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TRANSFORMING CARE SYSTEMS IN NORTH MACEDONIA:

Gender, Care Needs, and Financing Pathways for an Inclusive Care Economy

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Executive Summary

This study examines how care is organized, financed, and experienced in North Macedonia, with a focus on identifying structural gaps and policy pathways for building a more inclusive and sustainable care system.

It is motivated by the growing recognition that care systems are central not only to social protection and well-being, but also to labour market functioning, gender equality, and long-term economic development. The analysis adopts a mixed-methods approach, combining: (i) documentary analysis of the legal and institutional framework; (ii) quantitative evidence from official statistics, administrative data, and existing surveys; and (iii) qualitative insights from semi-structured interviews with caregivers, care recipients, and providers. This integrated approach allows the study to capture both the structural characteristics of the care system and the lived realities of care provision.

Care demand in North Macedonia is rising while informal care capacity is shrinking.

Demographic change is fundamentally reshaping the care landscape in North Macedonia. Population ageing, declining fertility, and sustained emigration are simultaneously increasing the need for long-term care while reducing the availability of family-based caregivers. Care needs are becoming more continuous, complex, and service-intensive, particularly in the context of chronic illness, disability, and ageing. At the same time, childcare demand remains significant due to rising expectations around early childhood development and female labour-market participation.

Macedonian care system remains structurally underdeveloped and service-constrained.

Despite a formally established institutional framework centred on the Ministry of Social Policy, Demography and Youth, the care system is not yet organized as an integrated system. Service provision - particularly in long-term care and community-based services - remains limited in scale and unevenly distributed across regions. Childcare coverage has improved but remains insufficient, while long-term care continues to rely predominantly on informal arrangements. As a result, access to care is shaped not only by need, but by geography and local capacity.

Households function as the *de facto* core of the care system.

In practice, care provision in North Macedonia is largely internalized within households. Families absorb the majority of care responsibilities, often in the absence of viable formal alternatives. This results in a system where informal, hybrid, and ad hoc arrangements substitute for structured service provision. Informality is not marginal but systemic - reflecting gaps in accessibility, affordability, and service availability rather than voluntary choice.

Women disproportionately bear the cost of systemic gaps.

The care economy is strongly gendered. Women perform the majority of unpaid care work and are overrepresented in low-paid, often informal care occupations. Care responsibilities constrain labour market participation, reduce working hours, and limit income opportunities. This creates a structural incompatibility between care and employment, particularly in rural and agricultural contexts. Gender inequalities are therefore both a cause and a consequence of the current organization of care.

Access to care is constrained by a combination of geographic and financial barriers.

Care services are unevenly distributed, with rural areas particularly underserved. In some municipalities, basic services such as kindergartens or rehabilitation facilities are entirely absent. Even where services exist, access is limited by long waiting times, travel constraints, and limited local capacity. Affordability further restricts access. Private services - both in childcare and long-term care - are prohibitively expensive for most households, while even publicly provided services (particularly residential eldercare) may be financially out of reach. As a result, households rely on informal care not as a preference, but as a necessity.

Home-based care emerges as a promising but underdeveloped model.

Within this constrained system, home-based and community-based care services stand out as one of the few models that effectively respond to both care needs and social preferences. These services allow individuals - particularly older persons - to remain in familiar environments, preserving dignity and autonomy while alleviating pressure on families. Importantly, home care is better aligned with prevailing cultural norms, which often resist institutionalization. However, despite its strong potential, this model remains limited in scale, unevenly distributed, and insufficiently financed to play a transformative role.

The financing model is insufficient in scale and misaligned in structure.

Public spending on care, estimated at approximately **1.3% of GDP**, is modest compared to European benchmarks. More importantly, the composition of spending is heavily skewed toward cash transfers rather than services, limiting the expansion of care infrastructure and workforce. The financing system is fragmented across sectors and levels of government, lacking a dedicated and predictable funding mechanism - particularly for long-term care. At the same time, reliance on out-of-pocket payments and unpaid care shifts a substantial share of the true cost of care onto households, where it remains largely unrecognized in economic terms.

Cultural norms reinforce but also increasingly strain the current system.

Strong social norms continue to frame care as a family responsibility, particularly for women. These norms shape both behaviour and policy preferences, reinforcing reliance on informal care. However, demographic change, migration, and labour market pressures are making these norms increasingly difficult to sustain in practice. This creates a tension between persistent expectations and emerging realities, with gradual shifts in attitudes - particularly among younger generations - toward greater acceptance of formal care services.

Informality reflects a systemic equilibrium, requiring gradual transition strategies.

The widespread informality observed in care provision is not simply a regulatory failure but a systemic outcome of affordability constraints and limited formal alternatives. As such, formalization cannot rely solely on enforcement. It requires a gradual, incentive-based transition that expands access to formal services while creating viable pathways for care workers and households to move into formal arrangements.

The evidence in this study shows that care in North Macedonia is not organized through deliberate choices among well-functioning alternatives, but through constrained adaptation to limited options.

Addressing care gaps therefore requires more than incremental policy adjustments - it calls for a system-level transformation that rebalances the role of the State, the market, and households. Strengthening the care system is not only a social policy priority but a structural economic reform. Expanding accessible and affordable care services - particularly home-based and community-based care - would reduce the burden on households, enable greater labour-market participation, and support a more inclusive and resilient development path.

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List of abbrevations

ALMP	Active Labour Market Policies
CEE	Central and Eastern Europe
CSO	Civil Society Organization
CSW	Centres for Social Work
ECEC	Early Childhood Education and Care
ESA	Employment Service Agency
EU	European Union
EVS	European Values Survey
GMA	Guaranteed Minimum Assistance
HCBS	Home-based and Community-Based Services
HIF	Health Insurance Fund
ILO	International Labour Organization
LTC	Long-Term Care
MoEL	Ministry of Economy and Labour
MoES	Ministry of Education and Science
MoF	Ministry of Finance
MoH	Ministry of Health
MSPDY	Ministry of Social Policy, Demography and Youth
OECD	Organization for Economic Co-operation and Development
QoL	Quality of Life Survey (Finance Think)
SSO	State Statistical Office
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UN	United Nations

1. Introduction

Care systems are increasingly recognized as a central pillar of inclusive economic development, social protection, and gender equality (Folbre, 2006; Picchio, 1992). Across Europe and globally, demographic change - characterized by population ageing, declining fertility, and evolving family structures - is transforming both the scale and nature of care needs (Bloom et al., 2015; Goldstein et al., 2009). At the same time, labour market dynamics, including rising female labour force participation and sustained migration, are reducing the capacity of households to provide care informally (Goldin, 1994; Thévenon, 2013). These trends are particularly pronounced in the Western Balkans, where care systems remain underdeveloped, fragmented, and heavily reliant on unpaid family provision.

In North Macedonia, these structural pressures are becoming increasingly visible. The country faces a dual challenge: a gradual increase in demand for long-term care driven by population ageing, alongside persistent gaps in access to childcare and other care services that constrain labour market participation, particularly among women. While care needs are expanding, the formal care system has not evolved at the same pace. As a result, care provision continues to rely predominantly on households, where responsibilities are unevenly distributed and largely borne by women. This configuration has important implications not only for social well-being, but also for economic outcomes, including labour supply, productivity, and fiscal sustainability.

The care economy - understood as the set of activities, services, and relationships that support individuals with care needs - thus represents both a social necessity and an economic opportunity (UN Women, 2024). Investments in care systems have been shown to generate multiple returns: improving well-being and quality of life, enabling greater labour market participation (particularly of women), creating employment in care sectors, and supporting more equitable and resilient societies (de Henau et al., 2016). Conversely, insufficient investment in care leads to hidden costs, including unmet needs, reduced economic participation, and the reinforcement of gender inequalities.

Despite its importance, the care system in North Macedonia remains characterized by fragmentation, limited-service provision, and a financing structure that prioritizes cash transfers over direct service delivery. While the system is institutionally anchored within the Ministry of Social Policy, Demography and Youth (MSPDY), care-related functions extend across multiple sectors - including education, health, and labour - reflecting the multidimensional nature of care needs. This multi-actor configuration, combined with a decentralized service delivery model, creates coordination challenges and contributes to uneven access across regions. At the same time, key policy instruments - such as leave arrangements, social services, and financial support - are not yet fully integrated into a coherent system framework. As a result, the system faces constraints in responding effectively to growing and increasingly complex care needs.

Against this background, this study examines how care is organized, financed, and experienced in North Macedonia, with a particular focus on care needs, service gaps, gender dynamics, and financing mechanisms. The analysis adopts a comprehensive perspective that combines institutional, economic, and social dimensions of the care economy. It seeks to move beyond a narrow sectoral view of care services and instead conceptualize care as a system that interacts with labour markets, social protection, and demographic change.

Methodologically, the study integrates multiple sources of evidence. It draws on documentary analysis of legal and policy frameworks, quantitative data from official statistics and administrative sources, and qualitative insights from semi-structured interviews with both care providers and individuals facing care responsibilities. This mixed-methods approach enables a more complete understanding of both the structural features of the care system and the lived realities of care provision, including the ways in which households adapt to gaps in formal services.

The objectives of the study are threefold. *First*, it aims to provide a comprehensive assessment of the current care system in North Macedonia, including its institutional structure, service provision, and financing patterns. *Second*, it seeks to identify key gaps and constraints in meeting care needs across different population groups, with particular attention to gender inequalities. *Third*, it develops a set of policy options for transforming the care system into a more integrated, accessible, and sustainable framework, aligned with international good practices and the country's development priorities.

The remainder of the report is structured as follows. Section 2 presents the conceptual definitions and methodological approach. Section 3 reviews the policy and institutional framework governing care provision. Section 4 provides stylized facts on demographic trends, service availability, and the distribution of care work. Section 5 examines care needs and gaps across key population groups, combining existing survey evidence with qualitative insights. Section 6 analyses the financing of the care system, including its scale, composition, and key constraints. Section 7 reviews international experiences and good practices in care system transformation. Section 8 outlines policy options and reform pathways, while Section 9 concludes with key findings and implications.

2. Definitions and methodology of the study

The care economy refers to the set of activities and relationships involved in meeting the physical, psychological, and developmental needs of individuals who require support due to age, disability, illness, or other circumstances. In line with recent international frameworks, the care economy encompasses both the production and consumption of care services, including all paid and unpaid activities that sustain human well-being and social reproduction (UN, 2024; ILO, 2024). These activities include both direct care - such as caring for children, older persons, or persons with disabilities - and indirect care activities that sustain daily living, including cooking, cleaning, and other household tasks. A key analytical distinction is therefore made between direct (relational, people-cantered) care and indirect (supporting, non-relational) care, as these have different policy implications and respond differently to public interventions. Together, these activities form a fundamental component of social reproduction and the functioning of societies and economies.

Care can be provided through different institutional arrangements involving the State, the market, households, and communities. This configuration is often conceptualized as the “care diamond”, which highlights that care provision is a shared responsibility across these four spheres rather than a purely private household matter (Razavi, 2007; Staab et al., 2024). Formal care services are typically delivered through public or private institutions, such as childcare centres, kindergartens, residential care homes, or specialized care facilities for persons with disabilities. These services rely on paid workers and institutional infrastructure. In contrast, informal care is provided outside formal institutions, most commonly within households and family networks. In contexts where formal care systems are underdeveloped, households tend to absorb the majority of care responsibilities, often resulting in unequal distributions of care work within families (ILO, 2018).

A key distinction within the care economy is between paid and unpaid care work. Paid care work refers to activities performed for remuneration, either within formal care institutions or within private households, such as domestic work or personal caregiving. Unpaid care work refers to care activities performed without monetary compensation, typically within households, by household members or family relatives. Importantly, these two forms of care exist along a continuum rather than as perfect substitutes, as formal services often complement rather than replace unpaid care within families. While unpaid care work is essential for the functioning of households and societies, it often remains underrecognized and underrepresented in official economic statistics.

The organization of care work is closely linked to gender inequalities in both households and labour markets. Across many contexts, including North Macedonia, women perform a disproportionate share of unpaid care work and are also overrepresented in paid care occupations. This unequal distribution of care responsibilities can affect women’s labour market participation, working hours, income opportunities, and overall economic empowerment.

Understanding the care economy therefore requires examining both formal care systems and the broader landscape of care provision within households. In the context of North Macedonia, this includes analysing demographic trends that shape care demand, the availability of institutional care services, the presence of paid domestic work, and the distribution of unpaid care work between women and men.

Building on these conceptual definitions, the study adopts a mixed-methods approach that combines documentary analysis, secondary quantitative data analysis, and qualitative evidence from semi-structured interviews. This approach allows for a comprehensive assessment of the care economy, capturing both its institutional and financial dimensions, as well as lived experiences and behavioural patterns that cannot be observed through administrative data alone.

The analysis begins with a systematic review of the legal, policy, and strategic framework governing care provision in North Macedonia. This documentary analysis covers key legislation - including the Law on Child Protection, the Law on Social Protection, and the Law on Labour Relations - as well as relevant national strategies, policy documents, and international reports. The objective is to map institutional responsibilities, identify existing policy instruments, and assess the degree of coherence and integration across sectors such as social protection, education, health, and labour. Particular attention is paid to the design features of care-related policies, their implementation gaps, and their alignment with international frameworks on care systems and gender equality.

This is complemented by secondary analysis of quantitative data from official statistical and administrative sources. The empirical component draws primarily on data from the State Statistical Office (SSO), including demographic projections, labour market indicators, time-use survey data, and sectoral employment statistics. In addition, administrative and budgetary data are used from the Ministry of Finance (MoF), the MSPDY, and the Health Insurance Fund (HIF) to construct estimates of public care financing and to analyse the composition of expenditures. Survey-based data sources, such as the European Values Survey (EVS) and national survey evidence (e.g. Quality of Life Survey), are further used to examine social norms, attitudes toward care, and perceived access to services. These datasets jointly enable the identification of structural trends in care demand, service provision, gender distribution of care work, and financing patterns.

Finally, the study incorporates qualitative evidence collected through semi-structured interviews with key target groups, aimed at complementing and contextualizing the quantitative findings. The key target groups include women in rural areas, informal workers, women farmers, older women, and caregivers of children and persons with disabilities, as well an interview with a private licensed care provider. The interviews were designed to capture perceptions of care needs, access constraints, affordability, institutional coordination, and cultural norms related to care provision. This qualitative component provides insights into the lived realities of care, the functioning of services on the ground, and the interaction between formal systems and informal care arrangements.

3. Policy and institutional framework for care

The care economy in North Macedonia operates within a policy and institutional framework that is formally established but substantively underdeveloped, particularly in terms of coverage, coordination, and gender responsiveness. While care-related functions are embedded across social protection, education, health, and labour policies, they remain fragmented and insufficiently integrated into a coherent care system, despite recent strategic commitments to strengthen social and care services outlined in the National Development Strategy (2024–2044).[1] This fragmentation is further reinforced by the division of responsibilities across multiple institutions, although the care system in North Macedonia remains strongly cantered MSPDY. This Ministry holds primary responsibility for the core components of the care economy, including early childhood education and care under the Law on Child Protection,[2] as well as long-term care and disability services under the Law on Social Protection.[3] By contrast, the Ministry of Education and Science (MoES) plays a more specialized role focused on the educational component of early childhood education and care, primarily through the Bureau for Development of Education, which is responsible for the design of pre-school curricula and pedagogical standards. While early childhood services are predominantly governed under the social protection system, the education sector contributes to the learning dimension of early childhood education and care (ECEC), reflecting a split governance structure between care provision and educational content. The Ministry of Health (MoH) contributes through the provision of medical and preventive services linked to care needs.[4] The operational delivery of services is largely decentralized to municipalities, which are responsible for managing childcare institutions and implementing social services. While this multi-actor arrangement reflects the multidimensional nature of care needs, it also results in overlapping mandates, weak inter-institutional coordination, and significant territorial disparities in access and quality of care services. This institutional configuration and the resulting fragmentation of care provision across sectors are summarized in **Table 1**.

Childcare services are primarily governed by the Law on Child Protection, which regulates early childhood education and care (ECEC), including kindergartens and early childhood development centres. These services are largely publicly provided, with municipalities holding shared responsibility for their establishment, financing, and management.[5] Over the past decade, policy efforts have aimed to expand childcare capacity, including through the licensing of private providers and the introduction of alternative service models. However, coverage remains uneven and insufficient relative to demand, particularly in rural areas and smaller municipalities. This reflects both infrastructural constraints and disparities in local fiscal capacity, which directly affect access to services (Petreski et al. 2020).

Long-term care for older persons and persons with disabilities is regulated under the Law on Social Protection, which introduced a broader range of social services, including home care (home; day care; foster care; and residential care), personal assistance, and community-based services. The reforms of 2019 signal a policy shift away from a predominantly institutional model toward more deinstitutionalized and community-based care, in line with European policy directions. However, implementation remains partial and limited in scale. In practice, the system continues to rely heavily on informal care provided by family members, with formal services playing

[1] www.nrs.mk/content/downloads/documents/thematic/МКД%20Национална%20развојна%20стратегија%202024-2044%20ФИНАЛНО%2021.01.2025.pdf

[2] Law on Child Protection (Закон за заштита на децата), Official Gazette of the Republic of Macedonia, No. 23/2013, with subsequent amendments (Official Gazette No. 12/2014, 44/2014, 144/2014, 10/2015, 25/2015, 150/2015, 192/2015, 27/2016, 163/2017, 21/2018, 198/2018).

[3] Law on Social Protection (Закон за социјална заштита), Official Gazette of the Republic of North Macedonia, No. 104/2019, with subsequent amendments (Official Gazette No. 146/2019, 275/2019, 311/2020, 163/2021, 294/2021, 99/2022, 236/2022).

[4] This is why healthcare is not treated as part of the care system in this study. It is considered only to the extent that it directly intersects with social care needs of older persons and persons with disabilities, where the two domains cannot be clearly separated. One example is palliative care, which is provided exclusively in healthcare institutions.

[5] https://cms.mtsp.gov.mk/detski-gradinki.nspx

Table 1 Mapping of the care system in North Macedonia: institutional responsibilities, services and key gaps

Care domain	Main institutions	Services / provision	Governance model	Key gaps (linked to policy instruments)
Childcare (ECEC)	MSPDY; Municipalities	Public kindergartens; limited private provision	Decentralized	Insufficient coverage; territorial inequalities; weak link with parental leave and flexible work policies
Long-term care (elderly)	MSPDY; Municipalities	Institutional care; limited home/ community services	Decentralized	Underdeveloped community care; high reliance on informal care; weak care leave provisions
Disability care	MSPDY; Municipalities	Institutional care; small-group homes; limited personal assistance	Mixed	Incomplete deinstitutionalization; limited personalized services; fragmented benefits
Health-related social care	MoH	Preventive and medical services	Centralized	Weak integration with social care; lack of coordinated care pathways
Labour market - care-related policies	MoEL; HIF; Employers	Maternity leave; limited parental leave; care leave; flexible work	National legislation + employer implementation	Weak redistribution of care; limited paternity leave; low accessibility of flexible work
Informal care (households)	Households	Unpaid care work	Private	High burden on women; lack of recognition and support mechanisms
System governance	Multiple institutions; MSPDY central role	Strategies and sectoral policies	Centred on MSPDY; Fragmented multi-level	Lack of fully integrated care system; weak coordination across sectors

Source: MSPDY, Bureau for Development of Education.

a secondary and often residual role. Institutional care still dominates the formal landscape, with a limited number of public facilities complemented by a growing but fragmented private sector, while home-based and community services - critical for both cost-efficiency and user well-being - remain underdeveloped and unevenly distributed, particularly outside urban areas. The availability of services is constrained by insufficient infrastructure, especially in rural regions, and by capacity limitations at the local level.[6] In the area of disability care, the process of deinstitutionalization has advanced through the development of small-group homes and independent living arrangements, yet the transformation of institutional care and the expansion of personalized community-based services remain incomplete.[7]

A central structural feature of the care system of North Macedonia is its decentralized governance model. Municipalities are responsible for delivering key care services, including childcare facilities and a range of social services (Petreski et al. 2020). While decentralization enables adaptation to local needs, it also generates significant territorial inequalities. Municipalities vary widely in administrative capacity, fiscal space, and prioritization of care services, leading to disparities in both availability and quality of care. In practice, this means that access to care is not determined solely by need, but also by place of residence.

Labour market regulations also play an important, though indirect, role in shaping the provision and distribution of care. The Law on Labour

[6] https://incare.euro.centre.org/wp-content/uploads/2022/12/InCARE-Factsheet_NorthMacedonia-Attitudes-experiences-and-expectations-on-long-term-care_EN.pdf

[7] https://www.peopleinneed.net/helping-people-with-disabilities-north-macedonia-7954gp

Relations[8] establishes a set of rights linked to care responsibilities, including maternity leave of up to nine months (extended to 15 months for multiple births), limited provisions for unpaid parental leave, short-duration leave for the care of sick family members, and the right to daily breaks for childcare. However, key gaps remain: the statutory paternity leave is confined to seven days, parental leave beyond maternity is largely unpaid and time-limited, and care-related leave provisions are short and narrowly defined. Flexible working arrangements - such as part-time work or adjusted schedules - exist in principle but are subject to employer discretion, limiting their effective use. These instruments are intended to support the reconciliation of work and family life and to enable individuals to respond to care needs within households. However, their design remains largely individualized and employment-contingent, rather than embedded within a broader care system perspective. As such, they function primarily as coping mechanisms for households rather than as instruments that systematically redistribute care responsibilities or reduce the overall care burden.

The main care-related policy instruments, including their design features and limitations, are summarized in **Table 2**.

Table 2 Care policy instruments in North Macedonia: policy areas, design features and assessment

Policy instrument	Exists?	Key design features	Assessment
A. Leave policies			
Paid maternity leave	Yes	39 weeks (9 months); 100% wage replacement; social insurance financed; transferable to fathers; coverage includes self-employed and adoptive parents; aligned with ILO Convention No. 183; protection against dismissal and right to return guaranteed	Strong design and protection; limited impact on redistribution of care
Paternity leave	Very limited	Seven days; 100% wage replacement; employer-funded; no coverage for self-employed, adoptive parents; basic employment protection applies	Very short duration; weak incentive for redistribution of care
Parental leave	Limited	13 weeks; unpaid; limited inclusiveness; low incentives for fathers; protection of employment applies	Low uptake; reinforces gendered care patterns
Care leave (family / LTC)	Very limited	No statutory long-term care leave; only short-term emergency leaves available; employer-funded; no coverage for self-employed	Major gap in responding to ageing-related care needs
Emergency leave	Yes	Short-duration paid leave; employer liability; limited scope and eligibility	Provides minimal short-term support only
B. Health-related care protection and working conditions			
Health protection (pregnant and nursing women)	Yes	Prohibition of night work and hazardous work; adaptation or reassignment required; no explicit provision for prenatal medical leave	Strong protective elements; gaps in preventive care support
Nursing provisions	Yes	Paid nursing breaks (90 minutes daily); one break; applicable until child is 12 months old; no requirement for workplace facilities	Supports early childcare; limited institutional support for breastfeeding

[8] Law on Labour Relations (Закон за работните односи), Official Gazette of the Republic of North Macedonia, No. 167/2015, with subsequent amendments (e.g., No. 27/2016, 120/2018, 110/2019, 267/2020, 151/2021).

Policy instrument	Exists?	Key design features	Assessment
C. Care services			
Childcare services (0–2 years)	Yes	Public system with universal framework; decentralized provision; coverage from age 0; half/full day services; limited private sector	Coverage gaps persist; strong territorial inequalities
Pre-primary education (3+ years)	Yes	Universal public system; coverage from age three half/full day services	Better coverage than childcare; still uneven across municipalities
Long-term care services (elderly)	Yes (partial in practice)	Public system; mix of residential, community and in-home services; tax-funded; family obligations legally recognized	Underdeveloped community care; heavy reliance on informal care
Disability care services	Yes	Combination of institutional care, small-group homes, and limited personal assistance services	Incomplete deinstitutionalization; limited personalized services
D. Financial support instruments			
Cash benefits / allowances	Yes	Various schemes (child benefits, disability support, social assistance); targeted or means-tested; not systematically linked to services	Fragmented; weak integration with care system objectives
E. Labour market and system-level instruments			
Flexible work arrangements	Limited	Legally possible; employer-dependent; limited enforceability; low uptake	Limited accessibility; weak impact on work–care reconciliation
Integrated care system	No	No unified framework linking services, leave policies, and financing; policies operate across sectors or levels of governance without coherent coordination	Major structural gap

Source: MSPDY; ILO (2022).

Despite incremental reforms, the care policy framework does not yet constitute a coherent care system. Care services remain segmented across sectors, with limited coordination between childcare, long-term care, disability services, and labour market policies. This fragmentation constrains the system's ability to respond effectively to demographic pressures, particularly population ageing and changing family structures, which are increasing both the volume and complexity of care needs.

From a gender perspective, the framework remains structurally incomplete. Although the National Strategy for Gender Equality (2022–2027) explicitly recognizes unpaid care work as a key barrier to women's economic participation and calls for the integration of a gender perspective across all public policies, these commitments are not systematically translated into operational policy instruments.[9] Measures aimed at recognizing, reducing, and redistributing care work remain fragmented and weakly coordinated across sectors. Existing provisions - such as maternity and parental leave, flexible work arrangements, and selected social services - continue to operate in isolation rather than as part of an integrated care strategy aligned with labour market and social policy objectives. As a result, the burden of care continues to fall disproportionately on women, reinforcing persistent gender gaps in labour force participation, working hours, and earnings.

[9] https://cms.mtsp.gov.mk/content/pdf/2022/strategija_/Стратегија_за_родова_еднаквост_2022_2027.pdf

4. Stylized facts about the care economy in North Macedonia

4.1. Demographic trends shaping care needs

The care economy in North Macedonia is shaped by the interaction between demographic demand for care, availability of formal care services, and the distribution of care responsibilities within households. Demographic change is a central driver shaping the care economy in North Macedonia, operating through both the demand for care and the availability of caregivers. Over the past decades, fertility has declined well below the replacement level of 2.1 children per woman, reaching approximately 1.5 births per woman in recent years, while outward migration - particularly among young working-age individuals - has remained persistent (Petreski, 2021).

These processes are contributing to a gradual reduction in population size and a transformation of the population's age structure, which points to a sustained increase in care needs over time. The demographic pyramid presented in **Figure 1**, comparing the population in 2025 with projections for 2040, shows a clear narrowing of the younger cohorts alongside a visible expansion of older age groups. This pattern illustrates the progressive ageing of the population, with smaller incoming generations and a growing share of elderly individuals. From the perspective of the care economy, these shifts have a dual effect: they increase the number of individuals likely to require care - particularly older persons - while simultaneously reducing the pool of potential caregivers within households and the labour market. As a result, care provision is increasingly shaped by a tightening balance between rising needs and declining informal care capacity.

Figure 1 Demographic pyramid of North Macedonia (2025 and 2040)

Source: State Statistical Office, Demographic projections - constant fertility.

The population sizes and shares displayed in Figure 2 further illustrate the changing balance between key population groups associated with care needs. The number and share of children aged 0–6 are expected to decline gradually, while those of individuals aged 65 and over are projected to increase steadily before flattening by 2070. These developments confirm the ageing pattern observed in the demographic pyramid and indicate a gradual shift in the composition of care demand. While childcare needs remain important, eldercare is expected to become an increasingly significant component of the care economy in the coming decades.

Figure 2 Past and projected shares of children (0-5) and elderly (65+) in total population

Source: State Statistical Office, Demographic projections - constant fertility.

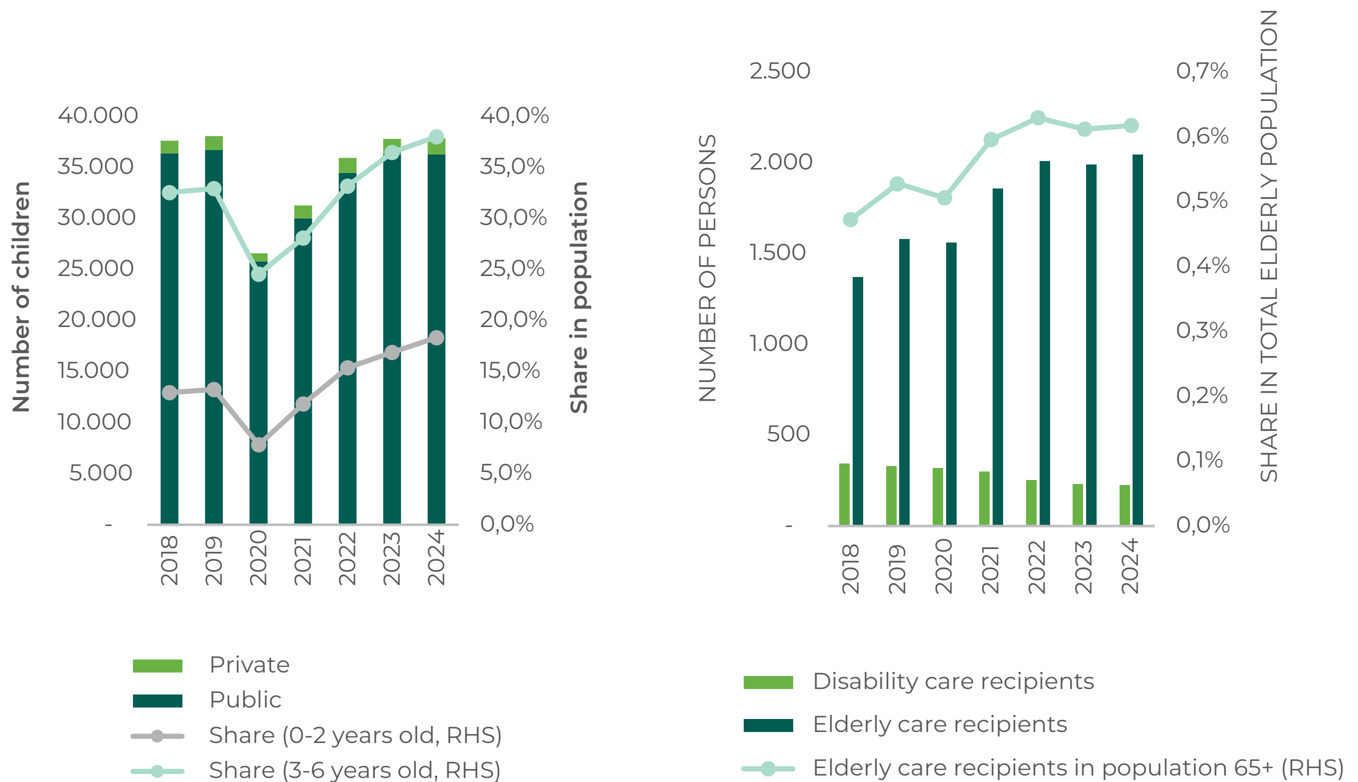
4.2. Availability of institutional care capacities

While the number of children aged 0–6 is broadly declining over time, this does not imply a reduction in childcare needs. On the contrary, as societies develop and modernize, the demand for formal childcare services tends to increase, driven by rising female labour-force participation, changing family structures, and shifting social norms around early childhood development (Blau & Currie, 2006). In North Macedonia, this dynamic is already visible: despite the demographic shrinking of young cohorts, over one third of children (3-6 y.o.) are now enrolled in kindergarten or early childhood education and care, up from around 15% two decades ago (**Figure 3**, left). Although this reflects an important gradual expansion of childcare services, the overall coverage remains modest, implying that a large share of young children continues to rely on informal care arrangements within households.

The availability of childcare services in these early years is pivotal for enabling women's participation in the labour market. When accessible and affordable childcare services are limited, parents - particularly mothers - are often compelled to reduce working hours, accept part-time or informal employment, or withdraw from paid work altogether (Del Boca, 2015; Thévenon, 2013). In North Macedonia, women's participation rate in the labour market hovered around 43% over the past two decades, and stood below that of men by about 20 percentage points, reflecting persistent structural constraints linked to care responsibilities. These dynamics are further reinforced by enduring gender norms and wage differentials,[10] which often make it economically rational within households for women to assume caregiving roles when care needs arise (Folbre, 2006). These patterns suggest that care needs are becoming increasingly service-intensive rather than purely demographic in nature, placing additional pressure on both the expansion and accessibility of childcare provision.

[9] The newest study on the gender pay gap in North Macedonia conducted by UN Women and ILO finds a factor-weighted gender pay gap raising from 14.6% in 2014 to 15.9% and 2022.

Figure 3 Number and share of children (0-6) attending kindergarten / early child development centre (left) and recipients of disability and eldercare (right)



Source: State Statistical Office.

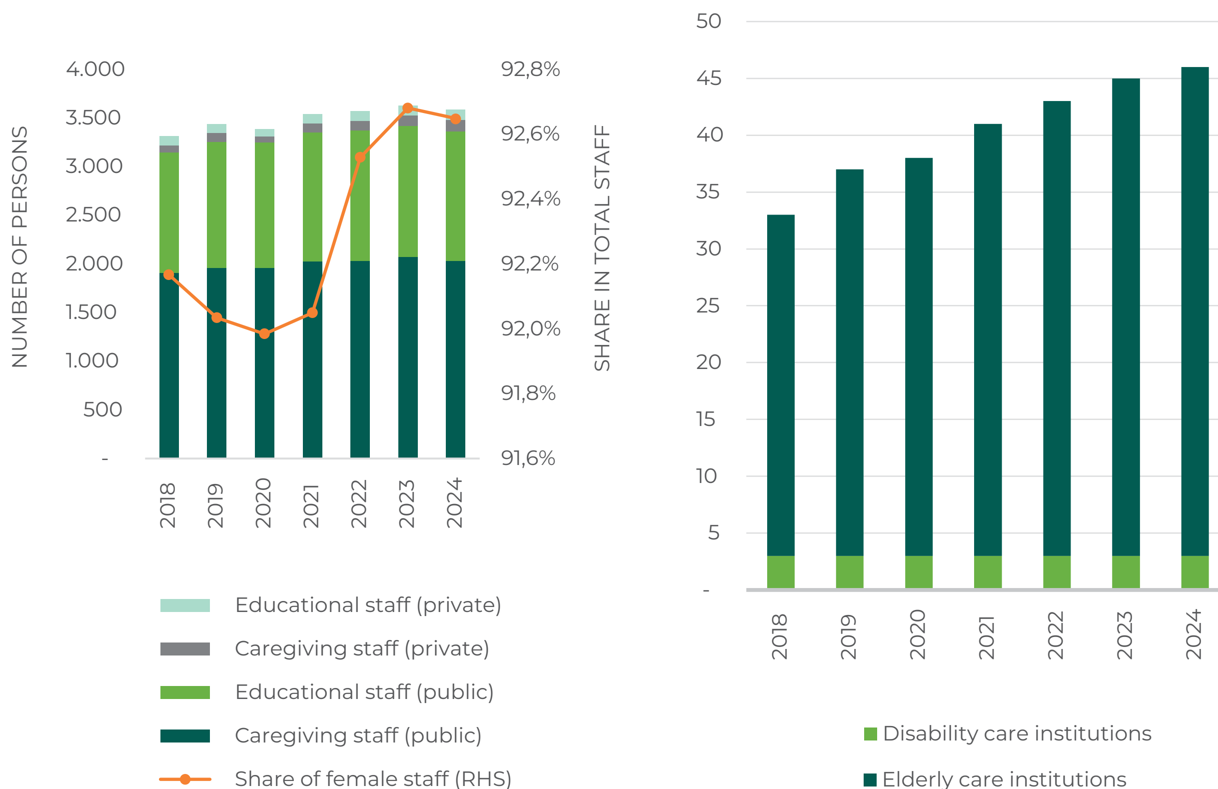
Institutional long-term care for older persons in North Macedonia remains particularly limited. As shown in **Figure 3** (right), the number of eldercare recipients has gradually increased in recent years, reflecting the growing importance of long-term care needs in an ageing society. However, the share of formal eldercare recipients in the total elderly population remains extremely small. Institutional long-term care therefore represents only a marginal component of elderly support, despite it cannot be assumed that every individual of this age cohort has a particular institutional care need. Instead, care for older persons continues to rely predominantly on informal arrangements within households, typically provided by family members. Cultural norms that emphasize family responsibility for eldercare, combined with the limited availability and relatively high cost of institutional services, likely contribute to this outcome. By contrast, the number of disability care recipients has declined somewhat over the same period. These patterns suggest that while formal care services are expanding, their reach remains limited relative to the demand generated by demographic change.

The capacity of the formal care system is further illustrated by the availability of institutional infrastructure and workforce in the care sector. Figure 4 presents the number of caregiving and educational staff employed in kindergartens and early childhood development centres, alongside the number of institutions providing disability care and eldercare services. The data show a gradual increase in the number of childcare staff over recent years, particularly in public institutions, reflecting the ongoing expansion of ECEC services. However, this growth remains moderate relative to the potential increase in demand for care services. In parallel, the number of eldercare institutions has gradually increased, while the number of disability care institutions has remained largely unchanged. Still, only five out of the 43 eldercare institutions in 2024 have been fully publicly funded. The private eldercare institutions are largely provided on a for-profit basis, while home care and community-based services are primarily provided by public and private non-profit entities.

In contrast, institutional capacity for disability-related care remains particularly limited and narrowly defined. Based on available administrative classifications, only a small number of facilities can be clearly identified as dedicated disability care institutions, including the Special Institute Demir Kapija, the Institute for Rehabilitation of Children and Youth, the Rehabilitation Institute Banja Bansko (Strumica), and a limited number of local day-care centres for persons with disabilities. This suggests that the formal infrastructure for disability care is both small in scale and fragmented in scope. At the same time, certain forms of assisted living are provided within the broader social protection system, primarily targeting persons with disabilities, although such services remain scarce and unevenly developed. Some residential facilities for older persons also offer elements of assisted living, but these are not systematically structured as part of a distinct care model. The services typically include basic health monitoring, hygiene support, nutrition management, transport to medical facilities, and limited rehabilitation services. More specialized forms of care - such as hospice and palliative care - are particularly underdeveloped, with only one public hospital providing dedicated in-patient and mobile palliative services.

The structure of the care workforce highlights the strongly gendered nature of paid care work. Women account for more than 90% of caregiving and educational staff in ECEC institutions (**Figure 4**, left). This concentration reflects the feminization of care occupations widely observed across countries. While the expansion of formal childcare services contributes to employment opportunities within the care sector, the strong gender segregation of these occupations is closely intertwined with the persistent undervaluation of care work and the prevalence of informal employment arrangements within households. Care-related jobs are often perceived as an extension of women's traditional roles within households, which contributes to lower wages, limited recognition, and constrained career progression. At the same time, informality remains widespread - particularly in segments such as domestic work, eldercare, and disability care - resulting in weaker labour protections, limited access to social security, and more precarious working conditions (Tumanoska, 2021). These dynamics reinforce each other: the feminized nature of care work contributes to its undervaluation, while informality further obscures its economic importance and undermines the well-being of care workers (ILO, 2018; Razavi, 2007).

Figure 4 Caregiving staff in kindergartens and early childhood development centres (left) and number of disability and eldercare institutions (right)



Source: State Statistical Office.

4.3. Care service provision outside formal institutions

Although formal care services are gradually expanding, their capacity remains limited relative to the evolving care needs of the population. As a consequence, a substantial share of care provision continues to take place outside formal and public institutions, within private providers, households and through domestic work arrangements. Understanding the structure of the care economy therefore requires examining not only institutional services but also the role of home care, community-based care, domestic work and unpaid care within families.

Home-based and community-based care represent an intermediate layer of the care system, intended to support individuals who require assistance but do not need full institutionalization. Assistance and care at home provide support with activities of daily living, enabling individuals with reduced functional capacity to remain in their homes and maintain a degree of independence. Since the adoption of the Law on Social Protection in 2019, these services have expanded, including provisions for publicly funded home care of up to 80 hours per month per beneficiary. In parallel, community-based services - most notably day-care centres for older persons - offer structured daily support through social, educational, and recreational activities, contributing to social inclusion and basic well-being. However, despite this policy shift toward deinstitutionalization, the scale and coverage of such services remain limited, while alternative arrangements such as foster care for older persons exist in legislation but are rarely implemented in practice.

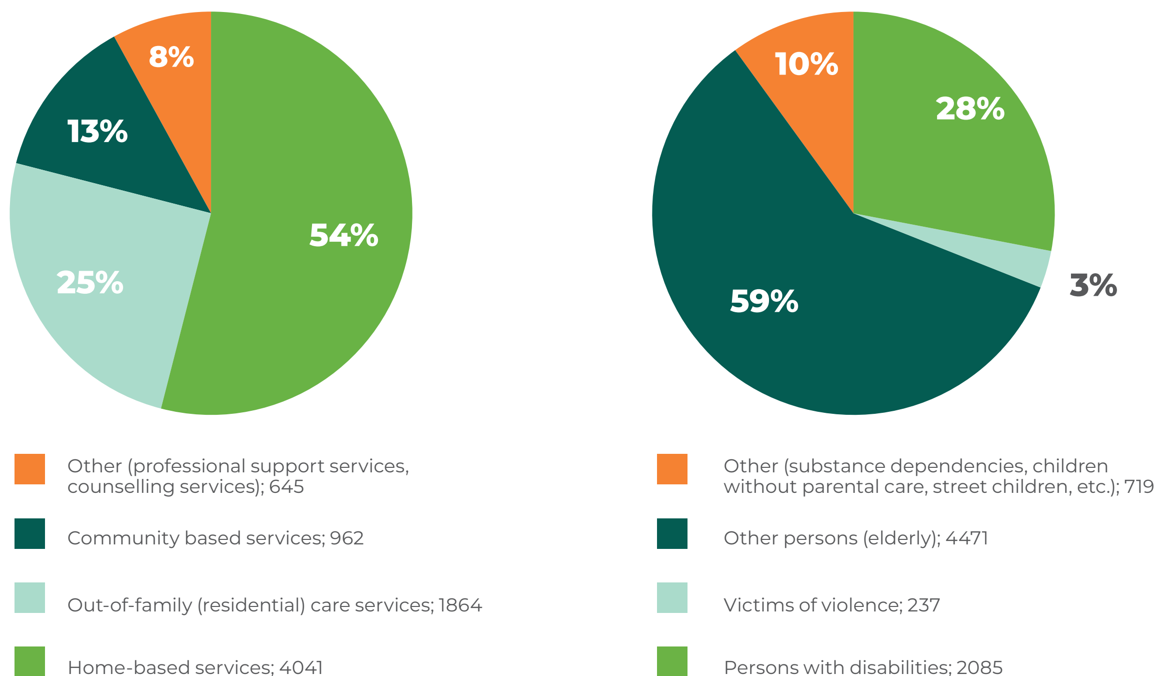
The availability of home-based and community-based care services provides an important indication of the system's capacity to support care outside institutional settings. Table 3 and **Figure 5** present the number of licensed providers and their beneficiary capacity across different types of out-of-institution services and target groups. The data reveal that provision remains limited in both scale and scope. While services for older persons are relatively more numerous - particularly in home-based and out-of-family care - coverage for persons with disabilities is more constrained and concentrated in home-based and community-based services. At the same time, services targeting other vulnerable groups, including victims of violence and socially excluded populations, remain marginal. Community-based services, which are critical for promoting independent living and reducing reliance on institutional care, are particularly underdeveloped in terms of both provider numbers and capacity. Overall, the distribution of services suggests that the system is still predominantly oriented toward basic support functions, with insufficient expansion of care-intensive and preventive services that would enable a shift toward more integrated and community-cantered care provision.

Table 3 Number of licensed providers of home-based and community-based care services, 2026

Type of service		Type of beneficiaries				
		Older persons (elderly)	Persons with disabilities	Victims of violence	Other (substance dependencies, children without parental care, street children, etc.)	Total
Type of service	Home-based services	43	23	0	0	**66**
	Community-based services	6	18	5	5	**34**
	Out-of-family (residential) care services	35	4	0	5	**44**
	Other (professional support services, counselling services)	0	0	3	3	**6**
Total		**84**	**45**	**8**	**13**	**150**

Source: Register of Licensed Providers of Social Services, MSPDY (2026).

Figure 5 Beneficiary capacity of providers of home-based and community-based care services, 2026



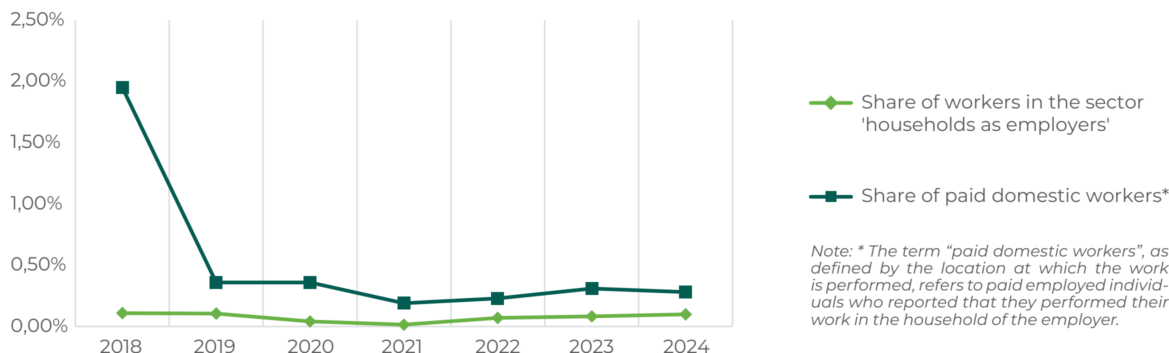
Source: Register of Licensed Providers of Social Services, MSPDY (2026).

4.4. Paid and unpaid domestic work

Paid domestic work represents only a very small segment of employment in North Macedonia, yet it constitutes an important component of household-based care provision. Figure 6 presents the share of workers employed in the sector "households as employers" together with an estimate of paid domestic workers who reported performing activities within employers' households. Both indicators remain extremely low throughout the observed period, generally well below 1% of total employment. After an initial decline following 2018, the share of paid domestic workers stabilizes at a modest level, while the proportion of workers formally recorded under the sector "households as employers" remains even smaller.

Within this already small segment of domestic workers, care-related occupations represent only a minor fraction. Occupations directly associated with care activities account for less than 6% of domestic workers. This limits the possibility of conducting a detailed statistical breakdown of paid care provision within household employment and suggests that paid domestic work occupies only a marginal position in the formal labour market. More broadly, the limited presence of paid domestic work reflects structural factors such as the limited ability of households to afford paid care services, the prevalence of informal (and hidden) employment arrangements, and cultural norms that emphasize family responsibility for care.

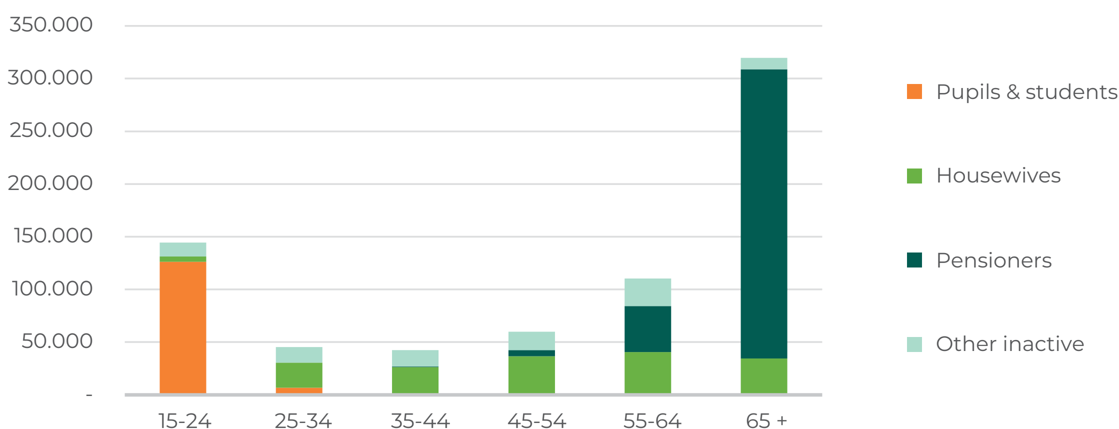
Figure 6 Share of paid domestic workers in total employed



Source: State Statistical Office.

The limited scale of paid domestic and care work stands in sharp contrast to the extent of care provision taking place within households. The marginal significance of paid domestic work does not imply that care needs are limited; rather, it reflects the fact that the vast majority of care is provided informally by household and family members. This imbalance highlights a core structural feature of the care economy in North Macedonia: care provision is predominantly unpaid and embedded within households, rather than externalized through market or public services. The scale of this reliance becomes more visible when examining the composition of inactivity and time allocation, where a substantial share of individuals - particularly women - remain outside the labour force due to care and household responsibilities. **Figure 7** reinforces this by showing that "housewives" - an almost exclusively female category in North Macedonia - are present well beyond early adulthood and constitute a structurally dominant share of the inactive working-age population**.** This indicates that unpaid care responsibilities are not confined to a specific life stage, but instead represent a persistent and systemic factor shaping women's labour-market disengagement.

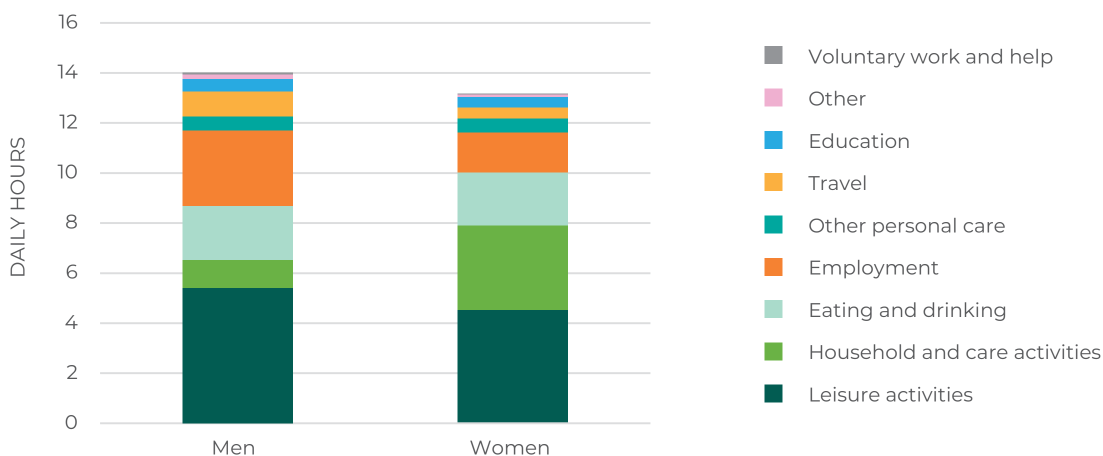
Figure 7 Distribution of inactive population, by categories (2024)



Source: State Statistical Office.

The reliance on household-based unpaid care provision becomes particularly visible when examining how men and women allocate their daily time. Figure 8 presents the average number of hours spent on various daily activities by gender. The data reveal a pronounced gender imbalance in unpaid household and care activities: women spend roughly three times more time on these tasks than men. At the same time, men allocate more time to paid employment and leisure activities. This substantial difference highlights the central role women continue to play in performing unpaid domestic and care work within households.

Figure 8 Daily hours spent on various activities by men and women



Source: State Statistical Office, Time Use Survey 2014/15.

Note: The residual to a full 24-hour day is 'sleeping' and is not shown.

The unequal distribution of unpaid care work has important implications for gender equality and labour market participation. When women assume a disproportionate share of household and care responsibilities, their participation in paid employment, working hours, and career opportunities may be constrained. In this way, the organization of care within households becomes closely linked to broader patterns of gender inequality in the labour market.

The evidence suggests that the care economy in North Macedonia remains heavily reliant on unpaid household provision of care. While formal childcare services and long-term care institutions are gradually expanding, they still cover only a limited share of care needs. At the same time, paid domestic work remains a very small segment of employment. Consequently, families - and within them primarily women - continue to absorb the majority of care responsibilities. Strengthening the care system therefore requires not only expanding formal services but also addressing the unequal distribution of unpaid care work that underpins the current functioning of the care economy.

5. Care needs and gaps for key target groups

Care needs and gaps in North Macedonia are shaped by the interaction between structural constraints in service provision and deeply embedded social norms governing care responsibilities. This section combines evidence from survey data with qualitative interviews to provide a comprehensive account of how care is experienced, accessed, and organized across different social groups. While survey-based evidence offers a system-level perspective on access, affordability, and attitudes, the interviews provide insight into the lived realities of care, revealing how households adapt to systemic gaps in provision.

The qualitative interviews provide a grounded perspective on how care is experienced, organized, and negotiated across different social groups. Despite diversity in profiles - rural women, informal workers, caregivers of children and persons with disabilities, older women, and licensed providers - a consistent pattern emerges: care needs are intensive, structurally undersupported, and largely absorbed within households, with women bearing the primary burden. Importantly, these experiences reveal not only the scale of unmet needs, but also the mechanisms through which households adapt to systemic gaps in service provision.

Across all interviews, care needs are not episodic but continuous and, in many cases, intensifying over time. This is particularly evident in situations involving chronic illness, disability, or advanced age, where care becomes a full-time responsibility that permeates all aspects of daily life. A respondent caring simultaneously for a paralyzed spouse and young children describes a routine in which *“almost the entire day is filled with some obligations”*, ranging from administering therapy and coordinating rehabilitation to managing childcare and household tasks. In such cases, care is not limited to physical assistance, but extends to emotional support, logistical coordination, and constant vigilance. Similarly, in multi-generational households, care evolves from relatively light support into a regime of continuous supervision, including meal preparation, monitoring mobility risks, and responding to deteriorating health conditions. Even where care needs appear less acute, such as among older couples in rural areas, they remain embedded in everyday survival, often taking the form of mutual but fragile support arrangements that depend on diminishing physical capacity, as reflected by a rural elderly woman who self-cares and cares for husband: *“for now we take care of each other, ourselves”*.

These dynamics are reinforced by broader demographic trends. Migration - particularly of younger family members - has reduced the availability of informal support networks, leaving older persons increasingly dependent on limited local resources. As a rural respondent notes, such households are often left without immediate family support - *children are abroad… we do not have anyone [to take care of us, n.b.]”*. From the perspective of service providers, demand is both high and rising, with waiting lists becoming a structural feature of the system. As a licensed care provider notes, *“we now have around 80 people on the waiting list… some wait up to a year”,* pointing to a persistent mismatch between demand and supply. Survey evidence confirms that this mismatch is widely perceived: according to the Quality of Life Survey (Finance Think, 2026), 78% of citizens assess state-funded eldercare homes as insufficiently accessible or completely inaccessible, while nearly half express dissatisfaction with access to childcare services.

The ability to meet these needs is severely constrained by structural barriers related to access, distance, and affordability. In rural areas, access limitations are particularly pronounced, reflecting both infrastructural deficits and geographic isolation. The absence of basic services - such as kindergartens, rehabilitation centres, or organized transport - directly restricts both care provision and labour market participation. In some municipalities, there is not even a single kindergarten, effectively excluding women from employment and reinforcing reliance on home-based care. In some cases, this reflects a complete absence of services - *13,000 residents, and not even a single kindergarten”* (a licensed care provider). Even where services exist, they are often concentrated in urban centres, requiring travel that is costly, time-consuming, and, in some cases, physically unfeasible for caregivers.

Waiting times further compound these constraints, with access to essential services such as speech therapy or specialized disability support often delayed by several months, or even up to a year.

Against this backdrop of constrained access, home-based care services for elderly and disabled individuals emerge in the interviews as one of the few forms of support that effectively respond to care needs. Unlike institutional care, which is often perceived as disruptive and undesirable, home care allows older persons to remain in familiar environments while receiving assistance with daily activities. This is particularly relevant in cases where care needs are continuous but not yet intensive or fully medicalized, and where households require partial relief rather than full substitution. As one service provider noted, *“home-based care… is one of the best things that could have happened for older people”*. At the same time, this model remains capacity-constrained and unevenly accessible, with waiting lists and limited geographic coverage preventing it from fully offsetting broader system gaps.

Affordability represents an equally binding constraint. Private care services are widely perceived as beyond the reach of most households, with informal caregivers costing around MKD 36,000 per month and formal services even more. For households reliant on pensions or irregular incomes, such expenditures are unsustainable. Public transfers, while important, are insufficient to bridge this gap. One respondent noted that the care allowance received - approximately MKD 9,800 - covers only a fraction of actual needs, as one caregiver to a person with disabilities explained, the amount *“… is only a week and a half of therapy”*. Survey evidence (Finance Think, 2026) reinforces this pattern: among households that report spending on care, costs can exceed MKD 30,000 per month, particularly for eldercare. As a result, care decisions are often driven not by preference, but by financial necessity, with households opting for informal solutions even when they would prefer formal services.

Against this setting, the relationship between care and employment emerges as deeply constrained. Care responsibilities frequently lead to withdrawal from the labour market, particularly among women. As a mother who cares for own children and a spouse with disabilities stated, *“for now, yes… this is why I am not working”*, highlighting the direct link between caregiving and economic inactivity. Even when employment is pursued, it must conform to highly restrictive conditions, such as part-time work, flexible schedules, or proximity to home. However, such opportunities are limited, particularly in rural areas and for individuals without specialized skills. In practice, this results in a structural incompatibility between care and work, rather than a simple trade-off.

This incompatibility is especially evident among women engaged in agriculture, where care responsibilities intersect with physically demanding and time-sensitive productive work. In these contexts, care is not a separate domain but embedded within daily economic activity. Women must simultaneously manage farm work, household responsibilities, childcare, and eldercare, often without external support. As a rural woman who works in agriculture and takes care of the household and children stated, this requires *“almost superhuman effort to manage everything”*, highlighting the intensity of overlapping responsibilities in contexts where *“there is no time… from early morning until late at night”*. The seasonal nature of agricultural work further intensifies these pressures, as peak labour periods coincide with persistent care demands. This creates a cycle in which care limits productive capacity, while economic necessity reinforces reliance on unpaid labour.

In response to these constraints, households develop a range of coping strategies that rely heavily on informal and hybrid arrangements. Family-based care remains the dominant model, with women typically assuming primary responsibility. This is often supplemented by informal paid care, neighbourly support, or co-residential arrangements, where caregivers provide assistance in exchange for accommodation or modest compensation. The informal childcare sector illustrates similar dynamics. Nannies, often older women excluded from formal employment, operate almost entirely outside formal systems. As a woman - informal childcare provider noted, *“there was no system… everything was based on oral agreement”*. Caregivers further indicated that employment was entirely contingent - *if they tell you to leave, you leave… there is no one to complain to”*. While these arrangements offer flexibility, they are inherently precarious, lacking formal contracts, social protection, or stable income. Informality thus emerges not as a cultural preference, but as a systemic response to gaps in formal provision.

Cultural norms further shape these patterns, reinforcing reliance on family-based care. Across interviews, there is a strong expectation that children should care for their parents, particularly among older generations. One respondent living in rural area and self-caring in old age captured this sentiment directly: *“we still believe that children should take care of us”*, even as respondents acknowledged that such expectations are increasingly difficult to sustain in practice. This expectation is often internalized by both caregivers and care recipients, influencing decisions even when formal services are available. Institutional care, such as eldercare homes, is frequently perceived as undesirable, associated with loss of autonomy, social stigma, and emotional detachment. At the same time, there is evidence of gradual change, particularly among younger respondents, who recognize that migration and changing family structures are making traditional care arrangements increasingly difficult to sustain.

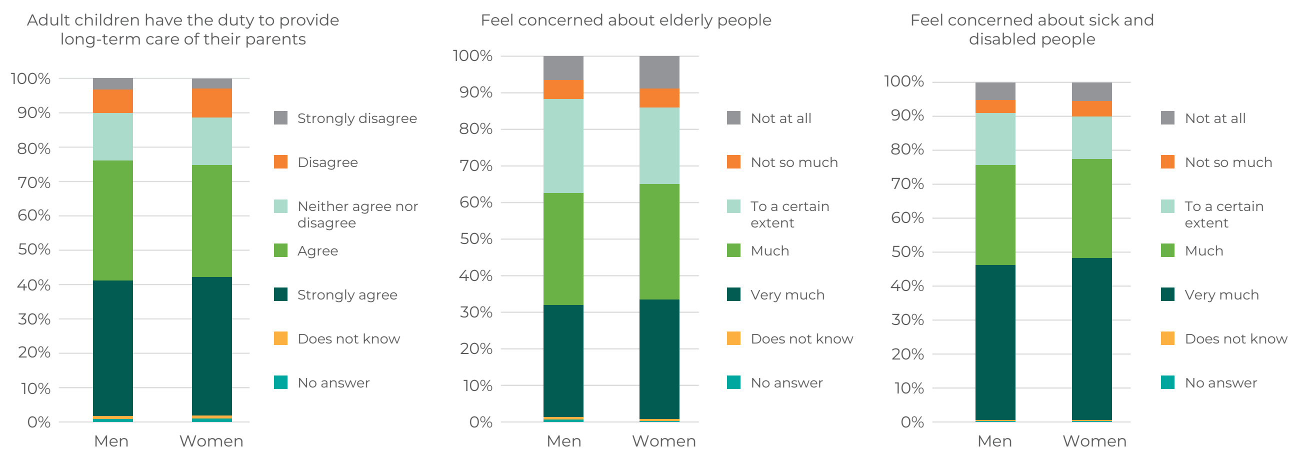
In this context, home-based care emerges as a more norm-compatible alternative. Allowing older persons to remain in familiar surroundings while receiving support preserves their autonomy and dignity while avoiding the stigma and adjustment challenges associated with institutionalization. Interview evidence suggests that even individuals initially resistant to external assistance

become more receptive over time when support is delivered in-home, where trust can be gradually built and care relationships personalized. At the same time, home care plays a critical role in alleviating pressure on families, particularly in cases where care needs are continuous but not yet at the stage requiring full-time institutional care.

Stigma and trust also play a role in shaping care choices. Some respondents expressed reluctance to allow outsiders into their home, while others pointed to social stigma associated with care work itself. As one licensed care provider explained, in certain communities, people question *"what others will say if you go clean someone else's home?"*. Gender norms further complicate these dynamics, with resistance to male caregivers and initial distrust toward formal providers. However, these attitudes are not static. Increased exposure to care services appears to reduce stigma and build trust over time, suggesting that cultural barriers may gradually weaken as services expand and normalize.

Evidence from the **European Values Survey (EVS) confirms the strength of these norms and stereotypes.** A large majority of respondents believe that adult children have a duty to care for their elderly parents (74.2% of men and 72.6% of women), reflecting deeply embedded intergenerational norms **(Figure 9)**. At the same time, respondents express high levels of concern about the well-being of older persons (62.3% of all respondents) and persons with disabilities (75.8%), indicating an awareness of growing care needs. However, this concern does not translate into a corresponding expectation of formal service provision. Instead, care is predominantly perceived as a family obligation, reinforcing the continued reliance on informal care arrangements.

Figure 9 Attitudes toward long-term care

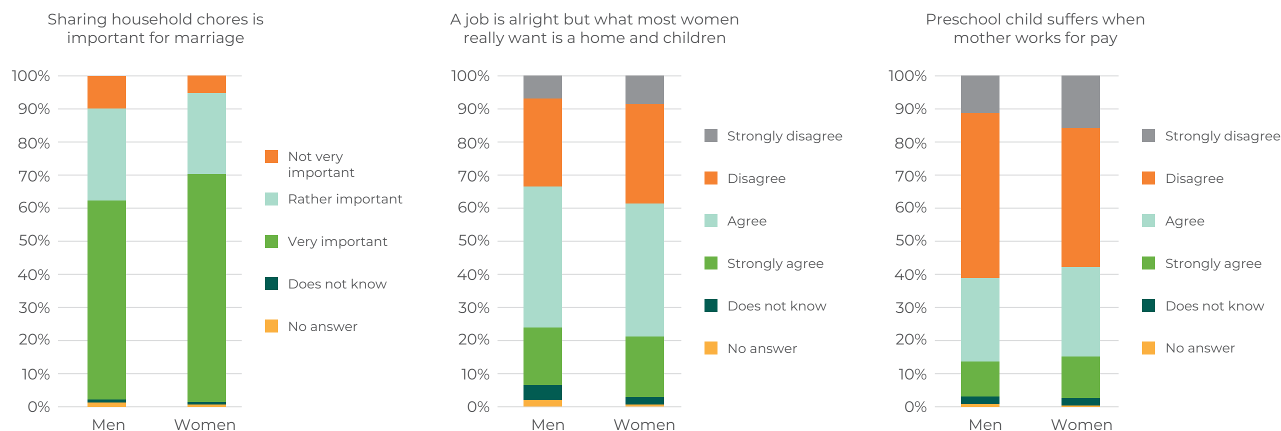


Source: European Values Survey (2019).

Across all groups, the gendered nature of care remains a defining feature. Women are expected to absorb unpaid care work, often at significant personal cost. This includes not only lost income and employment opportunities, but also physical exhaustion and psychological strain. Even in households where care is nominally shared, women typically act as the primary coordinators and providers of care. Importantly, this pattern is not always perceived as a matter of choice, but rather as an unavoidable consequence of limited alternatives. Structural constraints - such as inadequate service provision, high costs, and inflexible labour markets - interact with cultural norms to reinforce gender inequalities. **These lived constraints are also reflected in policy preferences:** women show significantly stronger support for measures directly linked to the care economy, such as flexible working arrangements and expanded State provision of childcare services, likely reflecting their greater involvement in caregiving and the disproportionate burden they bear in unpaid care work (Finance Think, 2026).

In the EVS data, a substantial share of respondents agree that women's primary role remains centred on the home and children. While a large majority of respondents (60.2% of men and 68.6% of women) consider the sharing of household chores important for a successful marriage, this does not translate into fully egalitarian views on gender roles **(Figure 10, left)**. A substantial share of both men (60%) and women (58.2%) agree that women's primary role remains attached to the household, even when they are engaged in paid employment **(Figure 10, middle)**. This reflects a dual burden placed on women, who are expected to reconcile labour market participation with primary responsibility for unpaid care.

Figure 10 Attitudes toward gender roles and norms related to early childhood care



Source: European Values Survey (2019).

Norms related to early childhood care further reinforce reliance on family-based care (Figure 10, right). A considerable proportion of respondents agree that preschool children suffer when mothers engage in paid work (35.8% of men and 39.6% of women), indicating a cultural preference for maternal care over institutional childcare. Such perceptions can reduce the social acceptability of the use of formal childcare services, particularly for younger children. However, when directly asked about preferred care arrangements, respondents who disagree that home-based childcare is superior to formal care prevail, which may signal a gradual shift in attitudes toward greater acceptance of institutional care.

This apparent tension suggests that while normative beliefs about maternal roles remain persistent, they coexist with emerging preferences for formal childcare services. This likely reflects changing economic realities, increased female labour force participation, and growing awareness of the developmental benefits of ECEC. While traditional expectations remain strong, particularly in rural areas and among older generations, respondents increasingly recognize that migration, labour market pressures, and changing family structures are making exclusive reliance on family-based care more difficult to sustain. These attitudes interact with existing supply constraints: even where childcare services are available, their utilization may be shaped by normative preferences, thereby limiting the effectiveness of policies aimed at expanding ECEC. These findings suggest that while traditional norms regarding care responsibilities remain persistent, there is also growing support - particularly among women - for policies that would facilitate a more balanced distribution of care. However, lower levels of support among men may limit the broader societal consensus needed to advance such reforms (Finance Think, 2026).

The combined evidence suggests that care in North Macedonia is not organized through deliberate choices among well-functioning alternatives, but through constrained adaptation to limited and often inadequate options. Care arrangements are shaped by insufficient public provision, high private costs, limited labour market flexibility, and deeply embedded cultural expectations. As a result, households internalize care responsibilities, and informal solutions substitute for formal systems. This leaves households to manage care internally - often because *"there was no system"* to rely on - and women bear a disproportionate share of the burden. In this context, expanding formal care services is not merely a matter of improving welfare provision, but a necessary condition for enabling labour market participation, advancing gender equality, and ensuring the long-term sustainability of care systems in the face of demographic change.

6. Financing the care system

6.1. Current financing of care services

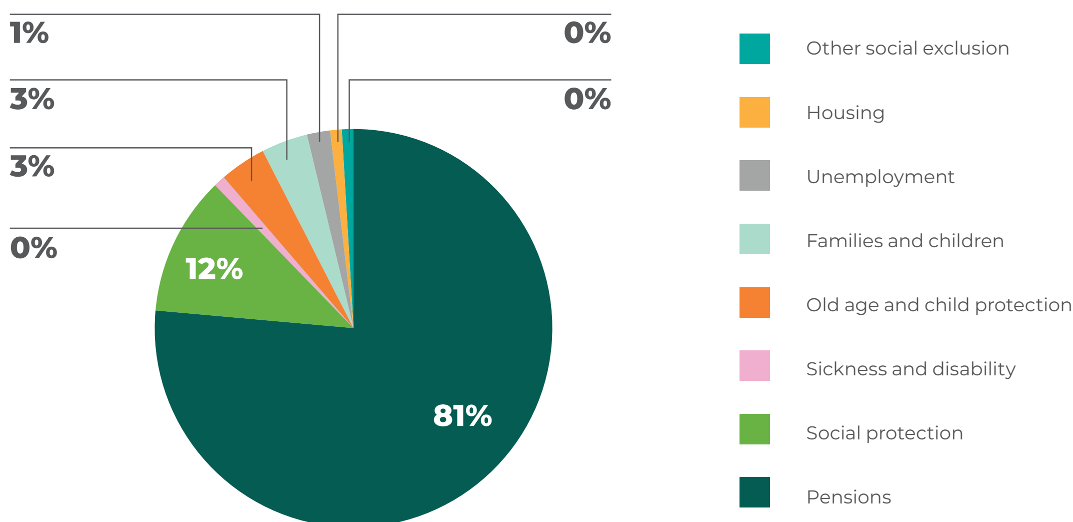
The financing of care services in North Macedonia is structured across three main channels: public financing through the central government budget, decentralized and own financing at the municipal level, and private or out-of-pocket spending by households. At its core, the system is **predominantly tax-financed**, with the central government budget constituting the main

source of funding for care services. While certain care services - most notably childcare and residential eldercare - are organized and delivered at the municipal level, their financing largely originates from the central budget. In particular, block grants transferred to municipalities cover the wages and a substantial share of operating costs of public kindergartens and residential elderly homes, implying that these resources should be understood as central-government, tax-based funding executed at the local level, with municipal own contributions largely confined to infrastructure and supplementary expenditures. By contrast, the rest of the long-term care (home-based and community-based care) and disability services remain predominantly financed directly from the central budget to licensed social-service providers, without a dedicated or earmarked financing mechanism.

Alongside this dominant tax-based core, a limited contributory component exists through the social insurance system. Certain care-related benefits - particularly maternity leave and sickness-related leave for care of dependents - are financed through health insurance contributions, while small part of the pension contributions finances disability-related benefits that are partly linked to care needs. However, these contributory elements remain narrow in scope and do not constitute a comprehensive or dedicated financing pillar for care. As a result, the system operates through a combination of central transfers, limited municipal resources, limited contributory schemes, and private co-payments, creating a multi-channel financing structure that lacks coherence and predictability. This has important implications for service provision: reliance on locally implemented childcare financing, combined with uneven municipal capacities, constrains investment in infrastructure and workforce, particularly in less developed areas. Furthermore, the absence of a dedicated financing instrument for long-term care - such as a social insurance scheme - limits the system's ability to respond to growing demand driven by ageing population. Across all segments, formal provision is complemented by private and out-of-pocket arrangements, as well as unpaid care within households, particularly where service coverage remains limited.

At first glance, the scale and composition of public financing for care could be inferred from the functional classification of the State budget, particularly under the category of social protection. This category provides an entry point for assessing expenditures related to social risks, including old age, disability, and family support. In 2024, North Macedonia spent 13.4% of its GDP on social protection. **Figure 11** presents the distribution of such spending across its main functions. However, this aggregate view offers only a partial and potentially misleading picture of care financing as care-related spending represents only a subset of social protection expenditure. A substantial share of the category is absorbed by old-age pensions (an astonishing 81%, representing 10.9% of GDP), which, while critical for income security, do not directly finance care provision. Their dominance within the social protection envelope tends to obscure the relatively limited resources allocated to services and benefits that directly address care needs. On the other hand, care-related expenditures extend beyond the boundaries of social protection as per its definition in the budget's functional classification: important components are embedded in other functional categories. In particular, early childhood education and care services (kindergartens) are largely nested under the education category, while certain services - especially those related to long-term care and disability - may partially fall in the health functional group, reflecting the blurred boundary between social and medical care.

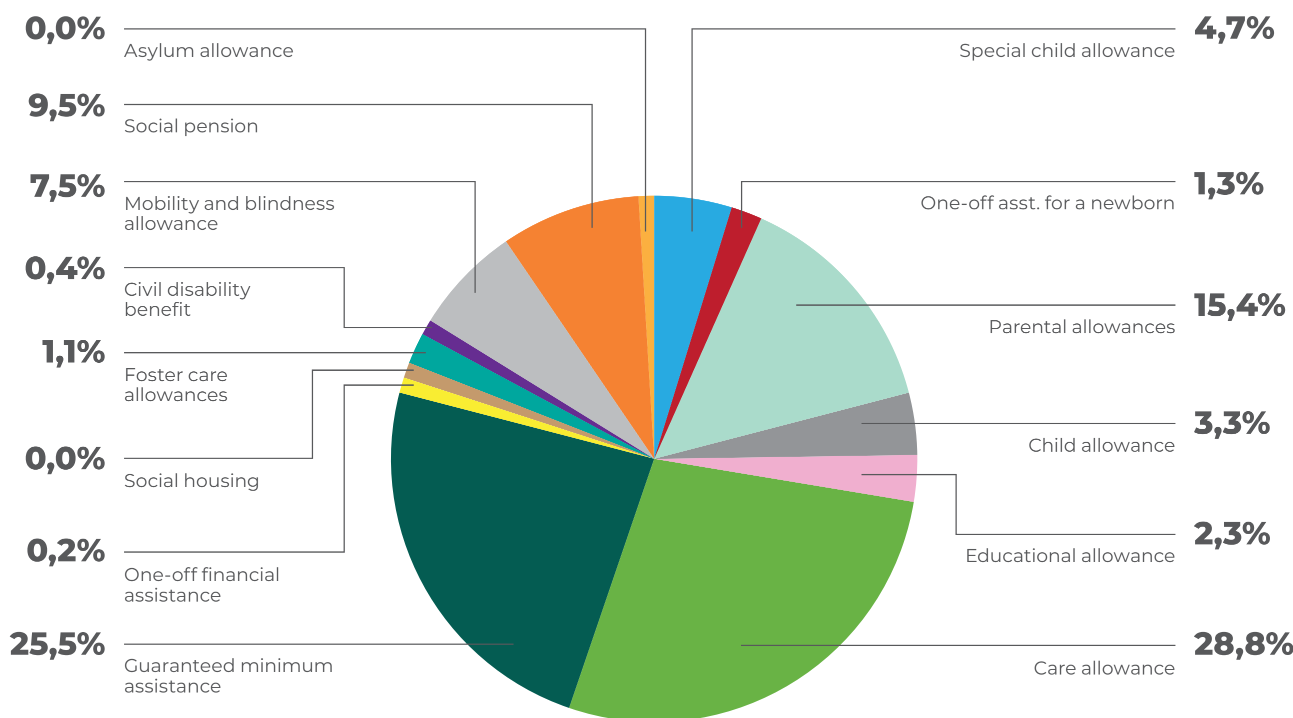
Figure 11 Composition of social protection financing, 2024



Source: MoF, 2024.

Approximating care spending with social assistance expenditure is likewise not appropriate. While social assistance constitutes a narrower component of social protection and may appear more closely aligned with care-related spending, it nevertheless encompasses a range of instruments that are not directly linked to care provision. North Macedonia spends 1.4% of its GDP on social assistance. As illustrated in **Figure 12**, the largest share of such spending is absorbed by the care allowance (28.8% or 0.41% of GDP) and by the Guaranteed Minimum Assistance scheme (GMA, 25.5% or 0.37% of GDP), followed by parental allowances (15.4%) and social pensions (9.5%). Among these, the GMA - the key social assistance scheme - primarily serves income support objectives rather than directly financing care services. Including such expenditures without distinction would therefore lead to a systematic overestimation of care financing and obscure the limited resources allocated to actual care services.

Figure 12 Composition of social assistance allowances, 2024



Source: MSPDY, 2024.

To approximate the scale of care financing, this study adopts a bottom-up identification strategy based on the functional and economic classification of public expenditures, complemented by programme-level information on social transfers and services. Given the absence of a dedicated budget classification for the publicly-financed care economy, care-related public spending cannot be directly observed in official statistics and must instead be constructed by isolating relevant components across multiple sectors.

The starting point is the functional and institutional classification of the State budget, particularly expenditures under social protection, education, and - where relevant - health, with a focus on the budget of the MSPDY. A filtering approach is applied to identify expenditure items that correspond to care functions, including: (i) early childhood education and care (kindergartens), (ii) long-term care services for older persons, (iii) services and benefits for persons with disabilities, and (iv) selected family-related and care-related cash benefits.

The identification of relevant expenditures follows a functional criterion, whereby only those expenditures that are directly linked to the provision of care or arise as a consequence of care needs are included. This implies the inclusion of benefits that enable or compensate care provision - such as care allowances, disability-related benefits, and maternity or parental leave - while excluding broader income-replacement schemes that are not contingent on care needs, such as pensions, general social assistance or pronatalist or income-support allowances. This distinction is critical to avoid conflating care provision with income maintenance and to ensure that the resulting estimates reflect resources directed toward care functions.

Within social protection, this requires distinguishing between care-related and non-care-related transfers. For example, programmes such

as guaranteed minimum income, social pension and general poverty alleviation measures are excluded, while benefits linked to care dependency (e.g. care allowance, disability-related benefits, and foster care support) are retained. Similarly, expenditures on residential institutions and community-based services are included where they directly correspond to care provision.

For childcare, financing is identified through expenditures on kindergartens, which are recorded under education functions but largely financed through central-government block grants executed by municipalities. This necessitates tracing expenditures across both central and municipal budget lines to avoid double counting and to correctly attribute financing sources. However, municipalities' own spending on kindergartens (and, potentially, other childcare services) cannot be separately identified due to the aggregation level of local budgets.

Importantly, the classification adopted in this study follows a functional rather than contributory logic. While several social transfers - such as pensions, maternity benefits, or sickness allowances - originate from employment-based social insurance systems, not all of them correspond to care functions in a strict sense. In this sense, benefits such as maternity leave and sickness leave for care of dependents are retained, as they explicitly substitute for unpaid care work or enable caregiving within households. By contrast, pensions - although also derived from employment - primarily serve as income replacement in old age and are not intrinsically linked to care provision, and are therefore excluded. This functional approach is consistent with the broader literature on the care economy, which conceptualizes care as a form of social infrastructure rather than a general component of social protection.

The resulting estimates therefore represent a conservative approximation of public care financing. Table 4 presents the resulting composition of care-related public expenditures based on this classification. North Macedonia is estimated to spend 12.9 billion denars per year publicly, equivalent to 209.6 million euros, or 1.34% of GDP on care.

It should be noted that the line item "social services" includes a heterogeneous set of interventions defined under the Law on Social Protection, ranging from information, counselling, and professional support to more care-intensive services. In particular, recently expanded services such as home-based and community-based services - including home care, personal assistance, day care, and respite care - are of central importance for the functioning of the care economy, as they directly substitute and reduce unpaid care within households. These are complemented by other forms of provision such as supported living, foster care, and institutional placement. As such, the reported spending on social services aggregates both direct care provision and broader social support functions.

Table 4 Detailed spending on public care provision, 2024

Category	Subcategory	Sub-subcategory, if any	Total public cost (million denars.)
Children	Childcare institutions - kindergartens and ECD centres	Functioning	4.5
		Construction	115.3
		Block grants to municipalities*	475.5
	Other childcare institutions**		121.3
	Allowances (Child protection)	Special allowance	651.9
		One-time financial assistance for newborns	174.1
		Unique parental allowance	0.5
		GMA - child allowance	457.0
	Allowances (Social protection)	Foster care placement	119.9
		Allowance for foster caregivers	27.3
	Allowances (Employment-related)	Maternity allowance	3,953.6
		Sickness allowance (care of other member)	336.6
	Social services***		274.1

Category	Subcategory	Sub-subcategory, if any	Total public cost (million denars.)
Elderly	Eldercare institutions	Functioning**	8.7
		Construction	104.7
	Social services***		426.6
Disability	Disability care institutions**		176.3
	Allowances	Personal care allowance	3,969.7
		Civil disability benefit	54.6
		Mobility and blindness benefit	1,039.0
	Social services***		398.4
TOTAL COST OF CARE			12,889.6

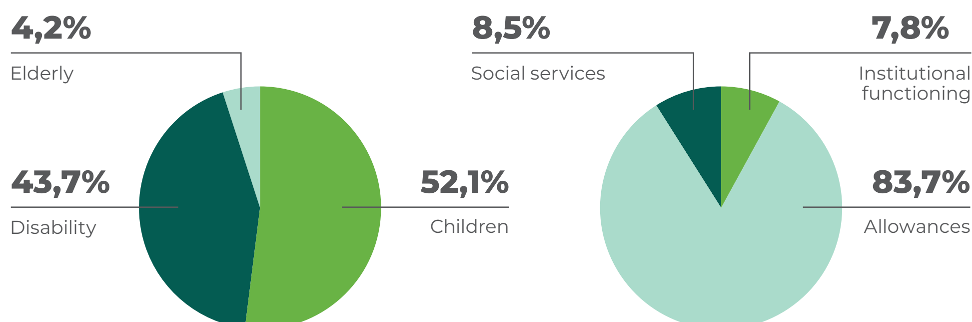
Source: Authors' estimates based on data collected from the Ministry of: Finance; Ministry of Social Policy, Demography and Youth; Ministry of Digital Transformation; and the Health Insurance Fund.

*Notes: * The share of block grants directed to childcare institutions is obtained by using the number of employees as distribution key. ** Share of cost for: day-care centres and shelters for non-institutional social protection; and centres for institutional social protection; where the number of employees of respective social protection institutions categorized in childcare, eldercare and disability care is used as a distribution key. *** Share of cost for deinstitutionalization and social services, where the number of employees of respective social protection institutions categorized in childcare, eldercare and disability care is used as a distribution key. Social services for elderly are amended by the cost for social services for pensioners (project-related financing within Pension and Disability Insurance Fund).*

The composition of care-related public spending reveals a system that is strongly skewed toward cash-based support rather than service provision, and is predominantly oriented toward children's needs (Figure 13). More than half of total care spending is directed toward children (52.1%), followed by persons with disabilities (43.7%), while care support for older persons accounts for a comparatively modest share (4.2%), despite ongoing demographic ageing pressures. This distribution reflects both the structure of existing entitlements and the relative expansion of disability-related benefits in recent years, but also points to a potential underdevelopment of formal long-term care for the elderly.

At the same time, the breakdown by type underscores a dominant reliance on monetary transfers, which account for 83.7% of total care-related spending, compared to only 8.5% for social services and 7.8% for institutional functioning and investment. This imbalance suggests that the system primarily supports households in coping with care needs financially, rather than ensuring the direct provision of accessible and quality care services. While such transfers play an important role in income support, their predominance indicates limited investment in the care infrastructure and workforce required for a functioning care economy. These patterns point to a public care system that remains transfer-oriented, service-constrained, and only partially aligned with emerging needs, particularly in the context of population ageing and the policy objective of expanding community-based care.

Figure 13
Composition of public care spending, 2024



Source: ***Table 4***

6.2. Co-payments and private financing

Private financing of care services in North Macedonia exists but remains structurally limited, particularly in the childcare segment. Public childcare provision is heavily subsidized and constitutes the dominant mode of service delivery. Parents' co-payments for enrolled children are set at approximately EUR 35 per month - equivalent to around 4.3% of the average wage and around 10% of the total public cost for childcare - while additional subsidies and exemptions are available for children from low-income households, including beneficiaries of the Guaranteed Minimum Assistance (GMA).[11] Private providers account for only a small share of total enrolment - 4.2% in 2024 - and are fully funded by parents-paid fees (**Figure 3**). Private childcare services are associated with substantially higher user fees (on average, around EUR 300 per month), effectively restricting their use to higher-income households. The approximate cost for attending private childcare facility is estimated at around 5% of the total public cost of childcare. This suggests that private childcare operates primarily as a gap-filling mechanism in response to capacity constraints in the public system, rather than as a parallel or systemic pillar of care provision. As such, while private spending is relevant for understanding inequalities in access and quality, its aggregate quantitative importance in childcare remains limited.

A similar pattern applies to residential eldercare. In publicly-funded institutions, monthly co-financing fees range between approximately EUR 200 and EUR 360, corresponding to roughly 46% to 85% of the average pension, while private residential facilities charge substantially higher fees - typically between EUR 685 and EUR 900 per month, or around 1.6 to 2 times the average pension. Such amounts are borne by the beneficiaries or their families (with exemptions for public institutions applicable for low-income beneficiaries, upon verification by the Centres for Social Work (CSW). This pricing structure indicates that access to private residential care is effectively restricted to higher-income households, while even publicly provided care entails a considerable financial contribution from beneficiaries. As a result, affordability constitutes a key constraint in accessing institutional long-term care, particularly for older persons with lower incomes.

Beyond residential care, home-based and community-based services are financed through a combination of public, donor funding and privately paid arrangements. Under the current system, providers that have formal agreements with the MSPDY or municipalities deliver services financed (fully or partially) from the public budget, typically following eligibility assessments by the CSWs. In non-negligible cases, such services are supported through donor projects channelled either directly to the private providers or through the State budget. For these publicly supported services, reference prices are administratively set, for example, EUR 6.50 per hour for home assistance and care, and between EUR 151 and EUR 257 per month for day-care services for older persons, depending on the service type. However, such arrangement-based and contractual approach limits predictability and continuity of service provision.

Home-based and community-based service providers may also offer services outside these public-private contractual agreements on a fully private basis, with prices determined by market conditions, care intensity, and local labour costs. This dual structure creates a segmented system in which access to care depends both on eligibility for publicly financed services and on the ability to pay for private alternatives. Despite the relevance of these financing arrangements, the absence of comprehensive data on service utilization and private expenditures prevents their systematic aggregation. Consequently, succinct estimates of care financing remain confined to the publicly observable segment and should be interpreted as a lower-bound approximation of total care spending in North Macedonia.

A substantial portion of care is provided in the form of unpaid household labour. Although this form of care has clear economic value and directly substitutes for market or publicly provided services, it is not captured in standard national accounts and cannot be directly measured through budgetary data. Existing estimates suggest that, when valued at the prevailing minimum wage, unpaid domestic work in North Macedonia amounts to approximately 25.3% of GDP, highlighting its substantial yet largely unrecognized contribution to the economy (Petreski et al., 2024). It should be noted that this is the estimated value of the total unpaid domestic work, which includes but is not exclusively care. Incorporating the value of unpaid care work in the estimates of the value of the care economy would significantly increase the estimated size of the care economy and further strengthen the case for policy attention and investment.

6.3. Adequacy, composition and gaps in care financing

The estimated level of public spending on care - amounting to approximately 1.3% of GDP - provides an initial indication of the scale of resources allocated to supporting care needs in North Macedonia. However, this aggregate figure must be interpreted in light of both the structure of spending and the broader institutional context in which care is provided. In comparative perspective, this level of spending appears modest. In many European countries, public expenditure on childcare and long-term care combined typically exceeds 2–3% of GDP, particularly where formal care systems are more developed and service-oriented (OECD, 2020b; 2023; OECD Family Database). While cross-country comparisons should be interpreted with caution due to methodological differences, this benchmark nonetheless points to a **financing gap** in the scale of investment in care in North Macedonia.

This financing gap is compounded by the composition of spending, which reveals a strong dominance of cash-based benefits, particularly in the domains of disability and family-related transfers. While such benefits play an important role in supporting households facing care responsibilities, they do not directly expand the availability of care services. As a result, a substantial share of public resources is directed toward income support rather than service provision, limiting the system's capacity to address structural gaps in access to care.

Financial and access barriers further reinforce these gaps across both long-term care and childcare. Long-term care is financed through a combination of public funds and out-of-pocket payments, placing a significant burden on households and constraining effective access, particularly for lower-income groups. Even within the public system, services such as residential eldercare may be financially unaffordable for a substantial share of the population, effectively confining access to relatively higher-income households. A similar pattern is observed in childcare, where public provision remains limited and private alternatives - most notably private kindergartens - are often prohibitively expensive, further restricting access along income lines. As a result, many individuals rely on informal care not as a preferred option, but as a necessity, despite clear preferences for formal services and reduced caregiving burdens, especially among younger generations.

These challenges are further exacerbated by system-level gaps in financing design and coordination. The absence of a dedicated and integrated financing mechanism for care - particularly in the area of long-term care - means that resources are fragmented across multiple budget lines, governance levels and institutions. Unlike systems that rely on earmarked social insurance schemes or consolidated care funds, the current arrangement limits predictability, constrains long-term planning, and reduces the system's ability to scale up services in response to rising demand. In addition, the financing of home-based and community-based services - despite their growing importance - may in practice depend on donor-supported programmes or project-based funding, raising concerns about sustainability and continuity of provision.

The limited scope of publicly financed services also translates into a coverage gap, reflected in continued reliance on private and informal arrangements, including out-of-pocket payments and unpaid care within households. As discussed in Section 6.2, unpaid care work alone represents a substantial share of total care provision, far exceeding publicly financed care when valued economically. This reliance introduces important distributional inequalities, as access to care becomes dependent on household resources and the availability of informal caregivers. In this context, privately financed alternatives - particularly in the domain of home-based and community-based care - are often accessible primarily to higher-income households, reinforcing stratification in access to quality care.

Finally, these financing gaps have a clear gender dimension. The current financing structure does not adequately support the recognition, reduction, and redistribution of unpaid care work. The predominance of cash transfers, combined with limited expansion of accessible services, reinforces existing gender roles, whereby women continue to bear the primary responsibility for care provision. This, in turn, perpetuates gender gaps in labour force participation, working hours, and earnings.

These findings suggest that care financing in North Macedonia is characterized by interrelated gaps in scale, composition, access, and gender responsiveness. This reflects not only insufficient aggregate public spending but also a structural imbalance between public provision and actual care needs. While public expenditure on care remains relatively modest, the total societal cost of care - when accounting for private spending and unpaid labour - is substantially higher, yet largely hidden within households. This indicates that the financing gap is not solely a matter of increasing resources, but also of reallocating existing costs more effectively across the system. In this sense, expanding public investment in care services would not necessarily generate new societal costs, but rather shift part of the existing burden from households to the public sector in a more equitable, efficient, and gender-balanced manner. Addressing these gaps therefore requires not only increasing the overall level of investment, but also rebalancing expenditures toward service provision, strengthening coordination across sectors, and developing more sustainable and coherent financing mechanisms.

6.4. International financing models

To contextualize the level and structure of care financing in North Macedonia, it is useful to benchmark it against selected international experiences that represent different models of care provision and financing. Given the country's institutional setup, demographic trends, and fiscal capacity, the comparison focuses on a **targeted set of European countries** that offer relevant policy lessons rather than a broad cross-country overview.

Three groups of countries are particularly informative.

First, Nordic countries (e.g., Sweden and Denmark) represent the most advanced model of publicly financed and service-oriented care systems. These countries are characterized by high levels of public expenditure on care - typically exceeding 3% of GDP - combined with extensive provision of universally accessible childcare and long-term care services. A defining feature of this model is the strong emphasis on **public service provision rather than cash transfers**, supported by integrated financing mechanisms and well-developed local government capaci-

ties (OECD, 2020a; European Commission, 2022). These systems are also explicitly designed to support gender equality through the redistribution of care responsibilities and high female labour-force participation.

Second, continental European countries (e.g., Germany and Austria) provide examples of systems based on dedicated long-term care financing mechanisms, most notably social insurance schemes. Germany's long-term care insurance (*Pflegeversicherung*), introduced in 1995, combines cash benefits and in-kind services, allowing beneficiaries to choose between formal care provision and family-based care arrangements (Jung and Oberamtsrat, 1995; Campbell et al., 2010; OECD, 2020a). While these systems still rely partly on informal care, they offer more predictable and structured financing compared to general budget-funded models. At the same time, they illustrate the trade-offs between flexibility, fiscal sustainability, and the balance between cash and service provision.

Third, Central and Eastern European (CEE) countries (e.g., Slovenia and Croatia) offer more directly comparable cases in terms of institutional legacies, fiscal constraints, and demographic dynamics. These countries have undertaken gradual reforms to expand childcare coverage and introduce elements of community-based long-term care, often supported by EU funding. Slovenia, in particular, has achieved relatively high childcare enrolment rates alongside increasing public investment, while Croatia has expanded early childhood education through a combination of national funding and municipal provision (European Commission, various years). However, similar to North Macedonia, these systems continue to face challenges related to fragmentation, regional disparities, and reliance on informal care.

In addition, the experience of **OECD and EU countries more broadly** highlights a consistent pattern: systems that allocate a greater share of resources to **formal care services - particularly early childhood education and home-based long-term care - tend to achieve better outcomes in terms of labour market participation, gender equality, and care quality** (OECD, 2020a; ILO, 2018). Conversely, systems that rely predominantly on cash transfers and informal care, as is the case in North Macedonia, tend to exhibit persistent gaps in access and higher unpaid care burdens.

Against this comparative backdrop, the care financing model of North Macedonia appears to be positioned closer to the lower end of the spectrum in terms of both scale of investment and degree of service orientation. Public spending remains below levels observed in both advanced and comparable economies, while the structure of financing is more heavily tilted toward cash benefits rather than service provision. At the same time, the absence of a dedicated financing mechanism for long-term care and the reliance on fragmented budgetary channels further distinguish it from more consolidated systems.

7. International good practices in transforming care systems

Recognizing the economic and social importance of care work, several countries have undertaken major reforms to transform their care systems. These reforms typically aim to expand access to care services, strengthen care infrastructure, improve labour conditions for care workers, and create sustainable financing mechanisms. International experience demonstrates that care systems can be strengthened through a combination of public investment, institutional coordination, and policy frameworks that recognize care as a shared responsibility between the State, the market, and families.

Table 5 presents a comparative overview of selected international experiences in transforming care systems, highlighting different institutional approaches and financing mechanisms through which countries have expanded care services and addressed the unequal distribution of care work. Although the institutional and economic contexts of the selected countries differ significantly, these examples illustrate several broad pathways for strengthening care systems. These include the establishment of integrated care frameworks, the development of dedicated financing mechanisms for long-term care, the expansion of community-based services, and large-scale public investment in childcare infrastructure. Together, these approaches demonstrate that care systems can be strengthened through coordinated public policy, sustainable financing models, and a clear recognition of care as a public good that supports gender equality and inclusive economic development (ILO, 2018; ILO & UN Women, 2021).

Table 5 Comparative overview of transformative care systems

Country	Focus	Financing	Lesson for North Macedonia
Uruguay	Integrated care system	Public budgets	Treat care as a national system
Germany	Long-term care insurance	Payroll contributions	Dedicated care financing
Slovenia	Community-based care	Mixed national + municipal	Role of local governments
Sweden	Universal childcare	Municipal + national funding	Childcare boosts female employment

Source: Authors' collection.

The experience of Uruguay demonstrates how care can be organized as a coordinated national system that integrates services for multiple population groups. Uruguay introduced the National Integrated Care System (*Sistema Nacional Integrado de Cuidados*) in 2015 with the aim of addressing growing care needs associated with demographic change while simultaneously promoting gender equality and women's economic empowerment. The reform created a national framework that integrates childcare services, support for persons with disabilities, and long-term care for older persons under a unified policy structure (Goyeneche et al. 2025). The system also includes training and professionalization programmes for care workers and initiatives aimed at supporting family caregivers. Importantly, Uruguay explicitly recognizes care as a social right and a shared responsibility between the State, the market, communities, and families. Financing for the system relies largely on public budgets and gradual expansion of services, reflecting the view that care infrastructure constitutes a long-term social investment (UN Women, 2019). The Uruguayan experience therefore illustrates how treating care as a coordinated public system can help reduce fragmentation in service provision while supporting women's participation in the labour market.

Germany provides an example of how dedicated financing mechanisms can be developed to address the growing demand for long-term care services. In response to demographic ageing and increasing care needs, Germany introduced mandatory long-term care insurance (*Pflegeversicherung*) in 1995 as a new pillar of its social security system (Jung and Oberamtsrat, 1995). The insurance scheme provides financial support to individuals who require long-term care due to illness, disability, or ageing. Beneficiaries can choose between receiving services from professional care providers or cash benefits that can be used to compensate family members who provide care at home. The system is financed through payroll contributions shared between employees and employers, ensuring a stable and predictable funding stream for long-term care services. This model illustrates how countries can create dedicated financing mechanisms that reduce the financial burden of care on households while expanding access to formal care services (OECD, 2020a; European Commission, 2022). For countries experiencing population ageing, such as North Macedonia, the German experience demonstrates the potential role of social insurance mechanisms in financing long-term care.

Many European countries have also expanded community-based care services as part of broader social policy reforms. Across the European Union, policy debates increasingly focus on the need to strengthen long-term care systems in response to demographic ageing, changing family structures, and rising demand for support services. The European Commission's Long-Term Care Report highlights that while many countries have expanded care services, significant gaps remain in access to formal care, particularly for older persons and persons with disabilities (European Commission and Social Protection Committee, 2021). These reforms increasingly emphasize home-based care and community services, which allow individuals to receive support while remaining in their own homes and communities. Community-based models also tend to be more cost-effective and better aligned with the preferences of care recipients.

Slovenia's experience highlights the role that community-based care services and local governments can play in strengthening care systems. In recent years, Slovenia has undertaken reforms aimed at expanding long-term care services through community-based models that allow individuals to receive support within their homes and local communities. Municipalities play an important role in organizing and co-financing care services, particularly home-care assistance for older persons and persons with disabilities. This decentralized approach combines national funding with municipal co-financing and user contributions, creating a mixed financing model that distributes responsibilities across multiple levels of government. The Slovenian example illustrates how local governments

can play a central role in delivering care services, particularly in contexts where decentralized governance structures shape the organization of social services (European Commission, 2022). For North Macedonia, which also operates within a decentralized governance framework, the Slovenian model highlights the importance of strengthening the role of municipalities in the provision and coordination of care services.

Sweden represents one of the most developed examples of publicly supported childcare systems and demonstrates how care services can contribute to gender equality in labour markets. Over several decades, Sweden has built an extensive system of publicly funded childcare services that ensures broad access to affordable early childhood education and care. Childcare services are primarily provided at the municipal level, with financing shared between municipal budgets, national transfers, and capped parental fees. This universal approach has significantly expanded access to childcare and has been associated with high levels of female labour-force participation and relatively small gender gaps in employment. Evidence from Sweden and other Nordic countries suggests that investments in childcare services are among the most effective policy tools for enabling women to participate in paid employment while balancing family responsibilities (OECD, 2022). The Swedish case therefore illustrates how childcare infrastructure can function not only as a social service but also as a key component of labour market and gender equality policy.

These international experiences highlight several common lessons for strengthening care systems. *First*, care policies are most effective when they are organized within coherent national frameworks that recognize care as a shared societal responsibility rather than a purely private family matter. *Second*, sustainable financing mechanisms - whether through public budgets, social insurance contributions, or mixed financing arrangements - are essential to ensure the long-term availability and quality of care services. *Third*, the organization of care systems often involves multiple levels of governance, with national governments providing policy direction and financing while local authorities play an important role in service delivery. *Finally*, investments in care services can generate broader economic benefits by supporting labour market participation, creating employment in the care sector, and reducing gender inequalities associated with unpaid care responsibilities.

In this context, the international examples provide valuable insights for policy dialogue on care system reform in North Macedonia. While each country operates within a distinct institutional and economic context, the core principles underlying successful care reforms - recognition of care as a public good, expansion of accessible services, sustainable financing mechanisms, and greater gender equality in care responsibilities - offer important guidance for future policy development.

8. Policy options for transforming the care system

The following is a set of policy recommendations that stem from the analysis presented in this study.

1. **Establish an integrated national care system framework under the coordinating leadership of the MSPDY.** Create a unified policy architecture linking childcare, long-term care, disability services, and labour market instruments under a single strategic and coordinating body to reduce fragmentation and improve coherence across sectors.

2. **Rebalance spending from cash transfers toward care services, with explicit targets for increasing the share of service-based spending.** Gradually shift the composition of care financing toward direct service provision (childcare, home care, community-based services), ensuring that public resources expand actual access rather than primarily compensating households financially.

3. **Introduce a dedicated long-term care financing mechanism.** Develop a sustainable financing pillar for long-term care (initially tax-funded, with potential expansion toward social insurance over the long haul) to ensure predictability and scalability in response to population ageing.

4. **Scale up home-based and community-based care services.** Prioritize expansion of non-institutional services - home care, personal assistance, day care, and respite care - to reduce reliance on institutionalization and unpaid household care.

5. **Expand childcare capacity with territorial equalization.** Increase early childhood education and care provision, particularly in underserved municipalities, through targeted public investment and support for alternative service models.

6. **Strengthen municipal capacity and equalize access.** Align decentralized responsibilities with adequate funding and technical capacity, using equalization transfers and minimum service standards to reduce territorial disparities.

7. **Formalize and professionalize the care workforce through a gradual and incentive-based transition.** Strengthen standards, certification, and improved working conditions in care occupations, while supporting the progressive formalization of domestic and informal care work through

simplified registration schemes, targeted subsidies, and reduced contribution burdens in the initial phase.

8. **Develop inclusive care-employment pathways for victims of violence and vulnerable women.** Create voluntary and supported pathways for the labour market reintegration of victims of domestic and gender-based violence through training, certification, and supervised employment in home-based and community-based care services. Such programmes should combine psychosocial support, mentoring, and gradual transition into formal care employment, in cooperation with shelters, Centres for Social Work, municipalities, and licensed care providers.

9. **Support and recognize informal caregivers.** Provide targeted measures such as caregiver allowances, pension credits, and respite services to reduce the burden on family caregivers and acknowledge their role within the care system.

10. **Reform leave policies to promote gender equality.** Expand and redesign parental and care leave - especially paternity leave and long-term care leave - to incentivize a more balanced distribution of care responsibilities between men and women.

11. **Strengthen enforceability of flexible work arrangements.** Move from employer-discretion models toward enforceable rights to flexible work, improving work–care reconciliation and labour market attachment.

12. **Address social norms shaping care provision.** Implement awareness and behavioural interventions to shift norms around gender roles and increase acceptance and demand for formal care services.

13. **Improve data systems and care financing transparency.** Develop better measurement tools (e.g., care satellite accounts, expenditure tagging) to accurately capture care provision, financing flows, and unmet needs.

14. **Position care as economic and social infrastructure.** Integrate care into broader development and fiscal strategies, recognizing its role in supporting labour supply, productivity, and inclusive growth.

The following is a set of three policy roadmaps to aid the transformation of the care system in the country.

Table 6 Policy transformation 1: Developing a comprehensive long-term care system, with home-based and community-based care as the primary model

Component	Primary pathway 1: Home-based and respite care	Primary pathway 2: Community-based services	Additional pathway: Institutional care expansion
Objective	Enable care at home while supporting formalization of informal caregivers and family members as informal caregivers, and reducing care burden	Provide accessible local services for care, rehabilitation, and social inclusion	Ensure sufficient capacity for high-dependency cases (residual function) for individuals requiring intensive or continuous care
Target groups	Elderly persons; persons with disabilities; informal caregivers	Elderly persons; persons with disabilities; vulnerable groups	Elderly persons with high dependency; individuals without family support
Core intervention	· Expansion of home care and personal assistance · Expansion of respite care services (temporary care replacement)	· Expansion of day-care centres, rehabilitation, reintegration, and social support services	· Expansion and upgrading of residential eldercare facilities · Investment in new infrastructure and modernization of existing institutions
Type of policy (design)	Needs-based service + caregiver support component; merit good	Needs-based service; merit good with social inclusion effects	Public service provision for high-dependency cases; safety-net function

Eligibility criteria	• Based on **functional dependency assessment** (e.g. person unable to perform ≥2 basic daily activities such as bathing, dressing, mobility)• **Respite care eligibility:** household member providing ≥20 hours/ week unpaid care • Priority groups: - Elderly persons living alone in rural areas; - Persons with severe disabilities (e.g. mobility impairment); - – Low-income household receiving GMA	• Based on **combined social and functional needs**• Referral through CSW • Examples: - Older persons needing daily supervision but not full-time care; - – Persons with disabilities needing rehabilitation or social integration; - Children or adults from vulnerable household needing day-care support	• Based on **high-level dependency and lack of alternatives** • Examples: - Bedridden older persons requiring 24-hour care; - – Persons with advanced dementia who lack family support; - Individuals discharged from hospital with no possibility of receiving home care
Service delivery model	Delivered at home by trained care workers; flexible respite options (home or short-term stay)	Delivered through local centres (public, private, CSO providers)	Delivered through specialized residential institutions
Frequency / intensity	Regular (home care) + temporary (respite care)	Daily or periodic participation	Continuous (24-hour care)
Rationale (evidence)	High reliance on informal care; caregiver burden; limited access to services	Underdeveloped community services; territorial inequalities	Extremely limited institutional capacity relative to ageing population
Financing approach	• **Central budget financing** for service provision (e.g. salaries of care workers financed via the MSPDY) • Municipal co-financing for local coordination • **Example:** State funds 80% of service cost, municipality covers 20% (logistics, transport) • Respite care introduced as **low-cost, high-impact service** in early phase	• Central budget + municipal co-financing • **Example:** Central government finances staffing and core services; municipalities provide facilities (day-care centres)• Potential contracting of CSOs/ private providers through public funding schemes	• **Capital investment financed centrally** (state budget or EU funds) • Operational costs covered by central budget • **Example:** New elderly home financed through public investment programme; operating costs co-financed through budget and user fees
User contribution	• **Income-adjusted co-payment** • Examples: - Low-income households (GMA beneficiaries): **0% co-payment; -** – Middle-income households: **10–20% of service cost; -** Higher-income households: **30%+ co-payment** • **Respite care:** minimal or symbolic fee (e.g. 0–5 EUR/ day) to ensure accessibility	• Income-adjusted co-payment • Examples:– Free access for vulnerable groups (persons with disabilities, low-income elderly)– Moderate fee (e.g. 2–5 EUR/day) for others • Subsidies for frequent users	• Co-payment based on income and pension level • Examples: - Pension-based contribution (e.g. 50–80% of pension); - Full subsidy for individuals without income • Additional support for low-income households
Role of municipalities	Organization and coordination of services	Key role in provision and infrastructure	Limited (mainly coordination; infrastructure often centralized)
Implementation priority	**High (quick-win + high impact)**	Medium - high	Medium (requires higher capital investment)

Expected impact - care system	Reduced institutionalization; sustained informal care; improved access	Expanded service network; improved territorial coverage	Increased capacity for high-need cases; reduced waiting lists
Expected impact - economic	Increased labour participation (especially women); job creation	Local service development	Construction and care sector employment
Expected impact - gender	Strong reduction of unpaid care burden; reduced caregiver burnout	Indirect support to women's participation	Limited direct gender effect
Expected impact - social	Improved well-being of both care recipients and caregivers	Increased social inclusion	Improved protection for most vulnerable

Table 7 Policy transformation 2: Redistributing unpaid care through leave and flexible work policies

Component	Pathway 1: Parental leave reform	Pathway 2: Care leave (elderly & disability)	Pathway 3: Labour market flexibility
Objective	Promote more equal sharing of childcare between mothers and fathers	Enable workers to respond to care needs of elderly and persons with disabilities	Allow workers to balance paid work and ongoing care responsibilities
Target groups	Parents of young children (both mothers and fathers)	Workers with dependent elderly or disabled family members	Workers with care responsibilities (children, elderly, persons with disabilities)
Core intervention	· Introduce **non-transferable paternity quota** (e.g. "use-it-or-lose-it") · Increase incentives for fathers to take leave	· Introduce **paid care leave scheme** for short-term and medium-term care needs · Emergency leave for sudden care needs	· Promote flexible work arrangements: flexible working hours; part-time options; remote work (where feasible)
Type of policy (design)	Social insurance-based benefit; gender-equality instrument	Social protection + labour policy instrument	Labour market regulation + employer-based arrangements
Eligibility criteria (with examples)	· All employed parents with social insurance contributions · Examples: - Father eligible for **at least 2 months non-transferable leave; -** Both parents employed → shared leave options	· Workers providing care to dependent family members · Examples: - Employed persons caring for older parents following hospital discharge; - Parents of children with severe disabilities · Certification via medical/social assessment	· All employees, with priority for workers with care responsibilities · Examples: - Parents with children under 6 years of age; - Workers caring for older parents · Right to request flexible work arrangements
Duration / intensity	· Total leave remains similar but **rebalanced between parents** · Example: 12 months total, with 2 months reserved for fathers	· Short-term: 5–10 days emergency leave/year · Medium-term: up to 3 months (partially paid)	· Continuous / long-term arrangement depending on needs

Rationale (evidence)	Women disproportionately take leave → reinforces labour market gaps	Ageing population → rising care shocks not covered by current system	Ongoing care responsibilities limit full-time employment
Financing approach (with examples)	· Funded through **social insurance system** · Example: Wage replacement at 60–80% financed via social contributions · Possible state subsidy for paternity quota introduction	· Mixed financing: - Social insurance for short-term leave; - State budget support for extended leave · Example: partial wage replacement (50–70%)	· **Low direct fiscal cost** · Cost borne mainly by employers (adjustment costs) · Possible state incentives for SMEs (e.g., tax reliefs)
User contribution / cost sharing	· No direct user payment · Indirect cost: reduced wage replacement (if below 100%)	· No direct user payment · Indirect cost: partial income loss during leave	· No direct payment · Potential indirect cost through reduced hours/ salary
Role of employers	Ensure job protection and return to work	Approve and manage leave arrangements	Implement flexible work policies
Implementation priority	**High (strong gender impact, institutional reform needed)**	High (currently missing policy instrument)	Medium–high (can be scaled gradually)
Expected impact - care system	More balanced childcare responsibilities	Reduced reliance on informal emergency care	Sustained ability to combine work and care
Expected impact - economic	Increased female labour participation; reduced career penalties	Reduced labour market exit due to care shocks	Higher retention of workers
Expected impact - gender	**Strong impact on redistribution of unpaid care**	Moderate–strong (supports caregivers, mostly women)	Moderate (depends on uptake by men)
Expected impact - social	Shift in norms toward shared parenting	Better response to ageing-related care needs	Improved work-life balance

Table 8 Policy transformation 3: Strengthening and professionalizing the care workforce

Component	Pathway 1: Improving wages and working conditions	Pathway 2: Training, Skills development and certification	Pathway 3: Formalization of care and domestic work
Objective	Improve attractiveness and retention in the care sector	Build a skilled and qualified care workforce aligned with service expansion	Reduce informality through gradual transition mechanisms and ensure decent work conditions in care provision
Target groups	Formal care workers (home care, community services, institutions)	Existing and potential care workers; unemployed and inactive persons; vulnerable women and victims of violence transitioning toward economic reintegration	Domestic workers; informal caregivers transitioning into paid work

Core intervention	• Gradual **increase in wages** in publicly financed care services • Improve working conditions (working hours, contracts, safety) • Introduce career progression pathways	• Develop **standardized training programmes** for care workers • Introduce certification and accreditation systems • Promote re-skilling and up-skilling programmes (e.g. for unemployed women) • Develop targeted and voluntary training and employment pathways for victims of violence, combined with psychosocial support and supervised transition into community-based care services	• Introduce simplified registration and taxation schemes for domestic workers • Provide transitional incentives for formalization (e.g. reduced social contributions, tax reliefs, or vouchers for households employing registered caregivers) • Promote formal employment contracts in care services through publicly supported service schemes • Gradually strengthen labour inspection and enforcement mechanisms once formalization pathways are established
Type of policy (design)	Labour market and public sector wage policy	Active labour market policy + education and training system	Labour market regulation + formalization policy
Eligibility criteria (with examples)	• Employees in publicly funded care services • Examples: - – Care workers employed in municipal home care services; - Staff in eldercare institution funded by the State	• Individuals entering or already working in care sector • Examples: - Unemployed women enrolled in certified care training programmes; - Existing care workers upgrading skills for specialized services	• Individuals providing paid care informally • Examples: - Household-employed caregiver without a contract; - Domestic worker providing eldercare services; • Employers of domestic workers (households)
Service delivery / implementation model	Implemented through public providers and contracted service providers	Delivered through vocational training centres, accredited institutions, and public employment services	Implemented through legal and administrative reforms; supported by labour inspectorates and simplified administrative systems
Rationale (evidence)	Low wages and poor conditions reduce attractiveness of care jobs and constrain service expansion	Lack of trained workforce limits quality and coverage of care services	High prevalence of informal care work leads to lack of protection and reduced quality of services; Informality reflects affordability constraints and system gaps rather than voluntary evasion

Financing approach (with examples)	• Central budget financing (public wage bill) • Example: gradual wage increase (e.g. 10–15%) in publicly funded care services • Potential co-financing through service contracts	• Public funding through active labour market policies and education budgets • Example: training vouchers or subsidized programmes for care workers	• Initial fiscal cost kept low through targeted and temporary subsidies • Example: reduced-rate contributions (e.g., 30–50%) for newly formalized care workers during a transition period • Administrative system setup financed by public budget
User contribution / cost sharing	• No direct user contribution • Indirectly reflected in service pricing (if co-payments exist)	• Training may be free or subsidized • Example: - Free training for unemployed persons / victims of violence; - Co-payment for advanced certification programmes	• Employers (households) contribute through formal wages and social contributions • Example: reduced-rate contributions to incentivize formalization
Role of institutions	MSPDY; municipalities; service providers	MoES; Employment Service Agency (ESA); training providers	MSPDY / Labour Department at the MoEL; Labour Inspectorate; tax authorities
Implementation priority	High (critical for service expansion)	High (enabler of system development)	Medium–high (gradual but essential reform)
Expected impact - care system	Increased availability and quality of care services	Improved quality and professionalism of care provision	More reliable and regulated care provision
Expected impact - economic	Job creation and retention in care sector	Increased employability and activation of inactive population	Expansion of formal employment and tax base
Expected impact - gender	Improved job quality in feminized sector	Increased opportunities for women's employment	Protection of women in informal care roles
Expected impact - social	Higher quality and continuity of care	Increased trust in care services	Improved labour rights and social protection

9. Conclusions

Care in North Macedonia is not organized through a fully integrated system, but through a combination of institutional provision and extensive household adaptation to persistent gaps in access, affordability, and coverage. While the care system is institutionally anchored within the MSPDY, the evidence shows that formal services do not yet meet the scale and diversity of care needs. As a result, households - particularly women - absorb a substantial share of care responsibilities. This configuration reflects both structural constraints in service provision and deeply embedded social norms, producing a system in which care is delivered through a mix of formal, informal, and hybrid arrangements rather than through a coherent and coordinated framework.

Care needs in North Macedonia are continuous, intensifying, and increasingly shaped by demographic and social change. Population ageing, rising prevalence of chronic conditions, and sustained outmigration of younger cohorts are transforming the demand for care, particularly long-term care for older persons. At the same time, the persistence of childcare gaps continues to affect working-age households. The analysis shows that care is not episodic but embedded in daily life, often requiring sustained and multifaceted support. These dynamics place growing pressure on both families and formal systems, highlighting the need for a forward-looking approach to care provision.

Access to care services remains uneven and constrained, particularly in rural areas, reflecting both infrastructural and geographic disparities. The availability of childcare facilities, rehabilitation services, and long-term care varies significantly across regions, with some municipalities lacking even basic services. Where services exist, they are often concentrated in urban areas and characterized by long waiting times. Transport barriers and limited local capacity further restrict access, effectively excluding certain groups from both care services and labour market participation. These territorial disparities underscore the importance of strengthening local service provision within a coordinated national framework.

Affordability represents a critical constraint, with the current system lacking a viable middle ground between limited public provision and costly private services. Care services - particularly long-term and specialized care - are often beyond the financial reach of households, especially those relying on pensions or unstable incomes. Public transfers provide partial support but are insufficient to cover actual care costs. As a result, households frequently rely on informal arrangements even when formal services would be preferred. This financing gap highlights the need to rebalance the system toward more accessible and sustainable service provision.

The organization of care is closely linked to labour market outcomes, with care responsibilities creating a structural barrier to employment, particularly for women. The analysis demonstrates that caregiving often leads to reduced labour-force participation, withdrawal from employment, or acceptance of precarious and flexible work arrangements. This is especially pronounced in rural and agricultural contexts, where care responsibilities are combined with physically demanding economic activities. The result is not a simple trade-off between care and work, but a structural incompatibility shaped by limited-service provision and inflexible labour markets.

Informality emerges as a systemic feature of the care economy, rather than a marginal or voluntary phenomenon. In response to gaps in formal provision, households develop coping strategies that rely on informal care arrangements, including unregistered caregivers, family networks, and community-based support. While these arrangements provide flexibility, they are often precarious and lack social protection for both caregivers and care recipients. This widespread informality reflects underlying institutional gaps and reinforces inequalities within the care system. This implies that formalization cannot rely solely on enforcement, but requires the creation of accessible and affordable pathways into formal care provision.

Cultural norms continue to play a significant role in shaping care arrangements, but are increasingly under pressure from structural change. Strong expectations that families - particularly women - should provide care remain prevalent, influencing both behaviour and policy preferences. At the same time, demographic shifts, migration, and labour market pressures are making exclusive reliance on family-based care increasingly difficult to sustain. This creates a tension between persistent norms and evolving realities, with gradual shifts in attitudes emerging alongside growing recognition of the need for formal support.

Within this constrained system, home-based care services emerge as a particularly effective and socially acceptable model, especially for older persons with moderate care needs. Unlike institutional care, which is often associated with stigma and loss of autonomy, home care allows individuals to remain in familiar environments while receiving necessary support. It aligns more closely with prevailing social norms and has demonstrated potential to alleviate pressure on families. However, its impact remains limited by capacity constraints, uneven geographic coverage, and insufficient scaling, preventing it from fully addressing system-wide gaps.

The current financing model, dominated by tax-based transfers with limited earmarking for care services, constrains the expansion and sustainability of the system. While public financing plays a central role, resources are often directed toward cash benefits rather than service development. Combined with fragmented responsibilities across sectors and levels of government, this limits the system's ability to scale up provision and respond to emerging needs. A more balanced and strategic financing approach is required to support both service expansion and system integration.

Transforming the care system in North Macedonia requires a shift from fragmented provision toward a more integrated, accessible, and sustainable model of care. This entails strengthening service provision - particularly home-based and community-based care - improving coordination across sectors and levels of government, and aligning financing mechanisms with service delivery objectives. It also requires addressing gender inequalities embedded in the current system and recognizing care as both a social priority and an economic investment. In the context of ongoing demographic change, such reforms are not only desirable but necessary to ensure the long-term resilience and inclusiveness of the care system.

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Interviews framework

Interview questions for care providers

1. How would you describe the main unmet care needs in your area of work (childcare, eldercare, disability care)?
   - Which groups are most affected (e.g. rural women, informal workers, older people living alone)?
   - Have these needs changed in recent years?
2. To what extent are formal care services (childcare, long-term care, disability services) available and accessible to those who need them?
   - Where do you see the largest gaps (urban vs rural, specific municipalities, vulnerable groups)?
   - Are there any waiting lists, capacity constraints, or service shortages?
3. What are the main barriers to expanding care services?
   - Infrastructure (facilities, equipment)?
   - Workforce (availability of trained caregivers)?
   - Administrative or regulatory constraints?
4. How affordable are existing care services for different population groups?
   - Are costs a barrier to accessing childcare or long-term care?
   - Do households rely on private services due to lack of public provision?
5. In your view, how do financial constraints affect care decisions within households?
   - Do families choose informal care because formal services are too expensive or unavailable?
6. To what extent do households rely on informal care (family members) instead of formal services?
   - Is this primarily a matter of preference or necessity?
   - How sustainable is this model given demographic changes (ageing, migration)?
7. How do social norms and cultural attitudes influence care arrangements in practice?
   - Is care still primarily seen as a responsibility of women?
   - Are attitudes toward formal childcare and eldercare changing?
8. Do you observe differences across generations, regions, or socio-economic groups in attitudes toward care?
9. From your perspective, what are the main institutional or system-level gaps in the care system?
   - Coordination between ministries?
   - Role of municipalities?
   - Fragmentation between services and benefits?
10. What would be the most important priorities to improve the care system in North Macedonia?
    - Expand services (which ones)?
    - Improve financing?
    - Address gender inequalities in care?

Interview questions for target groups

A. Core questions (for all respondents)

1. Can you describe the care responsibilities in your household (children, older persons, persons with disabilities, illness)?
2. Who usually provides this care, and how is it shared within the household?
3. What is the most difficult part of providing or arranging care?

4. Are there any services you use or would like to use (e.g. kindergarten, eldercare, home care, day centres)? Why or why not?
5. What makes access to care difficult: distance, cost, lack of places, information, transport, or something else?
6. How do care responsibilities affect your daily life, work, or income?
7. In your opinion, who should mainly provide care: family, the State, or private providers?
8. Compared to the past, are attitudes in your community toward care and women's roles changing?

B. Tailored questions by respondent group

1. Women in rural areas

- How far are the nearest care services (childcare, health, social services)?
- Does transport or infrastructure make access difficult?
- If you need help with care, where do you turn first?
- Has migration (children moving away) made care more difficult?

2. Women farmers

- How do you combine farm work with care responsibilities?
- During busy periods, who provides care?
- Have you had to reduce or stop work due to care needs?
- Are existing services compatible with your working hours?

3. Informal workers

- How do care responsibilities affect your ability to find or keep work?
- Have you lost income because of care duties?
- What do you do when care is needed during working hours?
- Would affordable care services help you work more?

4. Older women

- Do you receive enough help with daily activities? From whom?
- If your children live elsewhere, how often can they support you?
- Are there any services available for older persons nearby?
- Would you use formal care services if they were accessible and affordable?

5. Mothers / women caring for children

- Have you tried to enrol your child in child-care? What difficulties did you face?
- Who stays home when a child is sick?
- Has childcare affected your ability to work?
- Do people in your community believe mothers should stay home with young children?

6. Caregivers of persons with disabilities

- What kind of daily care is required and how intensive is it?
- What support do you receive (allowances, services)? What is missing?
- How has caregiving affected your work and well-being?
- What would reduce your care burden the most?