Public Disclosure Authorized

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

October 30, 2015

WORLD BANK GROUP
Poverty & Equity

WHY SHOULD WE CARE ABOUT CARE? THE ROLE OF CHILDCARE AND ELDERCARE IN BOSNIA AND HERZEGOVINA[1]

The World Bank

October 30, 2015

[1] This report is prepared by the Poverty & Equity Global Practice, Europe and Central Asia team: Victoria Levin, Ana Maria Munoz Boudet, Beth Zikronah Rosen, Tami Aritomi, Julianna Flanagan, Lourdes Rodriguez-Chamussy. This work was done as part of the activities under the Trust Fund "Promoting Gender Equality in the Western Balkans", supported by the Swiss Cooperation Agency via the World Bank's Umbrella Facility for Gender Equality multi-donor Trust Fund.

Contents

Tables

Figures

Executive Summary

Despite significant progress in closing the gender gap in education, there is a significant disparity between male and female labor participation rates in Bosnia and Herzegovina (BiH). Among men aged 15 to 64 years, 65.7% participate in the labor force compared to only 41% of females in the same age group.[2] It is estimated that BiH forgoes around 16 percent of gross national income due to gender disparities in labor force participation.[3] The conflicting demand of 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.

Failing to meet the challenge of rising care burden in aging societies can undermine the achievement of other fundamental policy objectives such as sustainable economic growth and poverty reduction. Increased recognition of the critical role of care in BiH and careful review of the policy environment related to formal and informal care provision can help capitalize the full potential of investments in increased women's human capital and promote progress on the twin goals of poverty reduction and shared prosperity.

International evidence shows that support for child and elder care impacts 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 BiH 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 perceptions and barriers for use of quality formal care in BiH.

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

1. Limited availability of affordable services characterizes existing formal childcare services.

2. Although BiH looks relatively progressive in terms of social perceptions of childcare, work and motherhood; norms tend to contribute to negative perceptions of the use of child care centers.

[2] BiH Labor Force Survey, 2013

[3] Teignier, Marc and David Cuberes (2015). "How Costly are Labor Gender Gaps? Estimates for the Balkans and Turkey." World Bank.

3. Regardless of location (rural/urban), the demand for formal childcare services is voiced predominantly by (a) parents perceiving benefits for child's development and (b) those working or willing-to-work women with little or no informal childcare support.

4. Supply of residential care for the elderly is below potential demand and characterized by insufficient infrastructure and staff capacity.

5. Social norms are a strong deterrent for use of residential eldercare while use of day-care centers and home-based formats –if available- would be more compatible with prevailing standards of filial obligation.

6. Quality is important for potential users of formal care services and the main challenges of the existing supply involve human resources as well as materials, curriculum and learning quality, for the case of childcare, and human resources for the case of eldercare.

A rising demand for care services in BiH provides an opportunity to develop a formal care industry and increase labor force participation and productivity. Policy options to appropriately address the challenges identified in this note include the expansion of publicly provided childcare centers, creation of education and accreditation programs to prepare caregivers and care-entrepreneurs, development of a plan to increase quality of services with attention to costs, and design of elder care system considering the impacts on care recipients but also on informal care providers and their ability to contribute to sustained economic growth.

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 impacts both on the extensive and intensive margins and reduced human capital accumulation (Becker 1985, Behrman and Wolfe 1984, Ribar 1995, Jaumotte 2003). There is also evidence that caregivers receive lower wages, further discouraging labor force participation (Correll et al 2007, Carmichael and Charles 1998, 2003, Heitmueller and Inglis 2007). Together, these may contribute to reduced lifetime earnings for caregivers, leading to a disadvantaged position in terms of financial status, lower pension accumulation, and long-term economic vulnerability.

3. Policy interventions that appropriately address care demands would 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. In terms of childcare, given that productive and reproductive years overlap for women, support for working mothers (and fathers) is essential to prevent women to drop 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. Given its demographic conditions, BiH cannot afford to underutilize a large share of women whose lifetime productivity in the labor market is currently reduced by informal care provision. The rate of female labor force participation has maintained the same levels over the past years around 40%

representing more than 900,000 women out of the labor market.[4] Incorporating as many of these potential workers into paid work would reduce the pressure of population aging on the economy**.**

5. **This note examines the provision of childcare and eldercare in BiH 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 Western Balkans countries. The note is structured as follows: Section II introduces the new, independent mixed methods data set that is the basis for the analysis and findings presented. Section III describes the use of formal care arrangements in BiH. 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 supply and demand of eldercare. Section VIII concludes by examining what we know in terms of 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 et al. 2008). Spiess and Schneider (2003) demonstrate that a negative effect on work 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 et al. 2015); and in Canada (Lefebvre and Merrigan, 2008). 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 price of childcare. In the Russian Federation, Lokshin (2000) used policy simulations based on panel household survey data

[4] BiH Labor Force Survey 2013.

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 study (World Bank, 2015) 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 impacts 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 a substantial body of 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 (Jacobs et al. 2014a; Gabriele et al. 2011; OECD 2011; Lilly et al. 2010; Bolin et al. 2008; Heitmueller and Inglis, 2007; Henz. 2006; Johnson and Lo Sasso, 2000; Sarasa, 2006; Carmichael and Charles, 1998). 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 SHARE data to look at caregivers' employment and finds caregiving decreases employment rates in countries with low supply of formal care (or 'family care countries') by 34 to 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 et al. (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 in order 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 in terms of the interaction between female labor force outcomes and care services in the ECA 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 quality, cost, and quality of care in the region. The study also builds up on relevant quantitative surveys including the Generations and Gender Survey (GGS), the Survey of Health, Ageing, and Retirement in Europe (SHARE), and data sources specific to Western Balkans countries, including the European Social Survey (ESS) and National Time Use Surveys (see Table 1 for a summary of data sources by Western Balkans countries).

Table 1: Summary of data sources

Western Balkans countries	Independent Data	ESS	National TUS
Albania		X	
Bosnia and Herzegovina	X		
Kosovo	X	X	
FYR Macedonia	X		X
Montenegro			
Serbia	X		X

7. **The field work, which was conducted between February and May 2014, was divided broadly into two components: (i) A supply assessment of available care services, and (ii) A household and demand assessment, including Focus Group Discussions (FGD) with adults with care needs, and questionnaires completed by participants.** The supply assessment was a census-type study, which investigated the types of child and elder care services available to households, both public and private, and explored their accessibility, affordability, and quality. This included site visits, mixed methods interviews, and, when 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 child or elder care services. Whenever possible, it 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 focus group discussions. 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	Daycare, kindergarten, and preschool, among others	Daycare, long-term care, permanent care and living facilities, and social clubs which are run by an administrator
Providers excluded	Live-in centers (such as orphanages) & 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: Bosnia and Herzegovina, FYR Macedonia, Kosovo, Serbia, Ukraine, Kyrgyz Republic, and Armenia.** A total of 12 FGDs were held in BiH with working women, non-working women and men. In most of the countries, the FGDs were held in 3 sites: in a rural community, in a small city, and in a middle-class neighborhood in the largest urban center of the country. Due to its unique political structure, in BiH, 4 sites were selected –two urban and two small cities- in order to maintain balance across the Federation of Bosnia and Herzegovina and Republika Srpska. For the supply assessment, 8 childcare facilities and 5 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, both childcare and eldercare). 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 we 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 focus group discussions were included.[5]

[5] 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.

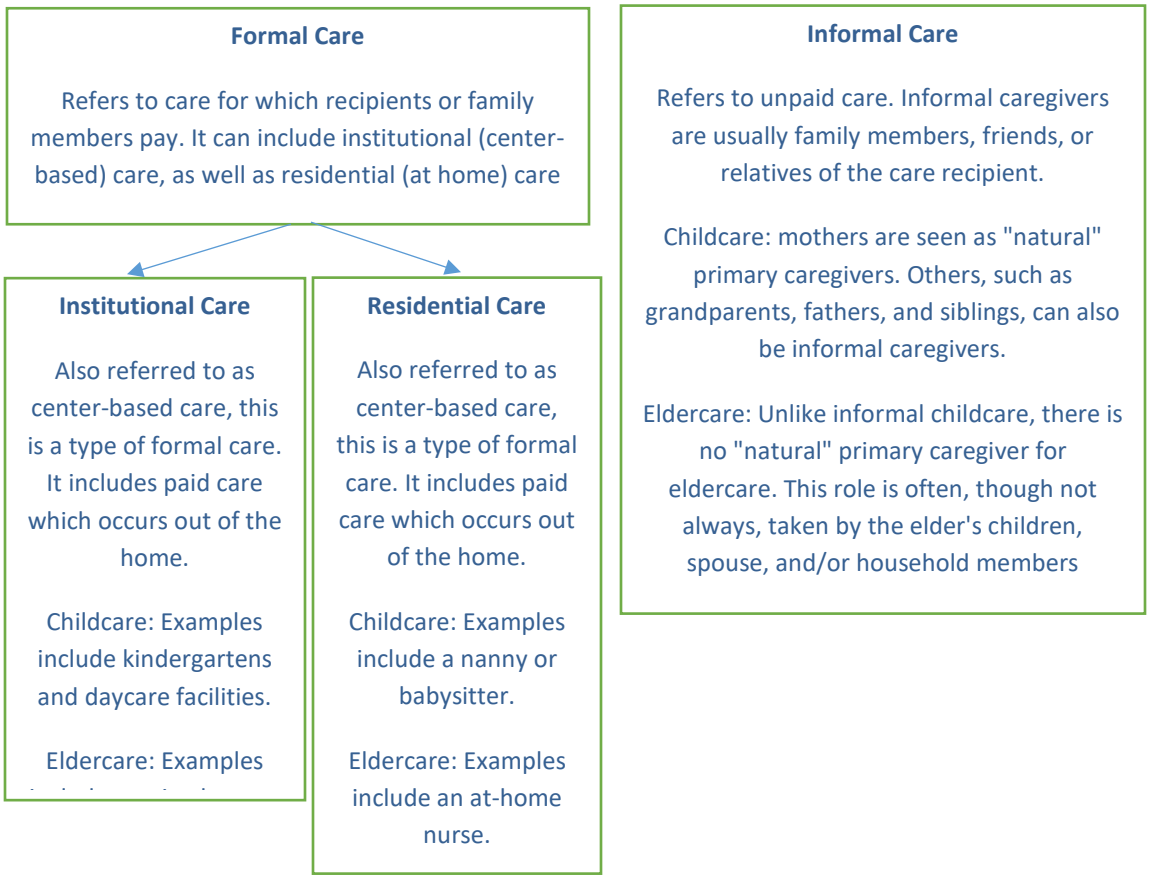
Table 3: Country-level data collected through independent mixed methods survey

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
FYR Macedonia	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.

Figure 1: Typologies of care

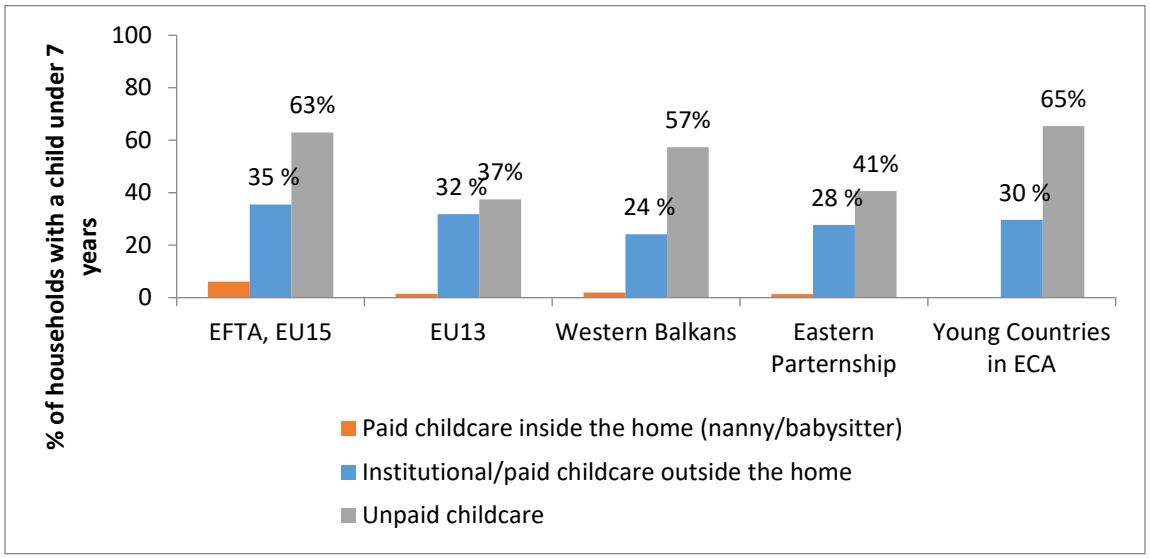


Source: Author's based on Krauss et al (2010)

10. Use of formal childcare services in BiH, as well as in other countries of the region, is low. Data from the Gender and Generations Survey 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 sub-regions. 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 intra-household decision-making processes underlies the relatively low utilization of formal childcare services.

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



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

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

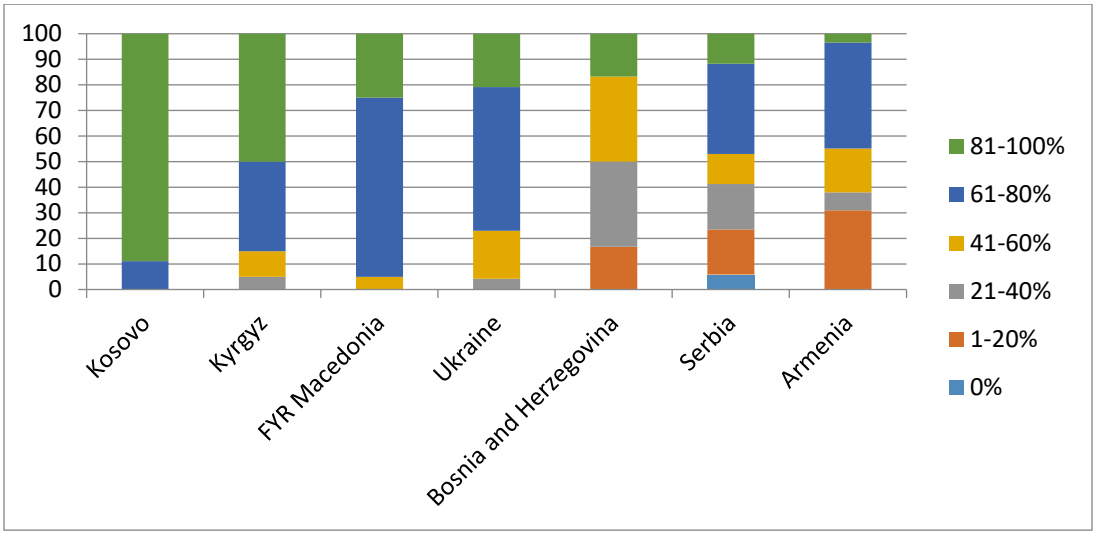
	Formal Care Only	Informal Care Only	Both Informal and Formal Care	Only maternal care; no use of either formal or informal care
Armenia	4.2%	34.7%	61.1%	0%
Bosnia and Herzegovina	13.4%	28.4%	13.4%	38.2%
Kosovo	0%	0%	0%	98.4%
Kyrgyz	14.6%	51.2%	13.4%	19.5%
Macedonia, FYR	0%	69.2%	21.5%	6.2%
Serbia	6.4%	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. **Users of formal child care services tend to be working mothers, however in most of visited facilities for the independent study in BiH working mothers do not reach 50% of users.** As can be observed in Figure 3, childcare is mostly used by mothers who are working full-time or part-time, although there is considerable variation across countries, and especially in BiH the field data show that in the great majority of facilities visited, user households where the mother works is below 60%. Whereas working women tend to use childcare services, some women who are not working or are working part-time cite childcare-related reasons for their reduced labor supply.

Figure 3: Percent 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 following question, "What percentage of mothers (whose children receive care here) are employed ('working mothers')?"

12. **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 BiH, a very small proportion of participants use formal care arrangements (2.1%). Among women who care for and elderly in the qualitative study report, 34% report receiving regular help from family or friends, however still more than 50% of them fulfill their care needs without regular use of other caregivers whether formal or informal (Table 5). Overall, qualitative analysis around supply and demand of formal elderly care suggests that social norms and quality considerations shape negative perceptions that 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 suit 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	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 elder person is not a job.

IV. Childcare Supply

Insufficient capacity is the most pressing problem with regard to child care in BiH

13. **Participants in the study perceive that formal childcare centers are less than what is needed and existing facilities suffer from overcrowding and lack of space for newcomers.** Accessibility of quality and affordable childcare is voiced as a general problem across Western Balkans, where supply of care services does not seem to meet (actual or potential) demand from households. In focus groups discussions held with urban groups, regardless of the country, the two inter-related 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 eroded by problems of insufficient supply and low capacity. In BiH, it is understood that not all urban neighborhoods have childcare centers. Nevertheless, problems related to location seem to be only secondary, and distances are a lesser challenge for enrollment in comparison to the problem of inadequate capacity.

"Kindergartens are not that expensive, but queues are long. [Because] there are few kindergartens." (Urban woman, Bosnia)

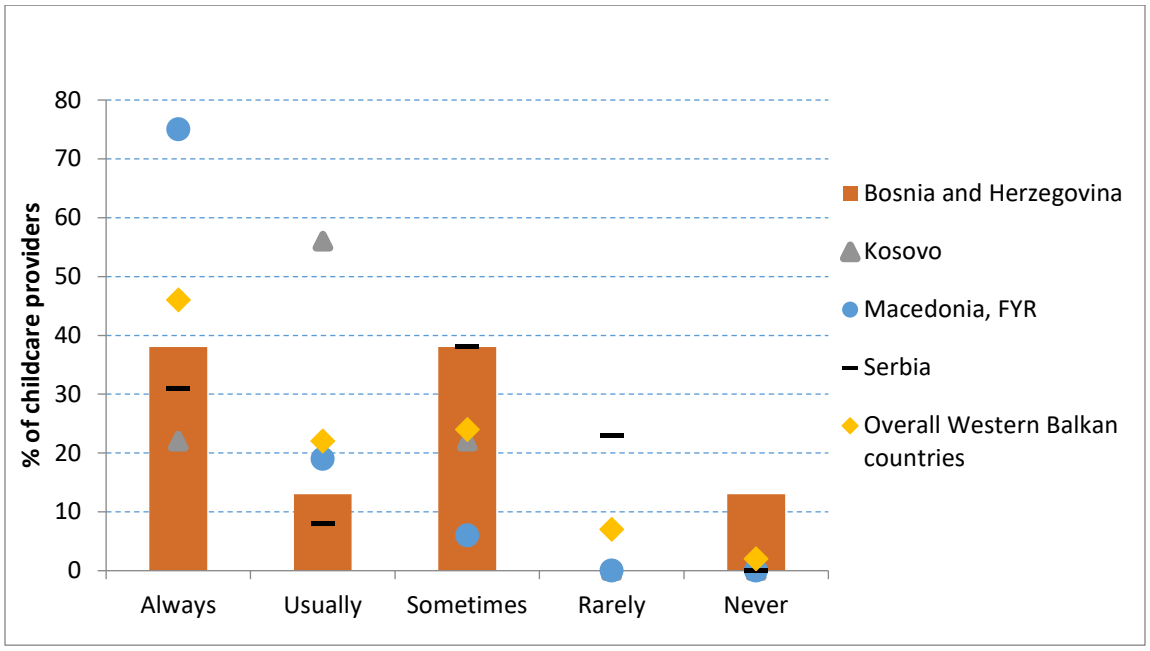
Table 6: The supply of childcare providers in urban and rural area

	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	1040	130	1	80	80	0	0	0
Macedonia	13	2375	183	2	345	173	1	120	120
Serbia	6	1323	221	5	681	136	2	136	68

Note: Total children served = total of capacity of all providers in the location. Ex: In Pristina, there were 8 providers who could altogether provide care for a total of 1,040 children.

14. **The inaccessibility due to limited capacity in urban areas is reported as the main problem in BiH.** Insufficient number of affordable/public childcare centers and high demand from families creates a capacity problem and makes childcare inaccessible for many. Regardless of country, FGD participants reported that low capacities of the state-owned kindergarten are overarching problem that confronts urban families across Western Balkans. Most childcare providers in the region (67%) reported that they are "Always" or "Usually" at capacity. Less than 10% reported that they are "Rarely" or "Never" at capacity. In BiH, nearly 40% of providers report that they are "Always" at capacity however 10% reported that they are "Never" at capacity. This suggests regional mismatches of supply and demand with urban areas lacking capacity and small cities or rural areas potentially having under-demand for child care services (Figure 4).

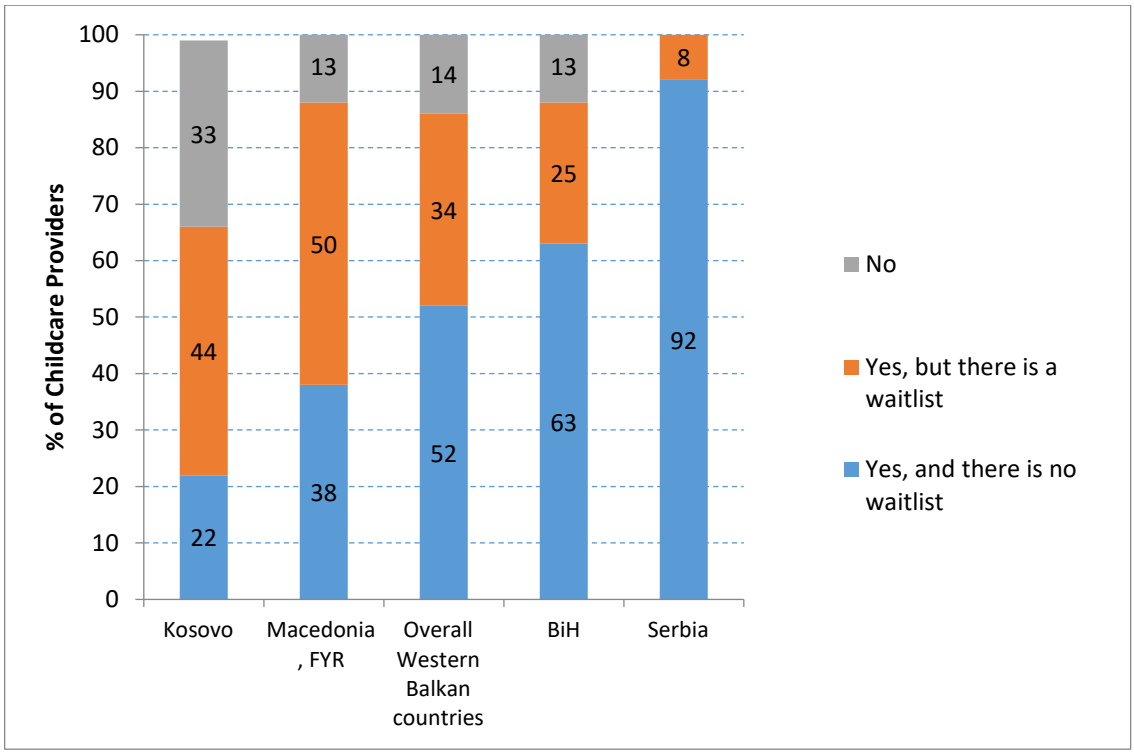
Figure 4: How often is this provider at capacity?



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

15. **Supply and demand mismatches are also suggested by the apparent contradiction between perceptions of long queues and actual wait lists.** Participants in BiH and across Western Balkan focus groups explained that there are kindergartens, but enrollment is managed by long waiting lists, and often times families' turn might never arrive. The supply-side data in the independent study shows however that in BiH 63% of providers declare accepting new clients without putting them in a wait list (Figure 5). Heterogeneous quality, targeted ages for service and location characteristics may explain this apparent lack of correspondence.

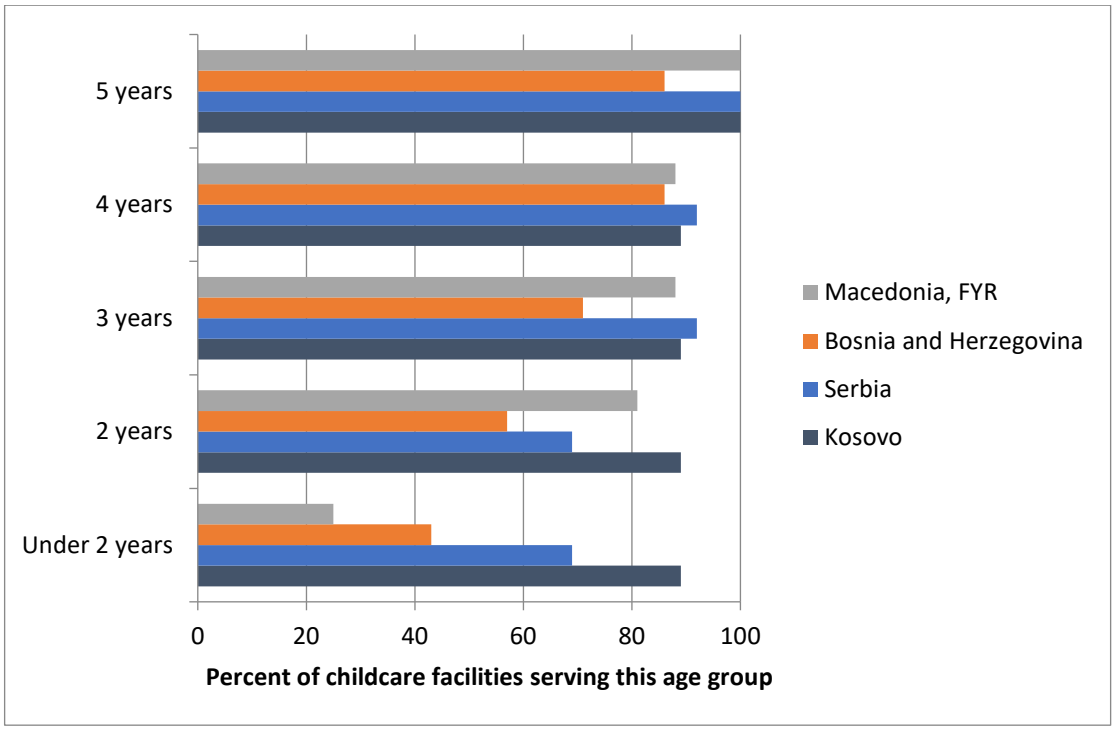
Figure 5: Is this childcare provider currently accepting new clients?



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

16. **In Bosnia and Herzegovina, there are even fewer spaces available for younger children, since most service providers serve a variety of age groups but are focuses on older children**. In Bosnia and Herzegovina and Macedonia FRY, for example, fewer than half of providers included in the supply-side data cater to children younger than 2 years old (Figure 6).

Figure 6: Percent of childcare facilities by age groups service



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

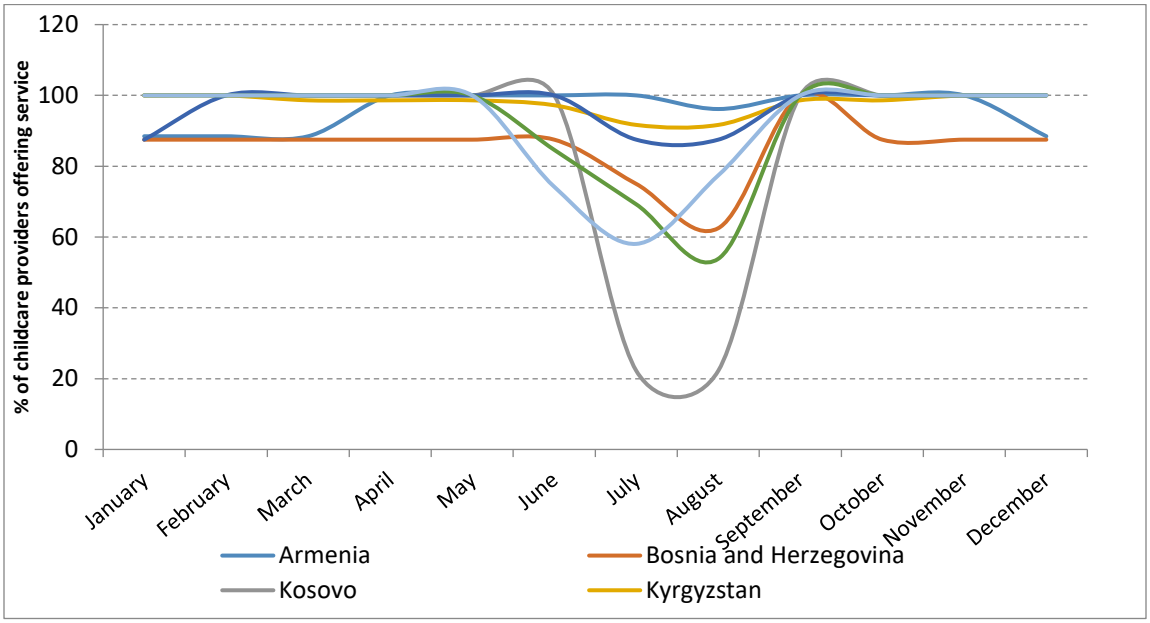
17. **The issue of overcrowding in kindergartens due to insufficient service supply, and consequent high child-staff ratios seems to be a common chronic problem across Western Balkans with various detrimental quality implications**. Overcrowding seems to affect public kindergartens the most and the number children that were mentioned across groups by class ranged from 30 to 60 children. The need for having more care staff to match the number of children (teachers) for adequate care was repeatedly voiced across groups. In some groups the number of children mentioned per staff was as high as 50. It was observed that even in cases where pre-schooling is mandatory by the state, and so high enrollment rates are to be expected, such as in Serbia, the capacities of facilities were still not perceived to meet the number of children.

18. **Days of operation of childcare do not always meet care needs of communities.** This was not discussed extensively in the FGDs yet participants mentioned that existing childcare centers shut down in August making it a non-compatible choice for working parents. In BiH, there are few options of services that operate during the summer months: in urban areas, 60% of facilities are open in July and August (Figure 7). In terms of opening hours during the day, the supply-side data shows similar average opening and closing times across the region. During the weekdays, childcare providers tend to open early (between

6 and 7 am), but very few are open after 6 pm. Fewer than 7% of childcare providers are open on the weekends.

"I liked everything. The only thing I did not like was that one entire month was off: August. No one has a month-long vacation." (Urban woman, Bosnia)."

Figure 7: Percentage of childcare providers offering service throughout the year calendar



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

Unaffordability is an important barrier to childcare use

19. **Problems of affordability of care are frequently referred as a barrier to use childcare services.** There is a general perception that kindergartens are very expensive. It was understood that costs of public care was less than private care centers. It was also understood that while public care is more affordable than private care, and although there were many participants who stated that public care was affordable, still there is an overall affordability problem that makes these services inaccessible for some segments of the population.[6] Moreover, for some more disadvantaged segments of the population that work for less pay (or minimum wage), income is not enough to cover costs of care services they want to use.

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

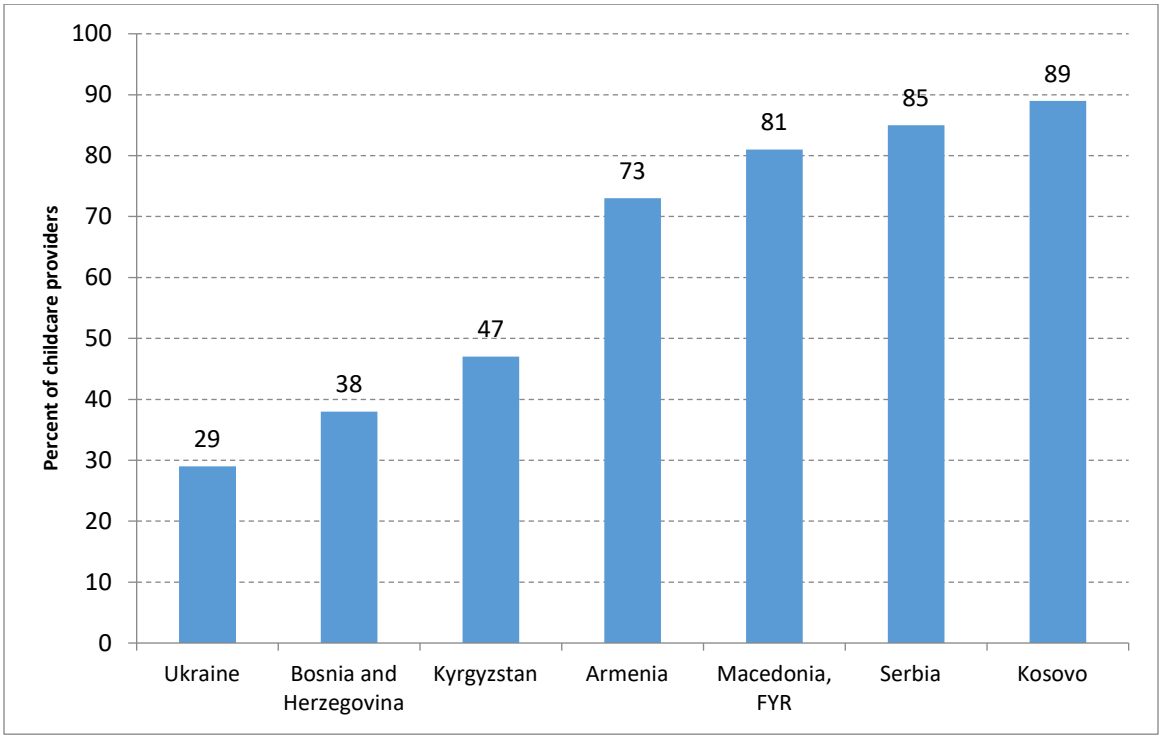
"I would not use them because I do not have the funds. Money is the number one issue for me" (Urban woman, Bosnia).

"Kindergartens are very expensive. It costs an entire salary. It costs 180 KM [and the minimum wage is 370 KM]. So for two children it costs an entire wage"; "It normal that the price should be at the level of personal income. Some realistic amount should be determined" (Urban women, Bosnia).

20. Subsidized or free public provision is almost non-existent among the participating childcare providers. A mere three 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% of public providers and 83% of private providers), though some private providers also require an entry deposit. In the middle-class neighborhood in Pristina where our supply-side assessment was conducted, full-day monthly pricing was offered by all eight providers. The overall average price was €66, with an average of €49 for the five public providers and €93 for the three private providers.

21. In some countries childcare providers offer discounts to families, especially for bringing multiple children to the provider or when family income falls below a certain level. In Bosnia and Herzegovina, only 38% of providers interviewed offered some type of discount, putting it far behind the sample in every other country in the region (8). 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 family, whether the father is a war invalid, and whether the family is using social assistance.

Figure 8: Percent of childcare providers with some price flexibility



Source: Questionnaire to child care providers, Independent field data (2014).

22. **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 challenges for quality childcare provision are high child-staff ratios and infrastructure

23. **Quality perceptions and expectations of participants in Western Balkan FGDs were discussed around three main themes: (i) quality of basic care services including infrastructure, (ii) quality of ECD activities, and (iii) 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. 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, doing physical activities, as well as socio-behavioral education provided by caregivers. Quality of caregiving staff is described in FGDs with regards 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.

24. **Overcrowding in public centers due to low capacity and inadequate supply seems to be the major problem in most Balkan FGDs with regards to quality, and BiH is no exception**. Not only overcrowding itself is a problem, but also it negatively impacts other quality attributes of care services, such as teacher attentiveness or epidemics. The primary problems that were voiced in BiH's FGDs with regards to quality are as follows:

a. **Overcrowding and very high child-staff ratios.** Participants mentioned that overall there was an overcrowding problem in childcare; the capacity of the facilities was inadequate as well as the number of teachers per children. This problem was voiced more with regards to public childcare centers, and it was demanded that more staff should be allocated:

> *"There are many children in the kindergarten, and if there are no sufficient kindergarten teachers, the state is responsible." (Urban woman, Bosnia)*

b. **Healthcare risks for children.** Overall safety of the children from harm is very important for parents. However, frequent epidemics in particular, seem to be a general problem for childcare centers also in BiH. Such healthcare risks also affect parents' decisions to use formal vs. informal care:

> *"Diseases are a problem. If one gets the flu, then everyone else also gets it. My godmother withdrew her children from kindergarten. They were sick, having high temperatures every once in a while. Now their grandparents babysit them" (Urban woman, Bosnia)*

c. **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.

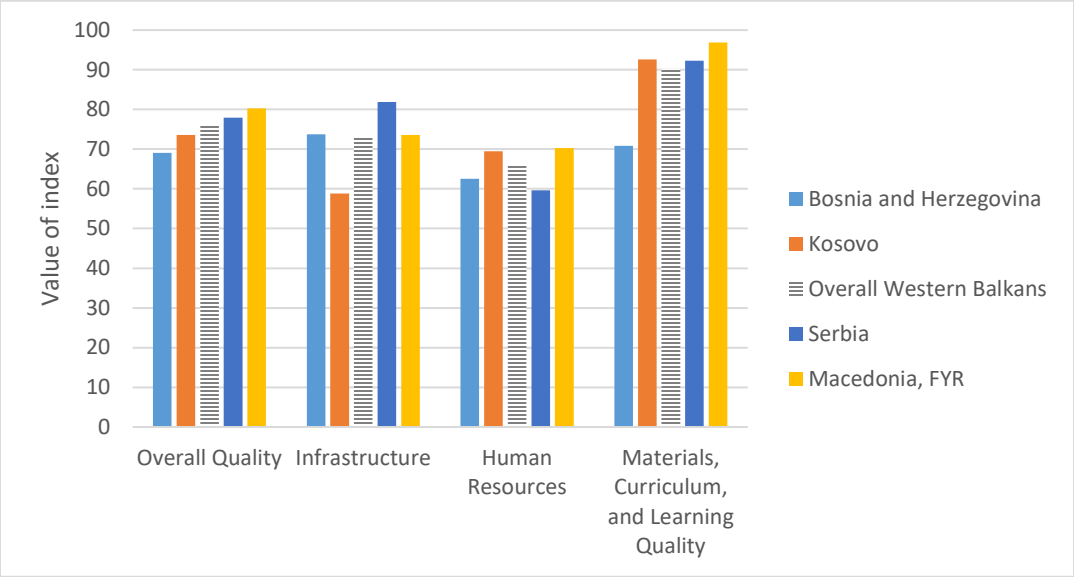
d. **Unsatisfactory qualifications of teachers and/or staff**. In comparison to Kosovo and Macedonia, mentions of this aspect including inattentiveness of staff and wrongful behavior, were few in BiH. Meanwhile one participant mentioned that teachers were not skilled enough to deal with children with special needs, and that this was a barrier against use.

25. **In BiH, participants perceived that quality is somehow better in private centers, however did not have such high views with regards to quality of private care services either.** Participants explained that private care services did not deliver good value for their money, although they were expensive.

26. **To complement the focus group discussions, supply-side data used a principal component analysis method to created three equally weighted quality sub-indices.** These mirrored the central concerns raised in focus group discussions, and include the following: 1) Infrastructure quality sub-index, 2) Materials, curriculum, and learning quality (MCLQ) sub-index, and 3) HR quality sub-index. All inputs varied between 0 and 1. The sub-indices and the overall scores were standardized to a scale between 0-100, where a higher score indicates better quality. The first sub-index, infrastructure, includes 17 indicators such as whether the space is in good repair and if there is no malodor in the classrooms. The second sub-index, materials, curriculum, and learning, includes eight indicators, including whether children are served food and if there are any provisions for children with special needs. The final sub-index, 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 sub-indices can be found in Annex 1.

27. **Bosnia and Herzegovina shows a wide distance with respect to other countries in the region in terms of quality of materials, curriculum and learning.** The score for BiH barely reaches 70 when in the other countries is at least 90 denoting one dimension of greater quality challenges (Figure 9). Visited childcare facilities reach an overall quality score of 69, which is 7 points below the Western Balkans average. While BiH's infrastructure score is just above the Western Balkans average, its score on human resources is 3 point below the average.

Figure 9: Childcare quality by country and sub-index



Source: Author's calculations based on data from visits to child care 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

28. 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.

29. FGDs show that benefits of childcare for children's social and cognitive development is an important motivation among Bosnian parents for using formal care services, like in other Western Balkan countries. In Bosnia a significant number of participants, emphasized these benefits in light of their own observations and experiences.[7] The benefits of formal childcare for children, mentioned in FGDs are as follows: socialization with own age group, becoming more independent, more quality education that could not be provided via informal care at home (such as grandmothers, who are said to spoil children), learning to take on small responsibilities, acquiring good behavior and habits, becoming more confident, getting used to a routine, and attaining future school readiness.[8] Furthermore happiness of children, and their positive emotions for their teachers at the center is viewed by some as a manifestation of these benefits for using childcare and thus have an influence on decisions to whether or not to use care centers.

> *"We are happy if our children are happy. We love it when we take them to the daycare and they run to the lady who works there" (Urban woman, Bosnia).*

30. Like in other Western Balkan FGDs, perceptions of Bosnian participants regarding benefits of care centers on children are highly related to perceptions regarding the quality of these centers. Those

[7] Among a total of 69 mentions in Bosnian FGDs, 67% were mentions of positive perceptions, and 33 % were mentiones of negative perceptions. Among the Western Balkan FGDs Bosnia has the highest % of positive mentions, and is followed by Serbia (64%), FYR Macedonia (62%) and Kosovo (59%) respectively

[8] While the majority emphasized views in favor of using childcare centers due to their benefits for children, one woman also stated that she could not use childcare because her husband saw it as a waste of money.

parents who mention the benefits of care for children also mentioned how children are well cared for: that they are "well fed" and happy, "teachers / nannies are very professional" and that "treat children like an own child". Particularly the quality of teachers is emphasized in the context of benefits of care centers for children. When quality of care centers are thought to be below inadequate standards (as will be explained below), however the potential benefits of these centers for children are also thought to be null and the risks to children's well-being is perceived to increase.

31. Discussions suggest that formal childcare also benefits (actual or potential) working women; it provides them with the care support they need during their working hours: For many actual or potential working parents, or employed women with no access to informal care services from their families, provision of affordable formal care services are vital to continue or resume their employment. Moreover, by lifting some of the burden of care from their shoulders, formal childcare enables non-working women to have more free ("coffee") time for themselves and therefore has the potential to increase the quality of life for women.

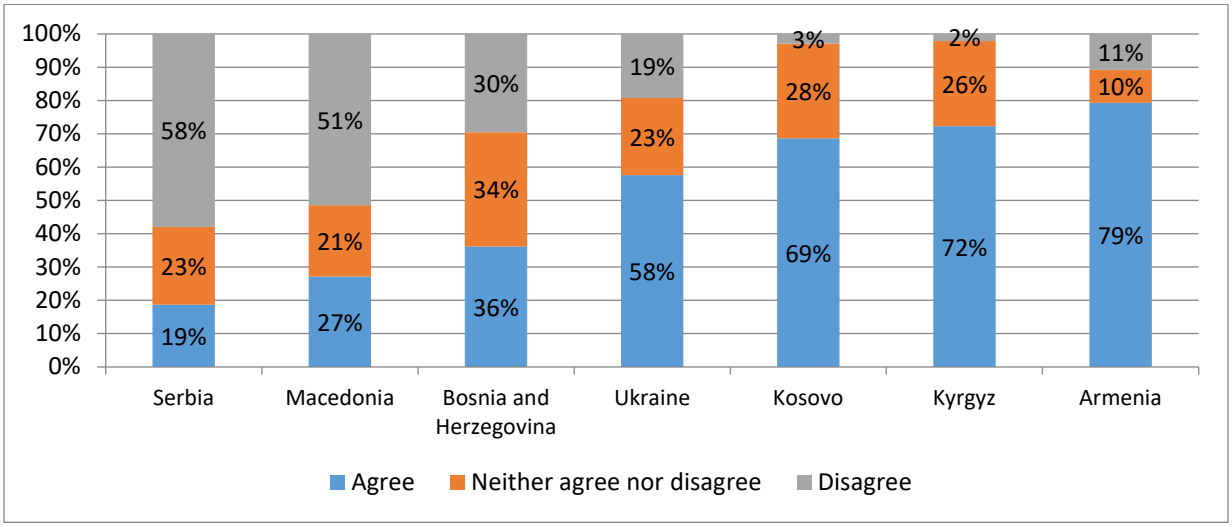
> *"Children can stay at a daycare for 8 hours … which is useful for children whose parents work" (Urban woman, Bosnia).*

32. **Furthermore, according to discussions, inaccessibility / unaffordability of childcare also has longer term implications for women, as the career breaks due care responsibilities makes it harder for women to get back to the labor force.** Participants drew attention to the fact that childcare benefits women not only in the short-term by enabling them to work, but also in the longer term by increasing the likelihood and the quality of their employment.

Social norms play a significant role in shaping negative perceptions about childcare use

33. **Norms on childcare, work, and motherhood may play a role in shaping negative perceptions on use of care centers, however in BiH views about women's role in the family are more balanced.** For example, 36% of individuals reported agreement with the following statement: "A pre-school child is likely to suffer if his/her mother works" while 30% reported disagreement compared to only 3% and 2% in Kosovo and Kyrgyz Republic respectively (Figure 10).

Figure 10: Percent of people who agree with the statement: "A pre-school 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 Bosnia and Herzegovina

34. **FGDs suggest that center-based eldercare services, regardless of format, are few.** The existing ones are not geographically accessible by all participants and/or suffer from insufficient capacity that make in inaccessible for some citizens. Furthermore, some participants also mentioned recent shutdown of some of the existing elderly care centers, despite the already low supply; unfortunately this issue was not explored in detail in discussions, as to their causes and effects.[9] Supply side data shows the limited number and capacity of live-in eldercare centers (Table 7 and Figure 11).

35. **Recreational facilities with day-based services exist to a limited extent.** However these are not to be mixed as care providers: instead, they are more for recreational facilities for socialization of elderly. There is demand for a similar format, which would also provide basic medical and day-to-day assistance for elderly.[10]

[9] This issue was also mentioned in Ukraine. In Ukrainian FGDs the reason the shut downs were briefly attributed to the recent financial measures of the government, but without further reflection.

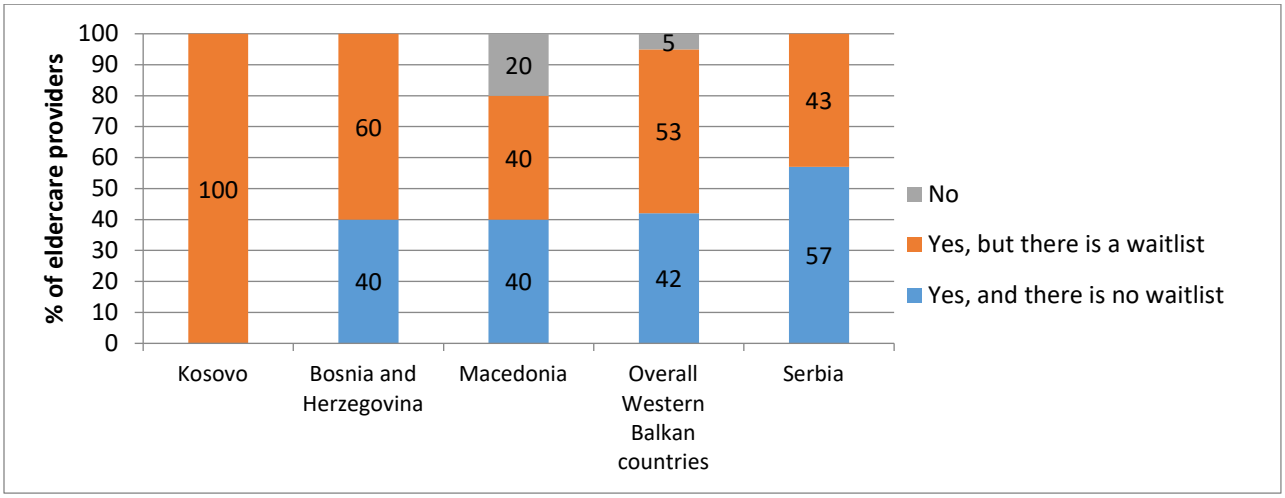
[10] Such centers were also mentioned in Serbia and Macedonia.

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	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	--
Kyrgyzstan	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 11: "Is this eldercare provider currently accepting new clients?"



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

In BiH, NGOs have an important role in provision of home care services for the elderly

36. **Home-based care provision from social actors such as NGOs are available.** In Bosnia, services of NGOs seem to have a particular role in provision of home care services for elderly, and various NGOs were mentioned to be providing physical and medical care for the bedridden.[11] Services offered include some medical support for elderly, as well as support to elderly in their daily tasks, such as shopping and house cleaning. The extent of the availability of these services and the extent to which they are systematized is unclear, but they are welcomed by participants.

High costs of eldercare are a barrier against use of these services

37. **Quality urban residential care elderly are generally stated to be very expensive and cannot be afforded by the majority.** Overall affordability of public care was not discussed in much detail in Bosnia. It is understood that quality urban residential care that is available is mostly private and is generally

[11] For example, several participants mentioned Caritas's at-home care services. Other national NGOs mentioned were Merhamet and Circle of Serbian sisters

expensive. Therefore there is an affordability problem with regards to access to quality care, even when there is willingness to use these services.

"*Quality services exist but it is impossible to pay them, even if two persons are working" (Urban woman, Bosnia);* "*My mother says that she would like to go to a nursery home, but the finances don't allow it" (Urban woman, Bosnia).*

38. **Retirement pensions of elderly also seem to affect affordability of residential care or at-home private care options and hence decisions.** Discussions show that pensions are seen to be the ideal potential source for formal care of elderly, however in many occasions they are not sufficient enough to cover the costs of care, leading families to use informal care.

"[Who can use it?] *Well, only those who have the money to pay for it. Those who have a small pension will not be able to afford that "(Urban man, Bosnia)*.

39. **Affordability of care services, and particularly of home-based care, also seems to have an influence on the decisions to use which form of care as well as household division of labor**. Some participants explained that where both center-based and home-based formal care is unaffordable, for many households provision of informal care and arranging an in-home division of labor remains as the only option.

40. **Among the live-in eldercare providers in the sample, care is never offered free of charge.** Of the live-in providers sampled across the Western Balkans, 83% charge a monthly fee, and the remaining providers use a different pricing scheme. Unlike childcare providers, only a third of eldercare providers offer price reductions for certain services, individuals, or families. The most common price reductions are based on elders' monthly income (5 providers) and family situation (3 providers). Other discounts are given based on the type of room, elder's health condition, and elder's status as a war invalid (2 providers each).

The main challenges for quality provision of eldercare involve human resources

41. **Regardless of location or gender, there is agreement across the WB FGDs that affordable center-based institutional services that are available for elderly suffer from serious quality impediments, and that the quality of care provision is far below standards that could be considered adequate.** Among all FGDs, the perceptions about quality seems to be relatively better in Bosnia and Serbia, however it is understood that some of the major problems associated with these services that are related to capacity, staff and basic service conditions are problematic in all countries.

42. **Perceptions about quality of residential eldercare centers in Bosnia seem to be relatively more positive than in other Western Balkan countries and ECA**.[12] Several participants praised the quality of services in terms of hygiene, medical care, staff attentiveness and basic care (such as food) of some facilities, most of which were private. Public centers on the other hand were viewed to be inadequate in terms of quality of services. Like in childcare, the benefits and quality of care was also measured by the happiness of the elderly people themselves. Meanwhile it was understood that participants did not personally use these services, so their impressions of both public and private care were based on observations and experiences of others or hearsay.

"I have an aunt in a nursing home in Zenica. It is good: she is really pleased with the service she gets" (Urban woman, Bosnia).

"While the word is that the state one is inadequate. You pay less, but the private ones are paid more but conditions are better" (Urban man, Bosnia).

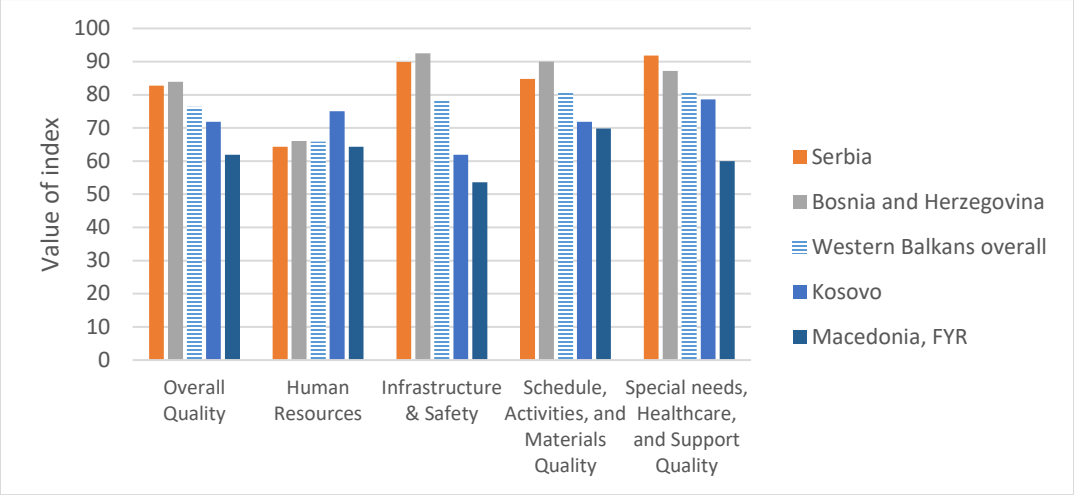
43. Provision of basic quality services is a particular problem regarding elder-care centers. Particularly public elderly homes are thought to suffer from lack of hygiene, poor infrastructure (such as stuffy rooms), and poor staff qualifications.

44. **As with childcare, supply-side data on quality was collected to complement the focus group discussions.** A principal component analysis method to create four equally weighted quality sub-indices (one more than in the childcare analysis). These mirrored the central concerns raised in focus group discussions, and include the following: 1) Infrastructure and safety quality sub-index, 2) Schedule, activities, and materials quality sub-index, 3) HR quality sub-index, and 4) Special needs, healthcare, and support quality sub-index. All inputs varied between 0 and 1. The sub-indices and the overall scores were standardized to a scale between 0-100. The first sub-index, infrastructure, includes 24 indicators such as whether the space is in good repair and if there is no malodor in the classrooms, as in the childcare sub-index, along with a questions relevant specifically to live-in elders, such as whether clinical mattresses or beds are available. The second sub-index, schedule, activities, and materials quality (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 elder care, such as whether there are visiting hours for family members. The third sub-index, HR quality, includes 8 indicators, such whether elders are organized into groups and whether staff members make an effort to ensure that the elder feels respected. The final indicator, special needs, health, and support quality (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 sub-indices can be found in Annex 2.

[12] In Serbia too, perspectives on quality were more positive.

45. **Bosnia and Herzegovina scores the regional average in terms of quality except for the dimension of human resources.** The two strongest components of the quality index in BiH are "Infrastructure and safety", and "Schedule, Activities and Materials Quality" sub-indices (Figure 12). The challenge remains in the Human Resources component involving measurement of caregivers' credentials and qualifications, training, the typical length of time that caregivers stay working at the center and the ratio of caregivers to elders, among others (See Annex 2).

Figure 12: Eldercare quality by country and component



Source: Author's 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

46. **FDGs In Bosnia and Herzegovina, as well as across the ECA countries, suggest that one of the main challenges in securing eldercare that meets families' and elderlies' needs, is the mismatch between available care formats and norms of care.** This mismatch is true of all ECA FGDs including the Western Balkans, and Bosnia and Herzegovina is no exception, as also mentioned above. Specifically, norms dictate that informal eldercare is mainly a task for women and girls (Figure 13).

"*I think that there are prejudices concerning the homes for the elderly. The view is that if a family sends someone to the home they renounced them; that they won't take care of them" (Urban woman, Bosnia).*

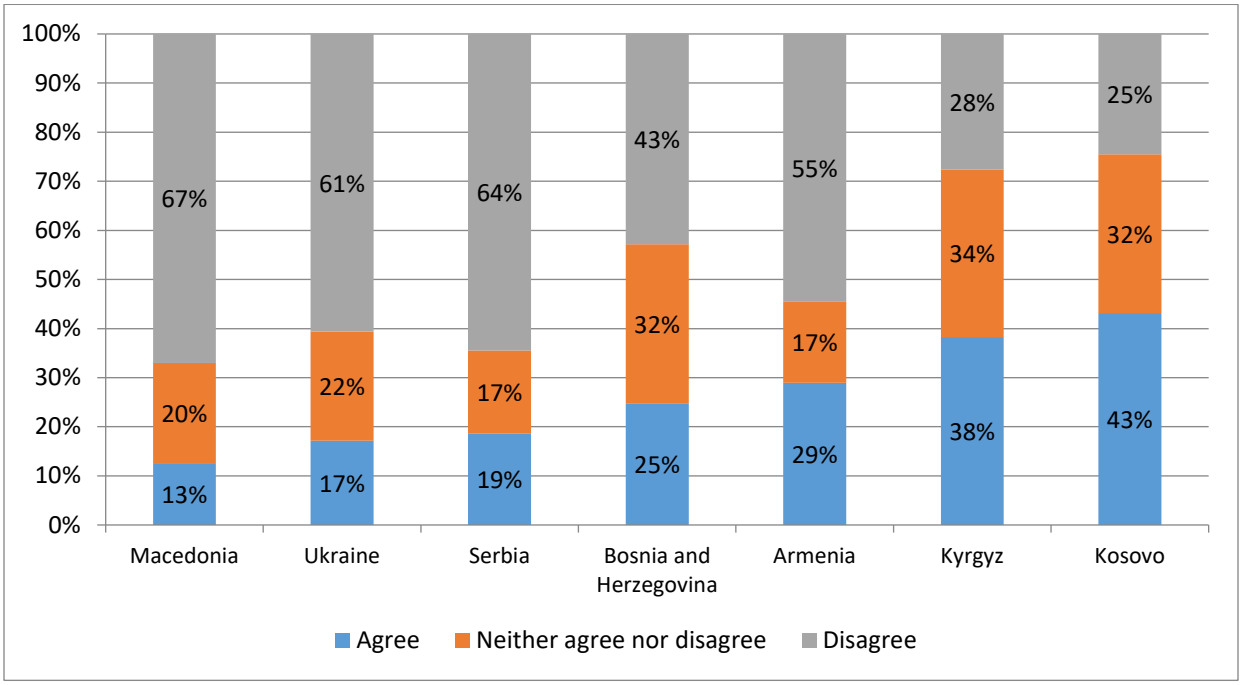
47. **The residential care format which is the primary elder care format available stands in contradiction with the social norms and filial obligations of families that participants mentioned throughout the discussions.** Other formats such as day-care centers or home-based formal eldercare are viewed more positively by Bosnia and Herzegovinians, 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 (due to provision and affordability) and unsystematic.

"Regardless of how much money we had, I think that we would accept someone [a care giver at home] serving them rather than sending them to the home for the elderly; because the very thought of the latter is horrible" (Urban woman, Bosnia).

48. **Caring for elderly at home by family members is viewed by many participants, as an obligation as well as the most appropriate way of helping their aging relatives to live out their remaining years in comfort, health, peace and dignity, in the companionship of their loved ones.** Focus group discussions 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, security) can be best met at home by their relatives vis-à-vis current provision of services.

"I believe that no one can care about you like your own family. No matter how much you would pay him/her" (Urban woman, Bosnia).

Figure 13: Percent 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).

The perception of potential benefits of formal care for elders without family support is manifest

49. **Greater ability to identify needs and visualize benefits of formal care for elders was found among participants in Bosnia and Herzegovina and Serbia compared to the rest of the region.** The ability to define benefits of use of formal eldercare appears to be related to the (imagined or actual) alternate formats that are more compatible with the norms, and are also conditional on the fact that these services offer adequate quality. The benefits of eldercare for the care receiver elderly mentioned in the Bosnia and Herzegovinian FGDs include the following:

a. **Elderly care centers benefit the elderly for meeting their needs of companionship.** Eldercare centers, and (imagined or actual) day-care centers for elderly in particular, can provide spaces for the socialization of the elderly, and meet their needs for companionship during the day.

b. **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.

c. **Residential care centers benefit those elderly that do not have family to care for them.** This becomes an important issue particularly because migration abroad for work is becoming more common among the younger generation, according to some participants.

d. **Private home-based care services (such as nurses) benefit the elderly who have demanding care 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.

e. **Free home-based services that are provided by NGOs or social services in regular intervals benefit elderly.** These services include basic medical services, such as measuring blood pressure as well as food and financial aid, and therefore seem to improve the quality of care received by the elders.[13]

"*In fact, they have much more company. They are with people of their own age. They understand each other better" (Urban woman Bosnia).*

"People condemn that, but there are such ill people that one cannot take care of. You work, but he can't take care of himself, so you have to put him under control somewhere" (Urban woman, Bosnia)
"I think people believe that those who go to a nursing home have no family here. Nursing homes are a great thing. They provide medical and every other care there is…" (Urban woman, Bosnia).

"It is a good solution for the people whose children live abroad." (Urban woman, BiH)

"No matter how rich we would be, I think that we would rather accept someone (a nurse) serving them rather than sending them to the home for the elderly –the very thought of the latter is horrible-." (Urban woman, BiH)

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

[13] Unfortunately the provision of such services were not described in further detail.

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.[14]

VIII. Conclusions and Policy Recommendations

51. **Bosnia and Herzegovina needs to increase labor participation among men and women alike, and capitalize the investments of valuable resources in education of a large group of young 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. **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 in The Western Balkans.** 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 mothers' employment, and enabling the combination of family and working life, as well as extending the working life..

53. **The rising demand for care services in Bosnia and Herzegovina 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 to increase quality of services with attention to costs, and revising the legal framework to be adaptable to the demands and expectations of care.

54. **Implementation of formal care systems is strongly compatible with the short and long term objectives of economic growth and poverty reduction objectives.** The expansion of formal care services can present a double benefit for the population: A well-developed childcare sector not only helps

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

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 health care sector.

55. **Analysis in this report shows evidence of a mismatch in the market for care services in terms of 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 in terms of supply and demand of childcare and eldercare services are summarized below in five salient points: (i) limited availability of affordable services that underlies the relatively low utilization of formal childcare services, (ii) 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, (iii) lack of day-based services and limited and expensive availability of residential care centers, (iv) social norms that act as a deterrent for use of residential eldercare while use of day-care centers and home-based formats –if available- would be more compatible with prevailing standards, and v) 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.

56. **In terms of 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. In order to tackle the real problem of accessing affordable and quality child care, 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.

57. **In terms of 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 essential to have efficient, multi-professional 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.

58. **Crucial elements in the design of care systems for successfully achievement of intended impacts are the gender neutrality in financing and service characteristics tailored to address constraints related to labor market participation.** In order 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 i) avoiding differential costs in hiring and employing women and men –for example, mandated

benefits that imply for employers higher costs of employing a women versus a men, and ii) providing flexibility in terms of service characteristics (hours of operation, year round service and so on) to respond to working women and family needs.

59. **Care leave and flexible work arrangements complement a supporting framework for the economic participations of women in Bosnia and Herzegovina.** The design, duration, and replacement rate of parental leave and care leave can affect uptake rates and effectiveness of protection against income shocks associated with caregiving, and prevent sub-optimal coping strategies. In a sense, care leave should be sufficiently long and generous to allow the caregiver the opportunity to fulfill the care obligations that are expected by the prevailing social norm and that are made necessary by the availability of formal care options. However, the duration and generosity of the care leave should not provide the caregiver with a disincentive for returning to the labor market at the earliest opportunity, as lengthy breaks in the work history can lead to human capital depreciation and thus a significant reduction in permanent income. Of course, the precise design of care leave policies has to depend on the state priorities and the local context. In the long run, the ability of caregivers to decrease labor supply on the intensive rather than extensive margin can increase the likelihood of transition back to full-time work after caregiving responsibilities abate. Policies supporting uptake of flexible work can take the form of "right-to-request" regulations, or if necessary, temporary subsidization of such arrangements in certain circumstances, where they can prevent costly labor market detachment of caregivers.

References

Agency for Statistics of Bosnia and Herzegovina. 2011. "Labor Force Survey, 2011. Final Results", Agency for Statistics of Bosnia and Herzegovina, Thematic Bulletin ISSN 1840-104X, November 2011.

Attanasio, Orazio and Marcos Vera-Hernandez. 2004. "Medium and Long Run Effects of Nutrition and Child Care: Evaluation of a Community Nursery Programme in Rural Colombia." *Centre for the Evaluation of Development Policies*, Working Paper 04/06, The Institute for Fiscal Studies, London, UK.

Asai, Yukiko, Ryo Kambayashi and Shintaro Yamaguchi. 2015. "Childcare Availability, Household Structure and Maternal Employment", SSRN Paper available at http://ssrn.com/abstract=2462366

Becker, Gary S. 1985. "Human Capital, Effort and the Sexual Division of Labor*", Journal of Labor Economics*, Volume 3, Issue 1, Part 2: trends in Women's Work, Education and Family Building, January 1985.

Behrman, Jere R. and Barbara L. Wolfe. 1984. "Labor force participation and earning determinants of women in the special conditions of developing countries", *Journal of Development Economics*, vol. 15 (1-3), 259-288.

Berlinski Samuel, and Sebastian Galiani. 2007. "The Effect of a Large Expansion of Pre-Primary School Facilities on Preschool Attendance and Maternal Employment." *Labour Economics* 14:665–80

Bolin, K. Lindgren B. and Lundborg, P. 2008. "Your next of kin or your own career? Caring and working among the 50+ of Europe" *Journal of Health Economics*, 27(3), 718-738.

Calderon, Gabriela. 2014. "The Effects of Child Care Provision in Mexico". Working Papers 2014-07, Banco de Mexico.

Carmichael, F. and Charles, S. 1998. "The Labour Market Costs of Community Care" *Journal of Healgh Economics,* 17(6), 747-765.

Carmichael, F. and Charles, S. 2003. "The Opportunity Costs of Informal Care: Does Gender Matter?" *Journal of Health Economics*, 22(5), 781-803.

Correll, Shelley J., Stephen Benard, and In Paik. 2007. "Getting a Job: Is There a Motherhood Penalty?" *American Journal of Sociology* 112 (5): 1297-1339.

Del Boca, Daniela and Marilena Locatelli. 2006. "The Determinants of Motherhood and Work Status: A Survey", *IZA Discussion Papers* 2414, Institute for the Study of Labor (IZA).

Deutsch, Ruthanne. 1998. “Does Child Care Pay?: Labor Force Participation and Earnings Effects of Access to Child Care in the Favelas of Rio de Janeiro.” Working paper #384. Inter-American Development Bank.

Fong, Monica and Michael M. Lokshin. 2000. “Child Care and Women’s labor Force Participation in Romania.” Policy Research Working Papers: 2400. The World Bank.

Gabriele, Stefania, Paola Tanda and Fabrizio Tediosi. 2011. “The Impact of Long-Term Care on Caregivers’ Participation in the Labour Market” ENEPRI Research Report No. 98, November 2011.

Geyer, Johannes and Thorben Korfhage. 2014. “Long-term Care Insurance and Carers’ labor Supply: A Structural Model”, Discussion Papers of DIW Berlin 1421, DIW Berlin, German Institute for Economic Research.

Heger, Dorte. 2014. “Work and Well-Being of Informal Caregivers in Europe*”, Ruhr Economic Paper* No. 512, Rhine-Westphalia Institute for Economic Research.

Heitmueller, A. and Inglis, K. 2007. “The Earnings of Informal Careers: Wage Differentials and Opportunity Costs*” Journal of Health Economics* 26(4), 821-841.

Henz, U. 2006. “Informal Caregiving at Working Age: Effects of Job Characteristics and Family Configuration”, *Journal of Marriage and Family*, 68, 411-429.

Jacobs, Josephine C., Audrey Laporte, Courtney H. Van Houtven, and Peter C. Coyte. 2014. “Caregiving Intensity and Retirement Status in Canada.” *Social Science & Medicine* 102 (February): 74-82.

Jaumotte, Florence. 2003. “Labor Force Participation of Women: Empirical Evidence on the Role of Policy and Other Determinants in OECD Countries.” OECD *Economic Studies* 37 (2): 51-110.

Johnson, R. and Lo Sasso, A. 2000. “The Trade-Off between Hours of Paid Employment and Time Assistance to Elderly Parents in Midlife. The Urban Institute Working Papers.

Krauss, M., M. Riedel, E. Mot, P. Willeme, G. Rohrling and T. Czpionka. 2010. “A typology of systems of long-term care in Europe”, ANCIEN project, Research Institute for Advanced Studies, Vienna.

Lefebvre, Pierre and Philip Merrigan. 2005. “Low-fee ($5/day/child) Regulated Childcare Policy and the Labor Supply of Mothers with Young Children: A Natural Experiment from Canada”. CIRANO

Lilly, M.B., Laporte A. and Coyte, P.C. 2010. “Do They Care Too Much to Work? The Influence of Caregiving Intensity on the Labour Force Participation of Unpaid Caregivers in Canada” *Journal of Health Economics*, 29(6): 895-903

Loken, Katrine Vellesen, Shelly Lundberg and Julie Riise. 2014. "Lifting the Burden: State Care of the Elderly and Labor Supply of Adult Children," *IZA Discussion Papers* 8267, Institute for the Study of Labor.

Lokshin, Michael. 2000. "Household Childcare Choices and Women's Work Behavior in Russia." *The Journal of Human Resources,* 39(4): 1094-1115.

OECD. 2011. *Doing Better for Families*. Paris, April 2011.

Paes de Barros, Ricardo, Pedro Olinto, Trine Lunde, and Mirela Carvalho. 2011. "The Impact of Access to Free Childcare on Women's Labor Market Outcomes: Evidence from a Randomized Trial in Low-Income Neighborhoods in Rio de Janeiro." Paper Prepared for the 2011 World Bank Economists'

Prada, Maria F., Graciana Rucci and Sergio S. Urzua. 2015. "The Effect of Mandated Child Care on Female Wages in Chile", *NBER Working Paper* No. 21080, April 2015.

Ribar, David. 1995. "A Structural Model of Child Care and the Labor Supply of Married Women". *Journal of Labor Economics*, vol. 13, No. 3.

Sarasa, Sebastian. 2006. "Do Welfare Benefits Affect Women's Choices of Adult Care Giving?" *European Sociological Review* 24 (1): 37-51.

Spiess, K. and U. Schneider. 2003. "Interactions between Care-Giving and Paid Work Hours among European Midlife Women, 1994 to 1996" *Ageing and Society*, 23(1), 41-68.

Todd, Petra. 2013. "How to improve Women's Employability and Quality of Work in Developing and Transition Economies", A Roadmap for Promoting Women's Economic Empowerment. Available at www.womeneconroadmap.org, November 2013.

Viitanen, Tarja. 2007. "Informal and Formal Care in Europe", Working Papers 2007010, The University of Sheffield, Department of Economics, revised June 2007.

World Bank. 2013. "What Matters Most for Early Childhood Development: A Framework Paper." *Saber Working Paper Series*. Number 5, January.

World Bank. 2015. "Supply and Demand for Child Care Services in Turkey. A Mixed Methods Study." *Forthcoming.*

Annex 1: List of Variables Used in the Construction of the Childcare Quality Sub-Indices

Questions included	Infrastructure quality sub-index	Materials, curriculum and learning quality sub-index	HR quality sub-index
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, etc.)	X		
Doors and windows are childproof when appropriate (for example, windows can't open fully, heavy doors close slowly, etc.)	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	
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 Sub-Indices

Questions included	Infrastructure and safety quality sub-index	Schedule, activities, and materials quality sub-index	HR quality sub-index	Special needs, healthcare, and support quality sub-index
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, etc.)	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			
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	
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 (i.e., those using wheelchairs, walkers, etc.)			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