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Network (ESPAN)

# Long-term care settings for older people in Montenegro

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EUROPEAN SOCIAL POLICY ANALYSIS NETWORK (ESPAN)

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## Summary

In Montenegro long-term care (LTC) for older people is primarily informal and family-based, underpinned by strong cultural norms and reinforced by legislation. Surveys show that most older people prefer to remain in their homes rather than enter residential care facilities, citing emotional proximity to family and concerns about residential care quality as primary reasons. In addition, data show that less than 0.001% of those in need make use of formal care services – highlighting the overwhelming reliance on informal care arrangements.

LTC for older people is not a distinct social policy field in Montenegro: it is regulated as an integral part of the system of social protection and is under the jurisdiction of the Ministry of Social Welfare, Family Care and Demography. The term “older people” is not defined in terms of age in the Law on Social and Child Protection and the related sub-regulation.

The formal LTC system is organised around three main categories. Residential care is provided through 5 public and 2 private licensed residential homes. At the end of 2023 the overall occupancy rate of those facilities was 77.2%, varying between 47.1% and 100%. Home-based care is provided by 7 providers (international organisations, public residential homes, and local NGOs) in 22 out of Montenegro’s 24 municipalities. Community-based care is primarily delivered through day centres, with 17 licensed centres operating across the country, many of which are managed by public residential homes. A notable innovation in Montenegro’s LTC landscape is the introduction of pilot community care centres, a hybrid model developed in two municipalities in cooperation with municipal authorities, the Red Cross of Montenegro, and international donors.

Eligibility for residential home care is assessed by centres for social work. When the right to the service is granted by the centre for social work, the state participates in covering the service costs. In the case of direct contracting, people with disabilities and their families bear the full cost of service-provision. The price of LTC services varies depending on the level of support required by the beneficiaries, which is determined by the licensed service-providers. On the other hand, in the case of community-based and home care services, licensed service-providers play a key role in assessing user needs and setting prices.

The availability of LTC services varies significantly by region. Central and southern municipalities have more developed infrastructure, while northern areas face limited service-provision, compounded by depopulation, lower income levels, and workforce shortages. International organisations have responded by supporting services in under-served areas.

There is no central registry of formal providers, and geographical variation in service availability remains poorly documented. Internal quality-assurance mechanisms are in place but are inconsistently implemented, and external monitoring remains limited. Financial transparency is hindered by the absence of disaggregated data on funding allocation and user affordability. These limitations constrain evidence-based planning and make it difficult to align Montenegro’s LTC system with international benchmarks and the European Union’s monitoring framework

Recent policy efforts are intended to address some of these gaps, including strategic frameworks to promote community-based models of care, new licensing standards, and international project-based support for home care. Nevertheless, challenges remain, including a lack of integrated healthcare and social care planning, uneven service access, and insufficient institutional coordination. Strengthening inter-sectoral collaboration, standardising data-collection, and expanding person-centred community services are key recommendations to ensure a more balanced and inclusive LTC system in Montenegro.

## Introduction

### European Union policy context

On 7 September 2022 the European Commission presented the European care strategy (European Commission, 2022), designed to ensure high-quality, affordable and accessible care services across the European Union (EU) and improve the situation for both care receivers and the people caring for them, professionally or informally. Three months later, as part of this strategy, the Council of the EU adopted the Council Recommendation of 8 December 2022 on access to affordable high-quality long-term care 2022/C 476/01 (Council of the European Union, 2022), with long-term care (LTC) to be understood as:

*“a range of services and assistance for people who, as a result of mental and/or physical frailty, disease and/or disability over an extended period of time, depend on support for daily living activities and/or are in need of some permanent nursing care”.*

The daily living activities for which support is needed may be either “activities of daily living” (ADL) – that is, the self-care activities that people must perform every day (e.g. bathing, dressing, eating, getting in and out of bed or a chair, moving around, or using the toilet), and/or “instrumental activities of daily living” (IADL) – that is, activities related to independent living (e.g. preparing meals, managing money, or shopping for groceries or personal items). LTC is therefore understood as both social (ADL/IADL) and medical (nursing) care, required for an extended period of time – thus excluding, for example, short-term recuperation/rehabilitation after surgery.

The European care strategy and the LTC Recommendation advocate a person-centred approach to care. This approach is defined as follows in the Recommendation:

*“Long-term care services are provided without any discrimination and address the specific and changing needs of each individual in need of long-term care. They fully respect the personal integrity of people in need of care, take into account their gender, and their physical, intellectual, cultural, ethnic, religious, linguistic and social diversity, and, where appropriate, that of their families or their immediate social circle. The person in need of long-term care is at the centre of attention and is the basis for service planning, care management, worker development and quality monitoring.”*

A key element of this approach is that LTC services address people’s individual LTC needs as these evolve over time, respecting individual choice. For this to happen, a mix of LTC services and settings is necessary. The LTC Recommendation therefore calls on Member States to provide a balanced mix of LTC options and settings to cater for different LTC needs and support freedom of choice. Availability of different types of LTC settings is also a precondition for accessibility and efficient resource allocation.

Traditionally, options for LTC have been limited to residential care or informal family care, while home care and community-based care have been less common and underfunded. This trend may be shifting, partly due to EU funding in some countries. Data-collection still primarily distinguishes between home and residential care, overlooking community-based options and variations within those broad categories of LTC settings. Additionally, cash benefits cannot necessarily be directly linked to specific types of LTC settings. Out of the total public expenditure in the EU-27 in 2022, 25.0% was allocated to cash benefits, 28.8% to home care, and 46.2% to residential care. There were marked variations from these averages across the EU, with, for example, six Member States allocating less than 10% of their LTC expenditure to

home care (Table A3 in Annex 2; see also European Commission and Economic Policy Committee, 2024).

## Objectives of the Thematic Report

This report is intended to present the supply of settings providing formal LTC for people aged 65+, in order to help design and monitor policy measures ensuring a balanced mix of LTC options and settings, and identify good practice and innovation within LTC services. Its focus is thus on the supply of LTC (in various types of settings) rather than on the demand and/or need for it.

The report focuses on people aged 65+ with LTC needs, which may include people with disabilities, whilst recognising that provision in the settings concerned may also be made for people of younger age groups. It provides findings to feed into future reports by the European Commission, Social Protection Committee and others, as well as contributing to mutual learning and further policy development, including better targeting of EU and national funding for LTC.

The report:

- gives a brief overview of informal care, to put the provision of formal LTC services in context and to reflect on the degree of reliance on informal care in Montenegro, and otherwise only describes informal care when it is combined with formal care-provision (Introduction);
- seeks to map the variety and prevalence of LTC settings for people aged 65+ in Montenegro, locating these within the three broad categories of residential, home and community-based care where possible, and also identifying hybrid and/or innovative models (Section 1.1) – in both cases focusing on settings/initiatives that are sufficiently widespread (for settings belonging to the first three broad categories) and/or documented (for those belonging to the fourth category);
- gives an overview of how formal LTC services are funded in Montenegro (Section 1.1);
- for residential, home and community-based care, provides data on the type of providers for each of these three broad categories of care, the capacity of each category, and the LTC workforce in each category (Section 1.2);
- where possible describes: services and eligibility criteria for the three broad categories of care; the structure of residential care; and quality-assurance arrangements for all three care categories (Section 1.3);
- identifies geographical imbalances in provision across these three categories (Section 1.4);
- discusses hybrid and/or innovative LTC models/settings, in order to identify good practice to support further expansion/adaptations of such models where relevant (Section 1.5);
- lists any gaps in knowledge and data in relation to the information provided in Sections 1.1-1.5 (Section 1.6);
- gives a critical assessment of the overall organisation and structure of formal LTC and the funding for this in Montenegro, as described in Section 1 (Section 2);
- sets out planned or ongoing reforms and structural measures in formal LTC for people aged 65+ (Section 3); and
- identifies challenges, good practice and recommendations (Section 4).

## Brief overview of the role of informal care in LTC provision in Montenegro

Informal care is not covered in this report, unless it is provided in combination with formal care. However, a brief overview of the place of informal care in the overall make-up of LTC provision is given here, with a view to setting the provision of formal LTC services in various settings in context, and also to reflect the reliance on informal care.

According to national census data for 2023 (MONSTAT, 2024a), in Montenegro there were 105,008 people aged 65+, representing 16.8% of the country's total population. Broader indicators for those aged 60+ reveal that more than half of this demographic (54.4%, or 79,055 people) experience some degree of difficulty performing daily activities, while 17,258 people (approximately 12%) officially hold disability status. Despite the evident need, formal LTC services reach only a fraction of this population. The latest administrative data show that only around 1,000 users are registered in residential and community-based care settings combined – a figure that includes all adult users and not exclusively older people (Institute for Social and Child Protection, 2024). Taken together, these figures indicate that less than 0.001% of older people who experience some degree of difficulty performing daily activities or who hold disability status are beneficiaries of formal LTC services.

In Montenegro, informal care constitutes the primary form of care-provision for older people and people with functional limitations. Rooted in strong cultural expectations, informal care – typically delivered by family members – is the dominant way in which care needs are met across both urban and rural settings. A comprehensive study conducted by SeConS Development Initiative Group in 2021 found that in Montenegro only 7-11% of people needing LTC preferred residential services. Approximately two thirds of respondents aged 65+ expressed a desire not to live in residential homes. The most commonly cited reasons were the wish to remain close to family, and concerns regarding the quality of residential care (SeConS, 2021). Reflecting these preferences and the prevailing role of family in care-provision, the informal care model is partially supported through modest state-provided cash benefits, which help reduce the financial burden on care-giving households.

### 1. Mapping formal LTC available in Montenegro

This section maps formal LTC available in Montenegro. First, it gives a short description of the LTC settings available (Section 1.1). Second, for each of the three broad categories of LTC care settings (residential care, home care and community-based care), it provides some key figures related to the category in the country (Section 1.2) and some key characteristics of the category (Section 1.3), and identifies potential geographical imbalances in the availability of the category in the country (Section 1.4). Third, it takes a closer look at the hybrid and/or innovative care settings/models available in the country (Section 1.5). Finally, it identifies knowledge gaps that would need to be filled in order to improve the information on formal LTC available in the country (Section 1.6).

#### 1.1 Short description of LTC settings available

This section starts with a short description on the overall provision of LTC in Montenegro, including the role played by formal care settings (Section 1.1.1). It then briefly describes each type of LTC setting (either designed for people aged 65+, or including them) available in the country, using the broad categories of LTC settings identified in Annex 1 – that is, residential care, home care and community-based care (described in Sections 1.1.2.1, 1.1.2.2 and

1.1.2.3, respectively), as well as hybrid and/or innovative care settings/models (described in Section 1.1.3).

### 1.1.1 Overall provision of LTC

LTC for older people is not a distinct social policy field in Montenegro. Social support for older people is defined by the Law on Social and Child Protection (2024), which defines the available services, providers and population groups that are covered. LTC for older people is regulated as an integral part of the system of social protection, with some services dedicated to older people, and others that cater to all age groups. In the Law on Social and Child Protection, the categories of social protection service beneficiaries are not defined by age. Only within the article that defines the terms used in the law is it stated that children are people up to age 18, and young people those up to 26. The age limit for “older people” is not defined. All services defined by the law, regardless of whether they are residential, home-based, or community-based, apply to categories of adults and older people, with no age limits specified.

The Ministry of Social Welfare, Family Care and Demography oversees social care services related to long-term support. Formal LTC provision is delivered through both residential and non-residential settings, with centres for social work serving as the main access point for needs-assessment and eligibility. There are no specific institutions in the system of social care in charge of healthcare; the latter is under the jurisdiction of the Ministry of Health. Formal care settings – particularly residential care homes and home-based assistance – play a central role in providing structured services for people with limited functional capacity, most of whom are aged 65+.

In Montenegro LTC services are financed from a combination of public, private, and international sources. Public funding for LTC is primarily channelled through the national budget (national taxation). Residential care homes are mainly supported by national funding. Community-based services are predominantly established and operated at the municipal level, although several are co-financed through donor-supported projects or implemented in cooperation with civil society organisations and/or international donors, including the EU and United Nations agencies. Private out-of-pocket payments from beneficiaries or their families also contribute to the financing of LTC, especially in licensed private residential homes. However, comprehensive data on the structure and total volume of LTC funding remain limited, and available figures typically cover only a portion of public spending, particularly for residential care. In 2023 a total of EUR 5.09 million was allocated to the five public residential care homes for older people and adults with disabilities, representing approximately 2.37% of the country’s total social protection budget (EUR 214.88 million) (Government of Montenegro, 2023). In addition, according to the latest available data for 2022 based on the ESSPROS<sup>1</sup> methodology (MONSTAT, 2024b), public spending on social protection for the old age category in Montenegro amounted to 6.2% of GDP, of which only 0.4% was allocated to benefits in kind – a category that includes LTC services.

### 1.1.2 Short description of LTC settings in residential care, home care and community-based care

#### 1.1.2.1 Residential care

Residential care for older people in Montenegro is provided in seven residential care facilities, which offer 24-hour accommodation, personal care, meals, and basic healthcare support.

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<sup>1</sup> European system of integrated social protection statistics.

These facilities correspond to the category of residential care homes (type of setting 1.5 in the typology presented in Annex 1) and are designed for people who require support with daily living activities. They are considered mainstream services and operate nationally under the supervision of the Ministry of Social Welfare, Family Care and Demography. Public residential care homes are predominantly funded by the central government, which covers operational costs through the Ministry of Social Welfare, Family Care and Demography.

**Table 1.1: Residential care**

	Setting present in country? If yes, widespread or not?	Annex 1 description appropriate for country?	Mainstream (i.e. well-established or new setting?)
1.1: Assisted living facilities	No	N/A	N/A
1.2: Facilities/hospitals specialising in chronic care	No	N/A	N/A
1.3: In-patient hospice facilities	No	N/A	N/A
1.4: Nursing homes or skilled nursing facilities	No	N/A	N/A
1.5: Residential care facilities, residential homes, care homes, care homes for older people	Yes, widespread	Yes	Mainstream
1.6: Hospices offering / specialising in palliative care	No	N/A	N/A

Note: N/A = not applicable.

#### 1.1.2.2 Home care

Home-based care services (type of setting 2.1 in Annex 1) are provided by municipal social welfare institutions and NGOs. They are mainstream, but coverage varies by region. The services support older people in performing daily tasks such as nutrition, maintaining personal hygiene, and household maintenance. Home-based care is primarily organised and financed at the local level. Although the central government provides policy direction and partial funding, municipalities are responsible for service implementation and financing.

**Table 1.2: Home care**

	Setting present? If yes, widespread or not?	Annex 1 description appropriate?	Mainstream or new setting?	Setting category <sup>1</sup>
2.1 Home-based care	Yes, not widespread <sup>2</sup>	Yes	Mainstream	Home care
2.2 Mobile hospice / palliative care teams	No	N/A	N/A	N/A

Notes: <sup>1</sup>Broad category to which the setting belongs in the country: residential care, home care, community-based care, hybrid. <sup>2</sup>Home-based care is provided by municipal social welfare institutions and NGOs: it is mainstream, but coverage varies by region.

#### 1.1.2.3 Community-based care

Community-based services include day centres for older people (type of setting 3.2 in Annex 1), which offer daytime care, structured activities, and opportunities for social interaction. These services are integrated into local community settings and are available in several urban municipalities. They are considered mainstream, where implemented, and are provided by

public residential homes. Funding for these services typically involves a mix of central government allocations, municipal budgets, and contributions from international development partners such as the EU and United Nations Development Programme (UNDP). The structure and availability of services may therefore vary across municipalities depending on local capacity and funding.

**Table 1.3: Community-based care**

	Setting present? If yes, widespread or not?	Annex 1 description appropriate?	Mainstream or new setting?	Setting category
3.1 Recreational or community centres (for people with care needs)	No	N/A	N/A	N/A
3.2 Day centres	Yes, not widespread	Yes	Mainstream	Community-based care
3.3 Day hospice centres	No	N/A	N/A	N/A

### 1.1.3 Short description of hybrid and/or innovative care settings/models

Community care centres were established on a project basis in two municipalities (Bar and Bijelo Polje). They represent a hybrid model of LTC that combines elements of home care and community-based care. Services provided include preventive home visits, basic care assistance, counselling, and dementia-related support. These centres are currently implemented on a pilot basis and are considered innovative within the national LTC context. Their funding reflects this experimental status, relying on centrally supported initiatives in combination with international donor programmes. Although promising, these models remain limited in scale and geographic coverage (Red Cross of Montenegro, 2024).

**Table 1.4: Hybrid and/or innovative care settings/models**

	Setting/model widespread?	Mainstream or new setting/model?	Setting/model hybrid? <sup>1</sup>	Setting/model innovative?
4.1 Community care centres	No	New	Yes (HC+CBC)	Yes

*Note: <sup>1</sup>Is the setting/model “hybrid”? If yes, to which two or three categories does it belong – residential care (RC), home care (HC) and/or community-based care (CBC)? If no, to which category does it belong – RC, HC, CBC or none (i.e. it is highly specialised and thus does not really belong to any of those three categories)?*

## 1.2 Some key figures related to residential care, home care and community-based care available

For each of the three broad categories of LTC care settings (residential care, home care and community-based care), this section provides some key figures related to the category in Montenegro.

### 1.2.1 Residential care

#### 1.2.1.1 Type of providers

Residential care for older people in Montenegro is delivered through 5 public and 2 private (for-profit) residential care facilities. 5 public ones – in Bijelo Polje, Pljevlja, Risan, Nikšić, and Podgorica – are overseen by the Ministry of Social Welfare, Family Care and Demography and

operate as mainstream components of the country's LTC infrastructure. In addition, 2 registered private residential care-providers – DOO Dom starih "Duga" and DOO Dom starih "Nana", both located in Danilovgrad – offer residential care on a for-profit basis. While the public residential homes form the core of the national system, the private sector supplements available capacity, particularly in regions where public provision is limited.

#### 1.2.1.2 Number of providers

The total number of residential care-providers is seven. These facilities represent the core infrastructure for LTC services in the country and are considered mainstream in the national context.

#### 1.2.1.3 Capacity

Residential care for older people and adults with disabilities in Montenegro is provided across seven residential homes offering a total capacity of 1,060 beds.

As of 31 December 2023 the total number of users residing in care homes was 818, representing an overall occupancy rate of 77.2% across the national residential LTC network. Capacity by care home ranged from 32 to 274 places, with individual occupancy rates varying between 47.1% and 100% depending on the facility (Institute for Social and Child Protection, 2024).

#### 1.2.1.4 Workforce

Montenegro is not included in the EU framework for monitoring the LTC Recommendation. Consequently, the indicators presented here are not directly comparable with EU countries' figures, but provide a descriptive overview of the LTC workforce in residential care settings based on national administrative sources.

A total of 584 people were engaged in Montenegro's residential care homes for older people and adults with disabilities (Institute for Social and Child Protection, 2024). Of these, 436 (74.7%) were employed on permanent contracts, while 55 (9.4%) were engaged under fixed-term contracts, 75 (12.8%) under service agreements, 5 (0.9%) in temporary roles, 6 (1%) in internships, and 7 (1.2%) as volunteers.

The workforce included 79 qualified professionals, representing 13.5% of the total workforce. These comprised 22 social workers, 12 psychologists, 10 lawyers, 4 pedagogues, 4 sociologists, and 27 medical doctors. Additionally, 68 professional associates<sup>2</sup> – including 17 medical technicians and 15 physiotherapists – accounted for 11.6% of the workforce. The largest category comprised 437 personnel classified as associates<sup>3</sup> (associates with secondary education), who made up 74.8% of total staff. Among them were 120 LTC nurses, 55 personal care workers, and 13 occupational therapy assistants. This group also included 222 technical and support staff such as cooks, cleaning staff, drivers, and laundry workers (Institute for Social and Child Protection, 2024).

Women comprised a substantial majority (72.4%) of the overall workforce, compared with 27.6% who were men (Institute for Social and Child Protection, 2024). This gender distribution

<sup>2</sup> Professional associates (*stručni saradnici*) are people with higher education in fields outside the core social and medical professions, working with service-providers in roles such as medical technicians, physiotherapists, or administrative experts (Law on Social and Child Protection, Article 123).

<sup>3</sup> Associates (*saradnici*) are support staff with secondary education qualifications who contribute to service-provision, including care-giving, occupational therapy support, and auxiliary roles (Law on Social and Child Protection, Article 123a).

reflects a broader pattern in Montenegro, where care-related professions such as nursing, personal support, and counselling are most commonly pursued by women.

## 1.2.2 Home care

### 1.2.2.1 Type of providers

Home-based care services are primarily organised and provided by residential homes licensed to provide home assistance services to adults and older people with disabilities. These include international organisations and local NGOs (private not-for-profit), and public residential homes (public).

### 1.2.2.2 Number of providers

There are in total 7 home care providers, 1 public and 6 private not-for-profit, covering 22 out of 24 municipalities in Montenegro (Ministry of Social Welfare, Family Care and Demography, 2025). Among those, the Red Cross of Montenegro is the largest. It delivered home care services in 14 municipalities in 2024.

A notable contribution to the provision of home care services is made by Caritas Montenegro (providing services in six municipalities), and the Grabovac public residential care homes (providing services in five municipalities). Other providers include local NGOs providing home services in one or two municipalities.

### 1.2.2.3 Capacity

There are no aggregate data on the number of beneficiaries served by municipal home care programmes. However, available data from other sources offer a partial insight into capacity. According to the Red Cross of Montenegro, 852 older people received professional home care services in 2024 (Red Cross of Montenegro, 2024). These numbers provide a limited but important indication of the scale at which non-state actors contribute to home-based care delivery.

### 1.2.2.4 Workforce

There are currently no available data on staff employed to provide home care services. The only available figures come from the Red Cross of Montenegro, which reported employing 90 professional home care workers in 2024 (Red Cross of Montenegro, 2024).

## 1.2.3 Community-based care

### 1.2.3.1 Type of providers

Community-based LTC services in Montenegro are primarily delivered by public residential homes, particularly state-run, that have expanded their activities to include licensed daycare services. These services are authorised by the Ministry of Social Welfare, Family Care and Demography and are targeted at older people and adults with disabilities living in the community. In most cases the day centres operate under the administration of existing residential care homes, although some municipalities may host additional centres supported through local government.

### 1.2.3.2 Number of providers

A total of 17 licensed day centres for older people operate across Montenegro. These centres are located in: Nikšić (2), Danilovgrad (2), Mojkovac (1), Plav (1), Cetinje (2), Rožaje (1), Bijelo Polje (2), Petnjica (1), Pljevlja (2), Risan (1), Kolašin (1), and Kotor (1). These centres are administered by public residential homes. In several cases, although formally managed through them, the centres are additionally supported or co-financed by local municipalities or international partners, including the UNDP.

### 1.2.3.3 Capacity

Day centres managed by residential homes report a combined service capacity of 265 places, with 226 active users (Institute for Social and Child Protection, 2024). These figures include daycare activities for older people and adults with disabilities. Individual capacities vary by location, typically ranging between 9 and 33 places per centre.

### 1.2.3.4 Workforce

There are currently no disaggregated or publicly available data on staff employed specifically within day centres. Although general workforce statistics exist for the residential homes that manage these centres, they do not distinguish between staff assigned to residential versus community-based services. As a result the number and qualification profiles of staff directly engaged in day centre activities remain undocumented.

## 1.3 Some key characteristics of residential care, home care and community-based care available

For each of the three broad categories of LTC care settings (residential care, home care and community-based care), this section provides some key characteristics of the category in Montenegro.

### 1.3.1 Residential care

#### 1.3.1.1 Services provided, eligibility criteria or entitlements

Residential care in Montenegro is provided in licensed public and private facilities offering accommodation, nutrition, hygiene maintenance, healthcare support, and psycho-social services to adults with disabilities and older people. These facilities must meet minimum standards defined by national legislation and are licensed by the Ministry of Social Welfare, Family Care and Demography. The main regulatory document is the *Rulebook on the Conditions, Norms, and Minimum Standards for Residential Care for Adults and Older People*<sup>4</sup>.

To qualify for residential care, people must be adults with disabilities, or older people who require long-term support due to reduced functional capacity or difficult family and social circumstances. Admission decisions are based on an assessment of people's ability to care for themselves and the level of support they need in daily life, classified into four nationally defined levels of support. These range from minimal assistance with daily tasks to full-time,

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<sup>4</sup> Official Gazette of Montenegro Nos. 058/14 from 29.12.2014, 021/16 from 25.03.2016 from 09.03.2018, 015/18 and 065/19 from 02.12.2019 available here

intensive care needs, and reflect people's capacity for self-care and participation in everyday life. The eligibility assessment and care planning are carried out by professionals within the residential homes, often in collaboration with case managers from centres for social work.

Services provided include long-term accommodation, daily meals, hygiene support and living environment maintenance, nursing support, rehabilitation, counselling, leisure and occupational activities, and healthcare in line with the national health and insurance framework. Each user receives an individual service plan based on regular assessments.

The demographic structure of users in residential care confirms that services are predominantly used by older people, particularly those aged 65+, who represent the vast majority of beneficiaries. This aligns with broader European trends, where advanced age is a strong predictor of LTC needs, particularly in residential home settings (Institute for Social and Child Protection, 2024). The high proportion of users aged over 80 reflects increased demand for intensive support among the oldest cohorts.

### 1.3.1.2 Quality assurance

All residential homes are subject to licensing conditions that ensure minimum quality standards, including adequate staff numbers and qualifications, defined procedures, and user rights protection. The Ministry of Social Welfare, Family Care and Demography oversees licensing, while the Institute for Social and Child Protection provides training and professional support. Several public facilities have adopted the international standard (ISO 9001:2015) on management quality. These include the homes in Risan (Grabovac), Bijelo Polje, Pljevlja, Podgorica, and Nikšić. ISO certification requires residential homes to conduct user satisfaction surveys and maintain documented procedures for service-provision and internal accountability.

Licensed providers are obliged to meet a comprehensive set of requirements to ensure the safety, dignity, and well-being of residents. These include: adequate housing infrastructure; appropriate material conditions; gender-sensitive accommodation arrangements; access to nutrition and healthcare; maintenance of personal and environmental hygiene; and the provision of a safe and supportive environment. Providers must also facilitate the empowerment and personal development of residents and ensure dignified handling and isolation in cases of death. Staffing requirements are strictly defined: one qualified professional is required for up to 30 beneficiaries; two professionals for 30 to 100; and one additional professional for every subsequent 100 residents. Facilities with 200-300 beneficiaries must employ a licensed medical doctor, with an additional medical professional required for every 150 residents beyond that. Furthermore, at least one occupational therapist and one legal affairs professional must be part of the staff team (*Rulebook on the Conditions, Norms, and Minimum Standards for Residential Care for Adults and Older People*<sup>5</sup>). These provisions collectively serve to uphold a baseline of quality and ensure structured care-delivery within residential homes.

Each facility is expected to perform internal evaluations and develop tailored procedures to meet specific user needs, including those of people with dementia. The system of regular service planning and reassessment ensures ongoing responsiveness to residents' evolving needs. Monitoring is performed through internal records, regular case assessments, and external supervision provided by the Institute for Social and Child Protection upon request.

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<sup>5</sup> Official Gazette of Montenegro Nos. 058/14 from 29.12.2014, 021/16 from 25.03.2016 from 09.03.2018, 015/18 and 065/19 from 02.12.2019 available here

Although internal evaluations are formally required, the extent and consistency of their application may vary across facilities.

### 1.3.1.3 Structure/organisation

Montenegrin residential care homes are internally organised into specialised care units. Although no information is available for the two private providers, all public residential homes operate dedicated units such as palliative care, psycho-geriatric care and dementia care. This internal structuring enables them to respond to distinct care needs and support levels.

## 1.3.2 Home care

### 1.3.2.1 Services provided, eligibility criteria or entitlements

Home-based care services are primarily organised and provided by residential homes licensed to provide home assistance services for adults and older people with disabilities. These include international organisations, public residential homes, and local NGOs. These services are intended to support older people in their homes, assisting with daily activities such as personal hygiene, nutrition, and household maintenance.

According to the *Rulebook on Detailed Conditions for the Provision and Use, Norms, and Minimum Standards of Community-Based Support Services*<sup>6</sup>, home care is provided to older people and older people with disabilities. In line with Article 5 of the rulebook, each licensed provider is required to develop a service-provision programme that outlines, among other elements, the specific categories of users eligible for the service, the number of beneficiaries and staff, the service area, working methods, planned activities, and operating hours. This means that eligibility is ultimately determined by the service-provider.

### 1.3.2.2 Quality assurance

Providers are required to meet licensing criteria defined by the Law on Social and Child Protection adopted in 2023, and related by-laws, which specify minimum staffing levels, service protocols, and internal documentation requirements. Quality-assurance standards for home care services in Montenegro focus on ensuring a safe environment, adequate facilities, and the empowerment of users. Providers of home-based care for older people and older people with disabilities are required to maintain specific staffing ratios based on the assessed level of support needed. For users requiring first- or second-level support<sup>7</sup>, the standard mandates one qualified professional for every 20 users and one care assistant for every two users. In cases where users require third-level support, the care assistant ratio shifts to one per four users. For people with the fourth-level care needs, one professional is responsible for needs-assessment and one care assistant is assigned to every 10 users. Each professional

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<sup>6</sup> Official Gazette of Montenegro, Nos 063/19 of 18 November 2019, 053/24 of 7 June 2024, 062/24 of 28 June 2024, and 104/24 of 31 October 2024 available [here](#)

<sup>7</sup> The levels of support are defined as follows (Rulebook on Community-Based Support Services, 2019):

- (a) first (highest) level – provided to users who are unable to take care of themselves or participate in daily community life activities without the continuous physical presence and assistance of another person;
- (b) second level – provided to users who are able to take care of themselves and participate in daily activities with the physical presence and assistance of another person;
- (c) third level – provided to users who are able to take care of themselves and participate in daily activities with supervision and support from another person; and
- (d) fourth level – provided to users who are able to perform all daily living activities independently, or with occasional reminders.

supervises and coordinates the work of the care assistants, who may not be assigned more than 40 working hours per week (*Rulebook on Detailed Conditions for the Provision and Use, Norms, and Minimum Standards of Community-Based Support Services*<sup>8</sup>). These standards are designed to ensure both quality and continuity in the provision of home-based LTC services.

Oversight is mainly exercised through centres for social work and the Ministry of Social Welfare, Family Care and Demography. However, no national-level outcome or quality-reporting mechanisms are currently in place for home care.

### 1.3.3 Community-based care

#### 1.3.3.1 Services provided, eligibility criteria or entitlements

Community-based services for older people and older people with disabilities are primarily provided through day centres, of which 17 are currently licensed and operational. Services typically include daytime supervision, meals, structured social activities, and basic personal assistance. Services are mostly accessed through referrals by centres for social work, although in some municipalities direct enrolment is possible. Beneficiaries are usually people who do not require continuous care but benefit from support and socialisation outside the home environment.

In addition to state-managed centres, the Red Cross of Montenegro operates older people's clubs that promote active and healthy ageing. These provide preventive and educational activities, exercise sessions, and peer-support networks, especially in more remote municipalities. The UNDP has also supported the development of local-level social service facilities for older people, improving geographical and financial access to services that were previously unavailable in some communities.

#### 1.3.3.2 Quality assurance

Licensing and oversight of day centres fall under the jurisdiction of the Ministry of Social Welfare, Family Care and Demography and the Institute for Social and Child Protection. All centres must comply with infrastructure and staffing requirements defined by national legislation. Providers must ensure: appropriate physical infrastructure and material conditions; meal provision; personal and environmental hygiene; and a safe, supportive environment that promotes user autonomy and empowerment. Services are delivered for 20-40 hours per week, depending on the centre's programme and user needs. Staffing requirements are clearly defined to ensure adequate support: for older adults without disabilities, one qualified professional and one assistant are required for every 30 users, with one additional professional and one assistant for every additional 15 users. For older people with disabilities, the regulation mandates a higher level of support, requiring one professional and two assistants for every 10 users, with incremental additions based on group size (*Rulebook on Community-Based Support Services*, 2019). These structured staffing ratios are designed to sustain consistent quality and responsiveness in the delivery of care.

Although internal evaluations are formally required, no publicly available documentation exists to assess their scope or consistency across facilities, making it difficult to ascertain the extent to which they provide an accurate or comprehensive picture of service quality.

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<sup>8</sup> Official Gazette of Montenegro, Nos 063/19 of 18 November 2019, 053/24 of 7 June 2024, 062/24 of 28 June 2024, and 104/24 of 31 October 2024 available [here](#)

## 1.4 Geographical imbalances in the availability of residential care, home care and community-based care

For each of the three broad categories of LTC care settings (residential care, home care and community-based care), this section identifies potential geographical differences in the balance of LTC categories in Montenegro.

### 1.4.1 Residential care

Montenegro's residential care infrastructure is predominantly concentrated in urban centres, particularly in the central and southern regions. Large public residential homes, such as those in Podgorica (274 beds) and Nikšić (208 beds), serve a significant portion of the population in these areas. In contrast, the northern region – despite exhibiting higher ageing rates and greater care needs – has significantly more limited access. For example, JU Dom starih in Pljevlja, located in one of the largest municipalities in the north, has a capacity of only 61 beds, while JU Dom starih in Bijelo Polje operates with 200 beds and recorded an occupancy rate of 75.5% at the end of 2023. In comparison, Pljevlja reached 95.2% occupancy at the end of 2024, suggesting latent demand in municipalities where supply is insufficient (Institute for Social and Child Protection, 2024). This regional imbalance is shaped by a combination of lower population density, and challenges in attracting and retaining qualified personnel in more remote areas. As a result, older people in the north often rely on informal care or face relocation to access residential care services.

### 1.4.2 Home care

Home care services are present in most (22 out of 24) municipalities (Institute for Social and Child Protection, 2024; Red Cross of Montenegro, 2024). However, even in some municipalities where services do exist, coverage remains partial and is often dependent on temporary donor-funded initiatives, rather being than integrated into long-term municipal planning or budgets.

### 1.4.3 Community-based care

17 licensed day centres for older people are currently operational across Montenegro, with most situated in urban and central municipalities (Institute for Social and Child Protection, 2024). Several municipalities still do not offer any community-based services for older people. As with residential and home care, this distribution reflects broader patterns in service development, with central and southern regions more likely to host structured facilities.

## 1.5 A closer look at hybrid and/or innovative care settings/models available

In Montenegro an example of a hybrid and socially innovative LTC model has been developed through the establishment of community care centres. These centres are implemented in cooperation with municipal authorities and the Red Cross of Montenegro, and with support from international donors including the European Commission. They are currently active in two municipalities (Bijelo Polje and Bar) and form part of broader efforts to strengthen local social protection and healthcare systems through integrated, community-based approaches (Red Cross of Montenegro, 2024).

Community care centres combine elements of home care and community-based care and include a range of services such as: preventive home visits; assistance with daily tasks; counselling; and support for informal carers, especially those caring for people with dementia.

Services are delivered either at the user's home or within the local community, with coordination between social care and healthcare actors when necessary. The model is intended to enable older people to remain in their homes for as long as possible and to reduce the risk of institutionalisation, particularly in regions where the formal LTC infrastructure is limited (European Commission, 2024).

This model is understood as hybrid because it integrates aspects of both home-based and community-based care. It is non-residential and does not include embedded healthcare professionals or 24-hour medical care, but offers social services and care coordination adapted to the needs of people with moderate dependency. Although currently implemented only in selected municipalities, the centres are new in the national context and align with wider efforts to diversify LTC options beyond institutional settings.

From an innovation perspective, the centres reflect a shift toward person-centred care and de-institutionalisation. Some centres have begun using digital tools for service scheduling and user record-keeping, though broader use of ICT (e.g. remote monitoring or telecare) has not yet been introduced.

## 1.6 Knowledge gaps: improving the information on formal LTC available

This section identifies knowledge gaps that would need to be filled in order to improve the information on formal LTC available in Montenegro.

Despite recent efforts to strengthen the LTC system in Montenegro, significant information gaps remain across several key areas, impeding policy development, resource planning, and outcome monitoring.

One notable gap concerns the availability of up-to-date and disaggregated data on the LTC workforce. Although total employment figures are available for residential care settings through their reports, there is no systematic national dataset that captures the number and type of LTC personnel across all care settings, particularly in home and community-based care. In addition, turnover rates, vacancies, and trends in workforce retention are not monitored on a regular basis, limiting the ability to assess sector stability and plan for future human resource needs.

There is also a lack of comprehensive and publicly accessible information on the coverage and geographical distribution of LTC services. Although certain data exist for residential homes, including bed capacity and occupancy rates, home care and day centre services remain under-reported. Montenegro does not maintain a central registry of all formal LTC providers at the national or municipal level. Data are not collected or published on unmet needs, waiting lists (except in residential care), or the number of applications denied, making it difficult to assess whether current service capacity aligns with population needs – especially given the country's ageing demographic profile.

In terms of quality assurance, the framework for internal monitoring is established through legislation and ISO 9001 certification in several residential care facilities. However, publicly available evidence on how internal evaluations are conducted remains sparse, and there is currently no national external monitoring body with standardised reporting practices for LTC providers. These facilities are not systematically assessed for care outcomes or user satisfaction, which are essential for ensuring quality and guiding service improvements.

Financial transparency and funding data also remain limited. Although public funding mechanisms are defined through national legislation, there are no disaggregated data on the level and structure of funding allocated to different types of LTC services or on how this funding is distributed across municipalities. Unit cost data – for example, the average cost per resident in residential home or per hour of home care – are not published, nor is there a public overview

of user co-payments and affordability thresholds, making it difficult to evaluate financial accessibility.

A further knowledge gap relates to the decentralised nature of LTC delivery. Municipalities play a key role in implementing home and community-based care, but there is no consolidated national overview of how responsibilities are exercised across local authorities. In the absence of inter-municipal comparisons or systematic monitoring, it is difficult to evaluate whether geographical variation in service-provision reflects local policy priorities, funding differences, or disparities in administrative capacity.

Finally, there is a lack of outcome-based monitoring across all formal LTC settings. No standard indicators are in place to measure service impact on the health, functional status, or quality of life of older people. Longitudinal data on care trajectories – for example, transitions from home care to residential care – are not collected, hindering the ability to track system performance or plan integrated care pathways. Similarly there is limited public documentation evaluating the results of hybrid or community-based care models introduced through EU or donor-funded pilot projects.

Together these gaps constrain evidence-based planning and limit Montenegro's capacity to benchmark its LTC system against EU peers or align with the monitoring indicators outlined in the EU LTC Recommendation.

## 2. Assessment of overall organisational structure and availability of various categories of LTC settings in Montenegro

This section provides a critical assessment of the overall organisational structure and availability of the three main categories of LTC settings in Montenegro (residential care, home care and community-based care). This assessment looks in turn at: the part played by categories of LTC settings in the broader structure of LTC provision (Section 2.1); the extent to which the structure and availability of LTC affect people's choice of the type of LTC for their needs (Section 2.2); the adequacy of the organisational structure and availability of the categories of LTC settings (Section 2.3); and finally, the impact of the structure of public funding on the broad categories of LTC settings available.

### 2.1 Part played by the categories of LTC settings in the broader structure of LTC provision

LTC in Montenegro continues to be dominated by informal care, underpinned by strong social norms and expectations regarding family responsibility for the older people. Many older people prefer to remain at home and be cared for by relatives, a preference shaped by both cultural values and economic necessity. This informal care model is supported to some extent by state-provided cash benefits, which can ease the financial burden on care-giving families. These benefits, though modest, offer a viable option for older people with lower care needs who do not require continuous medical supervision or professional healthcare services. For such people, the combination of family care and financial support remains the most accessible form of LTC.

Formal care settings, by contrast, represent a structured and regulated segment of LTC provision. Residential care homes, home care services, and day centres offer essential services, particularly for people with severe or complex healthcare needs. Among these, residential care homes play a key role in caring for people with high levels of dependency,

including those with dementia, cognitive impairments, or requiring palliative care. Community-based services, such as day centres and municipal home help, provide lower-intensity support and are instrumental in preventing premature transitions to residential care.

## 2.2 Extent to which the structure and availability of the broad categories of LTC settings affect people's personal choice of the type of LTC

The availability of LTC services varies significantly across Montenegro and influences the degree to which people can exercise real choice in selecting care options that best fit their needs. In the central and southern regions, where services are more concentrated and better funded, people are more likely to find appropriate LTC services within reach. This is not the case in the north, where a combination of limited infrastructure, low population density, and lower local budgets restricts access to all types of formal care. As a result many people in the north rely heavily on informal care or are forced to relocate southward for LTC support.

This imbalance means that personal preference is often secondary to availability. People who would prefer to remain at home or attend a local day centre may have no choice but to enter a residential facility due to the absence of local alternatives. Additionally, awareness of available services is limited, especially in more remote municipalities, which further reduces people's ability to make informed care choices.

In terms of affordability, residential care in Montenegro is financed through a mixed model. A significant share of residents rely on co-financing mechanisms involving personal resources, family contributions, and public support. Fully self-funded users represent a minority, indicating that residential care may not be easily affordable without external assistance.

## 2.3 Adequacy of the organisational structure and availability of the broad categories of LTC settings

The adequacy of Montenegro's LTC system can be best understood through the lens of its service segmentation and how it accommodates different levels of care needs. The existing framework broadly recognises four levels of support, ranging from people who can perform daily activities with minimal assistance to those requiring intensive, continuous care. The organisational structure aligns formal LTC services accordingly, with home care typically designed for low- to medium-dependency users, while residential care caters to those with higher needs, such as severe cognitive decline or limited mobility.

However, access to appropriate care settings is often constrained by a lack of services that match the specific profile of needs, particularly in less accessible areas. In municipalities where home care or day centres are unavailable or difficult to reach, people – especially those without family care-givers – are more likely to transition directly into residential homes. This pathway may not always align with their actual care requirements but becomes the default due to structural limitations.

Eligibility criteria for formal care settings are another important factor shaping access. For example, residential care is typically restricted to people with higher care needs, often confirmed through social work assessments. This targeted approach helps allocate resources effectively but may exclude those with intermediate needs who could benefit from expanded home or community-based services. In addition, although respite care and home adaptation services exist, they are not systematically integrated into the broader care framework and are not easily accessible in most areas.

Recognising these systemic gaps, international organisations (such as the UNDP and the Red Cross of Montenegro) have initiated programmes to deliver home-based assistance to older people in remote regions. These initiatives involve trained staff and volunteers who provide basic support with hygiene, mobility, and household maintenance – services that fill a critical void in areas lacking public provision.

## 2.4 Impact of the structure of public funding on the broad categories of LTC settings available

Public funding in Montenegro is provided primarily at the national level for residential care homes, and partially delegated to municipalities in the case of home care and community-based services. This dual structure has a significant impact on the availability and consistency of LTC services. Centralised funding ensures stable operation of large residential care homes, but the decentralised model for home and day services means that their development is uneven and contingent on local political will and budget capacity.

As a result, central and southern municipalities are better positioned to support a broader range of LTC services, while northern municipalities are more dependent on donor-funded programmes. This is due to uneven regional development: municipalities in the north face additional challenges, including populations living in remote and hard-to-reach areas, underdeveloped infrastructure, and limited municipal resources to finance community- and home-based care. Although donor-funded programmes have helped introduce some innovation and localised development, this reliance reinforces regional disparities and limits the sustainability of services. The absence of earmarked national transfers for community- and home-based care further hinders equal access and balanced service development across the territory.

International donors, notably the EU and multilateral agencies, have played a prominent role in supporting care models in underdeveloped areas. However, the long-term continuation of such services remains uncertain without consistent public financing and stronger national policy alignment.

## 3. Planned or ongoing reforms, policy debates and structural measures in formal LTC in Montenegro

This section describes planned or ongoing reforms, policy debates and structural measures in formal LTC, including those benefiting from EU funding, and/or policy debates regarding the availability of different categories of LTC settings in Montenegro.

Recent years have seen increasing momentum in Montenegro toward enhancing the formal LTC system, driven by both domestic policy priorities and external support from international organisations, particularly the EU. Although there was no unified, comprehensive LTC strategy in place as of 2024, reforms have been introduced incrementally through social protection frameworks, national ageing policies, and project-based interventions.

The government of Montenegro's social protection strategy for 2025-2028 identifies the development of integrated and decentralised social services as a priority, including expanding care options for older people and people with disabilities. The strategy emphasises de-institutionalisation and support for community-based alternatives. Although the LTC components within this strategy are not highly detailed, the document signals the government's intent to diversify care options beyond traditional residential models.

In parallel the Red Cross of Montenegro has initiated several donor- and publicly funded projects aimed at improving LTC provision for older people (Red Cross of Montenegro, 2024).

Notably, the “services for older people in the community” project (2023-2025), financed through the EU Instrument for Pre-Accession Assistance (IPA II) under the Ministry of Finance’s CFCU<sup>9</sup> programme, is being implemented in Bar and Bijelo Polje. It focuses on piloting respite care, providing home visits by mixed healthcare and social care teams, counselling, and accredited training for informal carers. Additionally, the ministry and the Red Cross collaborate on the “home care for adults and older people with disabilities” programme, currently implemented in 15 municipalities, reaching over 700 older users with support from municipal partners. Another ongoing initiative, “care for older people – cross-border project Montenegro-Albania-Bosnia and Herzegovina (phase V)”, supported by the Italian Red Cross, is active in nine municipalities and combines home visits, mobile outreach teams, and older people’s clubs to reduce isolation and strengthen local service capacity. These projects reflect growing efforts to diversify LTC services and promote community-based models through inter-sectoral collaboration and international support.

Institutional reform is also being shaped by Montenegro’s alignment with the European Pillar of Social Rights and the EU LTC Recommendation of 2022. National authorities have expressed commitment to strengthening the quality, accessibility, and sustainability of LTC services, as reflected in their inputs to the EU’s Employment and Social Policy Analysis Network.

Key policy debates revolve around the fragmentation of service-provision and the need for improved coordination between social care and healthcare sectors. Stakeholders, including civil society organisations and professional associations, have also raised concerns about workforce shortages and the absence of licensing or accreditation for private LTC providers. These discussions are particularly relevant in the light of Montenegro’s demographic trends and the increasing demand for diversified, person-centred care options.

Efforts to address these concerns are evident in the updated Law on Social and Child Protection (2023), which introduced clearer conditions for service licensing, supervision, and quality control. The reform provides a legal basis for expanding community-based care services and enhancing the role of local government in service-provision. However, implementation remains uneven, and further steps are needed to develop a national registry of LTC providers, standardised monitoring tools, and data systems for policy evaluation.

Several strategic documents, including the economic reform programme for 2023-2025 and the 2024 EU progress report on Montenegro, underline the importance of improving LTC availability and coordination as part of broader social policy reform. These assessments highlight the role of IPA funds in strengthening Montenegro’s social protection infrastructure.

## 4. Challenges, good policies or practice, and recommendations in Montenegro

Based on the findings in Sections 1-3, this section provides reflections on the main challenges related to formal LTC in Montenegro (Section 4.1). It also identifies any good policies or practice in the country that other countries might wish to follow (Section 4.2). Lastly, it puts forward recommendations for improvements that would be worth considering in the country to ensure a more balanced mix of LTC options and settings (Section 4.3).

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<sup>9</sup> Directorate for Finance and Contracting of the EU Assistance Funds.

## 4.1 Challenges

The findings in previous sections highlight several systemic and operational challenges across Montenegro's formal LTC sector. These challenges affect each of the three broad categories of LTC settings – residential care, home care, and community-based care – and have an impact on the overall coherence, accessibility, and sustainability of the system.

In residential care, although the institutional infrastructure is well-established in the central and southern regions, the north of the country remains under-served. Public residential care facilities often operate at or near full capacity, as shown by occupancy rates exceeding 95% in facilities such as JU Dom starih in Pljevlja. However, there is no uniform mechanism for service allocation, and waiting lists persist, particularly for those requiring higher levels of support. Affordability also remains a concern, as a significant number of residents must co-finance their care, and self-funded users account for a substantial share of beneficiaries. Although a licensing system and minimum standards are in place, consistent quality monitoring and external evaluations are lacking, and internal reviews may not always reflect the actual service conditions.

A key challenge in improving the quality of care in residential settings lies in the insufficient integration between social protection services and the healthcare system. Currently, residential homes operate largely outside the formal healthcare framework, which undermines the quality of care provided to users with complex medical needs. Integrating healthcare services into residential care – both structurally and financially – would significantly enhance service-delivery.

Home care relies greatly on donor-funded initiatives or civil society organisations such as the Red Cross of Montenegro. This fragmented implementation model hinders the sustainability and continuity of care. Moreover, data on user needs and service outcomes remain insufficient, making it difficult to assess the long-term impact of these interventions.

Community-based care, mainly delivered through day centres for older people, suffers from similar disparities. Only 17 licensed centres are currently operational, and they are predominantly located in urban areas. Furthermore, no external quality-assurance mechanism is in place for community-based services, and there is little integration with healthcare services.

Across all categories, gaps in care pathways are evident, particularly in transitional arrangements between settings. For example, people with moderate care needs may not only not qualify for residential care but also lack sufficient home care support. This results in a service vacuum that is often filled by informal carers. However, the sustainability of informal care is increasingly in question due to emigration, urbanisation, and shifting family dynamics. Data systems for LTC remain underdeveloped, preventing comprehensive monitoring of needs, coverage, and quality.

## 4.2 Good policies or practices

Despite systemic challenges, several initiatives stand out as promising. The piloting of integrated service models through donor-funded projects, particularly those led by the Red Cross and supported by the EU and UNDP, has demonstrated how community and home care services can be effectively combined to reach remote populations. These projects often include preventive visits, volunteer training, and support for informal carers, offering a scalable model for decentralised LTC provision.

A good practice example of community-based service development can be seen at the Grabovac public residential care homes. In line with the ongoing reform of the social and child protection system – which emphasises the transformation of traditional institutions and the expansion of services within local communities – Grabovac has recognised the importance of

supporting independent living for adults and older people. Drawing on its institutional experience and sensitivity to the needs of its beneficiaries, it has developed and implemented three key services: a shelter/drop-in centre for adults and older people, a daycare centre for people with dementia, and a home assistance service. This example illustrates how a residential home can effectively transition toward a more inclusive, community-oriented model of care, contributing to the goals of de-institutionalisation and improved quality of life for vulnerable populations.

Moreover, the adoption of ISO 9001:2015 quality management standards by several public residential homes (e.g. Grabovac, Podgorica, and Pljevlja) provides a structured framework for user feedback and continuous quality improvement. This approach could inform similar efforts in home and community-based care, where quality-assurance mechanisms are currently lacking.

### 4.3 Recommendations for policy and practice

A comprehensive national LTC strategy should be developed and implemented as a matter of priority. This strategy should articulate clear eligibility pathways, define transitions across types of care, and clarify the respective roles of residential, home-based, and community-based care settings. Particular attention should be paid to expanding non-residential services that allow for more flexible and accessible care options.

It is also essential to establish a national LTC data system capable of capturing detailed information on service availability, utilisation, quality, and workforce characteristics. Such a system would support evidence-based planning, transparency, and long-term system monitoring. A centralised registry of users and providers would help identify gaps and inform targeted interventions.

Investment in digital infrastructure should also be expanded to enhance individualised service planning. Enabling social workers to tailor services to each user's family and medical situation through improved information systems would not only reduce administrative burdens but also increase the efficiency and personalisation of care. Importantly, private LTC providers should be integrated into national information systems to ensure full oversight and evaluation of their operations.

Stronger ties between residential homes and healthcare facilities are also needed. Structured engagement with neuro-psychiatric clinics and primary care physicians is necessary to ensure that pre-admission assessments are conducted directly and professionally, rather than based on family descriptions, which can sometimes lead to inappropriate admissions and service mismatches. Additionally, primary care providers should be required to supply full medical records during the admission process.

External quality-assurance mechanisms should be introduced and made applicable to all LTC services. This function could be managed by the Institute for Social and Child Protection and linked to the licensing and accreditation processes to improve accountability and service quality across the board.

Efforts should also be made to ensure adequate staffing in LTC settings, especially in residential homes. Salary harmonisation between the LTC and healthcare sectors, coupled with targeted incentives for professionals working in remote areas, would support staff retention. In addition, social care work in residential homes should be promoted at university faculties of social sciences and helping professions. Awareness campaigns and targeted education efforts could help motivate young professionals to enter the sector.

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## Annex 1: Typology of LTC settings

### 1) Category 1: Residential care

Residential care settings include all LTC services and interventions delivered in facilities that provide 24-hour accommodation services and various levels of care and support services commensurate with users' care needs, available on a full-time residential basis.

**1.1 Assisted living facilities:** Facilities providing housing, hospitality services and personal care for adults who can live independently and make decisions on their own behalf, but who require a supportive environment due to reduced functional ability and are at risk when living in their own home. The facilities may consist of a room, an apartment unit in a building, or a private home in a retirement community.

**1.2 Facilities/hospitals specialising in chronic care:** Facilities offering specialised care services for people needing a higher level of medical care and/or intermediate care while recovering from a medically complex condition (e.g. pressure injuries, severe strokes, or conditions following trauma or surgery). The aim is for people to achieve the maximum functional recovery and/or stabilise their clinical status in order to allow them to be discharged to their home. In some countries these may be referred to as transitional care or rehabilitation facilities.

**1.3 In-patient hospice facilities:** Varying in structure and providing highly skilled medical and nursing care for people in need of palliative care, these care facilities may be similar to hospitals, while attempting to create a more peaceful environment and offer shelter for terminally ill patients, irrespective of the timing of admission in relation to the course of their illness or the duration of their stay.

**1.4 Nursing homes or skilled nursing facilities:** A type of LTC facility that provides 24-hour medical care and skilled nursing support in addition to residential care, usually for people with severe sensory, cognitive, behavioural, nutritional and mobility problems, and/or bowel and bladder incontinence, which result in high levels of dependency. Such care facilities may be used for shorter periods, usually following hospital discharge, or for extended periods of time by people with a permanent or irreversible decline in functioning.

**1.5 Residential care facilities, residential homes, care homes, and care homes for older people:** Formal LTC is provided to people residing and receiving care services in LTC facilities. These residential care homes provide 24-hour personal care and support for people who need help with daily tasks, but who may not need skilled nursing care. The aim is to provide a safe and supportive environment, adapted to people's individual care needs, where people can lead a meaningful life.

**1.6 Hospices offering / specialising in palliative care:** Formal LTC provided in facilities offering / specialising in palliative care during the last weeks/days of life.

### 2) Category 2: Home care

**2.1 Home-based care:** Home-based care addresses the healthcare and social care needs of older people, including a wide range of services that allow them to live safely in their homes and participate in the community. It also supports the needs of informal carers so that they can provide high-quality care, reduce overload and relieve stress. Home-based care can take different forms and combinations:

- formal care by relatives: relatives providing LTC are formally employed by a public body (e.g. municipalities in Denmark; the state in the Austrian province of Burgenland) and may receive some guidance, supervision etc.;

- live-in carers (with various possible arrangements); and/or
- mobile home-based care, provided by various service-providers (public, non-profit private, for-profit private).

**2.2 Mobile hospice / palliative care teams:** Mobile services for people with LTC needs in their last weeks/days of life, and related support for informal carers, formal mobile carers and live-in carers. Mobile hospice / palliative care teams are usually linked to hospices or in-patient palliative care units, and provide home visits, information and palliative medication.

### 3) Category 3: Community-based care

**3.1 Recreational or community centres (for people with care needs):** A type of care service located in local community buildings, designed to improve and maintain the physical and mental capacities of people with care needs, as well as to provide opportunities for them to connect with community resources.

**3.2 Day centres:** Centres providing care, including services for people who require assistive and supportive services during the day, usually on a regular basis, and/or need opportunities to socialise. They are mostly located within the community, close to people's homes, and do not offer accommodation.

**3.3 Day hospice centres:** Centres offering a type of care designed for people with palliative care needs being cared for in the community. They may be based within hospitals, hospices, palliative care units or other healthcare facilities, but do not offer accommodation.

### 4) Category 4: Hybrid and/or innovative LTC settings/models

This fourth category of LTC includes settings/models that are "hybrid" and/or "innovative". Hybrid settings/models are those that do not (wholly) belong to one of the broad categories 1-3 above. Innovative LTC settings/models may belong to one of the broad categories 1-3 above, may be hybrid, or may be highly specialised and thus not really belong to any of categories 1-3.

## Annex 2: EU performance indicators, context information items and policy levers

The Indicators' Sub-Group of the Social Protection Committee and the European Commission have developed jointly an "EU Monitoring Framework on the Council Recommendation on access to affordable high-quality long-term care". A first version ("[version 0](#)") of the framework was adopted by the Social Protection Committee in May 2025 (European Commission, 2025). It constitutes the baseline against which progress in the various Member States can be evaluated and will be updated on a regular basis.

The framework contains three types of data. First, the "performance indicators"; these are quantitative and should allow an assessment of progress towards the key objectives of the LTC Recommendation. Second, the "policy levers"; these are indicators of Member States' policies and provide qualitative information as to whether the specific provisions of the Recommendation are reflected in national legislative or policy frameworks. Both performance indicators and policy levers show Member States' progress towards implementing the Recommendation. Finally, the "context information" recalls the context (demographic, socio-economic, fiscal...) in which the various dimensions of the Recommendation are situated; it may be quantitative or qualitative. The different dimensions are monitored through a mix of performance indicators, policy levers and context information.

This statistical annex only presents a selection of performance indicators, context information items and policy levers included in this EU monitoring framework.

**Table A1: Share of the population providing informal care or assistance at least once per week on average, %, 2019**

Country	
<b>EU-27</b>	17.0
<b>Austria</b>	15.3
<b>Belgium</b>	12.9
<b>Bulgaria</b>	13.6
<b>Croatia</b>	26.1
<b>Cyprus</b>	8.3
<b>Czechia</b>	12.9
<b>Denmark</b>	29.2
<b>Estonia</b>	13.9
<b>Finland</b>	20.5
<b>France</b>	24.9
<b>Germany</b>	21.7
<b>Greece</b>	14.3
<b>Hungary</b>	13.8
<b>Ireland</b>	12.6
<b>Italy</b>	16.7
<b>Latvia</b>	16.7
<b>Lithuania</b>	13.8
<b>Luxembourg</b>	14.6
<b>Malta</b>	14.8
<b>Netherlands</b>	15.9
<b>Poland</b>	14.2
<b>Portugal</b>	12.0
<b>Romania</b>	7.5
<b>Slovakia</b>	13.2
<b>Slovenia</b>	14.5
<b>Spain</b>	10.8
<b>Sweden</b>	10.9

Source: European Commission, 2025 (context information item C23; based on 2019 European Health Interview Survey [EHIS data]).

**Table A2: Total public expenditure on LTC as % of GDP and total cost of ageing, 2022**

Country	Public LTC expenditure in % of total GDP	Public LTC expenditure in % of total cost of ageing
<b>EU-27</b>	1.7	7.1
<b>Austria</b>	1.6	5.7
<b>Belgium</b>	2.3	8.6
<b>Bulgaria</b>	0.5	2.9
<b>Croatia</b>	0.5	2.7
<b>Cyprus</b>	0.2	0.9
<b>Czechia</b>	1.5	7.2
<b>Denmark</b>	3.0	12.2
<b>Estonia</b>	0.4	2.4
<b>Finland</b>	2.1	8
<b>France</b>	1.9	6.3
<b>Germany</b>	1.9	7.6
<b>Greece</b>	0.1	0.6
<b>Hungary</b>	0.5	3.4
<b>Ireland</b>	1.2	10.2
<b>Italy</b>	1.6	6.0
<b>Latvia</b>	0.5	2.8
<b>Lithuania</b>	1.0	6.6
<b>Luxembourg</b>	1.1	6.4
<b>Malta</b>	1.2	6.9
<b>Netherlands</b>	3.8	18.2
<b>Poland</b>	0.5	2.8
<b>Portugal</b>	0.5	2.0
<b>Romania</b>	0.3	2.2
<b>Slovakia</b>	1.0	5.3
<b>Slovenia</b>	1.0	4.6
<b>Spain</b>	0.8	3.4
<b>Sweden</b>	3.2	13.4

Source: European Commission, 2025 (context information item C3; based on 2024 Ageing Report data).

**Table A3: Share of public LTC expenditure by setting, %, 2022**

Country	Public LTC expenditure by setting		
	Home care	Residential care	Cash benefits
<b>EU-27</b>	28.8	46.2	25.0
<b>Austria</b>	9.7	40.5	49.8
<b>Belgium</b>	28.0	61.3	10.8
<b>Bulgaria</b>	49.8	39.4	10.8
<b>Croatia</b>	4.7	53.7	41.6
<b>Cyprus</b>	35.2	4.2	60.6
<b>Czechia</b>	8.3	60.2	31.5
<b>Denmark</b>	65.8	34.2	0.0
<b>Estonia</b>	42.7	52.7	4.6
<b>Finland</b>	77.1	11.5	11.5
<b>France</b>	37.2	57.2	5.6
<b>Germany</b>	23.2	40.2	36.7
<b>Greece</b>	16.9	83.1	0.0
<b>Hungary</b>	14.9	66.5	18.7
<b>Ireland</b>	34.8	42.1	23.1
<b>Italy</b>	21.2	25.8	53.0
<b>Latvia</b>	17.0	53.6	29.3
<b>Lithuania</b>	6.4	55.7	38.0
<b>Luxembourg</b>	33.1	59.3	7.6
<b>Malta</b>	8.2	89.5	2.3
<b>Netherlands</b>	16.4	51.0	32.6
<b>Poland</b>	34.0	65.4	0.5
<b>Portugal</b>	41.8	57.5	0.7
<b>Romania</b>	47.3	48.6	4.2
<b>Slovakia</b>	9.6	44.3	46.1
<b>Slovenia</b>	28.3	47.8	23.9
<b>Spain</b>	20.5	66.1	13.4
<b>Sweden</b>	43.5	53.8	2.6

Source: European Commission, 2025 (context information item C8; based on 2024 Ageing Report data).

**Table A4: Share of people aged 65+ receiving public home care, residential care or cash benefits, %, 2022**

Country	Home care	Residential care	Cash benefits
<b>EU-27</b>	5.5	3.3	6.2
<b>Austria</b>	4.5	3.5	19.8
<b>Belgium</b>	15.2	5.2	8.5
<b>Bulgaria</b>	0.7	1.1	2.6
<b>Croatia</b>	0.3	1.0	8.2
<b>Cyprus</b>	5.4	4.0	2.2
<b>Czechia</b>	4.3	3.9	11.5
<b>Denmark</b>	13.6	3.6	0.0
<b>Estonia</b>	2.9	4.3	2.7
<b>Finland</b>	7.6	1.5	13.0
<b>France</b>	5.8	4.4	0.0
<b>Germany</b>	3.3	3.7	12.1
<b>Greece</b>	9.1	0.0	0.0
<b>Hungary</b>	4.2	2.9	1.0
<b>Ireland</b>	7.8	3.0	7.6
<b>Italy</b>	5.4	2.5	10.0
<b>Latvia</b>	3.6	1.8	3.8
<b>Lithuania</b>	12.0	12.3	14.0
<b>Luxembourg</b>	5.4	4.5	4.3
<b>Malta</b>	18.2	4.5	0.9
<b>Netherlands</b>	17.8	5.0	1.2
<b>Poland</b>	2.6	2.0	0.8
<b>Portugal</b>	0.6	1.1	0.3
<b>Romania</b>	5.2	3.9	5.4
<b>Slovakia</b>	5.3	5.8	8.2
<b>Slovenia</b>	4.1	4.2	7.1
<b>Spain</b>	3.9	2.8	2.6
<b>Sweden</b>	10.8	2.5	14.4

Source: European Commission, 2025 (performance indicator P7; based on 2024 Ageing Report data).

**Table A5: Share of potential dependants aged 65+ who receive public home care, residential care or cash benefits, %, 2022**

Country	Home care	Residential care	Cash benefits
<b>EU-27</b>	29.6	17.7	33.7
<b>Austria</b>	18.2	13.8	79.4
<b>Belgium</b>	74.8	25.4	41.5
<b>Bulgaria</b>	6.5	9.6	23.3
<b>Croatia</b>	1.3	3.7	31.1
<b>Cyprus</b>	23.5	17.5	9.3
<b>Czechia</b>	23.7	21.7	64.0
<b>Denmark</b>	117.2	31.5	0.0
<b>Estonia</b>	10.2	15.1	9.5
<b>Finland</b>	46.4	9.0	79.3
<b>France</b>	24.3	18.3	0.0
<b>Germany</b>	20.1	22.7	73.9
<b>Greece</b>	32.5	0.2	0.0
<b>Hungary</b>	20.0	14.1	4.6
<b>Ireland</b>	55.0	20.9	53.5
<b>Italy</b>	33.1	15.4	61.7
<b>Latvia</b>	14.2	7.0	14.7
<b>Lithuania</b>	42.9	43.7	50.0
<b>Luxembourg</b>	23.3	19.6	18.6
<b>Malta</b>	161.6	39.9	7.9
<b>Netherlands</b>	126.4	35.8	8.4
<b>Poland</b>	13.4	10.4	4.0
<b>Portugal</b>	2.8	5.3	1.5
<b>Romania</b>	26.3	19.8	27.0
<b>Slovakia</b>	17.6	19.1	27.2
<b>Slovenia</b>	17.9	18.3	30.8
<b>Spain</b>	28.2	20.3	19.4
<b>Sweden</b>	109.6	25.2	146.0

*Note: This context information item can complement other indicators by pointing towards a gap in the provision of LTC services. Data limitations apply in particular as data for some settings may be imputed in a small number of cases in which a Member State was not able to provide data on recipients for a specific setting (typically settings with few recipients). Coverage is estimated as the ratio between recipients aged 65+ and potential dependants aged 65+. Recipient data are provided by Member States. Coverage may be above 100%, as the European Union statistics on income and living conditions (EU-SILC) variable used to define dependency status focuses on (self-reported) "severe" limitations only, whereas some social protection systems may also provide coverage for less severe needs, such as people who need help with IADL: this biases the coverage estimate upwards as it underestimates the dependent population, but relative comparisons of coverage across Member States are still valid in most cases. In addition, some recipients may receive cash benefits and in-kind benefits at the same time, which is why this indicator is separate for each care setting. For Germany, coverage refers to the social insurance funds' members only.*

*Source: European Commission, 2025 (context information item C12; based on 2024 Ageing Report data).*

**Table A6: People aged 16+ in households with at least one member in need of LTC not using (more) professional home care services, by main reason, %, 2024**

	No unmet needs				Financial reasons (5)	No care services available (6)	Quality of services available not satisfactory (7)	Services refused by person needing them (8)	Other reason (9)
	No unmet needs & professional care used (1)	No unmet needs & no professional care used (2)	Total "No unmet needs" [(1)+(2)] (3)	Share of (2) in (3) (4)					
<b>EU-27</b>	20.8	51.8	72.6	71.3	10.6	4.8	1.5	2.2	8.2
<b>Austria</b>	20.5	58.7	79.2	74.1	6.5	2.3	2.0	5.9	4.0
<b>Belgium</b>	55.1	4.8	59.9	8.0	19.0	8.8	2.5	7.1	2.7
<b>Bulgaria</b>	7.2	46.9	54.2	86.5	29.4	6.1	1.9	3.7	4.7
<b>Croatia</b>	17.7	44.8	62.5	71.7	16.3	6.7	2.1	3.9	8.6
<b>Cyprus</b>	49.6	7.1	56.8	12.5	29.5	1.2	1.3	6.9	4.2
<b>Czechia</b>	18.5	56.9	75.4	75.5	11.6	2.4	1.5	4.3	4.7
<b>Denmark</b>	49.5	24.3	73.8	32.9	1.5	4.3	3.5	2.2	14.8
<b>Estonia</b>	6.4	79.6	86.0	92.6	5.0	2.3	0.5	1.2	5.0
<b>Finland</b>	33.0	50.5	83.5	60.5	3.1	6.2	0.6	0.6	6.0
<b>France</b>	31.6	27.4	59.0	46.4	16.2	5.8	1.3	3.4	14.4
<b>Germany</b>	24.6	61.8	86.5	71.4	5.1	1.1	0.7	1.3	5.3
<b>Greece</b>	10.2	52.2	62.4	83.7	26.6	4.6	1.9	2.2	2.2
<b>Hungary</b>	7.0	77.7	84.7	91.7	8.4	2.0	0.2	2.4	2.4
<b>Ireland</b>	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
<b>Italy</b>	18.1	42.0	60.1	69.9	13.9	12.7	3.4	1.3	8.5
<b>Latvia</b>	18.4	55.8	74.2	75.2	11.9	4.2	1.1	2.7	5.9
<b>Lithuania</b>	20.6	34.8	55.4	62.8	13.7	5.4	3.4	4.9	17.3
<b>Luxembourg</b>	21.4	59.6	81.0	73.6	4.7	3.7	2.3	2.6	5.7
<b>Malta</b>	16.9	62.7	79.6	78.8	5.4	2.6	1.4	0.9	10.1
<b>Netherlands</b>	33.3	39.3	72.6	54.1	7.2	7.7	1.2	1.9	9.5
<b>Poland</b>	7.2	71.8	79.1	90.8	6.9	5.2	2.7	2.1	4.2
<b>Portugal</b>	33.7	19.5	53.2	36.7	25.6	8.3	0.5	3.1	9.4
<b>Romania</b>	7.9	89.6	97.6	91.8	1.9	0.2	0.1	0.1	0.1
<b>Slovakia</b>	21.7	70.8	92.5	76.5	3.9	0.9	1.0	1.4	0.2
<b>Slovenia</b>	34.0	42.9	76.9	55.8	10.0	4.9	0.6	1.3	6.2
<b>Spain</b>	12.4	52.8	65.2	81.0	13.4	4.2	1.2	2.2	13.7
<b>Sweden</b>	19.7	70.3	90.1	78.0	1.6	0.3	2.1	0.7	5.3

Note: N/A = not available.

Source: European Commission, 2025 (performance indicator P1), updated on the basis of data from the 2024 ad hoc module on access to services (EU-SILC).

**Table A7: People aged 16+ in households with at least one member in need of LTC not using (more) professional home care services primarily due to lack of availability of care services, by degree of urbanisation, %, 2024**

Country	By degree of urbanisation			Whole country
	Cities	Towns and suburbs	Rural areas	
<b>EU-27</b>	4.8	4.9	5.2	4.8
<b>Austria</b>	1.7	3.1	3.7	2.3
<b>Belgium</b>	8.9	12.1	4.7	8.8
<b>Bulgaria</b>	0.0	2.7	12.3	6.1
<b>Croatia</b>	8.6	3.8	8.6	6.7
<b>Cyprus</b>	0.7	4.2	2.4	1.2
<b>Czechia</b>	6.6	2.2	0.3	2.4
<b>Denmark</b>	8.3	3.0	4.0	4.3
<b>Estonia</b>	1.4	1.6	3.1	2.3
<b>Finland</b>	8.6	3.3	6.7	6.2
<b>France</b>	6.5	6.8	5.6	5.8
<b>Germany</b>	1.1	1.0	1.6	1.1
<b>Greece</b>	1.3	8.0	5.1	4.6
<b>Hungary</b>	0.8	3.2	1.8	2.0
<b>Ireland</b>	N/A	N/A	N/A	N/A
<b>Italy</b>	13.5	13.8	7.4	12.7
<b>Latvia</b>	3.9	7.8	2.8	4.2
<b>Lithuania</b>	6.5	3.6	5.0	5.4
<b>Luxembourg</b>	2.3	6.4	2.6	3.7
<b>Malta</b>	3.3	1.0	0.0	2.6
<b>Netherlands</b>	8.5	6.1	2.9	7.7
<b>Poland</b>	1.9	3.9	9.0	5.2
<b>Portugal</b>	8.5	4.9	11.8	8.3
<b>Romania</b>	0.2	0.0	0.2	0.2
<b>Slovakia</b>	2.6	0.1	0.8	0.9
<b>Slovenia</b>	3.2	5.7	5.3	4.9
<b>Spain</b>	3.6	4.4	5.4	4.2
<b>Sweden</b>	0.3	0.6	0.0	0.3

Note: N/A = not available.

Source: European Commission, 2025 (performance indicator P9), updated on the basis of data from the 2024 ad hoc module on access to services (EU-SILC).

**Table A8: People aged 16+ in households with out-of-pocket expenditure on professional home care services, by degree of difficulty in affording these services, %, 2024**

Country	With great difficulty	With moderate difficulty	With some difficulty	Fairly easily	Easily	Very easily
<b>EU-27</b>	8.2	14.3	23.8	29.4	20.4	4.0
<b>Austria</b>	14.9	14.4	15.8	31.9	20.2	3.0
<b>Belgium</b>	15.9	14.7	21.9	17.7	25.2	4.6
<b>Bulgaria</b>	9.1	21.2	51.3	16.6	1.8	0.0
<b>Croatia</b>	26.4	9.4	20.7	27.6	15.9	0.0
<b>Cyprus</b>	22.4	27.9	20.2	15.1	11.8	2.7
<b>Czechia</b>	8.8	14.9	30.2	34.2	11.3	0.5
<b>Denmark</b>	9.2	8.0	18.1	32.0	13.0	19.6
<b>Estonia</b>	5.3	21.7	33.9	15.9	23.1	0.0
<b>Finland</b>	6.1	5.8	9.5	36.6	30.9	11.2
<b>France</b>	3.3	15.4	19.0	35.0	24.2	3.2
<b>Germany</b>	5.2	7.9	13.9	44.7	22.9	5.4
<b>Greece</b>	48.7	30.2	16.4	4.2	0.6	0.0
<b>Hungary</b>	23.4	21.3	29.9	22.2	1.5	1.6
<b>Ireland</b>	6.0	0.0	72.5	11.1	9.1	1.3
<b>Italy</b>	11.0	21.0	36.8	22.2	8.4	0.6
<b>Latvia</b>	16.6	39.2	11.7	27.1	5.4	0.0
<b>Lithuania</b>	8.6	26.5	25.4	25.3	6.8	7.3
<b>Luxembourg</b>	N/A	N/A	N/A	N/A	N/A	N/A
<b>Malta</b>	25.6	6.9	30.2	20.0	13.6	3.7
<b>Netherlands</b>	1.0	7.0	16.2	25.1	38.7	12.0
<b>Poland</b>	10.9	19.1	47.1	21.4	1.5	0.0
<b>Portugal</b>	16.4	12.7	37.3	22.9	8.9	1.7
<b>Romania</b>	8.9	26.4	53.9	10.8	0.0	0.0
<b>Slovakia</b>	11.3	10.4	35.1	39.4	3.7	0.0
<b>Slovenia</b>	7.5	21.2	20.4	25.2	23.7	2.1
<b>Spain</b>	9.3	16.0	27.8	27.5	18.8	0.6
<b>Sweden</b>	5.1	7.9	17.6	33.9	19.0	16.5

Note: N/A = not available. If LTC costs are fully covered by the state, people are not asked this question.

Source: European Commission, 2025 (performance indicator P2), updated on the basis of data from the 2024 ad hoc module on access to services (EU-SILC).

**Table A9: People aged 65+ who have severe difficulties in ADL and/or IADL and who have unmet need for assistance in those activities, as % of people with at least one severe difficulty in ADL/IADL, 2019**

Country	Person does not need assistance	Person receives enough assistance	Person lacks assistance
<b>EU-27</b>	13.3	40.1	46.6
<b>Austria</b>	7.2	60.4	32.4
<b>Belgium</b>	N/A	N/A	N/A
<b>Bulgaria</b>	9.5	22.9	67.5
<b>Croatia</b>	5.6	23.3	71.0
<b>Cyprus</b>	11.4	58.1	30.4
<b>Czechia</b>	31.9	30.2	37.9
<b>Denmark</b>	21.2	35.8	43.0
<b>Estonia</b>	1.9	39.6	58.4
<b>Finland</b>	13.6	16.0	70.4
<b>France</b>	15.4	45.9	38.7
<b>Germany</b>	6	44.3	49.7
<b>Greece</b>	3.9	53	43.1
<b>Hungary</b>	24.8	26.2	49.0
<b>Ireland</b>	13.2	38.3	48.5
<b>Italy</b>	13	42.9	44.2
<b>Latvia</b>	15.7	60.9	23.4
<b>Lithuania</b>	5	57.8	37.2
<b>Luxembourg</b>	6.4	18.9	74.6
<b>Malta</b>	26.9	16.9	56.3
<b>Netherlands</b>	17.2	58.3	24.5
<b>Poland</b>	22.7	30.6	46.7
<b>Portugal</b>	16.7	44.4	38.9
<b>Romania</b>	11.9	26.5	61.6
<b>Slovakia</b>	6.1	43.0	50.9
<b>Slovenia</b>	14.9	46.4	38.8
<b>Spain</b>	6.6	45.3	48.0
<b>Sweden</b>	8.1	38.3	53.6

Note: N/A = not available.

Source: European Commission, 2025 (performance indicator P8; based on 2019 EHIS data).

**Table A10: People aged 65+ with severe difficulties in ADL/IADL who used home care services for personal needs in the previous 12 months, as % of people with at least one severe difficulty in ADL/IADL, 2019**

Country	
<b>EU-27</b>	28.6
<b>Austria</b>	31.5
<b>Belgium</b>	53.7
<b>Bulgaria</b>	11.6
<b>Croatia</b>	26.9
<b>Cyprus</b>	19.3
<b>Czechia</b>	16.2
<b>Denmark</b>	52.3
<b>Estonia</b>	10.3
<b>Finland</b>	33.0
<b>France</b>	40.1
<b>Germany</b>	43.3
<b>Greece</b>	20.1
<b>Hungary</b>	22.5
<b>Ireland</b>	35.4
<b>Italy</b>	28.5
<b>Latvia</b>	14.6
<b>Lithuania</b>	14.2
<b>Luxembourg</b>	35.2
<b>Malta</b>	23.5
<b>Netherlands</b>	50.8
<b>Poland</b>	18.8
<b>Portugal</b>	15.9
<b>Romania</b>	4.7
<b>Slovakia</b>	12.1
<b>Slovenia</b>	15.8
<b>Spain</b>	28.9
<b>Sweden</b>	29.8

Source: European Commission, 2025 (performance indicator P6; based on 2019 EHIS data).

**Table A11: Number of LTC workers per 100 people aged 65+, 2024**

Country	Number of LTC workers per 100 people aged 65+
<b>EU-27</b>	3.3
<b>Austria</b>	2.6
<b>Belgium</b>	4.7
<b>Bulgaria</b>	2.4
<b>Croatia</b>	1.6
<b>Cyprus</b>	0.8
<b>Czechia</b>	2.5
<b>Denmark</b>	8.8
<b>Estonia</b>	1.1
<b>Finland</b>	6.6
<b>France</b>	2.9
<b>Germany</b>	5.5
<b>Greece</b>	0.3
<b>Hungary</b>	0.9
<b>Ireland</b>	0.8
<b>Italy</b>	1.5
<b>Latvia</b>	0.9
<b>Lithuania</b>	1.2
<b>Luxembourg</b>	2.9
<b>Malta</b>	6.0
<b>Netherlands</b>	7.8
<b>Poland</b>	0.4
<b>Portugal</b>	3.4
<b>Romania</b>	0.9
<b>Slovakia</b>	3.7
<b>Slovenia</b>	2.2
<b>Spain</b>	3.3
<b>Sweden</b>	10.6

Source: European Commission, 2025 (performance indicator P12), updated on the basis of 2024 EU labour force survey (EU-LFS) data.

**Table A12: Share of LTC workers in residential care and non-residential care, %, 2024**

Country	Residential care	Non-residential care
<b>EU-27</b>	62.9	37.1
<b>Austria</b>	93.2	6.8
<b>Belgium</b>	71.5	28.5
<b>Bulgaria</b>	12.9	87.1
<b>Croatia</b>	59.2	40.8
<b>Cyprus</b>	56.7	43.3
<b>Czechia</b>	73.6	26.4
<b>Denmark</b>	55.0	45.0
<b>Estonia</b>	84.7	N/A
<b>Finland</b>	60.1	39.9
<b>France</b>	61.9	38.1
<b>Germany</b>	65.7	34.3
<b>Greece</b>	50.6	49.4
<b>Hungary</b>	69.4	30.6
<b>Ireland (*)</b>	70.1	N/A
<b>Italy</b>	77.7	22.3
<b>Latvia</b>	61.1	N/A
<b>Lithuania</b>	42.4	57.6
<b>Luxembourg (*)</b>	56.8	N/A
<b>Malta</b>	96.6	N/A
<b>Netherlands</b>	65.2	34.8
<b>Poland</b>	44.6	55.4
<b>Portugal</b>	77.7	22.3
<b>Romania</b>	32.6	67.4
<b>Slovakia</b>	38.2	61.8
<b>Slovenia</b>	57.5	42.5
<b>Spain</b>	56.1	43.9
<b>Sweden</b>	50.5	49.5

Note: N/A = not available. (\*) For IE and LU, 2023 data.

Source: European Commission, 2025 (context information item C19), updated on the basis of 2024 EU-LFS data.

**Table A13: LTC workers' mean gross hourly wage as % of mean gross hourly wage in all other sectors, 2022**

Country	LTC workers' mean gross hourly wage as % of mean gross hourly wage in all other sectors
<b>EU-27</b>	89.2
<b>Austria</b>	94.9
<b>Belgium</b>	80.6
<b>Bulgaria</b>	64.2
<b>Croatia</b>	86.4
<b>Cyprus</b>	74.4
<b>Czechia</b>	89.5
<b>Denmark</b>	78.1
<b>Estonia</b>	65.3
<b>Finland</b>	75.8
<b>France</b>	85.6
<b>Germany</b>	83.6
<b>Greece</b>	80.7
<b>Hungary</b>	84.4
<b>Ireland</b>	89.6
<b>Italy</b>	64.8
<b>Latvia</b>	68.6
<b>Lithuania</b>	88.7
<b>Luxembourg</b>	103.8
<b>Malta</b>	67.7
<b>Netherlands</b>	95.5
<b>Poland</b>	66.0
<b>Portugal</b>	67.3
<b>Romania</b>	75.5
<b>Slovakia</b>	81.8
<b>Slovenia</b>	90.4
<b>Spain</b>	69.3
<b>Sweden</b>	78.5

Source: European Commission, 2025 (performance indicator P11: based on 2022 structure of earnings survey data).

**Table A14: LTC quality standards**

Country	Existence of quality standards in home care, community-based care and residential care	Existence of rules regulating quality assurance in public and non-public providers
<b>Austria</b>	Yes*	Yes*
<b>Belgium</b>	Yes*	Yes*
<b>Bulgaria</b>	Yes	Yes
<b>Croatia</b>	Yes	Yes
<b>Cyprus</b>	No	No
<b>Czechia</b>	Yes	Yes
<b>Denmark</b>	Yes	Yes
<b>Estonia</b>	Yes	Partial
<b>Finland</b>	Yes	Yes
<b>France</b>	Yes	Yes
<b>Germany</b>	Yes	Yes
<b>Greece</b>	Partial	No
<b>Hungary</b>	Yes	Yes
<b>Ireland</b>	Partial	Partial
<b>Italy</b>	Yes	Yes
<b>Latvia</b>	Partial	Partial
<b>Lithuania</b>	Partial	Partial
<b>Luxembourg</b>	Yes	Yes
<b>Malta</b>	Partial	Partial
<b>Netherlands</b>	Yes	Yes
<b>Poland</b>	Partial	Partial
<b>Portugal</b>	Yes	Yes
<b>Romania</b>	Yes	Yes
<b>Slovakia</b>	Yes	Yes
<b>Slovenia</b>	Partial	N/A
<b>Spain</b>	Yes*	Yes*
<b>Sweden</b>	Yes	Yes

Note: N/A = not available. "Yes" means that quality standards exist and apply to different care settings (at least residential care and home care) and to all types of providers. "Yes\*" indicates decentralised systems with central administration on the issue. "No" suggests the absence of quality standards. "Partial" refers to national cases in which quality standards do not cover all settings or providers, or compliance is non-compulsory; as well as cases where the issue is a regional competence, or legislation is incomplete or in preparation.

Source: European Commission, 2025 (policy lever L6; information primarily based on the EU mutual information system on social protection).



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