Some participants explained that longer hours of employment or working in shifts require rearrangement of childcare service hours accordingly.[3] In comparison, operating hours of private childcare centers are seen to be more in line with the needs of families where both parents are working.[4] Moreover, in Serbian FGDs, it is not only urban but also rural parents who emphasize the importance of working hours for labor force participation. Furthermore, the ability to use the childcare services during the summer months, crucial service characteristic for working parents, is actually limited in Serbia (figure 8).

"A few hours don't mean anything to people, but all-day stay really is very relevant because of agriculture. You are simply not worried whether your child is hungry and thirsty, and you know that he is safe and that he will take a nap." (Rural men, Serbia).

[3] Meanwhile, it is understood that, like in FYR Macedonia, recently, there have been some positive changes in the working hours of some services in Serbia, and the hours were extended from 4.30 p.m. to 6 p.m.

[4] One participant mentioned that some private services offer additional working hours until 8–9 p.m. for children of those families who work in shifts. However, this does not seem to be a widely accepted policy.

Figure 9: Percentage of childcare providers offering service throughout the calendar year



Source: Questionnaire to childcare providers, independent field data (2014).

Affordability is an issue in rural areas given the limited availability of childcare

20. **In comparison to focus groups of the other three Western Balkans states, affordability of childcare was discussed less in Serbian FGDs.** Overall, it is understood that there is a general affordability problem regarding private kindergartens; however, public childcare also is not always affordable, especially if one or both parents are unemployed.[5]

21. **Discussions suggest that in Serbia, prices of public childcare services seem to be not fixed but vary depending on the income and the marital status of the parents.** A woman from the urban groups explained that she is paying half the monthly fee since she is a single mother. Another urban woman explained that the monthly fees correlated with income/social security premiums of parents; however, she also explained that this policy was abused and caused injustices.

[5] There is need for further research on this, as it is not possible to tell from FGDs and qualitative analysis which segments of the population can afford the currently available services or what the conditions are for affordability.

"Prices differ. They punish anyone who studied and who is working all day long or anyone with higher income. On the other hand, people who have their own companies pay lower social insurance and they get away with paying the minimal amount 3,700 dinars. My son was the child who paid the highest fee in the whole group." (Urban woman, Serbia)

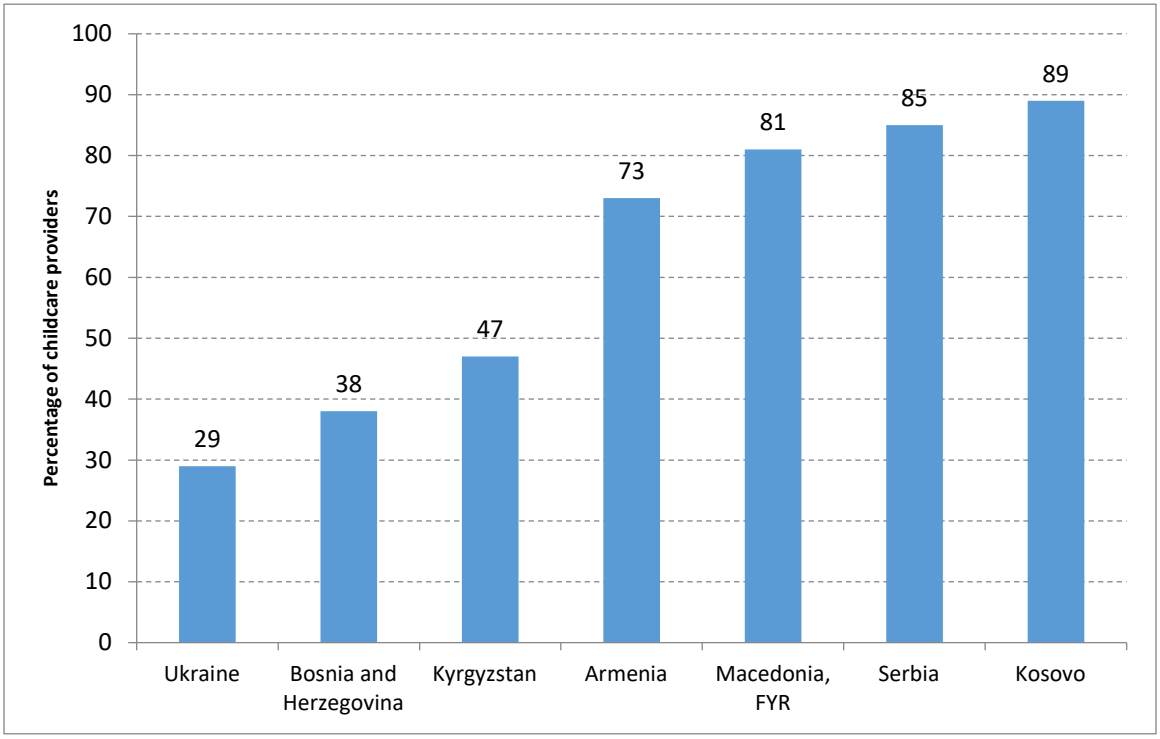
22. **In rural areas, inaccessibility by location also creates a different type of affordability problem.** This is because the costs of having to commute long distances to reach care are not affordable for many participants.

"I couldn't send my children to kindergarten, only my son. He went to the kindergarten in Topla for three years, from age four to age seven. I couldn't afford the petrol to drive them to the kindergarten in Topla and back anymore so they stayed home alone." (Rural woman, Serbia)

23. **Among the participating childcare providers, childcare is never free of charge.** Across the Western Balkans, a mere 3 percent of public childcare providers offer full-day care for free, and none of the private providers do. A monthly deposit is the most common arrangement (97 percent of public providers and 83 percent of private providers), though some private providers also require an entry deposit. In the middle-class neighborhood in Belgrade where our supply-side assessment was conducted, full-day monthly pricing was offered by all five providers who discussed proving. (One private provider declined to discuss pricing.) The overall average price was €114 (BAM 13,560; MKD 3,044), with an average of €25 (MKD 1,533) for the 12 public providers and €203 (MKD 12,500) for the one private provider.

24. **Many childcare providers offer discounts to families, especially for bringing multiple children to the provider or when family income falls below a certain level.** In Serbia, 85 percent of providers interviewed offered some type of discount, making it the leader in our sample of the region (figure 9). Though the discounts vary by public and private providers, the most common discounts provided in the region overall are for the number of children from a family who go to a given center, the monthly incomes of the family, whether the father is a war invalid, and whether the family is using social assistance.

Figure 10: Percentage of childcare providers with some price flexibility



Source: Questionnaire to childcare providers, independent field data (2014).

25. **In urban areas, costs of public childcare seem to be affordable, and yet, families suffer from other barriers to use, particularly accessibility by location and capacity, as well as regulative challenges mentioned above.** Moreover, discussions suggest that the number of children in the family also affects some parents' perceptions of affordability: some participants mentioned that they would be able to send only one of their children and not the other(s) although they would like to do so.

26. **Private care services in urban areas seem to be inaccessible for the majority of the population due to high costs.** Some participants explained that as an alternate to public care, private services do not suffer from the capacity problems that are borne by the former, and sometimes offer higher-quality services. However, they also seem to be unaffordable for the majority of the population due to high costs.

Main challenge for quality childcare provision is human resources

27. **Quality perceptions and expectations of participants in the Western Balkans FGDs were discussed around three main themes: (a) quality of basic care services including infrastructure, (b) quality of early childhood development (ECD) activities, and (c) quality of caregiving staff.** Quality of basic services, by participants' own accounts, includes sufficient care provision for children's basic needs such as eating, cleaning, sleeping as well as measures that ensure children's health, safety, and security. The quality of ECD activities relates to the content and/or variety of

activities that benefit children's social, behavioral, and cognitive development, such as drawing, playing, singing, and doing physical activities, as well as socio-behavioral education provided by caregivers. The quality of caregiving staff is described in FGDs with regard to capabilities of caregivers in adequately meeting both basic and ECD needs of children and, therefore, is closely related to both the basic service quality and the quality of ECD.

28. **Overall, participants think that the private services offer better quality in comparison with public services, but the level of satisfaction with public services is also high among the Serbian FGDs.** Not only is overcrowding itself a problem, but it also negatively affects other quality attributes of care services, such as teacher attentiveness or epidemics. The primary problems that were voiced in Serbia FGDs with regard to quality are as follows:

(a) **Overcrowding and very high child-staff ratios in public centers.** Participants mentioned that the number of children per teacher was inadequate in public childcare centers: numbers as high as 40–50 children per teacher were mentioned. Hence, Serbian women demand that more staff should be allocated so as to improve the quality of care and education. Private care centers in this respect were seen to provide more quality than public centers as they have fewer children.

"There are simply too many children so they can't work with them individually [in public centers], but we all basically expect same treatment, we expect children to be looked after" (Urban woman, Serbia).

(b) **Low quality of basic services.** For example, low hygiene standards in the facilities and/or inadequate teacher attentiveness to children's basic care needs, such as hygiene or feeding.

(c) **Healthcare risks for children.** Overall safety of the children from harm is very important for parents. However, frequent epidemics in particular were voiced as a general problem for childcare centers in Serbian FGDs. Many participants explained that children attend kindergartens on and off due to sickness. Such healthcare risks also affect parents' decisions to not use formal but informal care so as to protect their children.

"The child attends the kindergarten for a few days and then falls ill. This repeats again and again in circles, so after a year, the child ends up spending more time at home than in the kindergarten" (Urban woman, Serbia).

"My daughter started kindergarten but then she became so prone to sickness that I just had to get her grandmother to look after her. And then it made no sense to only send our son to the kindergarten" (Urban woman, Serbia)

(d) **Unsatisfactory qualifications of teachers and/or staff.** This includes inattentiveness of staff and wrongful behavior, as in other countries. In addition, some parents believe that lack of smooth transition from home to childcare, which is a particular barrier for use of these services despite parents' willingness, is also due to inadequate staff qualifications. Some believe that overcrowding also influences maltreatment.

> *"There are teachers that treat children inhumanely. This is because it's theoretically impossible to manage a group of thirty kids" (Urban woman, Serbia)*

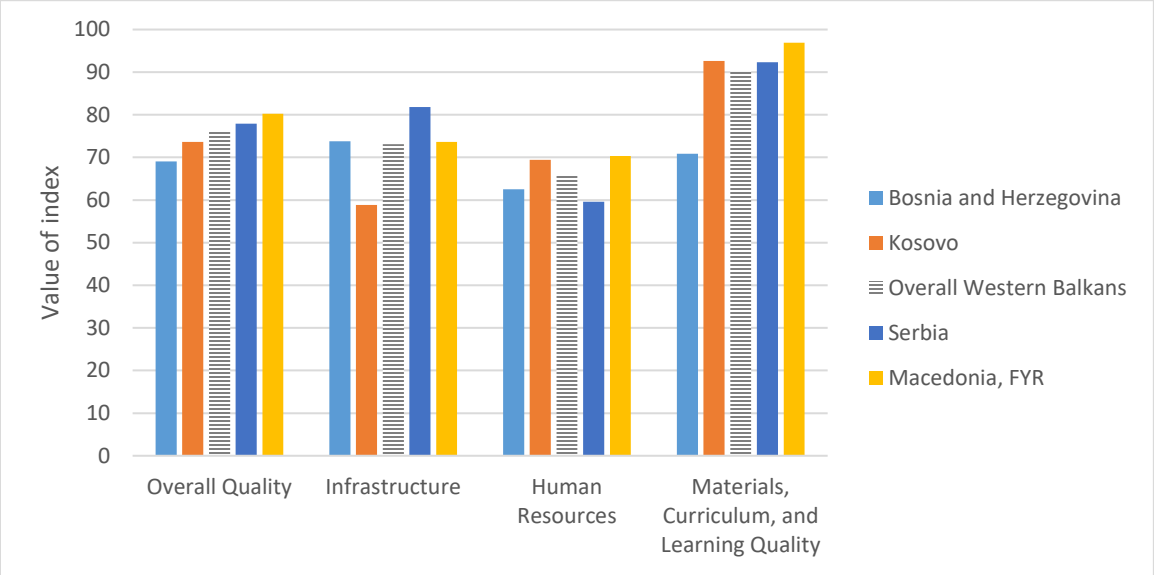
29. **One of the challenges voiced by parents across the Europe and Central Asia FGDs and also in Serbia in formal childcare has been the lack of smooth transition from home to childcare; or in other words frequent dropouts due to the inability of children to adapt to care centers.** By their own accounts, the challenge is especially troubling for parents with no access to alternate formal or informal childcare, and constitutes both a practical problem and a psychological challenge for parents willing to use these services. On the other hand, it is understood that sufficient teacher qualification and skills to handle this problem are seen to be of primary importance to overcome this challenge.

> *"I thought I was going to go crazy during those 3 months [when my daughter could not adapt to school and kept crying], but the teacher supported me to stay calm and not give up, because I had no one else to look after my children" (Urban woman, Serbia).*

30. **To complement the FGDs, supply-side data used a principal component analysis method to create three equally weighted quality subindices.** These mirrored the central concerns raised in FGDs and include the following: (a) infrastructure quality subindex, (b) materials, curriculum, and learning quality (MCLQ) subindex, and (c) HR quality subindex. All inputs varied between 0 and 1. The subindices and the overall scores were standardized to a scale between 0 and 100, where a higher score indicates better quality. The first subindex, infrastructure, includes 17 indicators such as whether the space is in good repair and if there is no malodor in the classrooms. The second subindex, MCLQ, includes eight indicators, including whether children are served food and if there are any provisions for children with special needs. The final subindex, HR quality, includes four indicators, including whether the caregivers' minimum credentials include higher school or university, and if a small group of children is primarily cared for by one designated staff member. Full details of the subindices can be found in annex 1.

31. **Serbia has an overall quality score of 78, just above the Western Balkans average.** Human resources score below the region's average and represent the more important quality challenge in Serbia (figure 10).

Figure 11: Childcare quality by country and subindex



Source: Authors' calculations based on data from visits to childcare facilities, independent field data (2014).

V. Demand for Childcare

Main determinants of childcare demand: Perception of benefits for children's development and need of support for working/willing-to-work mothers

32. **Regardless of location (urban/rural distinction), the need and demand for and willingness to use childcare services have been voiced primarily by:**

(a) those parents who believe that children will benefit from the education and social environment, and/or

(b) those women with little or no informal childcare support and yet are working or are willing to work.

33. **Benefits of childcare for children's social and cognitive development was stated as an important motivation among Serbian participants for using formal care services, like in other Western Balkans FGDs.**[6] The benefits of formal childcare for children, mentioned in both urban and rural FGDs, and particularly by women and also some men**,** are as follows: socialization with own age group, more quality social and behavioral early childhood education that could not be provided via informal care at home (and particularly not by grandmothers), becoming more

[6] Among a total of 50 mentions in Serbia, 64 percent were mentions of positive perceptions, and 36 percent were mentions of negative perceptions. Among the western Balkan FGDs, Serbia has the second highest percentage of positive mentions after Bosnia and Herzegovina (67 percent), and before FYR Macedonia (62 percent) and Kosovo (59 percent).

independent, developing creative skills, learning new vocabulary, and developing behavioral and psychological readiness for school.[7] Furthermore, in Serbian FGDs, the benefits of formal childcare for children with special needs, such as those having speech problems or having an introverted nature, were also mentioned.

34. **One particularity about Serbian FGDs was the mention of use of nurseries for children under 2 years (as opposed to other countries).** Some participants in urban FGDs mentioned that they used nurseries for their very young children since they were working. While it is difficult to assess the extent to which this demand is generalizable, there is some demand in Serbia for formal childcare for even very young children so that women can work.

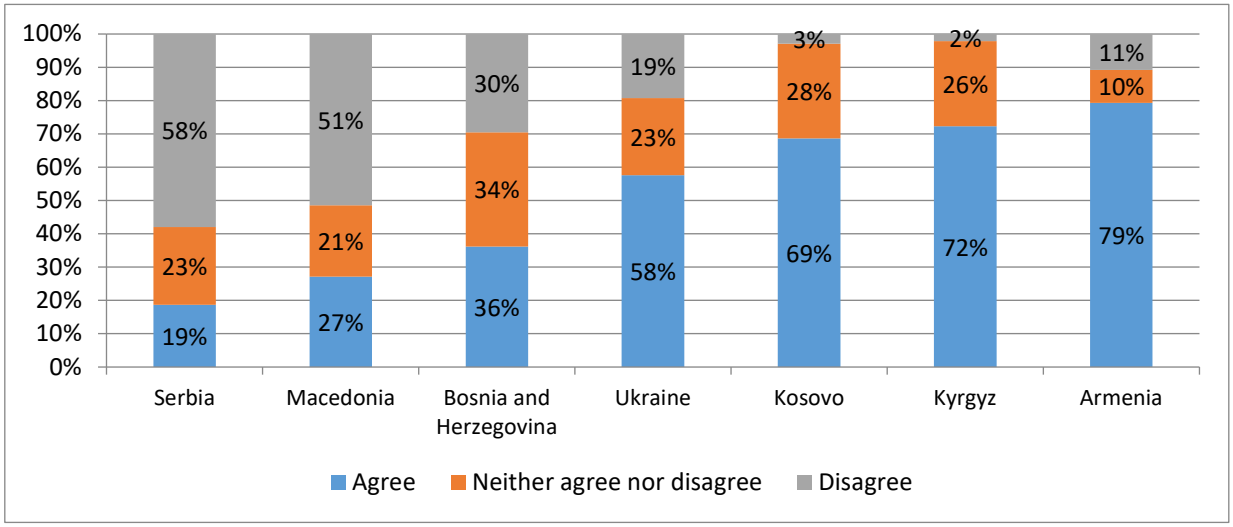
> *"There should be a kindergarten and a nursery for children from their earliest age, and it should be open 8 hours a day, so that we can work. Children would spend time with each other and we would be able to earn money" (Rural woman, Serbia).*

Serbia, relatively progressive on social norms about childcare use

35. **Norms on childcare, work, and motherhood often play a role in shaping negative perceptions on the use of care centers.** In this regard, Serbia looks relatively progressive. Mentions of norms in shaping negative perceptions were very few, and a majority (58 percent) of individuals reported disagreement with the following statement: "A preschool child is likely to suffer if his/her mother works" (figure 11).

[7] Even some women with access to informal care from children's grandmothers explained that they would still opt for these formal services due to their benefits for children. On the other hand, some men also expressed the reverse perspective, that they see no added benefits in using formal care centers, and so they would not use them and 'waste' their finances as long as informal care was available within the family.

Figure 12: Percentage of people who agree with the statement: "A preschool child is likely to suffer if his/her mother works"



Source: Independent field data (2014).

VI. Eldercare Supply

Limited availability of residential eldercare and lack of day-based services characterize supply in Serbia

36. **The FGDs suggest that there is an accessibility problem regarding residential eldercare centers, both with regard to location and capacity.** Leaving aside the issue of whether they would use these services or not, when asked about accessibility, participants mentioned that residential care centers for elderly in urban centers are generally few and/or suffer from insufficient capacity. Supply-side data shows the limited number and capacity of live-in eldercare centers, especially in rural areas (table 7). Regardless of the city size, in Serbia, the overall accessibility was not discussed in much detail. The supply-side data illustrates that Serbia is the only country in the study where the majority of eldercare providers interviewed can accept new clients without a wait list (figure 12).

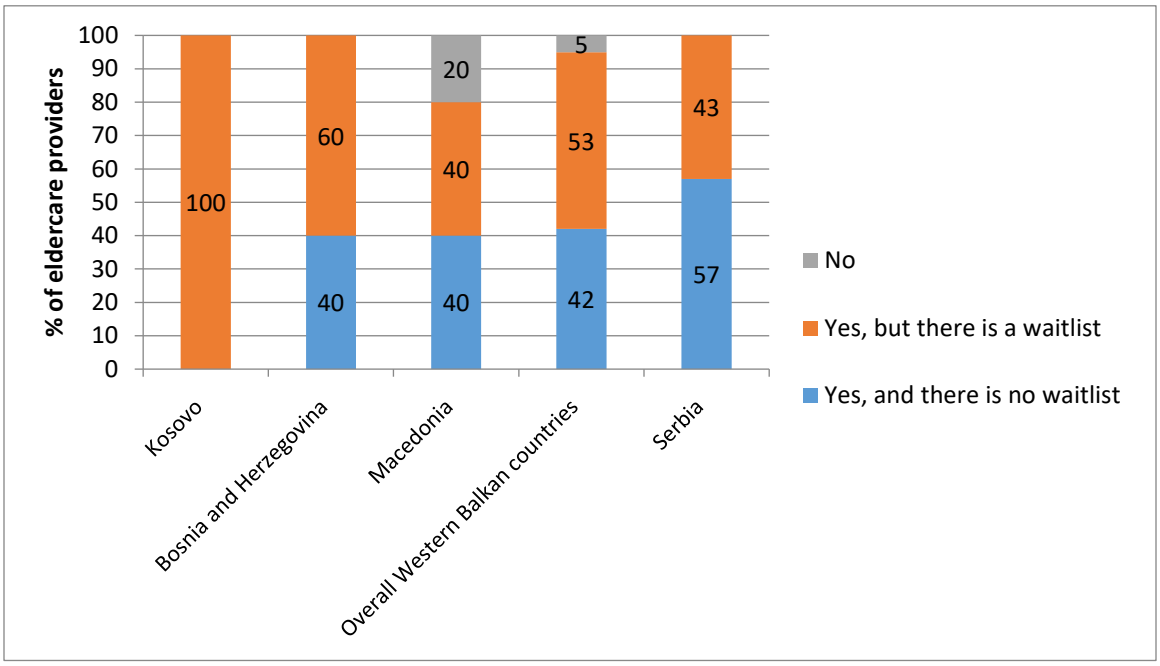
Table 7: Live-in eldercare provision by country

	Urban			Small City			Rural		
	Number of Providers	Total Elders Served	Average Elders Served per Provider	Number of Providers	Total Elders Served	Average Elders Served per Provider	Number of Providers	Total Elders Served	Average Elders Served per Provider
Kosovo	1	110	110	1	20	20	0	0	—
Bosnia and Herzegovina	2	585	293	1	155	155	2	320	160
Macedonia, FYR	2	173	87	2	20	10	1	20	20
Serbia	6	936	156	1	220	110	0	0	—
Armenia	2	42	21	0	0	—	0	0	—
Kyrgyz Republic	2	955	478	2	131	131	1	11	11
Ukraine	0	0	—	1	250	250	0	0	—

Source: Independent field data (2014).

Note: Total elders served = total of capacity of all providers in the location.

Figure 13: "Is this eldercare provider currently accepting new clients?"



Source: Questionnaire to eldercare facilities, independent field data (2014).

Affordability is a necessary but not sufficient condition for utilization

37. **Quality urban residential care and at-home private nurses for elderly are generally very expensive and cannot be afforded by the majority.** There were few mentions of eldercare services being expensive, and overall affordability was not discussed in much detail in Serbian FGDs. Quality urban residential care that is mostly private and at-home private nurses/caregivers for elderly are both generally very expensive and are reported to be not affordable for the majority. On the other hand, it was observed that affordability of services is a necessary but not sufficient condition for utilization by the participants.

> *"An elderly care home costs around €400. I was able to pay this, but I would never do this to my father" (Urban woman, Serbia)*

38. Finally, no matter how good the quality of the care centers is, participants explained that for some elderly, the total transformation in the lives of the elderly by enrollment in these centers is itself a problem. Therefore, participants suggest that good quality would not always encourage use of these centers.

> *"There can be perfect conditions there, but it doesn't matter, what is important is [the elderlies'] perception of these homes. Even though we may think that the conditions there are super, most of them won't be able to adapt to the new conditions [because of age]" (Urban woman, Serbia)*

Human resources remain an important challenge for quality provision of eldercare

39. **Perceptions of quality of residential eldercare centers in Serbian FGDs are relatively more positive than in other Western Balkans FGDs.**[8] Several participants praised the quality of services with regard to hygiene, medical care, staff attentiveness, and basic care (such as food) of some facilities, most of which were private. Like in childcare, the benefits and quality of care were also measured by the happiness of the elderly people themselves. Meanwhile, it was understood that participants did not personally use these services, but their impressions were based on observations and experiences of others or sometimes television shows.

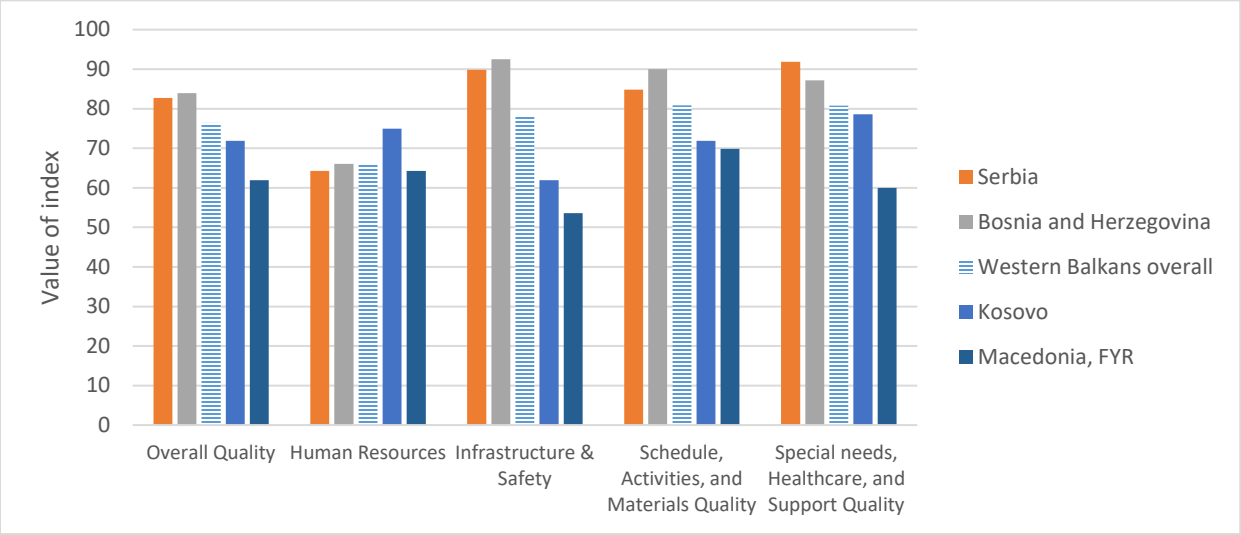
> *If they can move (more healthy), then it's great because they can socialize with each other - same as they show it on TV. Pensioners socialize, they have dinners, something interesting to do, they have nurses to take care of them. If they are sane then they know if they had their medicines, they have doctors there to measure their blood pressure. So it functions well until they become demented or immovable or fall ill. And then it depends on that nurse. There is always one good nurse who all pensioners love, who sits with them reading them newspapers, and there is always one bad nurse. It all depends on what kind of people we are in both private and state homes." (Urban woman, Serbia)*

40. **As with childcare, supply-side data on quality was collected to complement the FGDs.** A principal component analysis method created four equally weighted quality subindices (one more than in the childcare analysis). These mirrored the central concerns raised in FGDs and include the following: (a) infrastructure and safety quality subindex, (b) schedule, activities, and materials quality (SAMQ) subindex, (c) HR quality subindex, and (d) special needs, healthcare, and support quality (SHSQ) subindex. All inputs varied between 0 and 1. The subindices and the overall scores were standardized to a scale between 0 and 100. The first subindex, infrastructure, includes 24 indicators such as whether the space is in good repair and if there is no malodor in the rooms, as in the childcare subindex, along with questions relevant specifically to live-in elders, such as whether clinical mattresses or beds are available. The second subindex, SAMQ, includes 16 indicators. Again, some indicators are the same or similar to those used in childcare, including whether care recipients are served food, and some that are specific to live-in eldercare, such as whether there are visiting hours for family members. The third subindex, HR quality, includes 8 indicators, such as whether elders are organized into groups and whether staff members make an effort to ensure that the elder feels respected. The final indicator, SHSQ, is unique to eldercare and includes 14 indicators, such as whether there are special services for elders with dementia and whether routine medical care is available. Full details of the subindices can be found in annex 2.

[8] In Bosnia and Herzegovina too, perspectives on quality were more positive.

41. **Overall, the supply-side data show that Western Balkans childcare providers score 81, above the average for the region.** The two strongest components of the quality index in Serbia are 'SHSQ,' and 'Infrastructure and Safety' dimensions. The main challenge is on the HR subindex (figure 14).

Figure 14: Eldercare Quality by Country and Component



Source: Authors' calculation based on visits to eldercare facilities, independent field data (2014).

VII. Demand for Eldercare

Filial obligations and social norms are a strong deterrent for residential eldercare use

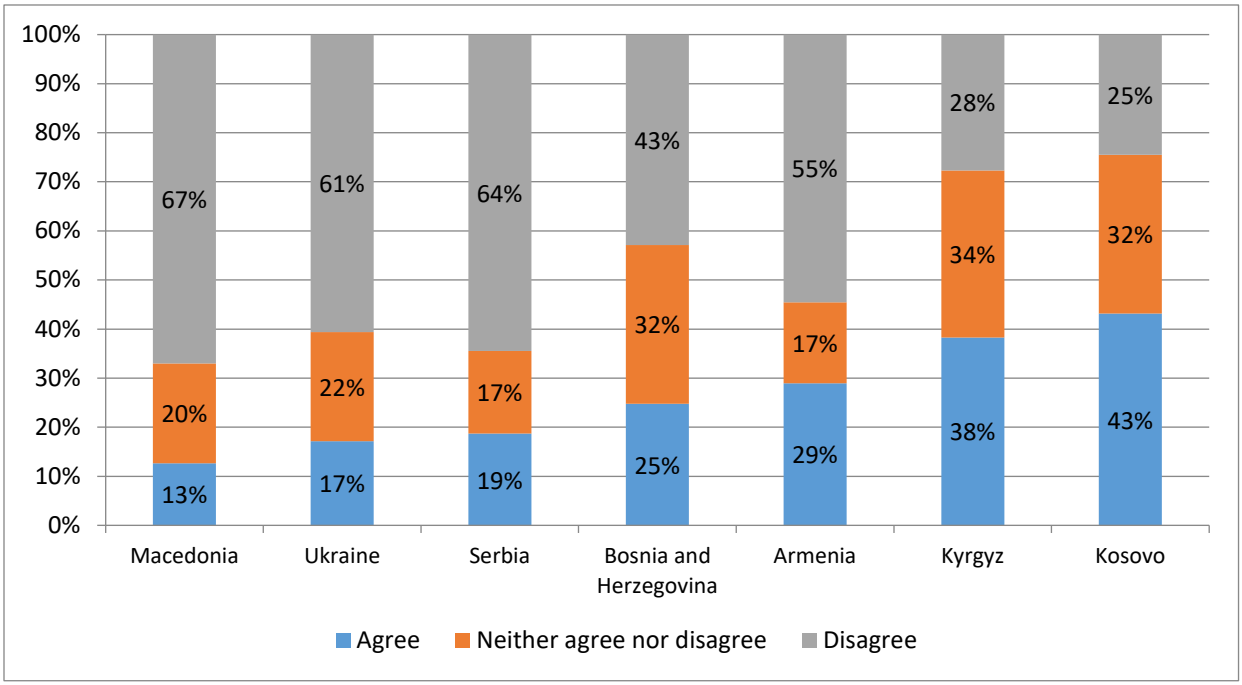
42. **There is a marked mismatch between available care formats and norms of care in Serbia.** This mismatch is true of all Europe and Central Asia countries including the Western Balkans, and Serbia is no exception (figure 15). Qualitative analysis of FGDs shows that the residential care format, which is the primary eldercare format available, brings in a total change in the elderlies' daily lives and stands in contradiction with the social norms and filial obligations of families that prioritize the needs of the elderly.

> *It's important for a person to know that you won't banish him from a home where he spent x number of years and force him into the unknown. And in their old age they are very much like kids and not very fond of change (Rural man, Serbia).*

43. **On the other hand, decision to use these services does not always rest with the families, and if the aging one is sane, she/he has a say in this decision.** Several participants said that, regardless of quality and/or benefits, elderly do not want to use these permanent facilities because the change they introduce in their day-to-day lives is too much for old people to bear.

Homes for the elderly have excellent conditions, but our parents' mentality is such that they don't want to go there. My mother won't leave her home and won't come to live with me, not to mention a home for the elderly. Some caregiver or other paid woman to be paid to come to her house, that's fine, but she won't leave her doorstep. " (Rural woman, Serbia).

Figure 15: Percentage of people who agree, disagree, or neither with the following: "When parents are in need, daughters should take more caring responsibility than sons"



Source: Independent field data (2014).

Day-care centers and home-based formal eldercare formats are more compatible with social norms

44. **Other formats such as day-care centers or home-based formal eldercare are viewed more positively by Serbians, as they are seen to be more compatible with the norms that emphasize the well-being of the elderly.** However, it is understood that accessibility of such services are at best limited and unsystematic, and when available not always affordable.

45. **Generally, the preferred format for care of elderly across Europe and Central Asia FGDs, including the Western Balkans, is informal care for elderly at home.** Caring for elderly at home by family members is viewed by many as an obligation as well as the most appropriate way of helping their aging loved ones to live out their remaining years in comfort, health, peace, and dignity, in the companionship of their loved ones. FGDs suggest that this is both due to social norms that emphasize filial obligations and to the belief that the care needs of the elders (social-emotional needs, companionship, medical assistance

needs, and basic day-to-day needs such as house chores, self-care, and security) can be best met at home by their relatives compared to the current provision of services.

46. **The current formats and quality of formal care service supply, and particularly residential care,[9] for elderly is seen by most participants as inadequate in addressing the care needs of the elderly and therefore mostly incompatible with social norms.** Poor quality of centers also seems to have a role in shaping the norms against use and therefore for many, residential care centers are seen to be for elderly with no family or care support. Accordingly, it is observed that participants' perceptions of the need for and benefits of use of formal care services are limited in comparison with formal childcare.

"We all have responsibility towards the parents who created and reared us. Not everything can be paid in cash. I need to pay them back in responsible and kind behavior" (Urban man, Serbia).

47. **The benefits of eldercare for the care receiver elderly mentioned in the Serbia FGDs include the following:**

- **Elderly care centers benefit the elderly for meeting their needs of companionship.** Eldercare centers, and (imagined or actual) day-care centers for the elderly in particular, can provide spaces for the socialization of the elderly and meet their needs for companionship during the day.
- **Residential care centers can benefit those elderly in need of medical care.** Participants explained that these services can be better than care at home for those elderly who needed constant medical attention and/or physical care labor.[10]

"I would prefer them to stay at home, but if they become really difficult, home for the elderly is fine" (Urban woman, Serbia)

- **Private home-based care services (such as nurses) benefit the elderly who have demanding care and/or medical needs.** This way, the elderly stays with his/her family in accordance with the care norms and the burden of care on the caregiver is also relieved.

"For me this would be an option only if I were unable due to my job to take care of him, then I would hire a woman to take care of him, only that. I simply think that people who have someone who can care about them should stay where they are. Rather this than going to a home for the elderly" (Urban woman, Serbia).

- **Home-based formal care in the form of regular visits by social workers or nongovernmental organizations also benefit elderly with no family and informal care**

[9] Residential care for elderly refers to those centers where the elderly citizens reside/live, as opposed to adult day-care centers, which provide care for elders only during day times, much like childcare. The most common format of residential care across Europe and Central Asia countries is the nursing homes.

[10] This view was also mentioned in Bosnia and Herzegovina and Kosovo.

support. This also creates an alternate to using residential care so that the elderly can choose what is most appropriate for themselves.

I think that there should be some sort of service with geriatric nurses who could go and visit these people [elderly without family]. Why not once a month? Nobody should be forced to go to an elderly care home, not everybody needs to go regularly. But we need more care, there are a lot of people who live alone, who don't have children, it would be good if somebody visited them, say hello, ask them how they are feeling, anything like that" (Urban woman, Serbia)

- **Center-based eldercare can benefit caregiver women by emancipating them from the severe psychological and physical costs of eldercare responsibilities**.[11] This view was particularly voiced by women who themselves are experiencing the physical and psychological burdens of eldercare as middle-aged women and by younger women who observe this in their own mothers' care burden.

"It is good to give children a break too, so why not. But care has to be adequate; staff has to be polite and decent; because they are paid for that" (Urban woman, Serbia).

48. **Analysis of discussions suggest a gradual shift in norms in Serbia with regard to using formal eldercare, particularly due to middle-aged women's own experiences with eldercare of their parents (and/or parents-in-law).** However, it is unclear as to what extent this normative shift is also related to the changes in the format and quality of services provision. Also, some women explained that they would rather be cared at home in old age, by having formal support in the form of a caregiver woman (a housewife).

"Of course, we are a generation that will consent to our children sending us to these homes for eldercare, but I think that our parents are still traditional and that this is a foreign [alien] concept for them" (Urban woman, Serbia).

49. **Consent of the elderly and his/her acknowledgement of these benefits are also voiced by participants as a condition for deciding to use formal care services/formats even when the benefits are acknowledged.** The current demographic structure in Serbia stresses the importance of the older adults and elderly's perspective on their own needs and decisions.

"I would put my parents in a home but I wouldn't do it if they wouldn't want that. As for me, it's a good option and things would be easier for me that way. I would have time for myself. When one of them stays alone, it will be a lot more time-consuming for me." (Rural woman, Serbia)

50. **From the public policy perspective, the reasons for directing public resources to support childcare and eldercare are not the same; however, the focus on the care recipient remains constant.**

[11] This view was voiced also in Macedonian FGDs.

With regard to policies, there are two sides when it comes to care, those intended at improving the outcomes of the recipient. For children, early childhood development via education and care to reduce inequalities later in life; for the elderly, the main focus is to protect them from increased vulnerability after retirement and to limit the effects of age-related functional limitations on the elderly quality of life, respecting their preferences. From the care provider side, the main focus is to support them in their care responsibilities and duties, so these responsibilities do not affect their access to opportunities and do not generate unintended effects such as increasing gender gaps in labor outcomes.[12]

VIII. Conclusions and Policy Recommendations

51. **Serbia needs to increase labor participation among men and women alike, and capitalize the investments of valuable resources in education of women by implementing policies to help balance care and work responsibilities.** Policy efforts for adequate job creation need to be accompanied by policies addressing care needs. Women tend to reduce their labor supply on either the extensive or intensive margin when market, normative, and institutional forces push them toward fulfilling their caregiving mandate in the household. Career interruptions or reductions in work hours can have a permanent negative impact on women's lifetime income, affecting their households' current living standards and human capital investments as well as future well-being due to reduced pension wealth and damaged health.

52. **Given the current demographic situation of Serbia, meeting the challenge of rising care burden is essential to ensure economic growth and poverty reduction.** The expansion of formal care services can present a double benefit for the population: A well-developed childcare sector not only helps generating economic participation opportunities for women but also implies potential improvements in the school readiness for children via better coverage of early childhood education; this, in turn, can translate into higher human capital accumulation, which is vital for sustaining economic growth. Similarly, quality provision of formal eldercare can potentially improve health outcomes of the elderly through prevention, early detection, and consistent maintenance of chronic diseases, which may imply long-term cost savings in the healthcare sector.

53. **The rising demand for care services in Serbia provides an opportunity to develop a formal care industry and increase labor force participation and productivity.** Policy priorities to appropriately address the challenges identified in this note include the expansion of publicly provided childcare centers, implementation of public subsidies to private childcare provision and use, creation of education and accreditation programs to prepare caregivers and care-entrepreneurs, development of a system and plan

[12] For example, for the case of Chile, Prada, Rucci, and Urzua (2015) show that a mandated childcare policy that introduces differential cost in hiring and employing women has negative impacts on wages.

to increase the quality of services with attention to costs, and revision of the legal framework to be adaptable to the demands and expectations of care.

54. **Analysis in this report shows evidence of a mismatch in the market for care services with regard to expectations on availability, prices, and quality between the supply and demand that is mainly caused by a lack of adequate public provision or financing to cover the latent demand.** Current challenges with regard to supply and demand of childcare and eldercare services are summarized in five salient points: (a) limited availability of affordable services, especially in rural areas, that underlies the relatively low utilization of formal childcare services; (b) latent demand of formal childcare services that is voiced predominantly by parents perceiving benefits for child's development and working (or willing-to-work) mothers, which also includes a demand for childcare for the youngest children; (c) lack of day-based services and limited and expensive availability of residential care centers; (d) day-care centers and home-based formats—if available—would be more compatible with prevailing standards; and (e) the main challenges of the existing supply in terms of quality—an important factor for potential users of formal care services—involve mainly human resources for both childcare and eldercare services.

55. **With regard to childcare, comprehensive policies that target both the supply and availability while making services more affordable particularly for women who have potential to join the labor market are expected and likely to have a high employment impact.** The employment impact of a purely demand-side subsidy is likely to be limited in the short term. To tackle the real problem of accessing affordable and quality childcare, a viable alternative is a neighborhood program—made widely available through public or private subsidized provision and based on the expectations of mothers and fathers—combined with a demand-side transfer for households with difficulties to afford the services.

56. **With regard to eldercare, evidence suggest prioritization of day-care provision and at-home support policies over institutionalization and long-term care in medical institutions.** At-home systems of elderly care and treatment make it essential to have efficient, multiprofessional workers capable of working with elderly people and their families. Government investment in training programs for staff working in elderly care is essential to ensure high standards.

57. **Crucial elements in the design of care systems for successful achievement of intended impacts are the gender neutrality in financing and service characteristics tailored to address constraints related to labor market participation.** To avoid unintended effects such as increasing gender gaps in labor outcomes or having low take-up of care facilities, the design and implementation of care programs will require (a) avoiding differential costs in hiring and employing women and men—for example, mandated benefits that imply for employers higher costs of employing a woman versus a man, and (b) providing flexibility with regard to service characteristics (hours of operation, year-round service, and so on) to respond to working women and family needs.

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Annex 1: List of Variables Used in the Construction of the Childcare Quality Subindices

Questions Included	Infrastructure Quality Subindex	Materials, Curriculum and Learning Quality Subindex	HR Quality Subindex
There is sufficient indoor space for children and adults to move freely.	X		
There is a dedicated space for naptime.	X		
At least one of the following are available for naptime: beds/cots, cribs, mattresses, soft mats	X		
Space is in good repair, clean and well-maintained.	X		
There is adequate lighting.	X		
No malodor in the classrooms.	X		
Floors, walls, and other surfaces are made of easy to clean materials.	X		
There are sufficient number of clean, appropriately sized toilets for potty-trained children.	X		
There is adequate temperature control (central heating).	X		
There is sufficient outdoors space.	X		
The outdoors space is generally safe (for example, mats under swings, fenced area, and so on).	X		
Doors and windows are childproof when appropriate (for example, windows cannot open fully, heavy doors close slowly, and so on).	X		
Safety covers are on all electrical outlets.	X		
Electrical cords are out of children's reach.	X		
Heavy equipment or furniture that could tip over is anchored.	X		
Stairway gates are locked into place when infants or toddlers are nearby.	X		
Sharp furniture edges are cushioned.	X		
There is a sufficient number of age-appropriate toys.		X	
There is organized and convenient storage for toys.		X	
Are there any systems in place to give feedback to parents about their children?		X	
Are there any systems in place to receive feedback from parents?		X	
Are there opportunities and provisions for parents to present and discuss additional needs?		X	
Is there a daily routine?		X	
Are children served food?		X	
Are there provisions for children with special needs?		X	

Questions Included	Infrastructure Quality Subindex	Materials, Curriculum and Learning Quality Subindex	HR Quality Subindex
Whether caregivers' minimum credentials include higher school or university degree.			X
Whether the typical length of time that caregivers stay working at the provider is 5 or more years.			X
Caregiver to pupil ratio.			X
Is a small group of children primarily cared for by one designated staff member?			X

Annex 2: List of Variables Used in the Construction of the Eldercare Quality Subindices

Questions Included	Infrastructure and Safety Quality Subindex	Schedule, Activities, and Materials Quality Subindex	HR Quality Subindex	Special Needs, Healthcare, and Support Quality Subindex
There is sufficient indoor space for elders and caregivers to move freely.	X			
Space allows for privacy when desired.	X			
Is there a dedicated space for naptime?	X			
What is the quality of the bedrooms? Please take into account cleanliness, lighting, ventilation, temperature, absence of unpleasant odors, comfort, quantity and quality of furniture, safety, and privacy.	X			
Space is in good repair, clean and well-maintained.	X			
There is adequate lighting.	X			
The facilities do not have unpleasant odors.	X			
Floors are smooth and have nonskid surfaces. Rugs are skidproof.	X			
There are clean toilets for staff members and elders.	X			
There is adequate temperature control.	X			
There is outdoors space for elders to use.	X			
The outdoors space is generally safe (for example, mats under swings, fenced area, and so on).	X			
Walls and ceilings have no peeling paint, have no cracked or falling plaster, and are free of crumbling asbestos.	X			
Cords and electrical elements are in good condition and do not present a hazard to elders.	X			
Heavy equipment or furniture that could tip over is anchored.	X			
Doorways to unsupervised or unsafe areas are closed and locked unless the doors are used for emergency exits.	X			
The facilities feel comfortable, and nurturing.	X			
Do elders sleep in individual or shared bedrooms?	X			
Who provides the furniture for the bedrooms?	X			
Are clinical mattress and bed available if needed?	X			
Do elders use individual or shared bathrooms?	X			

Questions Included	Infrastructure and Safety Quality Subindex	Schedule, Activities, and Materials Quality Subindex	HR Quality Subindex	Special Needs, Healthcare, and Support Quality Subindex
What are families required to provide for their elders?	X			
Are there standards and regulations that pertain to safety?	X			
Do your safety policies and procedures meet these standards and regulations?	X			
For each of the following activities, please check whether it is a frequent part of the elders' activities, happens on a limited basis, or is not allowed		X		
There is a sufficient number of mentally stimulating materials, such as chess sets.		X		
There is organized and convenient storage for materials, such as books and games.		X		
Are there any systems in place to give feedback to families about their elders?		X		
Are there any systems in place to receive familial feedback?		X		
Are there opportunities and provisions for families to present and discuss additional needs?		X		
Is there a daily schedule?		X		
Are elders served food?		X		
When are elders served food?		X		
Where is the elders' food prepared?		X		
Does the food follow nutrition and health standards and regulations?		X		
Does the food follow hygiene and cleanliness standards and regulations?		X		
Does the food follow other relevant standards and regulations?		X		
Is there a set procedure around elders' first time arrival?		X		
Is there a set procedure to prepare for elders' departure (moving out or death)?		X		
Are there visiting hours for family members?		X		
What are the caregivers' credentials and qualifications? (include minimum required)			X	
What is the typical length of time that caregivers stay working at [service provider]?			X	
What is the current ratio of caregivers to elders?			X	
Are elders organized into groups?			X	

Questions Included	Infrastructure and Safety Quality Subindex	Schedule, Activities, and Materials Quality Subindex	HR Quality Subindex	Special Needs, Healthcare, and Support Quality Subindex
Do staff members make an effort to ensure that elders feel respected?			X	
Are there opportunities for continued education, training, and professional development for current caregivers?			X	
What is the typical contract type for caregivers?			X	
On what basis are caregivers evaluated?			X	
Space is accessible for persons with disabilities				X
Protected access to stairs and facilities allow for limited mobility elders to circulate (that is, those using wheelchairs, walkers, and so on).				X
Are there provisions for special needs?				X
Are elders' dietary needs and food allergies considered?				X
What are the types of staff members that are employed by [service provider]?				X
Who does laundry and cares for elders' personal items?				X
Does the [service provider] care for physically able elders, mentally able elders, some disabled elders, and/or all disabled elders?				X
Are elders given help with their personal hygiene, cleanliness, and appearance?				X
Is routine medical care available to elders?				X
What provisions are in place for elders who use wheelchairs or have trouble walking?				X
Are ambulance services available?				X
Are elders given help with bathing, shaving, and hair washing?				X
What services are offered to elders with Alzheimer's Disease or related dementias?				X