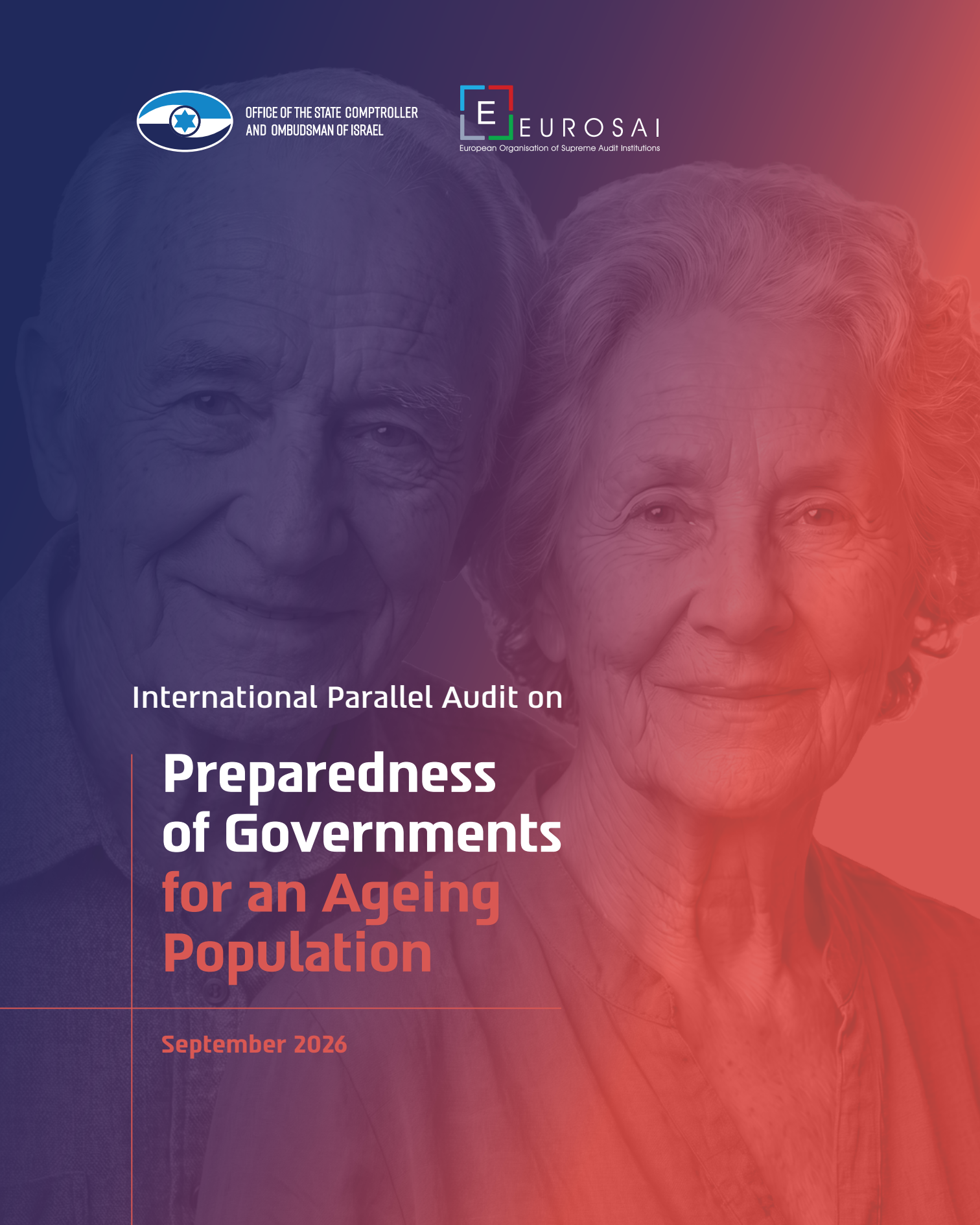


OFFICE OF THE STATE COMPTROLLER
AND OMBUDSMAN OF ISRAEL

EUROSAI
European Organisation of Supreme Audit Institutions

International Parallel Audit on

Preparedness of Governments for an Ageing Population

September 2026

Foreword by the President of EUROSAI

"Thou shalt rise up before the hoary head,
and honour the face of the old man..."

(Leviticus 19:32, KJV)

Population ageing is one of the defining demographic transformations of our time. It is not a narrow social issue, nor is it a challenge confined to the health sector alone. It is a broad, long-term and cross-governmental phenomenon that affects health and long-term care systems, welfare, pensions, labour markets, housing, transport, public finance, community services and social inclusion. As life expectancy continues to rise, and as the gap between longer lives and healthy years becomes an increasingly important policy concern, governments are required to plan ahead with clarity, responsibility and determination.

From EUROSAIs perspective, the importance of this report lies in its broad and forward-looking view of ageing. The report examines government preparedness for population ageing across key policy areas: comprehensive governmental plans and budgetary aspects; community-based health services for elderly people; well-being and quality of life after retirement; and the sustainability of pension systems. Together, these areas reflect the need for a coordinated, preventive and future-oriented approach that enables governments to respond effectively to demographic change.

This international parallel audit was led by the Office of the State Comptroller and Ombudsman of Israel, with the participation of Albania's Supreme Audit Institution, the National Audit Office of Lithuania, National Audit Office of Malta, the State Audit Office of the Republic of North Macedonia, Office of the Comptroller General of the Republic of Paraguay, the Supreme Audit Office of Poland, Portugal's Court of Auditors and the Supreme Audit Office of the Slovak Republic. Austria's Court of Audit and the Supreme Audit Office of the Czech Republic participated as observers.

The joint work carried out by these SAIs has made an important contribution to bringing the issue of population ageing to the attention of state audit institutions, governments and the wider public agenda across Europe and beyond. When several audit institutions examine the same policy challenge in parallel, each within its own national context, the result is a broader and richer understanding than any single national audit can provide. Such cooperation enables the identification of common trends, the comparison of policy responses, the highlighting of good practices and the development of insights that may not emerge from

isolated national work.

I regard parallel audits as one of the most valuable professional endeavours within the EUROSAI community. Their value lies not only in the final comparative report, but also in the process itself: shared learning, methodological exchange, peer dialogue, stronger analytical thinking and the building of lasting professional relationships among SAIs. The experience gained through this report joins other important international audit initiatives, including the international report on artificial intelligence, and demonstrates EUROSAIs ability to address complex, future-oriented issues that are central to public governance in the 21st century.

The findings of the report convey a clear message: while many countries recognize the importance of preparing for population ageing, gaps often remain between declared policy and actual implementation. In the area of governmental plans and budgetary aspects, the report points to challenges such as fragmented strategies, insufficiently measurable objectives, unclear allocation of responsibility, limited inter-ministerial coordination and the absence of dedicated multi-year budgets. Without strong governance and budgetary anchoring, national plans may remain declarative rather than operational.

In the field of health, the report emphasizes the growing importance of community-based and home-based medical services for older persons. These services can serve as an alternative or complement to institutional and inpatient care, improve continuity of care, support quality of life and contribute to the efficiency of health systems. However, the transition from institutional models to community-based care requires strategic planning, dedicated resources, trained personnel, reliable information systems and effective monitoring mechanisms.

The report also underlines that ageing well is not measured only by the extension of life, but also by the quality, dignity and meaning of later life. Well-being after retirement depends on autonomy, social connection, participation, employment opportunities, community belonging and the ability to address loneliness among older persons. The findings show that although the participating countries acknowledge the importance of these issues, further efforts are needed to transform policy responsibility into effective, individualized solutions.

With regard to pension systems, the report highlights the central role of pensions in ensuring social security and economic stability. At the same time, population ageing places growing demographic, fiscal and actuarial pressure on pension systems. The findings point to the need for long-term reforms, automatic balancing mechanisms, early identification of risks and the use of international experience to strengthen pension sustainability while protecting the living standards of older persons.

The overall conclusion is that preparedness for population ageing requires a shift from fragmented and reactive measures to comprehensive, whole-of-government policy. Governments should establish clear national strategies, measurable goals, designated responsibilities, effective coordination mechanisms, reliable data, monitoring of outcomes and dedicated multi-year resources. At the same time, public policy must not focus only on systems and budgets. It must also safeguard the dignity, autonomy, rights, participation and quality of life of older persons.

Looking ahead, I encourage SAIs to continue examining government preparedness for population ageing as a central and ongoing audit issue. Ageing is not a one-time challenge. It is a long-term transformation that requires continuous assessment of policy, implementation, budgeting and impact. SAIs have an important role in asking whether governments are acting in time, planning for the long term, allocating resources effectively and improving the lives of older citizens in practice.

I wish to express my sincere appreciation to the audit teams of the Office of the State Comptroller and Ombudsman of Israel for leading this important project, and to all participating SAIs for their professionalism, commitment and contribution. I also thank the observer SAIs and the audit teams whose knowledge, experience and cooperation brought this project to completion.

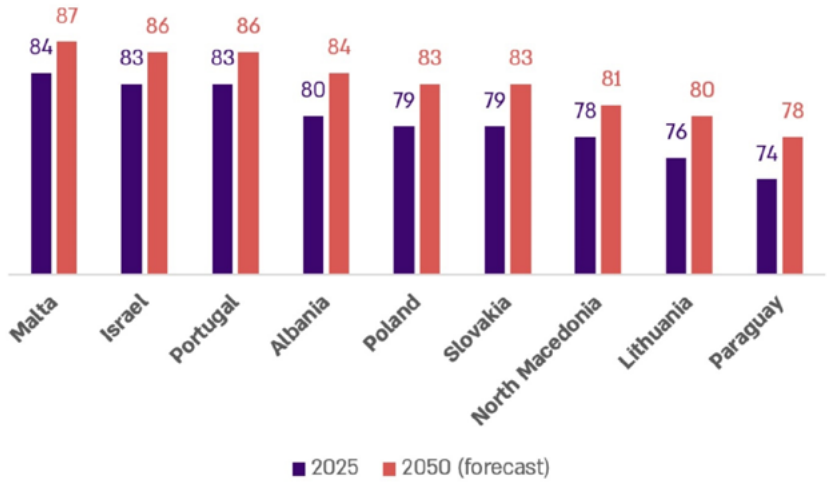
This report is a strong example of EUROSAIs ability to work together, learn together and contribute together to better public governance. I trust that its findings and conclusions will assist governments, parliaments, policymakers and SAIs in preparing for a future in which longer lives are accompanied by better health, economic security, social participation and human dignity.

Matanyahu Engelman
EUROSAI President
State comptroller and Ombudsman of Israel

Introduction: Global population ageing and key challenges

The world is undergoing a profound demographic transition: populations are ageing in virtually every region as fertility declines and life expectancy rises. According to the United Nations (hereinafter, UN) population projections, the share of the global population aged 65 and over is expected to increase from 17% in 2024 to 33% in 2054 to 40% in 2100. By the late 2070s, the number of persons at ages 65 years and higher globally is projected to reach 2.2 billion, surpassing the number of children (under age 18), while the number of persons aged 80 or older is projected to surpass the number of infants (1 year of age or less)[1]. This shift is increasingly concentrated in low and middle-income countries. The World Health Organization (hereinafter, WHO) highlights that by 2050, around 80% of older people will be living in low- and middle-income countries , where systems may have less time and fiscal space to adapt[2].

Figure 1: Life Expectancy at Birth in the Countries participating in the audit, 2025 & 2050 (forecast)[3]



The figure shows that in all the countries participating in the audit report, life expectancy at birth is expected to increase by approximately three to four years between 2025 and 2050, reflecting the continued ageing of the population and the growing importance of long-term planning for older age.

1 United Nations, World Population Prospects 2024 Summary of Results (2024), pp. 12, 22.
2 World Health Organization, Ageing and Health (October 1st 2025) **[link]**.
3 Based on United Nations data, Life Expectancy at birth **[link]**.

Studies consistently show that investing in the health and well-being of the older population yields very high economic returns, both at the individual level and for the economy as a whole. Healthy ageing reduces chronic disease and functional limitations, lowers long-term healthcare and long-term care expenditures, sustains productivity and labor-force participation in midlife, and increases economic contributions even after retirement through activities such as volunteering and family caregiving. A U.S. study estimates that delaying ageing by one year (i.e. extending the healthy lifespan by one year) is equivalent to about $38 trillion, and by ten years to about $367 trillion. In addition, each dollar invested in healthy ageing has been found to generate roughly $3 in economic and health benefits. Taken together, these findings indicate that promoting healthy and beneficial ageing is not only a social and public-health goal, but also a high-return engine of economic growth.[4]

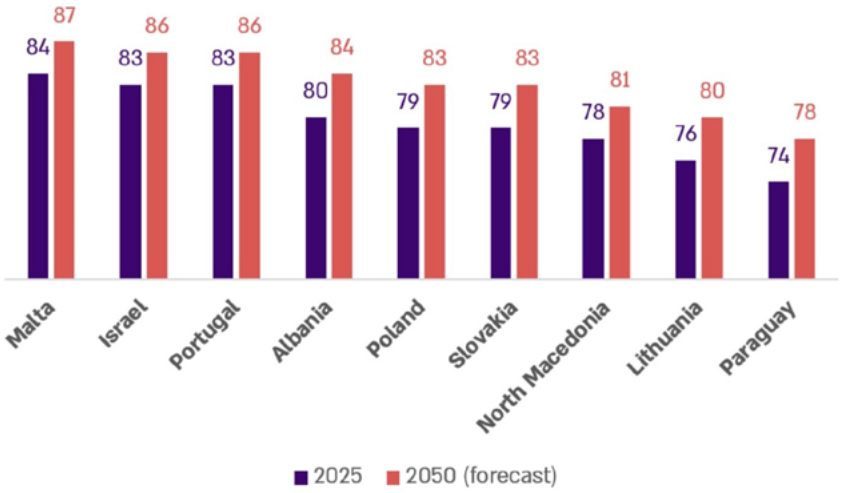
Healthy life expectancy

Population ageing creates complex, cross-sector challenges for governments and public services. It increases pressure on health systems including prevention and management of chronic conditions, multimorbidity[5] and geriatric syndromes, and on the availability, quality and financing of long-term care and support for family caregivers[6].

Healthy life expectancy, often referred to as "health-adjusted life expectancy" (hereinafter, HALE) is a summary measure that goes beyond how long people live, to estimate how many years, on average, a person can expect to live in "full health", by adjusting remaining life expectancy for the prevalence and severity of morbidity and disability at a given point in time (by age and sex). This concept matters because population ageing can increase the number of years which a person may live with chronic conditions and functional limitations even when overall life expectancy rises. HALE helps policymakers assess whether added years of life are being lived with good health and functioning, or whether they translate into higher needs for health services, rehabilitation and long-term care[7]. In other words, improving HALE supports the strategic goal of enabling people to maintain functional ability and wellbeing in older age, which is increasingly central to sustainable planning in ageing societies (e.g., prevention, integrated care, and supportive environments that preserve independence and participation)[8].

4 Scott, A. J., Ellison, M., & Sinclair, D. A. (2021). The economic value of targeting ageing. Nature Ageing, 1(7), 616-623.
5 Multimorbidity is the coexistence of two or more chronic health conditions in the same person.
6 World Health Organization, Ageing and Health (October 1st 2025) **[link]**.
7 World Health Organization, Healthy Life Expectancy (HALE) **[link]**.
8 World Health Organiztion, Global strategy and action plan on ageing and health (2017) **[link]**.

Figure 2: Life Expectancy at birth categorized by healthy and unhealthy years in the countries participating in the audit, 2023[9]



* Updated to 2022
** Updated to 2012

The figure indicates that although the total number of years differs between countries, a significant share of later life is still expected to be lived with illness or health limitations, highlighting the importance of policies that promote healthy ageing, prevention, community-based care, and wellbeing among older adults.

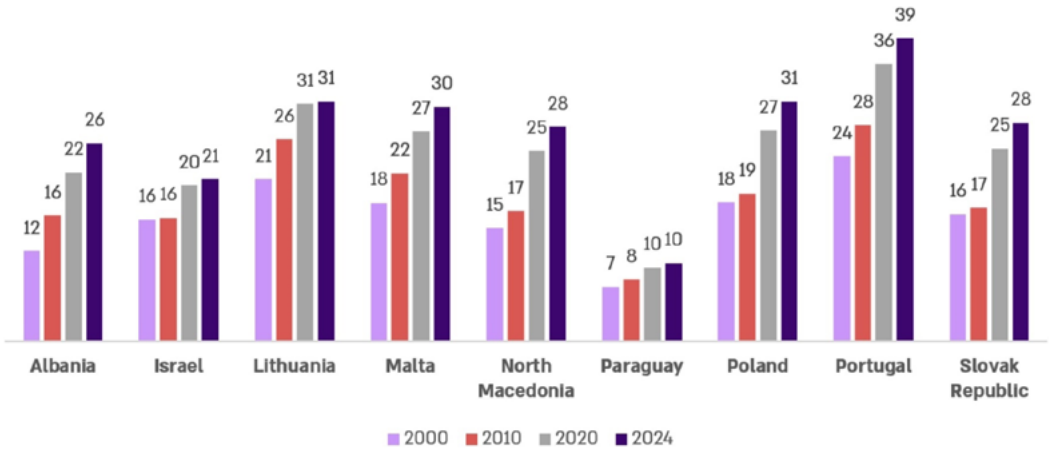
Ageing, Equity, and Fiscal Readiness

Population ageing also raises questions of fiscal sustainability and intergenerational equity e.g., pensions, social protection, and age-related expenditures, while reshaping labor markets - workforce participation, skills renewal, productivity, and age-friendly workplaces. Beyond service capacity, a central policy challenge is safeguarding wellbeing and functional ability i.e., enabling older people to meet basic needs, maintain relationships, and continue contributing to society through supportive environments and integrated health and social care[10]. These trends underscore the need for integrated, evidence-based policies that address both system readiness and the protection of older persons' dignity, autonomy and inclusion.

9 Based on UN data, EuroStat and Israel's Central Bureau of Statistics.
10 World Health Organization, Healthy ageing and functional ability (October 26th 2020) **[link]**.

The old-age dependency ratio measures the number of people above retirement age relative to the working-age population. It is calculated by dividing the number of people above age 65 by the number of people of working age. The ratio is usually presented as the number of older people per 100 working-age people. The significance of this ratio is that it reflects the potential economic burden on the working-age population. A higher number means that there are more older people relative to the number of people who are of working age and potentially supporting the economy through work and taxes. This may place greater pressure on pension systems, healthcare services, and public spending. Therefore, a higher dependency ratio is generally considered less favorable, as it may indicate a heavier burden on the workforce and greater challenges for the sustainability of social and economic support systems[11].

Figure 3: The old-age dependency ratio in the Countries participating in the audit, 2000-2024



Source: World Bank Group[12]

The figure shows a clear upward trend in the indicator between 2000 and 2024 across all the countries presented. Although the scale of change differs between countries, the general direction is similar: the indicator has risen over the past two decades, reflecting a growing demographic pressure that is relevant for long-term ageing policy and planning.

11 OECD, Old-age dependency ratio **[link]**.
12 **[link]**

All of the trends described above require a systemic, holistic and long-term approach to ageing. Population ageing is not merely a health-sector issue, nor can it be addressed through isolated policy measures; it affects health and long-term care systems, labor markets, pension sustainability, social protection, public finance, community services, and the protection of older persons' dignity, autonomy and social inclusion. The increase in life expectancy, the gap between total life expectancy and healthy life expectancy, the rising old-age dependency ratio, and the growing need for prevention, integrated care and age-friendly environments all demonstrate that ageing must be planned for across the life course and across government sectors. Moreover, ageing is a global and transnational challenge, affecting countries at different levels of income and institutional capacity, and requiring shared learning, coordinated policy responses and long-term investment. A narrow or short-term response would be insufficient; governments must adopt forward-looking strategies that promote healthy and active ageing, strengthen system readiness, and ensure that longer lives are accompanied by better health, continued participation and sustainable support systems.

International Norms on Ageing Population

The following norms represent a clear statement of intent by nations to address ageing populations and systematically prepare for demographic shifts. The fact that these prominent bodies have taken the initiative to draft such guiding principles underscores the critical importance of the subject, serving as the foundational framework for this report. Although not all participating countries have taken part in each of these norms, and despite their limited legally binding nature, they nevertheless establish a powerful consensus on the significance of this issue.

United Nations Principles for Older Persons (1991)

Adopted by the UN General Assembly in 1991 (Resolution 46/91), the UN Principles for Older Persons provide a concise rights and dignity-based framework that encourages governments to incorporate specific principles into national programs. The Principles are organized under five thematic clusters: Independence, Participation, Care, Self-fulfilment, and Dignity. The Principles emphasize older persons' access to basic needs and services (including health care), opportunities for work and income, and the ability to participate in decisions affecting their well-being. They also stress access to appropriate care and protection, including respect for dignity, privacy and autonomy, particularly relevant to institutional or community-based care settings[13].

13 Unites Nations, United Nations Principles for Older Persons (December 16th 1991) General Assembly 46/91 **[link]**.

Madrid International Plan of Action on Ageing (MIPAA) (2002)

The Madrid International Plan of Action on Ageing (2002) and its Political Declaration adopted at the Second World Assembly on Ageing are widely treated as a turning point in international policy on ageing, explicitly linking ageing to broader social and economic development and human rights objectives. MIPAA sets out a policy agenda structured around three priority directions: (1) Older persons and development; (2) Advancing health and well-being into old age; (3) Ensuring enabling and supportive environments.

MIPAA functions as a policy roadmap that outlines objectives and recommended actions for governments and stakeholders to adapt services, remove barriers to participation, and "mainstream" ageing across sectors (e.g., employment, social protection, health, housing, and community support)[14].

United Nations Decade of Healthy Ageing (2021–2030)

The UN Decade of Healthy Ageing (2021–2030) is a UN-wide initiative intended to catalyse coordinated action by governments and stakeholders to improve older people's lives over a ten-year period[15]. WHO was asked to lead implementation and serve as the Decade Secretariat, emphasizing a "whole-of-government" and "whole-of-society" approach.

The Decade concentrates on four action areas: combatting ageism - changing how people think, feel and act towards age and ageing, creating age-friendly environments, delivering person-centred integrated care and primary health services, and ensuring access to quality long-term care for those who need it[16].

ILO Older Workers Recommendation, 1980 (No. 162)

The International Labour Organization's Older Workers Recommendation, 1980 (No. 162) is the principal international labour standard focused directly on older workers[17]. It frames older workers as those who may encounter employment-related difficulties due to advancement in age, and it calls for addressing their employment challenges within an overall, well-balanced employment strategy (so that problems are not shifted between population groups).

Core expectations include preventing age discrimination in employment and occupation, promoting equality of opportunity and treatment, and ensuring access to vocational guidance, training/retraining, fair working conditions, occupational safety and health protections, and relevant social security and welfare benefits. The Recommendation also addresses policy directions for adapting work and supporting a gradual, dignified transition to retirement, making it particularly relevant to audits of labor-market policies, lifelong learning systems, and retirement pathways in ageing societies[18].

14 United Nations, Political Declaration and Madrid International Plan of Action on Ageing (April 8th – 12th 2002) **[link]**.
15 United Nations, UN Decade of Healthy Ageing: Plan of Action 2021-2030 **[link]**.
16 World Health Organization, WHO's work on the UN Decade of Healthy Ageing (2021-2030) **[link]**.
17 International Labor Organization, Ninth Meeting of the SRM TWG Examination of Instruments Concerning Older Workers (September 16th-20th 2024); International Labor Organization, R162 – Older Workers Recommendations, 1980 (No. 162) **[link]**.
18 International Labor Organization, R162 – Older Workers Recommendations, 1980 (No. 162) **[link]**.

WHO Global Strategy and Action Plan on Ageing and Health (2016–2020)

Endorsed by WHO Member States, the Global Strategy and Action Plan on Ageing and Health establishes a coordinated framework to advance "healthy ageing" and to align national systems with demographic change. The Strategy defines two overarching goals: (i) five years of evidence-based action to maximize functional ability; and (ii) building the evidence and partnerships needed to support a Decade of Healthy Ageing.
The Strategy highlights five strategic objectives that are particularly relevant as audit criteria or benchmarks: commitment to action on healthy ageing; development of age-friendly environments; alignment of health systems to older populations; development of sustainable and equitable long-term care systems; and improved measurement, monitoring and research[19].

European Union Charter of Fundamental Rights

Article 25 of the Charter of Fundamental Rights of the European Union[20] recognizes the rights of older persons to dignity, independence and participation in social and cultural life. Principle 18 of the European Pillar of Social Rights[21] establishes the right to affordable, good-quality long-term care, especially home-care and community-based services. The Council Recommendation of December 8, 2022, on access to affordable high-quality long-term care further provides a relevant EU soft-law benchmark for assessing the accessibility, affordability, quality, territorial availability and governance of long-term care services[22].

National Norms and Strategies in Participating Countries

While international frameworks provide a broad foundation, countries participating in this audit have adopted diverse national strategies and laws to address the specific challenges of population ageing within their borders. Analysis of the national norms reveals several common pillars across the different jurisdictions:

19 World Health Organization, Global strategy and action plan on ageing and health (2017).
20 Charter of Fundamental Rights of the European Union, Equality, Article 25.
21 The European Pillar of Social Rights in 20 principles **[link]**.
22 The Council of the European Union Recommendations on access to affordable high-quality long-term care (2022/C 476/01).

Table 1: Pillars of National Strategies for an Ageing Population

Promotion of "Active Ageing" and Social Participation	Employment Integration and Economic Resilience	Ageing in Place: Deinstitutionalization and Community-Based Services	Legislative Frameworks, Rights, and Data-Driven Monitoring
Malta National Strategic Policy for Active Ageing (2023–2030) Focuses on social inclusion, healthy ageing and the need to address diversity and inequality.	**Lithuania** The 100% Pension-Salary model Under the Law on State Social Insurance Pensions, pensioners can continue working while receiving 100% of their old-age pension	**Republic of North Macedonia** National Deinstitutionalization Strategy (2018-2027) Implementing a National Deinstitutionalization Strategy focused on relocating elderly persons to community settings	**Republic of Paraguay** Law No. 1885/2002 On Adult Persons guarantees the right to dignified treatment, non-discrimination, and priority access to healthcare
Portugal Action Plan for Active and Healthy Ageing 2023-2026 Features a dedicated pillar for participation in political, social, and cultural life, including senior volunteer programs	**Portugal** Action Plan for Active and Healthy Ageing 2023-2026 Promotes the "Economy of Ageing" by supporting senior entrepreneurship and adapting workplaces for employees over the age of 50		**Poland** Act on Elderly Persons Obliges public administration to monitor the situation of seniors and produce periodic reports
Poland Social Policy for Older People 2030 Utilizes the Safety-Participation-Solidarity framework, aimed at fostering intergenerational cooperation	**Albania** National Employment and Skills Strategy 2023–2030 Focuses on lifelong skills development to ensure vulnerable groups remain economically active	**Slovak Republic** National Strategy for the Deinstitutionalization of the Social Services and Alternative Care System focuses on the transition from institutional to community-based care	**Slovak Republic** Council of the Government of the Slovak Republic for the Rights of Seniors Advisory body for the protection of the rights for older persons and the adaptation of public policies to population ageing
Albania National Action Plan on Ageing 2020–2024 Prioritizes dignified ageing and the social inclusion of older persons	**Israel** The National Indicators of optimal ageing & Socio-Economic Strategic Assessment Identifies the integration of older adults into employment and the gradual adjustment of the retirement age as core strategic courses of action		**Malta** Office of the Commissioner for Older Persons The Commissioner for Older Persons is empowered by law (Cap. 553) to promote and safeguard the interests of older persons and investigate any alleged breaches or potential infringements of the human rights of older persons, the promotion of such rights as well as the protection and monitoring of the compliance with the United Nations Principles for Older Persons
Slovak Republic National Program for Active Ageing 2021-2030 Supports dignified, healthy and active life for older people	**Malta** Incentives for persons opting to defer their pension entitlement and continue in employment or self-employment Persons who satisfy the eligibility conditions to claim their Retirement Pension prior to their pension age or persons who have reached their pension age, but opt to defer such claim and continue in employment or self-employment, are eligible for a percentage increase in their pension rate	**Poland** Social Services Development Strategy Set "Ageing in Place" as a strategic objective, developing community-based support to allow seniors to live independently in their residences for as long as possible	**Lithuania** The Lithuanian Parliament adopted the Law on the Framework of Older Persons Policy, providing the first comprehensive legal framework for older persons policy (adopted on 25 June 2026)
Israel The National Indicators of optimal ageing Marks social participation as a key indicator			**Israel** National Indicators Map for Optimal Ageing Developed a data-driven tool used to measure health, sense of meaning, and economic resilience

Key Areas Addressed in the Report

This report examines several key policy areas that are central to preparing for population ageing and ensuring the wellbeing, health, and quality of life of older adults. It focuses on the importance of government programs and long-term planning, the sustainability of pension systems, the role of community-based services, and the promotion of wellbeing in later life. Together, these areas reflect the need for a coordinated, preventive, and future-oriented approach that enables governments to respond effectively to demographic change.

Comprehensive Governmental Plans

Population ageing is a broad national challenge that affects many public systems at the same time, including health, long-term care, welfare, employment, pensions, housing, transport, and urban planning. Therefore, government programs in this field are essential for ensuring a coordinated, preventive, and long-term response, based on clear objectives, measurable indicators, inter-ministerial cooperation, accountability mechanisms, and dedicated multi-year budgets. Such programs help translate demographic challenges into practical policy measures, reduce duplication and gaps between government bodies, and ensure that public services and fiscal planning are adapted to the needs of an ageing population.

Community Based Health Services for Elderly People

Community-based services are increasingly significant in the context of population ageing, as longer life expectancy and a growing number of older people create rising demand for health services and long-term care. Older adults often require more frequent and continuous care due to chronic illness, multimorbidity, functional decline, and the need for ongoing monitoring, while hospitals and institutional care systems face growing pressures related to workforce shortages, infrastructure, bed availability, and costs.

In this context, community services, including home-based medical and clinical care, and nursing services in the older person's living environment, offer an essential alternative or complement to institutional care. Shifting from an institutional model to a community-based model requires more than organizational change; it requires coordinated policy, strategic planning, dedicated resources, skilled personnel, reliable information systems, and monitoring mechanisms to ensure that services are accessible, high-quality, and aligned with the needs of an ageing population.

Preparing the Welfare System - Well Being and Quality of Life After Retirement

Wellbeing is a central component of ageing well, as it reflects not only physical health but also mental, emotional, and social welfare aspects. For older adults, wellbeing is shaped by their ability to maintain autonomy, preserve meaningful social relationships, feel a sense of belonging, and continue to experience purpose and satisfaction in daily life. As life expectancy and healthy life expectancy increase, older people are expected to spend more years in relatively good health and functioning, making it increasingly important to ensure that these years are not only longer, but also meaningful and fulfilling. Government action can support this goal through programs that encourage participation in the labor market, community involvement, social connection, and active ageing, particularly after retirement, when individuals may lose the structure, social role, and sense of purpose previously provided by work. Such efforts are also important in addressing loneliness, which is a major risk to wellbeing in old age and may negatively affect mental, physical, and functional health.

Preparing the pension system

Pension systems are a central pillar of social security and economic stability in modern societies, and their importance becomes even more significant in the context of population ageing. Their role goes beyond the distribution of benefits: they serve as a strategic mechanism for protecting citizens' welfare throughout the life cycle, ensuring economic security in old age. As populations grow older, pension systems face increasing demographic and actuarial pressures that may threaten their long-term sustainability. A failure to address this challenge could harm retirees' standard of living and place a heavy burden on public budgets. Early recognition of risks such as population ageing and actuarial imbalance enables policymakers to take preventive action, reduce policy mistakes, and strengthen the system's ability to respond to future challenges in an effective and sustainable manner.

Conducting an international audit report on population ageing is of significant importance, as it enables participating countries to examine how effectively their public systems are preparing for one of the most profound demographic transformations of the 21st century. An international audit provides a valuable opportunity to compare national approaches, identify common challenges, highlight good practices, and strengthen evidence-based policymaking across sectors. By addressing ageing through a comparative and forward-looking audit perspective, Supreme Audit Institutions can support governments in developing sustainable, coordinated, and rights-based responses that ensure longer lives are accompanied by better health, meaningful participation, and quality of life for older people.

About the Parallel Audit Project

Population ageing is a global challenge affecting many countries. It has implications for many areas of public policy, including health, welfare, employment, housing, and social inclusion.

The parallel audit process began in August 2024, with an invitation to all EUROSAI members to participate in an audit on the topic of ageing populations. In addition, the Office of the Comptroller General of the Republic of Paraguay was also invited to join. As the next step in the process, the Office of the State Comptroller and Ombudsman of Israel initiated a virtual kick-off meeting, which was held in November 2024, to discuss the possibility of conducting an international parallel audit on government preparedness for an ageing population. The meeting was attended by fourteen SAIs. Following the meeting, nine SAIs confirmed their participation in the parallel audit, and two additional SAIs joined as observers.

The international Parallel audit on preparedness of governments for an ageing population was conducted as a parallel audit under the auspices of EUROSAI strategic goal 1 – Supporting effective, innovative and relevant audits by promoting and brokering professional cooperation.

Parallel international audits enable several audit institutions to examine a shared policy challenge through a broader comparative lens, while still considering the specific circumstances of each country. Conducting the audit in parallel makes it possible to identify common trends, compare policy responses, highlight good practices, and generate broader insights that may not emerge from a national audit alone.

Parallel audits also make a significant contribution to the audit teams themselves: they strengthen professional learning, encourage the exchange of methodologies and tools, improve analytical thinking through peer dialogue, and build lasting cooperation between institutions. In this way, parallel international audits contribute both to a deeper understanding of the audited issue and to the professional development of the audit teams.

The Office of the State Comptroller and Ombudsman of Israel led the project with the following participating SAIs: Albania's Supreme Audit Institution, National Audit Office of Lithuania, National Audit Office of Malta, State Audit Office of the Republic of North Macedonia, Controller General of the Republic of Paraguay, Supreme Audit Office of Poland, Portugal's Court of Auditors, and the Supreme Audit Office of the Slovak Republic. Austria's Court of Audit and the Supreme Audit Office of the Czech Republic participated as observers.


Albania


Israel


Lithuania


Malta


North Macedonia


Republic of Paraguay


Poland


Portugal


Slovak Republic

Table 1: Participating SAIs

Country	SAI establishment year	Interesting Fact	Workforce Diversity
The Supreme State Audit Institution of Albania (KLSH)	1925	The Supreme State Audit Institution of Albania (KLSH) is one of the oldest independent state institutions in the country, originally established in 1925, which reflects a long-standing tradition of public financial oversight and accountability in Albania.	243 employees, 50% women 50% men
Office of the State Comptroller and Ombudsman of Israel	1949	In Israel, the State Comptroller also serves as the Ombudsman (Commissioner for Public Complaints)—a dual role that is quite unique compared to most countries. This structure means that the same independent authority is responsible both for auditing government ministries and public bodies, and for handling complaints submitted by individual citizens.	573 employees, 60% women, 40% men
National Audit Office of Lithuania	1919, restored in 1990	In the 35 years since restoration of Lithuania's independence, out of eight Auditors General three were women.	195 employees, 74% women, 26% men
National Audit Office of Malta	1997	State Audit in Malta dates back to 1812, but the modern NAO was formally established as an autonomous Constitutional body in 1997. NAO Malta follows the Westminster model, similar to the UK NAO. In terms of parliamentary oversight, in practice, the Auditor General (or his Deputy) physically presents every report to the Speaker. Reports tabled by the NAO are passed on to the Public Accounts Committee (PAC), the standing committee empowered to inquire into matters relating to public accounts and to consider reports by the NAO.	67 employees, 60% women, 40% men

Country	SAI establishment year	Interesting Fact	Workforce Diversity
The State Audit Office of the Republic of North Macedonia	1997	SAI of North Macedonia is established by the law for state audit and is responsible for audit the financial and economic activities of the state. The highest number of recorded visits to the State Audit Office website was in September 2024 with 28,394 visits in one month. The SAO's Facebook profile recorded over 1.4 million visits in 2024. Website traffic in 2024 increased by 460% compared to 2023.	143 employees, 55% women, 45% men
The Comptroller General of the Republic of Paraguay (CGR)	1994	The Comptroller General of the Republic of Paraguay (CGR) is the body in charge of the control of the State's economic and financial activities, of the Departments and Municipalities, as established by the National Constitution and Law No. 276/94 "Organic and Functional of the Office of the Comptroller General of the Republic." It enjoys functional autonomy and administrative.	1,014 employees, 55% women, 45% men
The Supreme Audit Office of Poland (NIK)	1919	For over 100 years, NIK has been assessing the functioning of the state and the management of public funds	1,650 employees, 50% women, 50% men
Portugal's Court of Auditors	1389	Within the European context, the Portuguese Court of Auditors is distinguished as one of the few SAIs that exercise judicial powers and carry out ex ante audits, meaning prior legality checks before certain expenditures or financial operations are executed.	519 employees, 69% women, 31% men
The Supreme Audit Office of the Slovak Republic	1993	The Supreme Audit Office of the Slovak Republic is facing the biggest challenge in its 30-year history, as it will assume the presidency of EUROSAI in 2027.	300 employees, 64% women, 36% men

Working method and audit themes:

The participating SAIs decided on the themes of the parallel audit:

1. Comprehensive Governmental Plans and Budgetary Aspects
2. Preparing the Health System for an Ageing Population: Community-Based Health Care
3. Preparing the Welfare System for an Ageing Population: Well-Being and Quality of Life After Retirement
4. Preparing the Pension System for an Ageing Population

Table 2: Audit Themes & Participating SAIs

	Comprehensive Governmental Plans and Budgetary Aspects	Preparing the Health System for an Ageing Population: Community-Based Health Care	Preparing the Welfare System for an Ageing Population: Well Being and Quality of Life After Retirement	Preparing the Pension System for an Ageing Population
Albania	✔			
Israel	✔	✔	✔	✔
Lithuania			✔	
Malta		✔		
Rep. of North Macedonia	✔			✔
Republic of Paraguay	✔			
Poland			✔	
Portugal	✔			
Slovak Republic	✔	✔		✔

In February 2025 and May 2025 two virtual meetings were held. Between the virtual plenary sessions, four working groups of the four themes, with representatives from the SAIs that chose to take part in each theme, held periodic virtual meetings. During the working group meetings sub-topics and audit questions were formed jointly. In September 2025 all participating SAIs met at a conference in North Macedonia, where preliminary results were presented. The conference also included a joint brainstorming session of all participants, during which the structure of the report and the data to be presented in it were jointly agreed upon. In June 2026 a second conference was held in North Macedonia. The conference provided an opportunity to discuss lessons learned from the parallel work, consider future prospects for collaborative audits, and exchange peer experiences on how each SAI makes its reports accessible to the public and monitors the implementation of corrective actions.

Structure of the consolidated report

For each of the four themes, the audit report includes a dedicated chapter. Each chapter opens with a general introduction to the topic. This is followed by the chapters of the participating countries, which address the jointly formulated audit questions. The chapter concludes with significant cross-cutting insights and overarching findings of the themes.

Comprehensive Governmental Plans and Budgetary Aspects

Introduction

Population ageing is a multi-system trend that simultaneously affects health, long-term care, welfare, employment, pensions, housing, transport, and urban planning. Therefore, addressing it effectively requires a comprehensive, forward-looking national policy based on clear goals and measurable indicators. The United Nations Population Fund emphasizes that harnessing the benefits of population ageing requires a "paradigm shift," so that negative or fragmented actions are replaced by positive, preventive, and integrated responses, including comprehensive policies and complementary reforms in the labor market, social protection, health, and education[1]. The European Commission stresses that the scale and speed of demographic change require new approaches and policies that are adapted to an era of profound transformation, including core issues such as the financing of pensions and health and long-term care service[2].

In governance terms, the World Health Organization (hereinafter, WHO) states that the implementation of the "Decade of Healthy Ageing" requires a whole-of-government and whole-of-society approach: state leadership together with broad cross-sector partnerships. It emphasizes that governments are responsible for establishing the policies, financial arrangements, and accountability mechanisms needed to enable age-friendly environments and functioning health and care systems, as well as for embedding national planning within broader state planning and budgeting processes. Accordingly, the program recommends establishing or expanding inter-ministerial mechanisms at the national level to ensure policy coherence and shared accountability — that is, a coordinating body that reduces duplication, resolves inter-ministerial contradictions, and enables joint ownership of goals[3]. Finally, OECD literature emphasizes that proper preparedness for ageing requires coherent fiscal strategies and tax-and-expenditure reforms based on a whole-of-government approach that connects different levels of governance, underscoring the importance of a dedicated multi-year budget. Without budgetary anchoring, even inter-ministerial coordination and a national plan remain at the level of declaration rather than implementation[4].

1 United Nations Population Fund, Ageing **[link]**.
2 European Commission, Green Paper on Ageing, 2021.
3 UN Decade of Healthy Ageing: Plan of Action 2021-2030.
4 Kim, J. and S. Dougherty (eds.) (2020), Ageing and Fiscal Challenges across Levels of Government, OECD Fiscal Federalism Studies, OECD Publishing, Paris.

Rationale for participation

The following shows the reasons that SAIs chose to participate in this theme:

Albania:

Participation is driven by the fact that population ageing has become an urgent and multidimensional challenge due to rapid demographic changes, including large-scale emigration and low birth rates. These trends impact the labor market, pension sustainability, and fiscal stability, prompting the need to evaluate government coordination and resource allocation.

Slovak Republic:

Participation resulted from previous audit findings showing that rising pension expenditures threaten the long-term sustainability of public finances. Key concerns include a general unpreparedness for demographic change, low capacity in social services, and the need for robust policy measures to support an ageing population.

Israel:

The SAI of Israel chose to participate because ageing is a cross-government issue with major implications for social resilience and public finances. The objective is to assess if the government has a coherent strategy and measurable targets across systems like healthcare, housing, and labor to protect older adults' rights and ensure sustainable state services.

Republic of Paraguay:

The country is experiencing a progressive ageing of its population, which is creating new demographic shifts. It joined the report to ensure these increasing demands are addressed in an organized and efficient manner.

Portugal:

Portugal's Court of Auditors decided to participate in the joint audit due to the country's rapid demographic shift toward an ageing population, which heavily impacts public finances, healthcare, and social protection. By participating, Portugal aims to benchmark its strategies against other nations to identify policy gaps, share best practices, and improve resource allocation. This effort directly supports and aligns with the implementation of Portugal's recently approved Action Plan for Active and Healthy Ageing 2023–2026 (APAHA), jointly coordinated by the ministries of health and social security.

Republic of North Macedonia:

Its involvement is rooted in a constitutional mandate as a social state responsible for the social protection and security of its citizens. The focus is on using policies and programs to prevent social exclusion and improve the overall quality of life for the elderly.

Country profiles – relevant audited bodies

Albania

The Ministry of Finance (MoF)	Responsible for designing and implementing macroeconomic, fiscal, and budgetary policies, including manageing state revenues, financial control, and EU funds. Regarding population ageing, the former Ministry of Finance and Economy (MFE) developed the National Employment and Skills Strategy 2023–2030 to address labour force decline due to ageing and migration, aiming to improve employment quality and align skills with market needs. In 2024, the MFE was restructured into the Ministry of Finance and the Ministry of Economy and Innovation (MEI), with responsibility for implementing the strategy transferred to the MEI.
Ministry of Economy and Innovation (MEI)	Operates in key areas such as employment, investment promotion, and vocational education and training. It is responsible for drafting and implementing economic policies aimed at sustainable growth, as well as ensuring access to vocational training and decent employment. MEI plays a leading role in implementing the National Employment and Skills Strategy 2023–2030 and is the main institution responsible for employment and vocational training. It also coordinates key sector institutions, including the National Employment and Skills Agency (NESA), which delivers employment services and manages vocational training providers.
The Ministry of Health and Social Welfare (MHSW)	Responsible for developing and implementing policies in healthcare and social protection, ensuring quality services, social inclusion, and support for vulnerable groups. In response to population ageing, it has adopted key long-term strategies, including the National Social Protection Strategy 2024–2030 and the National Policy Document on Ageing with its Action Plan 2020–2024, aimed at improving quality of life.
The State Social Service (SSS)	A budgetary institution under the Ministry of Health and Social Welfare, supports the implementation of social protection policies by providing economic assistance, community programs, and services for individuals in need. The State Social Service (SSS) is responsible for the practical implementation of social policies and programs in line with ministry directives, and monitors and supports local units in delivering social services, including for the elderly.
The Institute of Statistics (INSTAT)	The central institution responsible for producing official statistics in Albania, providing accurate, transparent, and impartial data on economic and social developments. INSTAT ensures data quality, implements the national statistical program, and represents Albania in international statistical systems. It also provides key data on ageing, migration, fertility, and labour market trends, and conducts the Census, which is essential for informing government policies.

Republic of Paraguay 

In 2002, Law No. 1885 "Of Older Adults" was issued, with the purpose of protecting the rights and interests of older persons, thereby establishing the Ministry of Public Health and Social Welfare (MSPBS) as the state body in charge of the application of the Law.

The aforementioned Law has Regulatory Decree No. 10068/07, through which the Directorate of Older Adults was created, under the General Directorate of Social Welfare of the MSPBS, assigning it specific functions related to the care and protection of older adults.

The MSPBS is responsible for the administration of resources for the economic management and execution of programs for the benefit of Older Adults, with specific focus on the assigned resources that are affected to Program 6 Improvement in Social Welfare for people in situations of Risk – Activity 1 "Comprehensive care of the Older Adult population".

Portugal 

In Portugal, the Ministry of Labour, Solidarity and Social Security and the Ministry of Health are the government bodies most directly responsible for ageing-related policies and they jointly coordinated the preparation of the Action Plan for Active and Healthy Ageing 2023–2026.

The Ministry of Labour, Solidarity and Social Security	Responsible for formulating, directing, implementing and evaluating policies on employment, vocational training, labour relations and working conditions, solidarity and social security, as well as for coordinating social policies relating to families, children and young people at risk, older persons, natality, the inclusion of persons with disabilities, poverty reduction, social inclusion, and the strengthening of the cooperative sector, the social economy and volunteering.
The Ministry of Health	Responsible for formulating, directing, implementing and evaluating national health policy and, in particular, the policy for the National Health Service, while ensuring the sustainable use of resources and the assessment of outcomes. The Ministry of Labour, Solidarity and Social Security and the Ministry of Health are jointly responsible for coordinating the National Network of Long-Term Integrated Care. In addition, in matters relating to demography and inequality, the Ministry of Labour, Solidarity and Social Security and the Ministry of Culture, Youth and Sport jointly exercise supervisory and oversight powers over the National Council for Solidarity, Volunteering, Family, Rehabilitation and Social Security Policies

Republic of North Macedonia 

The planning, prioritization, allocation of funds, and implementation of activities related to the audit topic are under the responsibility of the following institutions:

Government of the Republic of North Macedonia	The Government of the Republic of North Macedonia and the Ministry of Social Policy, Demography and Youth are the main actors in the Republic of North Macedonia with regard to the provision of care for the elderly. According to the Law on Social Protection, the Government has the following obligations: a. to adopt a National Program for the Development of Social Protection, with measures for the medium term up to 5 years and for the long term up to 10 years; b. to adopt an annual program for the implementation of social protection, which determines the areas of social protection; c. to establish public institutions for social protection, and d. to grant approval for the establishment of social protection institutions by local governments and other legal and natural persons for the performance of social protection work.
Ministry of Social Policy, Demography and Youth	The Ministry of Social Policy, Demography and Youth, has the following obligations: a. to develop a national policy for social protection; b. to draft laws and other regulations regulating this matter; c. to establish standards and norms for social services; d. to establish a system for recording data for social protection; e. to provide financial resources for the performance of social protection work; f. to issue permits for performing social protection activities; g. to determine prices for social protection services; h. to supervise the operation of institutions and other legal and natural persons performing social protection activities and other duties. In general, this is the institution responsible for developing policies and plans, providing an adequate level of financial support, coordinating the execution of plans between other institutions, and monitoring and controlling every aspect of the social protection system.
Social Protection Institutions	According to the Law on Social Protection, social protection institutions are: the Center for Social Affairs, Institutions for Non-Family Social Protection and Social Service Centers. The responsibilities of the Center for Social Affairs are: preparing plans and programs for social protection, resolving social protection rights, informing and referring citizens, ensuring access to services in the home, community and outside the family, providing professional assistance and support to individuals, providing professional assistance and support to individuals, keeping records and collecting documentation for social protection beneficiaries and submitting reports to the Ministry. Basically, these institutions, numbering 30 across all municipalities in the country, are the main centres to which people in need of social assistance or services turn, and they carry out activities related to submitting applications, deciding on the applications received and implementing them. Institutions for non-family social protection are: residential homes, care homes, educational institutions, treatment and rehabilitation institutions, group homes and institutions for accepting asylum seekers. They provide social assistance and social services outside the homes of the persons in need. Social service centers provide daily and temporary services in the residence of the beneficiary and in the community.

Institute for Social Activities	The Institute for Social Activities The Institute for Social Activities is a public institution established by the Government for the promotion of social activity. It carries out activities throughout the territory of the country and performs work related to proposing measures for the promotion of social protection. The Institute conducts a licensing procedure for professionals in the social protection sector as well as activities for the professional development of professionals in social protection institutions and other social service providers, provides expert opinions in the preparation of programs and strategies for the development of social protection, prepares standards and procedures for the work of professionals in social protection institutions and other authorized social service providers, and supervises the professional work of social protection institutions and other authorized social service providers.
Units of local self-government	Units of local self-government (LSGs) have their own competencies in relation to the performance of social protection activities. According to the Law on Social Protection, LSGs have the right to determine other rights and social services, in a larger scope than that determined by the law, as well as more favorable conditions for their performance. Additionally, LSGs have the obligation to adopt annual programs for social protection based on the social plan of LSGs, and in accordance with the National Strategy for the Development of Social Protection. LSGs also establish a Council for Social Protection of the municipality as well as a Council for Social Protection for the purpose of planning and developing the network of social services.

Slovak Republic

The Ministry of Labour, Social Affairs and Family (MoLSAF SR)	The Ministry of Labour, Social Affairs and Family of the Slovak Republic (hereinafter MoLSAF SR) serves as the central managing and coordinating authority of the National Active Ageing Programme (hereinafter NAAP). It is responsible for the development, implementation, evaluation and monitoring of the Programme. The Ministry coordinates an inter-ministerial working group on active ageing, composed of representatives of ministries, local governments, the third sector and the Government Council of the Slovak Republic for the Rights of Seniors and the Adaptation of Public Policies to the Ageing Population (hereinafter Government Council for the Rights of Seniors).
Ministry of Health (MoH SR)	Responsible for healthcare, preventive programmes, and long-term care.

 Ministry of Education, Research, Development and Youth (MoERDY SR)	Responsible for lifelong learning, including Universities of the Third Age and the promotion of digital literacy.
 Ministry of Finance (MoF SR)	Participates in financing measures and ensures sustainability of the pension system.
 Ministry of Culture (MoC SR)	Supports cultural and leisure activities for seniors, including intergenerational programmes.
 Ministry of the Interior (MoI SR)	Ensures protection of seniors from violence and discrimination.
 Ministry of Transport (MoT SR)	Responsible for housing accessibility and infrastructure.
 Ministry of the Environment (MoE SR)	Addresses environmental aspects, including climate change adaptation affecting senior citizens.

Ministry of Investment, Regional Development and Informatization of the Slovak Republic	Participates in EU funds management and supports regional development.
The Social Insurance Agency, as a public-law institution	Plays a key role in the administration of social insurance (pensions, sickness, accidents, guarantee, unemployment, and special social insurance) and old-age pension savings. It is responsible for collecting insurance contributions, processing data, granting and paying benefits, conducting audits, and providing informational support.

In addition to government ministries, a range of other organizations are involved in promoting active ageing, including home care agencies, universities, the Statistical Office of the Slovak Republic, labour, social affairs and family offices, as well as local governments, non-governmental and senior citizens' organizations, and social partners

Israel

Ministry of Health	Responsible for safeguarding the health of the population. It establishes policies related to health care and medical services while overseeing the planning, supervision, control, licensing, and coordination of the health care system. The ministry provides health care in areas such as hospitalization and preventive medicine, and it also addresses mental health, geriatrics, public health, and rehabilitation devices for the population[5]

5 Ministry of Health website **[link]**.

	Ensures public welfare by overseeing social services. It works with government bodies to identify, prevent, and address crises affecting individuals, families, and communities—whether temporary or ongoing—stemming from disability, poverty, exclusion, ageing, unemployment, neglect, discrimination, exploitation, or other social challenges[6].
Ministry of Welfare and Social Affairs	The Senior Citizens Administration views all older adults as entitled to full, meaningful lives that require diverse and personalized responses, adapted to their changing needs and desires throughout the complex journey of ageing. The Administration focuses on the development and provision of services within the community and in residential frameworks. It works to promote the quality of life and well-being of Israel's senior citizens in accordance with their functional status. In light of increasing life expectancy and population ageing, the Administration's goal is to address the national challenge of successful ageing by improving quality of life, offering comprehensive welfare services, enhancing social and community belonging, and creating meaning through engageing activities that are valuable to both participants and their communities[7].
Ministry for Social Equality	Works to promote populations of senior citizens, the young, women, and minorities. The Senior Citizens Division works to advance the rights of older adults in Israel across various fields. The Division acts, among other things, to improve the quality of life of older adults in Israel, enhance the accessibility of services for senior citizens, strengthen intergenerational connections within Israeli society, promote the integration of the older population into the labor market and society in Israel, and provide cultural, educational, and leisure activities for the older adult population.[8]
National Insurance Institute of Israel (NII)	A central pillar of Israel's social policy, the NII operates under the National Insurance Law, serving as the country's public social security institution and providing economic protection to vulnerable individuals and families through the payment of benefits[9]. In the context of older adults, the NII pays an old-age pension to eligible senior citizens, and provides long-term care benefits to older persons living at home who need assistance with daily activities and/or close supervision[10]. In addition, the NII's Counseling Service for the Elderly and their Families supports the take-up of rights and offers sensitive emotional support to help older adults maintain quality of life within their community[11].
Prime Minister's Office (PMO)	Coordinates between the government ministries and organizations. The Governance and Social Affairs Division deals with national-level policy planning and coordination in the social sphere and leading government reforms, in accordance with the guidelines of the Director-General of the Prime Minister's Office and with the Prime Minister's policy[12].

6 Ministry of Welfare and Social Affairs website **[link]**.
7 Ministry of Welfare and Social Affairs website, Senior Citizens Administration **[link]**.
8 Ministry for Social Equality website **[link]**.
9 National Insurance Institute of Israel website **[link]**.
10 National Insurance Institute of Israel website **[link]** **[link]**.
11 National Insurance Institute of Israel website **[link]**.
12 Prime Minister's Office website **[link]**.

Audit Questions

The main audit questions that formed the basis of the national reports, and which serve as the foundation for this chapter, are presented in the following table:

Table 1: Audit questions and participating SAIs

Question	Albania	Republic of North Macedonia	Republic of Paraguay	Portugal	Slovak Republic	Israel
Is there a comprehensive plan in place?	✔	✔	✔	✔	✔	✔
What areas does the plan cover?	✔	✔	✔	✔	✔	✔
Is there an integrative policy or separate sectorial plans by ministries?	✔	✔	✔	✔	✔	✔
Is there interaction and coordination between ministries?	✔	✔	✔	✔	✔	✔
Is there a central body coordinating all plans?	✔	✔	✔	✔	✔	✔
Is population ageing addressed within broader national plans?	✔	✔	✔	✔	✔	
Examples of good practices	✔	✔	✔	✔	✔	✔

Through a cross-country comparison, this chapter identifies common patterns, gaps, and systemic risks, alongside country-specific deficiencies and recommendations. It also points to possible courses of action and guiding principles that may contribute to strengthening government preparedness for population ageing and to promoting a coherent, coordinated, and effective long-term policy response.

Albania

Introduction

Why we chose this topic

Albania is currently facing a profound demographic transformation, characterized by sustained emigration, persistently low birth rates, and a steadily increasing proportion of elderly citizens. These trends have significantly altered the country's population structure and are generating wide-ranging pressures on the labour market, the sustainability of the pension system, and the growing demand for social and healthcare services. As a result, population ageing is emerging as a critical policy challenge with direct implications for the country's long-term economic and fiscal stability.

Against this backdrop, the Supreme Audit Institution of Albania chose to participate in the audit topic "Comprehensive Government Plans and Budgetary Aspects for an Ageing Population". The SAI identified the need to assess whether the government has established effective institutional structures, coordination mechanisms, and adequate resource allocations to address ageing in a coherent and strategic manner.

Demographic structure of Albania

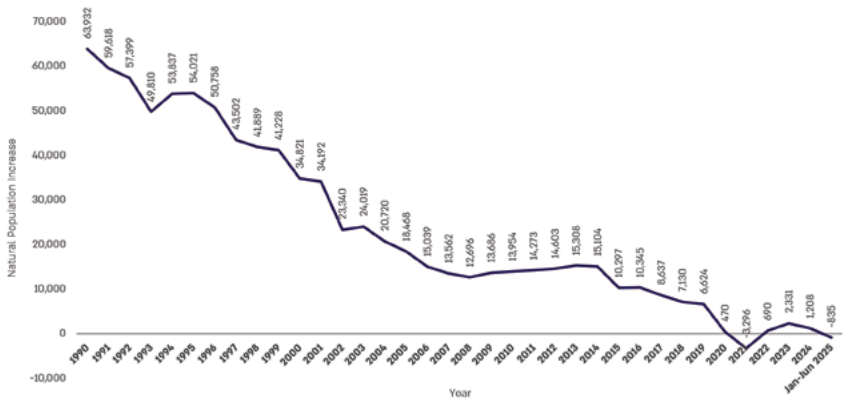
Albania's population is facing a contraction in natural growth rates, which is a result of a decrease in the number of births and high emigration. Demographic data obtained from INSTAT and processed by the audit group show that in 2024 the lowest number of births was recorded since 1990. Specifically, in 2024, around 23,310 births were registered in our country, continuing a downward trend that has been occurring for several years.

Figure 1: Birth rate in Albania for the period 1990–2025

Data source: INSTAT, processed by the audit team.

The natural population increase is also another important demographic indicator, which represents the difference between births and deaths. This indicator is an important factor that indicates demographic dynamics, as it informs us whether the population is growing or shrinking naturally, without taking into account emigration. The natural population increase is positive if the number of births exceeds that of deaths.

Figure 2: Natural population increase in Albania for the period 1990–2025



Data source: INSTAT, processed by the audit team.

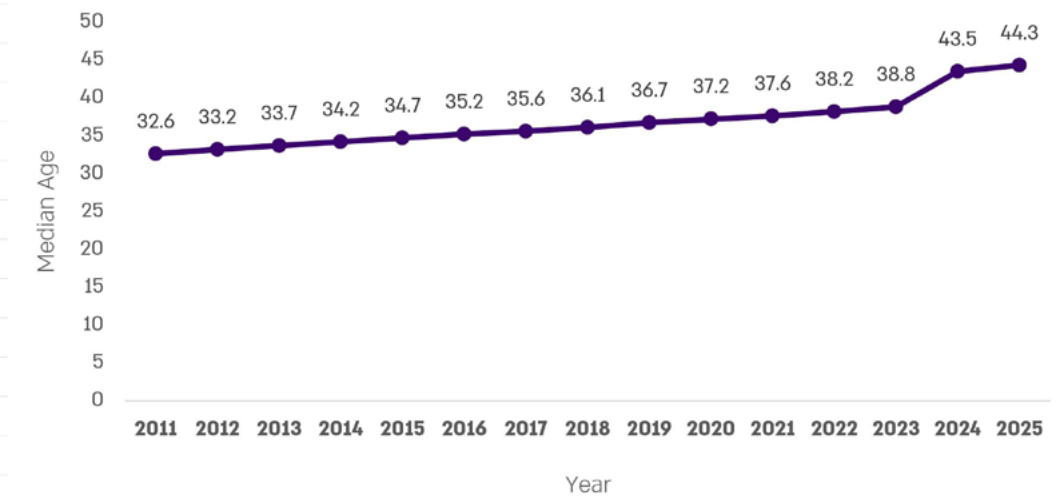
The graph shows that the natural increase in population has been on a downward trend for more than three decades. For example, in the last 10 years alone, we have seen a decrease in natural increase by approximately 88.3%, from 10,297 in 2015 to 1,208 in 2024.

According to the 2023 Census, the resident population in the Republic of Albania on September 18, 2023 was 2,402,113 inhabitants, marking a decrease of about 420 thousand people compared to the 2011 Census. This reduction in the number of inhabitants follows the continuous trend of demographic decline that has begun since the 1990s, mainly as result of emigration.

According to the 2023 Census, mass emigration and declining birth rates were the main factors behind the demographic decline. During the period 2001–2011, around 500,000 citizens emigrated from the country, an average of 50,000 people per year, a trend that has continued in a similar manner since then.

During the period 2011–2025 the median age[1] in Albania has increased, from around 32.6 years in 2011 to 38.8 years in 2023 and with an even faster increase in 2024 and 2025, respectively 43.5 and 44.3 years. This trend reflects the combination of low fertility[2], significant youth emigration, improving health and increasing life expectancy. These factors affect the reduction of the young population and the increase in the weight of the middle-aged or elderly groups.

Figure 3: Median age in Albania 2011–2025[3]



Data source: INSTAT, processed by the audit team.

1 The median age is the age that divides the population into two equal parts: 50% of the population is younger than this age; 50% of the population is older than this age. This indicator highlights the demographic structure of a country, to understand whether the population is ageing or not.

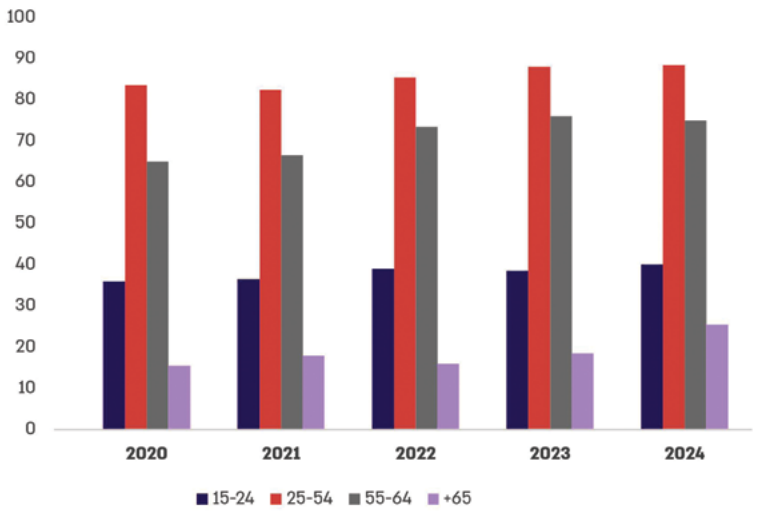
2 The average number of births per woman has fallen significantly over the past decade. Official data from Eurostat show that the fertility rate in Albania was 1.71 children per woman in 2012 and in 2023 it dropped to 1.21 children per woman, while the EU rate is 1.38 births per woman in 2023.

3 **[link]**. INSTAT publication – Population of Albania, January 1, 2025 **[link]**.

About the labour market

The labour market represents one of the main indicators of a country's economic and social development.

Figure 4: Labour force participation rate by age group



Source: INSTAT

The participation rate among individuals aged 25–54, who form the core of the workforce, is notably higher and has steadily increased from 83.0% in 2021 to 87.7% in 2024. This indicates a high inclusion of this age group in the labour market and a stability in the economic activity of the active population.

Compared to this age group, the participation of those aged 55–64 is lower, nevertheless has seen a significant increase from 64.6% in 2021 to around 75% in 2024.

While for the 65+ age group, participation remains much lower, but with a gradual increase from 15.1% in 2021 to 25.1% in 2024.

Introduction to audited entities

The Ministry of Finance (MoF)

is responsible for designing and implementing macroeconomic, fiscal, and budgetary policies, including manageing state revenues, financial control, and EU funds.

Regarding population ageing, the former Ministry of Finance and Economy (MFE) developed the National Employment and Skills Strategy 2023–2030 to address labour force decline due to ageing and migration, aiming to improve employment quality and align skills with market needs.

In 2024, the MFE divided into two institutions, the Ministry of Finance and the Ministry of Economy and Innovation (MEI), and the responsibility for implementing the strategy transferred to the MEI.

Ministry of Economy and Innovation (MEI)

operates in key areas such as employment, investment promotion, and vocational education and training. It is responsible for drafting and implementing economic policies aimed at sustainable growth, as well as ensuring access to vocational training and decent employment.

MEI plays a leading role in implementing the National Employment and Skills Strategy 2023–2030 and is the main institution responsible for employment and vocational training. It also coordinates key sector institutions, including the National Employment and Skills Agency (NESA), which delivers employment services and manages vocational training providers.

The Ministry of Health and Social Welfare (MHSW)

is responsible for developing and implementing policies in healthcare and social protection, ensuring quality services, social inclusion, and support for vulnerable groups.

In response to population ageing, it has adopted key long-term strategies, including the National Social Protection Strategy 2024–2030 and the National Policy Document on Ageing with its Action Plan, aimed at improving quality of life.

The State Social Service (SSS)

is a subordinate institution of the Ministry of Health and Social Welfare, it supports the implementation of social protection policies by providing economic assistance, community programs, and services for individuals in need.

The State Social Service is responsible for the practical implementation of social policies and programs in line with ministry directives, and monitors and supports local units in delivering social services, including for the elderly.

The Institute of Statistics (INSTAT)

is the central institution responsible for producing official statistics in Albania, providing accurate, transparent, and impartial data on economic and social developments.

It ensures data quality, implements the national statistical program, and represents Albania in international statistical systems. INSTAT also provides key data on ageing, migration, fertility, and labour market trends, and conducts the Census, which is essential for informing government policies.

Policies that address the phenomenon of population ageing (National Norms)

The phenomenon of population ageing is addressed directly or indirectly through a strategic sectoral approach linked to the NSDI[4], including it in:

- **The Employment and Skills Strategy 2023-2030**, which has as its vision "Quality employment and lifelong learning for all". It focuses on skills development, improving the matching between supply and demand in the labour market, increasing the inclusion of women and people with disabilities, and the digital transformation of employment services. This strategy contributes to manageing the challenges of population ageing by promoting the employment of active generations, creating opportunities for vulnerable groups to remain economically active, and encourageing young people into the labour market through the Youth Guarantee Program.
- **The National Youth Strategy and Action Plan 2022-2029**, aims to place young people at the center of the country's social and economic development, creating real opportunities for their inclusion, activation and empowerment. The strategy aims to ensure that young people have better access to quality education, decent employment, active participation in decision-making and support for innovative, cultural and sports initiatives. It aims to ensure that investments in youth turn into sustainable development for the country, making youth an active force for positive change and Albania's European integration.
- **The National Social Protection Strategy 2024-2030** is the main document guiding public policies for poverty alleviation, social inclusion, improving the quality of life and care for the elderly.
- **The National Policy Document on Ageing and the Action Plan for its implementation 2020-2024**, which sets out strategic directions and concrete measures to improve the quality of life of the elderly, focusing on health, social support and their active inclusion in society. The document is essential for the assessment of comprehensive plans for an ageing population, as it measures the level of institutional readiness to guarantee sustainable services and policies in a context where the elderly age group is growing rapidly.

4 The National Strategy for Development and Integration (NSDI) 2022–2030 is the main strategic document for Albania's socio-economic development and sets out the long-term vision for sustainable development and integration into the EU.

- **The National Migration Strategy 2024-2030** aims to ensure effective migration governance, by comprehensively manageing migratory movements, and at the same time to maximize the positive impact of migration on the socio-economic development of the country, as well as to promote regular migration, protect the rights of migrants.

The audit team chose to analyze these strategies as part of comprehensive plans in the context of an ageing population.

The policies and objectives according to the strategies selected for evaluation and analysis by the audit team are:

In the Employment and Skills Strategy 2023-2030

- Policy 1, which aims to develop skills and better match demand with supply in the labour market for more employment. In this policy, we have selected two objectives, "Better functioning of the labour market for all" and "Increasing the level of skills of women and men of working age".
- Policy 2, which aims to enable decent employment for women and men through the implementation of comprehensive labour market policies. The selected objective in this policy is "More comprehensive employment mediation".

In the National Youth Strategy and Action Plan 2022-2029, the objectives are:

- Active participation of young people in society and their empowerment to express themselves freely.
- Increasing employment opportunities through skills development and career counseling.
- Improving the physical, mental and social well-being of young people.
- Quality education and innovation, which helps develop their full potential.
- Security and social inclusion for all, especially for at-risk youth.
- Coordinated and evidence-based youth policies, with well-funded mechanisms for implementation, monitoring and evaluation.

In the National Social Protection Strategy 2024-2030

Policy A - Poverty alleviation and livelihood improvement.

- Priority measure A 1.2, which aims to improve the socio-economic reintegration of individuals (women and men) part of the economic assistance scheme, through the link to employment and the promotion of social enterprises.
- Specific objective A3 aims to improve child targeting through a child-focused and gender-sensitive social protection program. This objective also includes the implementation and monitoring of the baby bonus for each child born.

In the National Policy Document on Ageing and the Action Plan for its Implementation 2020-2024.

- The objective is to create motivating work environments for people before retirement and to promote lifelong learning.

Audit methodology

The audit methodology adopts a structured and evidence-based approach to ensure a thorough and reliable assessment of the audit questions. It integrates both qualitative and quantitative methods for data collection and analysis, including a review of the legal, regulatory, and strategic framework governing the audited area, as well as the examination of data gathered during the preliminary phase of the audit.

Furthermore, primary data are collected through interviews and questionnaires with relevant staff and stakeholders, providing practical insights into the implementation of policies. Secondary sources—such as reports, studies, and publications—are also analyzed to support the findings. Document and file reviews are carried out to verify procedures and ensure compliance, while statistical data provided by audited institutions are examined to assess performance and effectiveness.

Overall, this approach enables a systematic, multi-source analysis that enhances the reliability of audit conclusions by incorporating diverse types of evidence and perspectives.

The audit questions

Is there a comprehensive national plan to address population ageing?

Albania does not have a comprehensive national plan that address population ageing issues. Although, the experts[5] support the idea of developing an inter-ministerial strategy to address the challenges of ageing and the importance of addressing ageing and demographic issues as priorities on the national agenda, to guarantee sustainable development and an inclusive society. The phenomenon of demographic ageing is addressed in sectoral plans and strategies that touch on different aspects of active ageing, such as the Employment and Skills Strategy 2023–2030, the National Social Protection Strategy 2019–2023 and 2024–2030, the National Youth Strategy 2022–2029 and the National Policy Document on Ageing 2020–2024.

5 **[link]**

What policy domains are currently covered?

Given that Albania is experiencing rapid population ageing- driven primarily by high youth emigration and persistently low birth rates- we considered it essential to focus our audit on the plans and strategies designed to address these demographic challenges. The available data show that current mechanisms for skills development, labour-market functioning, youth inclusion, social protection, active ageing, and migrant reintegration are not delivering the expected results, creating significant gaps in the country's ability to respond to ageing. For this reason, our audit concentrated on evaluating those governmental plans that directly influence human-capital development, support vulnerable groups, encourage active participation of older persons, and help mitigate the negative effects of emigration and low fertility. The existing policy framework encompasses a wide range of areas; however, for the purposes of this audit, the focus was placed on selected key sectors and objectives as outlined below:

Employment and Skills, with a focus on lifelong learning, the digital transformation of employment services, alignment of skills with labour market needs, and the inclusion of vulnerable groups.

Social Protection, addressing poverty reduction, the transition of beneficiaries of economic assistance into employment, and family support measures such as the baby bonus scheme.

Youth Policies, covering civic participation, access to education and employment, physical and mental well-being, and social inclusion.

Active and Healthy Ageing, including measures related to workplace motivation for older workers, flexible transition to retirement, and opportunities for lifelong learning.

Migration and Reintegration, comprising measures for the reintegration of returnees, strengthening coordination mechanisms, and providing labour market support for migrants.

Is the policy framework cross-sectoral or sector-based?

The policy framework is cross-sectoral, as it integrates health, social protection, employment and community development measures to address the multidimensional needs of the ageing population.

Table 1: Policies for ageing populations involve coordination across several sectors

Sector	Focus
Health	Long-term care, preventive services, healthy ageing
Social protection	Pensions, social assistance, community support
Employment	Active ageing, labour market inclusion
Housing & infrastructure	Age-friendly environments, accessibility
Education & participation	Lifelong learning, social inclusion

The Ministry of Health and Social Welfare is the primary institution responsible for ageing policy, social protection, and long-term care, and it oversees the implementation of the National Policy Document on Ageing. The Ministry of Economy and Innovation plays a central role in employment policy, labour-market development, youth activation, and economic planning- all of which are linked to the challenges posed by an ageing workforce. The Ministry of Interior and migration-related structures manage emigration and reintegration policies, which are major demographic drivers shaping the ageing process in Albania. Agencies such as the National Employment and Skills Agency (NESA), the State Social Service, and local government units are responsible for employment services, social-care delivery, and community support for older persons. The Institute of Statistics (INSTAT) provides the demographic and socio-economic data needed for planning, monitoring, and policy evaluation. These institutions constitute a broad governance structure.

Are coordination mechanisms between ministries functioning?

Although some formal coordination mechanisms exist, in practice they do not ensure consistent and effective cooperation between ministries. This results in partial policy implementation and a lack of a unified approach to addressing population ageing.

Table 2

Sector	Institutional coordination
Social protection & long-term care	MoHSP (via SSS) – social care services and standards; MEI (via NESA/AKPA) – activation of social assistance beneficiaries
Employment & labour market activation (55+)	MEI/AKPA – employment & re-skilling programs; MoHSP/SSS – identification and referral of vulnerable groups
Education, skills & lifelong learning	MEI/AKPA – vocational training; MoHSP – active ageing inclusion
Migration & reintegration	MEI – labour market integration of returnees; MoHSP – social support
Data & demographic monitoring	INSTAT – population statistics and projections- Ministries
Budgeting & sustainability	Ministry of Finance – funding and financial oversight; line ministries – implementation

Is there a central coordinating body for population ageing?

Although Albania does not have a dedicated national coordination body focused exclusively on population ageing, the coordination of sectoral strategies—including those addressing social care and ageing issues—is carried out within the national strategic framework.

All related sectoral plans are linked to the National Strategy for Development and European Integration (NSDEI). Cross-sectoral coordination for the implementation of this national strategy is ensured by the Integrated Policy Management Group (IPMG) established by the Prime Minister's Order No. 90, dated 01.08.2023.

Is population ageing integrated into broader national or socio-economic strategies?

It is addressed indirectly through several policy documents, including:

- Employment and Skills Strategy
- Social Protection Strategies
- Migration Strategy
- Youth Strategy
- Ageing Policy Document

Have the objectives been met?

The responsible institutions have undertaken several important steps in implementing policies related to population ageing. However, the implementation of policies in the areas of employment, skills, and social inclusion has been partial, with some measures only partially completed and indicators showing a declining trend. The results of the youth-focused programs are not fully reflected, while the objectives related to the inclusion of older adults have not been achieved.

A review of strategic documents, action plans, progress reports, and information received from responsible institutions indicates that progress has been made toward addressing population ageing. However, the objectives that the audit team analyzed, have not yet been fully achieved.

How is progress tracked and assessed?

Monitoring and evaluation of policies related to population ageing are unevenly developed across social protection, employment, and youth sectors. In social protection, the system appears more consolidated, with the 2019-2023 strategy monitored through a structured framework of indicators and annual reports. However, for the 2024-2030 strategy, monitoring remains largely preparatory, with incomplete performance indicators and draft reporting, limiting the assessment of effectiveness and impact.

In employment and skills, although a formal monitoring framework exists, its linkage to population ageing is weak. There are no dedicated indicators or systematic reporting for the 55+ age group, and missing data for key indicators limits the assessment of policy impact on older persons' labour market inclusion.

In the youth sector, monitoring is formally structured, with regular reporting aligned with national planning systems. However, its effectiveness is constrained by limited institutional capacities, fragmented coordination, and a focus on quantitative reporting rather than analytical evaluation. Recent institutional changes further underline the need to strengthen clarity of responsibilities and coherence in reporting.

Conclusion: In Albania monitoring and evaluation of policies on population ageing and human capital development are supported by established institutional and methodological frameworks. However, newer strategies face challenges in defining performance indicators and producing analytical reporting, limiting the full assessment of progress and impact.

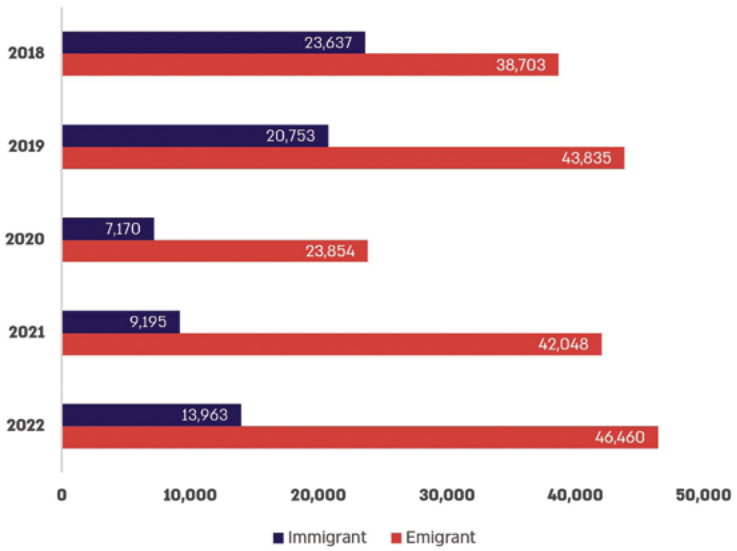
As a result, monitoring remains largely reporting-oriented and preparatory, with limited emphasis on performance analysis and the effectiveness of inter-institutional coordination.

To what extent is the plan based on data and evidence?

At a time when Albania is facing depopulation, population ageing, and the growing outflow of young people, the national strategies related to migration, employment, and youth aim to create a policy framework for manageing these challenges. However, an analysis of these documents shows that they often rely on partial data and retrospective approaches, failing to anticipate future developments and identify the regions or population groups most affected by migration and the lack of economic opportunities.

The National Migration Strategy 2023-2030 seeks to establish an integrated approach to migration management, but it remains constrained by the absence of detailed demographic data and the lack of projections for the period 2024-2030. The National Migration Strategy 2023-2030 is based in part on national and international statistical sources such as INSTAT, EUROSTAT, FRONTEX, IOM, UNHCR, and the European Commission. The document incorporates several important indicators that describe Albania's migration context, including the negative migration balance, with net migration worsening significantly from 15,030 persons in 2018 to 32,853 in 2021, and remaining relatively stable at 32,497 in 2022.

Figure 5

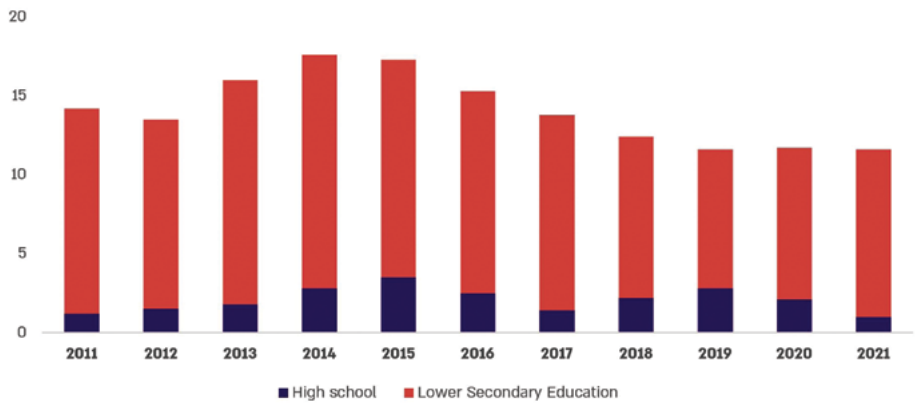


The strategy lacks detailed demographic and territorial data on migration, as well as projections, limiting its usefulness for targeted policies and long-term planning. It does not adequately analyse regional disparities or the link between labour market conditions and migration, reducing its ability to identify high-risk areas. Furthermore, the impact of migration on human capital, particularly the high emigration of skilled individuals ("brain drain"), is insufficiently addressed, posing risks to long-term development.

The National Employment and Skills Strategy 2023-2030 provides a solid overview of past labour market developments, including declining unemployment and structural shifts in employment, while identifying key vulnerable groups and sectoral trends. However, it remains largely backward-looking, lacking demographic projections and analysis of the impact of population ageing, youth emigration, and rural labour market dynamics.

The limited use of disaggregated data and insufficient integration of available statistical sources constrain the development of targeted, evidence-based policies. As a result, the strategy risks remaining general in scope and less effective in addressing challenges such as depopulation, rural decline, and skills shortages.

Figure 6: Scale of unemployment



The National Youth Strategy 2022-2029 lacks a comprehensive demographic and regional analysis of the youth population and does not adequately link key factors such as unemployment, poverty, education, and migration. It also overlooks brain drain and reintegration opportunities, making it more declarative than evidence-based.

Overall, the national strategies on migration, employment, and youth lack projections, demographic analysis, and territorial assessments, limiting their ability to address depopulation, youth emigration, and skills shortages, and weakening their role in guiding long-term policy.

Conclusion: National strategies on migration, employment, and youth development lack comprehensive statistical bases, detailed demographic and regional analyses, and projections, limiting their effectiveness as evidence-based policy tools. This weakens their capacity for targeted interventions, efficient resource allocation, and sustainable planning.

Moreover, the absence of analysis on different forms of migration and the weak linkage between education, employment, and youth mobility reduce their ability to address brain drain and long-term demographic challenges, undermining their overall impact on economic development and social cohesion.

What are the sources of financing?

Since its introduction in 2019, the "Baby Bonus" scheme has aimed to support new families and increase birth rates; however, the number of beneficiaries declined from 42,740 in 2023 to 26,358 in 2024. Demographic indicators continue to worsen, with births decreasing by 14.1% in Q1 2025 and 7.4% in Q2 2025 compared to 2024, and a negative natural increase of 883- persons. The fertility rate fell from 1.71 children per woman in 2012 to 1.21 in 2023 (below the EU average of 1.38), while families with dependent children face a poverty risk of 24.8% compared to 10.5% for those without children, indicating that the policy has not achieved its intended impact.

At the same time, the implementation of related policies shows financial and operational weaknesses. The Ageing Plan 2020-2024 recorded low execution rates (61% in 2020, 56% in 2021, 36% in 2022, 51% in 2023, and 50% in 2024), with only about 48% of planned funds disbursed and limited financial reporting. The Social Fund remains under-resourced, with insufficient data on allocated versus planned funds and weak local capacities for manageing social services. Additionally, budget execution for Employment Promotion Programmes and the Youth Guarantee Programme has been unstable and incomplete during 2020-2025, highlighting inefficiencies in planning, funding, and implementation.

Conclusion: Family policies aimed at increasing fertility require comprehensive and sustained support, as the baby bonus alone is insufficient to reverse current trends. Additional measures should be evaluated and implemented by the MHSW in cooperation with experts, through coordinated actions at both local and national levels and across short-, medium-, and long-term planning horizons.

Policymakers should prioritise integrated and sustainable family support services, allocate adequate resources, and work closely with experts and stakeholders to address the key economic and social barriers influencing decisions on parenthood.

What good practices were identified?

Despite significant shortcomings, some noteworthy positive practices exist:

1. The new National Policy Document on Ageing 2025-2030
2. Digital improvements in employment services
3. Enhancements to the "puna.gov.al" portal and development of digital training materials and labour-market analyses.
4. Support for economic-assistance beneficiaries
5. Over 12,000 individuals engaged in employment or activation programs; 13 social enterprises created under the Social Enterprise Law.
6. Lifelong-learning initiatives for older individuals
7. Training courses for caregivers and several professional courses for people aged 65+, although participation remains limited.
8. These are promising elements that could form the basis for more robust, integrated demographic policy in the future.
9. Starting from year 2025, tax breaks have been approved for families with children, which mean a deduction from the tax base of around €480 per year for each child under 18 years old.

Main audit conclusion

Albania does not have a comprehensive and cross-sectoral plan that addresses the phenomenon of population ageing. This phenomenon is addressed through sectoral strategies or plans which, in themselves, do not provide full, coordinated, and comprehensive support for population ageing issues. The sectoral policies implemented so far by the responsible institutions, taken as a whole, have not led to improvements in key indicators, as the country continues to experience a decline in fertility by approximately 72% from 1990 to 2024, a negative migration balance with net migration increasing from 15,030 persons in 2018 to 32,497 in 2022, as well as an increase in the median age from 32.6 years in 2011 to 44.3 years in 2025.

Based on the analysed indicators, it is necessary to design and implement direct policies with a long-term perspective, recognising that changes in employment, fertility, migration, social protection, and economic development policies require decades to produce a sustainable impact on society.

Summary of Audit Findings

The audit findings reveal significant weaknesses in the design, implementation, monitoring, and data use of public policies across employment, social protection, migration, youth, and ageing. A number of planned interventions have not been implemented or have been only partially achieved, resulting in declining performance indicators and limited policy impact. Monitoring and reporting systems are insufficiently developed, with missing or poorly defined performance indicators, lack of disaggregated data, and reports that are largely descriptive rather than analytical. In addition, the use of statistical data remains fragmented and not fully integrated, with gaps in demographic analysis, projections, and regional breakdowns, and in some cases reliance on outdated or inaccurate data. Financial management also presents challenges, including low and inconsistent budget execution, limited transparency in reporting, and inefficiencies in resource utilisation. Overall, these shortcomings reduce the effectiveness of policies, hinder evidence-based decision-making, and limit the ability to address key socio-economic challenges such as labour market participation, demographic change, and migration trends.

More detailed audit findings

1. The implementation of the Employment and Skills Strategy is partial, as key planned interventions for 2024 have not been completed. There is a decline in core performance indicators, including participation in training and job placements, indicating limited effectiveness of measures.
2. The Youth Guarantee Portal lacks transparency, as it does not publish data on programme performance, despite available results. This limits its function as a reliable information tool and may undermine trust among young people.
3. The National Action Plan 2020-2024 on Ageing has not been fully implemented. Key activities such as awareness campaigns and the establishment of the "University of the Third Age" have not been achieved, and participation of older persons remains low.
4. Monitoring of the National Social Protection Strategy 2024-2030 for 2024 is incomplete, with missing performance indicators and lack of a comprehensive, approved monitoring report.
5. The Employment and Skills Strategy does not include dedicated performance indicators or reporting for the population aged over 55, making it difficult to assess policy impact on this group.
6. Monitoring reports lack key data and disaggregation by beneficiary categories, resulting in descriptive rather than analytical reporting and limiting evidence-based decision-making.
7. The National Migration Strategy lacks integrated and detailed statistical analysis, including demographic breakdowns and projections, weakening its analytical foundation.
8. The Employment and Skills Strategy does not adequately address emerging labour market dynamics, including population ageing, youth emigration, and rural labour market challenges.
9. The National Youth Strategy relies on incomplete and, in some cases, inaccurate data, and lacks comprehensive demographic analysis, projections, and analysis of youth migration trends.
10. The "baby bonus" policy has not achieved its intended impact on increasing birth rates, despite financial support measures, and demographic indicators continue to decline.
11. Budget execution for the National Action Plan on Ageing is low (41%), with insufficient financial reporting and lack of detailed breakdown of expenditures by activities.
12. Financial resources of the Social Fund are insufficient to meet increasing demand, while monitoring reports lack detailed analysis of fund utilisation and achievement of objectives.
13. Budget execution for Employment Promotion Programmes is unstable and inconsistent, with significant variations across years and challenges in programme implementation, particularly in manageing agreements.

Summary of Audit Recommendations

The audit recommendations focus on strengthening the effectiveness, transparency, and evidence-based nature of public policies across employment, social protection, migration, and youth sectors. Key priorities include improving the implementation of strategic interventions through better planning and integration into annual work programmes; enhancing monitoring and reporting systems by establishing clear, measurable performance indicators and ensuring regular, analytical, and publicly available reporting; and increasing transparency, particularly through the publication of reliable and up-to-date data. The recommendations also emphasise the need to develop integrated and harmonised data systems across institutions to support informed policymaking, as well as to improve the use of statistical data for demographic and labour market analysis. Furthermore, they highlight the importance of strengthening financial management by ensuring adequate resource allocation, better budget execution, and clearer tracking of expenditures. In addition, specific measures are proposed to enhance the effectiveness of social and employment policies, including revising family support schemes, improving the functioning of the Social Fund, and ensuring the proper implementation of employment promotion programmes, with the overall aim of achieving more sustainable, inclusive, and results-oriented policy outcomes.

More detailed audit recommendations for the responsible institutions

1. Strengthen the implementation of the Employment and Skills Strategy by conducting national assessments of skills needs, developing micro-credentials, and integrating planned interventions into annual work plans.
2. Improve transparency of the Youth Guarantee Programme by regularly publishing updated performance data on the official portal.
3. Analyse the causes of underperformance in the National Action Plan on Ageing and ensure adequate resources and monitoring mechanisms for future policy implementation.
4. Enhance monitoring of the Social Protection Strategy by defining performance indicators and ensuring regular, analytical, and publicly available reporting.
5. Ensure comprehensive reporting of all performance indicators within the Employment and Skills Strategy to allow proper assessment of progress.
6. Strengthen migration data systems by establishing a unified and updated database through institutional cooperation.
7. Improve transparency by regularly publishing detailed migration data on official platforms.
8. Develop an integrated data system linking labour market and youth data to support evidence-based and targeted policymaking.
9. Review and strengthen family support policies, including revising the baby bonus scheme and introducing additional financial and non-financial support measures.
10. Improve financial management by identifying additional funding sources and ensuring clear differentiation between planned and actual expenditures.
11. Address inefficiencies in the Social Fund by reassessing resource allocation, improving fund utilisation, and strengthening monitoring and reporting.
12. Improve budget planning and execution for Employment Promotion Programmes and the Youth Guarantee Programme through better financial management and monitoring of implementation mechanisms.

Republic of Paraguay

Introduction

CONTRALORÍA GENERAL DE LA REPÚBLICA
PARAGUAY

Justification

A comprehensive plan is essential to ensure compliance with the fundamental rights of older adults, as established by the National Constitution of Republic of Republic of Paraguay , which guarantees the right to comprehensive protection for all older adults.

Ageing is not just a health issue; it encompasses social, economic, psychological, and legal aspects. A comprehensive plan ensures that all these areas are addressed simultaneously, avoiding duplication of effort and fragmented, uncoordinated policies that only partially meet the needs of older adults.

In this sense, the implementation of Public Policies and Action Plans in the field of older adults is fundamental to ensure their well-being, dignity and full exercise of their rights, even more so considering that, in Republic of Republic of Paraguay the number of people aged 60 and over is growing, which implies a greater need for social, health and economic services.

It is important to have a Coordinating or Governing Body to direct, coordinate and monitor the implementation of public policies, so that it acts as the highest technical and political authority on ageing, establishing guidelines and standards for all institutions involved, serving as a focal point for civil society, international organizations and other entities, facilitating collaboration and the channeling of resources and technical assistance.

Interministerial (or intersectoral) cooperation is important because solutions to the problems of older adults transcend the capacity of a single ministry. The complexity of the issue requires that the coordinating body not act alone, but rather foster cooperation among different ministries and institutions . Coordination ensures a comprehensive and efficient response to needs, preventing gaps in service provision.

Allocating a budget is vital to serve the growing elderly population throughout Republic of Republic of Paraguay, which requires significant and planned investment in both infrastructure (day centers, geriatric units, homes, clubs) and human resources (gerontologists, caregivers, among others). A specific budget ensures the continuity of services in the long term, regardless of political changes or current priorities.

Country Profile

Republic of Republic of Paraguay, like many countries, is experiencing a progressive ageing of its population. This demographic shift generates increasing demands that must be addressed in an organized and efficient manner.

In this regard, in 2002 Law No. 1885/02 "Of the Adults" was issued, with the purpose of protecting the rights and interests of older adults, establishing the Ministry of Public Health and Social Welfare (MSPBS), as the state body in charge of the application of the Law.

The aforementioned Law has Regulatory Decree No. 10068/07, through which the Directorate of Older Adults was created, under the General Directorate of Social Welfare of the MSPBS, assigning it specific functions related to the care and protection of older adults.

By Resolution of the MSPBS SG No. 264/23, the National Policy for Older Persons of Republic of Republic of Paraguay was approved, its implementation and application throughout the territory of the Republic was ordered, entrusting the Social Welfare Institute of the MSPBS, the coordination of actions aimed at compliance with the policy.

The MSPBS is responsible for the administration of resources for the economic management and execution of programs for the benefit of Older Adults, in this sense, of the assigned resources that are affected to Program 6 Improvement in Social Welfare for people in situations of Risk – Activity 1 "Comprehensive care of the Older Adult population".

In light of the foregoing, the Republic of Republic of Paraguayan Supreme Audit Institution (SAI) chose to participate in the chapter "Comprehensive Government Plans and Budgetary Aspects," as it represents the origin of the process aimed at ensuring the quality of life of older adults, in order to evaluate the management of the Ministry of Public Health and Social Welfare as the governing body, regarding the implementation of Public Policies and action plans within the framework of Law No. 1885/02 "On Older Persons" and Regulatory Decree No. 10068/07; the audit covered the fiscal years 2023, 2024 and 2025.

Presentation of audit questions

1. Is there a comprehensive plan in place?
2. What areas does the plan cover?
3. Is there an integrated policy or separate sectoral plans by ministries?
4. Are there interactions and coordination between ministries?
5. Is there a central body that coordinates all the plans?
6. Is population ageing addressed in broader national plans?

Working methodologies

During the execution phase of the Audit, the audit team requested and carried out the analysis of documents and information provided by the Entity Subject to Control, in addition to carrying out on-site verifications in the National Homes for Older Adults, dependent on the MSPBS, and interviews with those responsible for some departments linked to the care of the adult population.

Findings of the SAI

Is there a comprehensive plan in place?

Law No. 1885 of 2002 "On Adults", protects the rights and interests of adults over 60 years of age, however, there was no approved Action Plan, only a draft Action Plan.

Although Republic of Republic of Paraguay has a Comprehensive National Policy for Older Persons, whose objective is to guarantee older persons and their families a dignified, long, and healthy life, its operation is deficient because, for the Specific Objectives and Lines of Action of said Policy, no goals and indicators were established, nor were the responsible parties designated. **The lack of goals** , indicators, and identification of responsible parties limits the effective implementation and evaluation of the National Policy for Older Persons, hindering the monitoring of progress and results.

Furthermore, the Directorate for Older Adults, the department responsible for specific functions related to the care and protection of older adults, did not have a formally approved and implemented Manual of Functions, Standards, and Procedures. The lack of guidelines, regulations, and procedures can cause delays, administrative errors, and the discretionary use of the public budget, which ultimately negatively affects beneficiaries and the credibility of the institution. It can also limit the directorate's ability to continuously evaluate and improve its performance.

What areas does the plan cover?

Based on the provisions of the Law that protects the rights and interests of older adults, they have priority in receiving services related to their health, housing, food, transportation, education, entertainment, and employment, as well as the timely receipt of any benefits they may have. Furthermore, the Action Plan, which was in draft form during the audit period, addresses the following areas: access to pensions, employment inclusion, technical and professional training, financial credit, entrepreneurship, comprehensive health services, access to public transportation, and recreation and leisure activities.

The review revealed deficiencies due to inadequate planning and execution of the budget allocated for the Comprehensive Care for the Elderly Population program . This included budget allocations to certain items that were not used, and others with low budget execution rates. Furthermore, the budget allocated for the purchase of food products was not fully utilized, despite having a remaining balance. This resulted in the planned menus not being followed, as they had to be modified or adjusted due to a lack of food supplies. The review also revealed a lack of budget allocation for the purchase of clothing and personal hygiene items.

also found that the human resources providing services to adults were not budgeted for the corresponding activity. This situation stems from a lack of coordination mechanisms and Review between the departments responsible for planning, human talent management and budget programming, generating inconsistency between the operational execution of the staff and the respective budget registration.

Furthermore, it was evident that food products and/or supplies, acquired with resources from the budget allocated to the elderly population, were being distributed to other beneficiaries who are not part of that population sector. The observed situation negatively impacts the provision of food to the elderly population residing in permanent care homes, who, on occasion, do not have all the supplies for the preparation of their meals according to the food and nutrition plans they require.

Is there an integrated policy or separate sectoral plans by ministries?

There is an integrated National Policy for Older Persons in Republic of Republic of Paraguay; however, fragmented and uncollaborative management was evident, failing to comply with the lines of action established in the Policy itself. Furthermore, during the audited period, no actions were taken by the governing body to promote links with national, international, or other institutions to benefit older adults.

In addition, agreements or contracts with private sector centers and dining halls that provide assistance to people Previous agreements with senior citizen centers were not renewed; it is important to note that these community centers provided services to senior citizens, primarily food. The lack of renewal of agreements with private sector organizations that provide assistance to senior citizens indicates weaknesses on the part of the oversight body in promoting and encourageing their participation in order to contribute to improving the quality of life of senior citizens.

Are there interactions and coordination between ministries?

No interactions or coordination between ministries were evident, although the Law that protects the rights and interests of older adults establishes that the responsible state body must develop and promote specific programs that benefit older adults in coordination with other ministries and private institutions, it was evident that the Advisory Committee and the Senior Citizens Liaison, whose functions include proposing policies, strategies and plans and integrating commissions according to areas of action, in favor of the senior citizen population, presenting projects and models or other proposals that favor the implementation of the law of Older Persons; was not in operation.

This Committee had defined very important functions intended to benefit the elderly population, which were not exercised; therefore, its inactivity did not favor interaction between the ministries, generating a negative impact on timely care, well-being and quality of life of adults and their families.

Is there a central body that coordinates all the plans?

If there is a central coordinating body, it is the Ministry of Public Health and Social Welfare (MSPBS); however, its coordination capacity is weakened in administrative processes , considering that some departments of the MSPBS Directorate of Older Adults, responsible for specific functions related to the care and protection of older adults, were without those responsible for carrying out activities related to the care of older adults; some positions were filled temporarily, only to become vacant again, in other cases officials from other areas who had their own functions, covered the tasks of the vacant positions, a fact that affects the execution of tasks in an effective and efficient manner.

Is population ageing addressed in broader national plans?

During the period under review, there was no approved action plan available to systematically address future needs and trends arising from the ageing of the Republic of Republic of Paraguayan population, in such a way as to contribute to the well-being and improvement of the quality of life of adults.

Furthermore, the verification carried out showed that the planning did not take into account the demographic change, considering that the same annual goal of providing services to care for older adults was projected for the years 2023, 2024 and 2025, without considering the real growth of the demand of said population.

Good Practices.

To strengthen comprehensive care for adults, the Ministry of Public Health and Social Welfare (MSPBS) developed new care manuals, provided training to community agents, health personnel from different health regions and caregivers, activated the promotion of the Health Club for active ageing, and provided health care services in outpatient or ambulatory consultations to adults:

- New Manuals: Presentation of new updated manuals, with support from PAHO/WHO, for the identification and prevention of mistreatment, and the promotion of active ageing: "Practical guide for informal caregivers of older people", "Good practices for dignified treatment of older people" and "Manual for care and prevention of mistreatment against older people.
- Caregiver Training and Good Treatment: The launch and implementation of training programs for formal and home-based caregivers were carried out.
- Training in health regions regarding the "Gerontological care model focused on the older person as a subject of rights".

- Promotion of the Health Club for Active Ageing: Encourageing physical activity, proper nutrition, reading and social participation to maintain autonomy.
- Residential and Institutional Care: The care homes (Santo Domingo, Emilio Sosa and Gijón Róga) for people in vulnerable or abandoned situations are fully operational.
- Health care services: Care is provided in specialized health areas (mental health, holistic wellness, nutrition) through outpatient services, both for residents in the homes and for non-residents.

Summary

Table 1: Audit Questions and Findings

Audit Questions	Findings
Is there a comprehensive plan in place?	For the Specific Objectives and Lines of Action of the National Policy for Older Persons of Republic of Republic of Paraguay, no goals and indicators were established , nor were those responsible for execution/evaluation.
	There is no approved comprehensive Action Plan. Only a draft exists, which creates uncertainty and inefficiency in the implementation of the National Policy.
	The Directorate of Older Adults, under the Ministry of Public Health and Social Welfare (MSPBS), does not have an approved Manual of Functions, Standards and Procedures.
What areas does the Plan cover?	Inadequate planning and execution of the budget for the Budgetary Activity for the " Comprehensive Care of the Elderly Person".
	The human resources that provide care services to adults were not budgetarily allocated to the corresponding program.
	The MSPBS distributed food products and/or supplies, acquired with resources from the budget allocated to the elderly population, to other beneficiaries who are not part of that population sector.
Is there an integrated policy or separate sectoral plans?	The MSPBS did not develop actions to promote links with national, international or other institutions. Agreements or Conventions with the Private Sector (Centers and Dining Halls) were not renewed by the IBS of the MSPBS.
Are there interactions and coordination between ministries?	Although the Ministry of Public Health and Social Welfare is the body in charge of implementing Public Policies and action plans, the Advisory and Liaison Committee for Older Adults was not operational.
Is there a central body that coordinates all the plans?	The Ministry of Public Health and Social Welfare (MSPBS) is the body in charge of the application of the Law that protects the rights of older adults, however it was evident that some departments of the Directorate of Older Adults of the MSPBS were without those responsible for the execution of activities related to care, with vacant positions or temporarily covered by officials with other functions of their own.

Audit Questions	Findings
Is population ageing addressed in broader national plans?	The MSPBS does not have an approved action plan to address future needs and population ageing trends. The target for the Budgetary Activity for " Comprehensive Care of the Elderly Person" was not adjusted based on superior results achieved in previous years.

These findings confirm that, although there is an established public policy, its implementation is fragmented, lacks rigorous operational and budgetary planning, and has deficiencies in the coordination and oversight mechanisms necessary to guarantee comprehensive care for older adults projected into the future.

To address the shortcomings and strengthen care for the elderly population, the following actions are recommended:

Strengthening of Regulations and Governance

Approve and immediately implement the National Policy Action Plan for Older Persons.

Approve and implement the Manual of Functions, Standards and Procedures of the Directorate of Older Adults and ensure that all departments have responsible persons.

Manage actions to ensure an adequate and timely staffing, so that the departments of the Directorate of Older Adults of the MSPBS have those responsible for the execution of activities on a permanent and formal basis.

Strategic and Budgetary Planning

Strengthen strategic planning by incorporating quantifiable goals with defined deadlines, measurable performance indicators, and designating those responsible for each Objective and Line of Action of the National Policy for Older Persons of Republic of Republic of Paraguay.

Improve the planning and execution of the budget allocated for the care of older adults, optimizing the use of resources to ensure that their basic needs are met.

Implement actions that improve the processes of institutional documentation, budget planning, purchases and distribution to beneficiaries, in order to achieve a precise correspondence between the programmed resources and the purpose for which they are intended.

To ensure the correct budgetary allocation of human resources to the budgetary activity " Comprehensive Care of the Elderly Person".

Conduct an analysis of the goals achieved in the budget activity " Comprehensive Care of the Elderly Person" in previous fiscal years, in order to plan and adjust the projected goals for the following years, so as to obtain efficient planning, considering possible improvements that can contribute to the provision of comprehensive and quality care to the elderly.

Develop a long-term action plan to address population ageing trends.

Coordination and Coverage

To put into operation the Advisory and Liaison Committee for Older Adults to improve inter-institutional interaction and coordination, in order to contribute to improving the care and quality of life of older adults in a comprehensive way.

Conduct a proper review of the Cooperation Agreements with private entities that were not renewed, in order to analyze the feasibility and relevance of renewing them, considering the crucial role they could play in providing services to older adults.

Implement and promote inter-institutional coordination actions for cooperation with national, international and other institutions in a way that contributes to the well-being of older adults.

Monitoring

Establish monitoring and evaluation instruments and mechanisms to measure the impact of actions derived from the National Policy, in order to ensure that the objectives are achieved and that the social welfare and quality of life of adults are ensured.

Portugal

Audit of the Preparedness of The Health and Social Protection Systems for Population Ageing: The Active and Healthy Ageing Action Plan 2023–2026

TRIBUNAL DE CONTAS

Introduction

The Portuguese Court of Auditors (Tribunal de Contas - TdC) decided to participate in the 'Comprehensive Governmental Plans and Budgetary Aspects' topic of the 'International Parallel Audit on Governments' Preparedness for an Ageing Population', as Portugal is experiencing significant demographic change, particularly a growing proportion of older persons. This trend has major implications for public policy, especially in areas such as social protection, healthcare, long-term care, and the overall sustainability of public finances.

Participation in this parallel audit contributes to strengthening the evidence base for assessing Portugal's response to population ageing, notably through comparison with the approaches adopted by other countries facing similar demographic pressures. It also supports the identification of good practices, policy gaps, and more effective ways of allocating public resources to address this challenge.

The relevance of the 'Comprehensive Governmental Plans and Budgetary Aspects' topic in the Portuguese context was further reinforced by the Government's approval, on 12 January 2024, of the Action Plan for Active and Healthy Ageing 2023–2026 (APAHA), prepared under the joint coordination of the Ministry of Labour, Solidarity and Social Security (MLSSS) and the Ministry of Health (MH), which are the government bodies most directly responsible for policy relating to population ageing. The Plan was intended to provide a coordinated national response to the challenges posed by population ageing.

Audit objective and scope

The TdC carried out an audit of the Action Plan for Active and Healthy Ageing 2023-2026 (APAHA), with the aim of verifying whether the Plan was developed in accordance with international best practices in the public policy process.

The objective of the audit was to assess the design of the APAHA, as well as its operationalization and monitoring by the end of the 1st half of 2025.

Audit Criteria and Methodology

Criteria

The audit criteria defined and used in the audit of the APAHA are outlined in Table 1.

Table 1: Audit criteria and its sources

Audit criteria	Sources
Policies, laws and regulations	• Articles 19 and 73 of the Budgetary Framework Law • Resolution of the Council of Ministers No. 14/2024, of 12 January, approving the APAHA. • Order No. 4762/2023, of 20 April, appointing the former National Coordinator of the APAHA. • Order No. 1191/2025, of 27 January, appointing the current National Coordinator of the APAHA.
Standards and other references from professional or international organisations	• European Commission (2015) – Quality of Public Administration • ISO 37000:2021 – Governance of organizations – Guidance. • ISO 37005:2024 – Governance of organizations – Developing indicators for effective governance. • World Health Organization (2024) – Measuring the progress and impact of the UN Decade of Healthy Ageing (2021-2030): framework and indicators recommended by WHO Technical Advisory • OECD (2023) – The Principles of Public Administration • OECD (2025) – Public Policy Evaluation – Implementation Toolkit
Subject matter literature	Kusek e Rist (2004)
Goals and key performance indicators	APAHA 1st Implementation Report on the activities of the APAHA

Methodology

The audit process was carried out in accordance with the standards and guidelines on performance auditing established by the International Organisation of Supreme Audit Institutions[1].

The methodology used combined qualitative and quantitative methods, comprising:

- Documentary review, including the APAHA and the First Report on the Implementation of APAHA activities;
- Interviews with officials from the entities responsible for implementing APAHA activities, namely the Executive Board of the National Health Service (EB-NHS) and the Social Security Institute (SSI), as well as with the former and current National Coordinators of the APAHA;
- Questionnaires sent to the EB-NHS, SSI, and the Competence Centre for the Social Economy – CCSE), and to the former and current National Coordinators of the APAHA; official letters were also sent to the MLSSS and the MH; and
- An in-depth analysis of five activities included in the APAHA, with a view to examining their implementation, monitoring and evaluation processes.

Key Findings

Overview

The APAHA is an integrated and comprehensive instrument of government action to address population ageing, framed in the context of the guidelines and priorities defined at the European level, in particular the European strategy for active and healthy ageing, as set out in the European Commission's[2] Green Paper on Ageing of 27 January 2021.

As shown in Table 2, the APAHA is structured around six thematic pillars: (i) health and well-being; (ii) autonomy and independent living; (iii) development and lifelong learning; (iv) healthy working life throughout the life cycle; (v) income and economics of ageing; and (vi) participation in society.

1 ISSAI 300 - Performance Audit Principles; ISSAI 3000 - Performance Audit Standard; GUID 3910 - Central Concepts for Performance Auditing; and GUID 3920 - The Performance Audit Process.

2 The Green Paper on Ageing promotes an approach that encourages healthy and active living throughout the life cycle, covering dimensions such as healthy lifestyles, continuous learning, adequate pensions, productivity, as well as health and long-term care.

Table 2: Pillars and catalysts of APAHA

Active and Healthy Ageing Action Plan 2023-2026					
I	II	III	IV	V	VI
Health and well-being	Autonomy and independent living	Lifelong development and learning	Healthy working life throughout the life course	Income and economics of ageing	Participation in society
Catalysts					
Science and Innovation					
Communication, stereotypes, education and literacy					

Source: Own elaboration based on APAHA.

The Plan includes 83 measures and 135 activities across several areas, as shown in Table 3, and involves various government sectors and public entities, without superseding other sectoral plans or strategies currently in force.

Table 3: No. of pillars, sub-pillars, measures and activities of the APAHA

Pillars	Sub-pillars	Measures	Activities
I	Health promotion and disease prevention	6	29
	Integrated, long-term care	15	19
	Training of caregivers and improvement of care delivery conditions	14	19
II	Independent Living	7	7
	Safe Environments	10	17
	Accessible environments	6	8
III	Lifelong learning	5	8
IV	Labour market participation	3	4
	Adaptation of professional careers and jobs	3	3
	Promoting intergenerational diversity in the workplace	2	2
V	Individual Income Guarantee	2	2
	Economics of Ageing	1	2
VI	Participation in society	9	15

Source: Own elaboration based on APAHA.

Pillar I

Health and well-being – comprises 67 activities, representing nearly 50% of all APAHA activities. Its aim is to reduce premature mortality, disease burden and dependency in future decades. Measures target disease prevention and early detection, and the promotion of preventative behaviours in physical and mental health within cardiovascular, oncological, and musculoskeletal domains.

Pillar II

Autonomy and independent living – comprises 32 activities promoting autonomy and independent living, such as: (i) the "Radar Social" programme for identifying isolated elderly people and ensuring their integration into social networks and regular contact; (ii) creation of autonomy enhancement units; (iii) differentiated, multidisciplinary home care support; (iv) ensuring the housing infrastructure is safe and adapted to older persons' needs; (v) promoting public safety and prevention of violence against elder people via community policing; (vi) implementation of the "eGuard" tele-assistance system for vulnerable persons; and (vii) establishing the "Linha 60+" to increase access to health and social care and support the reporting of violence against older persons.

Pillar III

Lifelong development and learning – comprises eight activities focused on vocational training to acquire new skills (reskilling and upskilling), digital skills development, and support for civil society programmes such as Senior Universities.

Pillar IV

Healthy working life throughout the life course – comprises nine activities aimed at promoting employment after the age of 50, vocational retraining, gradual and flexible retirement pathways, work–life balance, adaptation of workplaces and careers to an older workforce, health and safety promotion at work, and public campaigns to combat age discrimination and underline the value of skills and knowledge transfer.

Pillar V

Income and economics of ageing – comprises four activities aimed at securing individual income, notably through social supplements and pension revaluation, and measures promoting the economics of ageing via senior entrepreneurship, training and empowering older people to start and manage businesses, thereby ensuring their participation in society and economic self-sufficiency.

Pillar VI

Participation in society – comprises 15 activities encourageing seniors' participation in volunteering, political life, and social and cultural activities, facilitating their access to and enjoyment of culture and heritage through guided visits to museums, monuments, palaces and other cultural sites.

For each of its 135 activities, the APAHA identifies the responsible government areas - twelve in total – and the entities involved in implementation and establishes output and impact indicators. These output indicators measure the extent to which activities have been carried out, as they generally capture the immediate products or deliverables resulting from implementation. The impact indicators are intended to measure the longer-term effects of the activities on the objectives of the APAHA. Some of the impact indicators are aligned with international socioeconomic assessment frameworks, notably the 22 indicators of the United Nations Economic Commission for Europe's Active Ageing Index.

A National Strategy for Longevity is being developed with the aim of consolidating and updating the national strategic framework for active and healthy ageing, while extending its scope to emerging areas such as the economy and social innovation, employment in later life, and demographic transition. The Strategy is expected to include integrated policies capable of providing responses tailored to the different stages of the life course, and the APAHA is expected to be incorporated into it.

Roles and responsibilities

The APAHA establishes a governance model and a monitoring model. In the governance model, a national coordinator is foreseen. For the monitoring model, an advisory council is foreseen, chaired by the national coordinator of APAHA. In addition to the national coordinator and the advisory council, there are other entities and officials involved in the implementation of the Plan. Table 4 identifies the entities and related responsibilities within the scope of the APAHA.

Table 4: Roles and responsibilities of the APAHA

Role	Responsibilities
MLSSS e MH	• Appoint the National Coordinator • Define the composition, organisation, and functioning of the Advisory Council
National Coordinator	• Chair the Advisory Council • Coordinate and monitor the implementation and execution of the APAHA, in accordance with the planning of each participating governmental area, with a view to fulfilling the measures and objectives set out therein • Liaise, in coordination with the respective governmental areas, with the entities responsible for implementing the APAHA measures, requesting information on the execution process whenever necessary • Align the implementation of the APAHA with existing strategies, programmes and plans • Communicate and promote the APAHA at national level, ensuring the necessary actions to, in partnership with and by mobilising municipalities, intermunicipal entities and other stakeholders involved, secure the dissemination of the APAHA • Ensure ongoing monitoring of the implementation of the measures and achievement of objectives, with the support and collaboration of the Advisory Council • Prepare and present to the members of Government responsible for labour, solidarity and social security, and for health, proposals to revise the APAHA measures and objectives deemed necessary and appropriate • Carry out all acts necessary to fulfil the mission entrusted and the objectives set, as well as exercise any responsibilities within the scope of ageing assigned by the members of Government responsible for labour, solidarity and social security, and for health
Advisory Council	Carry out participatory monitoring of civil society entities and decision-making members within the national context
Secretariat-General of the Ministry of Labour, Solidarity and Social Security.	Logistical, administrative, and financial support for the activities of the National Coordinator
CCSE	Support in terms of technical and administrative human resources for the management of the APAHA
Entities involved	• In partnership with the Plan Coordinator, communicate and promote the APAHA at national level and ensure the necessary actions to secure its dissemination • The monitoring of indicators will be undertaken through the preparation of a report by the competent entities

Source: Own elaboration based on APAHA.

Due to the fact that the national coordinator of the APAHA only has responsibilities for coordination, follow-up and monitoring of the Plan, without decision-making capacity in the implementation of measures and activities, combined with the multiplicity of entities involved in its implementation, the accountability structure is diffuse, increasing the risk of delays in implementation. The monitoring model is impaired due to the non-constitution of the Advisory Council.

Stakeholder involvement and interinstitutional coordination

The preparation of the APAHA benefited from contributions from a range of actors, including academia and the social sector. Although the process was not formalised or systematically documented, efforts were made to incorporate diverse technical and social perspectives, reflecting openness to the participation of relevant stakeholders.

As part of coordination with local government entities, the national coordinator established direct and effective collaboration with municipalities and intermunicipal bodies, particularly in the development of Municipal Plans for Active and Healthy Ageing, with technical support from the district branches of the CCSE.

Nevertheless, the interinstitutional coordination mechanisms under the APAHA were not sufficiently structured or documented. This, combined with changes in the composition of the Government, in the leadership of the central administration entities involved in its implementation, and in the national coordination arrangements, adversely affected the implementation of the Plan.

Budgetary resources

The APAHA does not have its own budget allocation, and its execution is subject to the financial resources availability of the entities involved. In addition, the Plan does not present an estimate of the financial resources needed for its implementation, a circumstance that limits transparency and makes it difficult to hold governance and management accountable.

Monitoring, evaluation and accountability

The APAHA includes output and impact indicators. However, no indicators were established for inputs, processes or outcomes. In addition, the APAHA does not establish an overall target or specific targets for its implementation and impacts to be achieved during the period covered by the Plan, nor does it set out documented baselines for all of those indicators. The absence of technical indicator passports, combined with the limited involvement of the entities responsible for implementing the activities in defining the indicators, further undermines the monitoring and evaluation of the Plan.

The APAHA does not define a specific periodicity for the preparation of monitoring reports on the implementation of the activities and the respective indicators. The first, and so far only, APAHA implementation report was presented by the national coordinator on 1 October 2024.

The APAHA implementation report provides information on the work carried out under each measure and activity and on the timetable envisaged for the completion of each activity. For most activities, it also identifies the frequency of indicator assessment and the entities responsible for assessing those indicators. In addition, for most activities, the report identifies the entities responsible for monitoring implementation and for preparing an evaluation report for each activity.

Table 5 shows the state of implementation of the Plan, by pillar, at the date of the implementation report, constituting an indicator of the degree of implementation of the Plan.

Table 5: State of implementation of the Action Plan in October 2024

Pillar	Activity			
	Implementing	Implemented	Not implemented	Total
I	33	15	19	67
II	23	0	9	32
III	0	7	1	8
IV	2	0	7	9
V	0	3	1	4
VI	0	11	4	15
%	42,96%	26,67%	30,37%	100%

Source: prepared by the auditors based on APAHA implementation report.

The implementation report does not provide quantified information on the implementation status of each activity or on the values of the indicators at the time of its preparation. As a result, the information provided is insufficient to support effective monitoring of progress towards the achievement of the Plan's objectives.

The entities responsible for implementing the activities of the APAHA use their own systems and methodologies to produce the information necessary for monitoring the implementation and calculating indicators, not following a harmonised model of data collection, validation and disaggregation by relevant characteristics. In addition, there is no central repository – other than an Excel file – that integrates or consolidates information and data relating to the APAHA. This situation compromises methodological coherence and limits the potential of the Plan's monitoring and evaluation to generate comparable, detailed and useful information for evidence-based decision-making.

The APAHA implementation report identifies risks, threats and weaknesses, which is consistent with good management practices. However, the absence of a systematic and continuous process for the identification, analysis and monitoring of these factors limits the ability to assess their evolution, anticipate challenges, and take decisions aimed at mitigating them.

The APAHA had a dedicated website containing the Plan, the implementation report, as well as related news and initiatives. The Plan was also disseminated through social media, events, conferences, and the media, particularly in 2024, thereby fostering transparency and accountability by the dissemination of information to stakeholders. However, as of February 2026, the website was no longer active, thereby limiting opportunities for scrutiny by stakeholders and the general public.

Recommendations

Given that a National Strategy for Longevity is currently under development and nearing completion, and is intended to serve as a strategic framework for integrating and guiding public policies on ageing, health, care, social inclusion, innovation, and participation throughout the life course, and given that the APAHA is expected to be incorporated into it, the TdC formulated the following forward-looking recommendations, addressed jointly to the Minister of Labour, Solidarity and Social Security and the Minister of Health, with a view to improving the design and implementation of that Strategy and of future action plans or similar strategic instruments.

- It is recommended that, in the design and implementation of the National Strategy for Longevity and in future action plans or similar strategies, the following aspects be considered: (i) definition and clear communication of the roles and responsibilities of the entities and responsible parties involved; (ii) establishment of formal mechanisms for interministerial and interinstitutional coordination; and (iii) implementation of structured and documented stakeholder participation mechanisms.
- It is recommended that, in the design and implementation of the National Strategy for Longevity, as well as in future action plans or similar strategies, baselines, targets for the different indicators used and a complete and methodologically validated framework of indicators be defined and properly documented from the outset, ensuring conditions for transparent and evidence-based monitoring and evaluation.
- It is recommended that, in the design and implementation of the National Strategy for Longevity, as well as in future action plans or similar strategies, an integrated monitoring and evaluation system be developed and institutionalised, including: (i) data on the financial resources involved, broken down by measure and activity; (ii) a timetable for monitoring and reporting; and (iii) the periodic and systematic recording of progress in implementing activities and of identified risks.
- It is recommended that, in the design and implementation of the National Strategy for Longevity and in future action plans or similar strategies, a structured information management framework be established, which ensures: (i) standard procedures for data collection, validation and quality assurance; (ii) data disaggregated by relevant variables; and (iii) a centralized system that allows the analysis of these data and draws conclusions that support decision-making.

- It is recommended that, in the design and implementation of the National Strategy for Longevity, as well as in future action plans or similar strategies, the following be ensured: (i) the systematic use of the monitoring results in the processes of reviewing goals, objectives, activities and priorities; (ii) the creation of formal mechanisms for collecting feedback and promoting stakeholder participation; and (iii) the wide dissemination of implementation and results, through different formats and means of communication.

Republic of North Macedonia

Comprehensive Governmental Plans & Budgetary Aspects

Introduction

The global phenomenon of population ageing represents one of the most significant demographic shifts of the 21st century, with profound implications for ec onomic sustainability, social protection systems, health care provision, labour markets, and intergenerational equity. According to United Nations projections, by 2050, one in six people worldwide will be aged 65 or over, rising to one in four in Europe and Northern America. This transition, driven by declining fertility rates and increasing life expectancy, places unprecedented pressure on public finances and service delivery models, while simultaneously offering opportunities for societies to harness the potential of longer, healthier lives through active and healthy ageing strategies. In this context, the effectiveness of national responses to population ageing is a matter of high public interest and a priority area for supreme audit institutions (SAI). An effective policy response requires more than fragmented or sectoral initiatives; it demands a comprehensive, whole-of-government approach supported by:

- a robust national strategy or program on ageing with clear objectives, measurable targets, and monitoring mechanisms
- a designated coordinating body with sufficient authority to align policies across sectors
- structured inter-ministerial and inter-agency cooperation to address the multifaceted nature of the challenge
- an identifiable and adequate budget that ensures sustainable financing of ageing-related policies and programs

The absence or weakness of any of these core elements risks policy fragmentation, duplication of efforts, accountability gaps, and ultimately the failure to safeguard the rights and well-being of older persons while maintaining fiscal sustainability. Recognizing the strategic importance of these governance arrangements, the SAI of North Macedonia selected the above mentioned as a priority topic for this audit. This chapter presents the findings of a parallel audit conducted by our SAI, focusing on the existence, design, and operational effectiveness of the governmental plans, financial frameworks and measures undertaken that enable our country to address ageing-related

challenges proactively and coherently. Our SAI elected to contribute to this chapter based on the specific relevance of population ageing within its national context, including the pace of demographic change, the maturity of existing plans, dedicated financial assets which are all preconditions for an effective, coordinated, and adequately resourced national response to one of the major challenges of the modern era, and additionally, to assess the risks to long-term fiscal and social sustainability.

Major institutions involved in the system

According to the Constitution, the Republic of North Macedonia is a sovereign, independent, democratic and social state that cares about the social protection and social security of citizens in accordance with the principles of social justice, which is actually the basis of protection under the Law on Social Protection. The state is responsible for creating and maintaining the social protection system. According to the Law on Social Protection, social protection is an activity of public interest that is carried out through measures, activities, programs and policies for protection from social risks, prevention and overcoming social problems that negatively affect the well-being of citizens, with the aim of promoting and maintaining the social security of citizens, preventing social exclusion and improving the quality of life of citizens.

The planning, prioritization, allocation of funds, and implementation of activities related to the audit topic are under the responsibility of the following institutions:

- Government of the Republic of North Macedonia
- Ministry of Social Policy, Demography and Youth
- Local Self-Government Units
- Social Protection Institutions
- Institute for Social Activities

Government of the Republic of North Macedonia

The Government and the Ministry of Social Policy, Demography and Youth are the main actors in the Republic of North Macedonia related to the provision of care for the elderly. According to the Law on Social Protection, the Government has the following obligations: a. adopts a National Program for the Development of Social Protection with measures for the medium term up to 5 years and for the long term up to 10 years; b. adopts an annual program for the implementation of social protection, which determines the areas of social protection; c. establishes public institutions for social protection and d. grants approval for the establishment of social protection institutions by local governments and other legal and natural persons for the performance of social protection work.

Ministry of Social Policy, Demography and Youth

The Ministry of Social Policy, Demography and Youth, has the following obligations: a. develops a national policy for social protection, b. drafts laws and other regulations regulating this matter; c. establishes standards and norms for social services; d. establishes a system for recording data for social protection; e. provides financial resources for the performance of social protection work; f. issues permits for performing social protection activities; g. determines prices for social protection services; h. supervises the operation of institutions and other legal and natural persons performing social protection activities and other duties. In general, this is the responsible institution for developing policies, plans, providing adequate level of financial support an coordinating the execution of the plans between other institutions, monitoring and controlling every aspect of the social protection system.

Social protection institutions

According to the Law on Social Protection, social protection institutions are: Center for Social Affairs, Institutions for Non-Family Social Protection and Social Service Centers. The responsibilities of the **Center for Social Affairs** are: preparing plans and programs for social protection, resolving social protection rights, informing and referring citizens, ensuring access to services in the home, community and outside the family, providing professional assistance and support to individuals, providing professional assistance and support to individuals, keeping records and collecting documentation for social protection beneficiaries and submitting reports to the Ministry. Basically, these institutions, which have a total of 30 in all municipalities in the country, are the main center where people in need of social assistance or services turn to and they carry out activities related to submitting applications, deciding on the applications received and implementing them. **Institutions for non-family social protection** are: residential homes, care homes, educational institutions, treatment and rehabilitation institutions, group homes and institutions for accepting asylum seekers. They provide social assistance and social services outside the homes of the persons in need. **Social service centers** provide daily and temporary services in the residence of the beneficiary and in the community.

Institute for Social Activities

The Institute for Social Activities is a public institution for the promotion of social activity, established by the Government, which carries out activities throughout the territory of the country and carries out work related to proposing measures for the promotion of social protection. The Institute conducts a licensing procedure for professionals in the social protection sector as well as activities for professional development of professionals in social protection institutions and other social service providers, provides expert opinions in the preparation of programs and strategies for the development of social protection, prepares standards and procedures for the work of professionals in social protection institutions and other authorized social service providers, and supervises the professional work of social protection institutions and other authorized social service providers.

Units of local self-government

LSGs have their own competencies in relation to the performance of social protection activities. According to the Law on Social Protection, LSGs have the right to determine other rights and social services, in a larger scope than the scope determined by the law, as well as more favorable conditions for their performance. Additionally, LSGs have the obligation to adopt annual programs for social protection based on the social plan of LSGs, and in accordance with the National Strategy for the Development of Social Protection. LSGs also establish a Council for Social Protection of the municipality as well as a Council for Social Protection for the purpose of planning and developing the network of social services.

Integrative vs. sectoral plans – National plans

In the past 15 years, several long-term national plans have been adopted in the country that also address the problem of ageing population in the country:

- National Program for the Development of Social Protection 2022-2032
- Program for the Implementation of Social Protection for 2024.
- National Strategy for Deinstitutionalization 2018-2027
- Strategy for Demographic Policies of the Republic of Macedonia 2015-2024
- National Strategy for the Elderly 2010-2020

All of the above documents have been developed by the Ministry of Social Policy, Demography and Youth (ex. Ministry of Labour and Social Policy). This ministry plays a leading role in the implementation of these plans, supported by several other government ministries, the Centers for Social Affairs and the Units for Local Self-Government in accordance with their competences. According to the Law on Social Protection, all activities of the institutions involved in social affairs should be coordinated with the Ministry of Social Affairs, Demography and Youth. Therefore, it can be said that the system for social protection of the elderly, as well as activities related to the ageing of the population, are highly centralized.

National Programme for Development of Social Protection 2022-2032

In November 2022, the Government of the Republic of North Macedonia adopted the National Programme for Development of Social Protection 2022-2032, pursuant to the Law on Social Protection.

Coverage of the Programme

The general objective of the Programme is to establish a sustainable, adaptable, and effective social protection system that is participatory and user-centred, with the aim of empowering beneficiaries to lead independent, productive, and active lives. The document defines specific objectives grouped into four main areas: i. the institutional framework, ii. cash benefits, iii. social prevention and social services, and iv. the role of users in the system. Additional separate sections address financing and human resource capacity. The Programme identifies numerous priorities and development directions, including strengthening local and regional social protection, involving non-state providers, enhancing professional capacities, improving inter-sectoral cooperation, digitalisation, quality standards, supervision, and greater user participation and transparency.

Findings

The audit examination of available documentation, public data, and information provided by the Ministry of Labour and Social Policy revealed significant shortcomings that seriously compromise the realistic prospects for successful implementation of the Programme. First, although measures, deadlines, and responsible institutions are formally listed for most specific objectives, the vast majority of deadlines are vaguely defined as "medium-term" or "long-term" without precise years. Many objectives remain overly broad, numerous, and difficult to measure. No fiscal implications have been calculated, and no exact performance indicators or baseline values have been established. Several objectives represent ongoing regular activities of the Ministry (such as payment of existing cash benefits, including allowances for persons over 65 years of age) that are already mandated by the Law on Social Protection which indicates overlapping and their inclusion in a strategic document unnecessarily burdens and dilutes focus on genuine systemic reform. Furthermore, the audit obtained no evidence that the stated objectives were derived from prior comprehensive needs assessments or analyses of the actual situation of service users. This significantly reduces the likelihood that the priorities reflect real needs on the ground.

Interactions and coordination between the relevant parties

Most critically, the Programme explicitly envisaged the establishment of a coordination body responsible for monitoring and evaluating its implementation. This body was supposed to bring together representatives of relevant institutions, municipalities, and regional councils, prepare annual operational plans, conduct evaluations, and submit reports to the Government at least once a year. The audit found no evidence that such a body has ever been established. No operational plans or implementation reports exist, and none have been submitted to the Government. The Ministry's own Report on the Execution of the 2024 Annual Work Plan explicitly lists the preparation of the implementation report for the National Programme as an unfulfilled measure. This constitutes official acknowledgement that, three years after adoption, the strategic activities remain stalled and their future realisation uncertain.

National Strategy for Deinstitutionalisation 2018–2027

The National Strategy for Deinstitutionalisation 2018-2027 defines deinstitutionalisation as a systematic process of closing residential institutions through integrated planning, gradual capacity reduction, and simultaneous development of community-based services grounded in human-rights standards. The process requires new approaches to planning, organising, and financing services that respond to the individual needs of each user.

Coverage of the Strategy

The Strategy distinguishes three distinct target groups: i. children, ii. adults under 65 with disabilities or mental health issues, and iii. persons over 65 years of age. It envisages two implementation phases. The first phase (2018-2023) focused on relocating children and adults with disabilities from institutions into the community. The second phase (2024-2027) was intended to intensify efforts for the remaining groups, particularly elderly persons and individuals with long-term mental health conditions.

For persons over 65, the Strategy explicitly required the preparation of a dedicated study and a separate sub-strategy by the end of 2024 to map specific transitional processes and address age-specific needs. It stressed that simple relocation is insufficient for elderly residents; high-quality community services must be developed, including home care, personal assistance, protected housing, meal delivery, intensive home-based medical care, and intergenerational programmes.

The Strategy established a comprehensive governance framework: a high-level National Coordination Body, a monitoring mechanism led by the Ombudsman, a dedicated organisational unit within the Ministry of Labour and Social Policy, an external mid-term evaluation in 2021 and 2024, detailed action plans for 2021-2023 and 2024-2027, and an advisory body composed of stakeholders and experts.

Findings

The audit revealed profound delays and systemic shortcomings. The first mid-term evaluation (2020) showed that, out of 132 planned tasks, only 22.73 % were largely completed, 33.33 % were partially or occasionally addressed, and 43.94 % had not been initiated at all. No revised action plan or second external mid-term evaluation was produced for the period 2021-2023, creating a three-year gap in strategic steering. The Ministry drafted a revised action plan for 2023-2025, but there is no evidence that it was formally adopted by the Government, and it was prepared without the required preceding evaluation. No sub-strategy or specific study for elderly persons has been developed by the end of 2024, despite being an explicit obligation. While certain community-based services (home care, personal assistance, small group homes, day-care centres) have been piloted or expanded under separate projects, these initiatives are not systematically aligned with the Strategy's timeline and targets.

Interactions and coordination between the relevant parties

The dedicated organisational unit within the Ministry tasked with facilitating interdepartmental cooperation and coordination between the various institutions that have responsibilities for implementing this strategy remains severely understaffed: only one junior associate is employed against three systematised posts and the advisory body of stakeholders has never been established. The National Monitoring Mechanism under the Ombudsman has not issued any reports on Strategy implementation. The absence of functioning coordination, monitoring, evaluation, and reprogramming mechanisms has rendered implementation largely discretionary and fragmented.

In conclusion, seven years into the ten-year Strategy, core governance and accountability structures remain non-operational, critical analytical and planning deliverables are missing. These deficiencies indicate over-ambitious planning, persistent lack of institutional capacity and political commitment, and a high risk that the fundamental objectives of the National Strategy for Deinstitutionalisation will not be achieved by 2027.

Strategy for Demographic Policies 2015–2024 Coverage

The Strategy for Demographic Policies 2015-2024 defined four strategic areas, one of which was policies for active ageing and intergenerational solidarity. Within this area the document established three priorities: improved health and social services for the elderly, bringing public services closer to older persons, and creating conditions for lifelong learning, active ageing, and intergenerational solidarity. Concrete measures and activities were listed for each priority. The Ministry of Labour and Social Policy was designated as the main implementing entity, with the obligation to establish a **dedicated organisational unit** for development, **coordination**, monitoring, and evaluation of demographic policies. The Strategy required the preparation of detailed action plans, twice-yearly progress assessments, and quarterly reports to the Government, together with revisions in case of deviations.

Findings

The audit established that an action plan was prepared only for the initial period 2015-2017 and that an implementation report was drafted but not provided for audit review. No documentation was submitted to the audit concerning any further action plans, progress evaluations, or reports to the Government for the remaining period (2018-2024). Consequently, there is no evidence of systematic inter-institutional coordination, monitoring of effectiveness, or adjustment of measures during the last seven years of the Strategy's lifespan. The planned organisational unit was formally created; however, out of the five posts, only the head of unit position was filled throughout the entire nine-year implementation period. The remaining four posts remained vacant and continue to remain vacant. The unit operates within the Minister's coordination sector rather than as a separate organizational unit, despite recent organisational changes that declared demography a priority area. Given that the Strategy formally expired at the end of 2024, the almost complete absence of institutional mechanisms, staffing, and reporting renders any objective assessment of achieved results very difficult. The lack of implemented governance arrangements significantly impaired the ability to address negative demographic trends, particularly population ageing and youth emigration. At the time of the audit, the Ministry, with support from UNFPA, had initiated the development of a new Strategy for Demographic Development and Resilience aligned with the National Development Strategy 2024-2044.

National Strategy for the Elderly (expired 2020)

Coverage

The National Strategy for the Elderly, valid until 2020, was aimed to improve the quality of life of persons over 65 by enhancing their socio-economic status, social integration, independence, and access to health and social protection, while preventing marginalisation and strengthening intergenerational cohesion. The document defined one general and three specific strategic objectives: improving the social protection system for the elderly, strengthening geriatric healthcare, and promoting societal integration of older persons. A total of 44 measures were envisaged.

Findings

The Strategy lacked essential implementation elements: measurable indicators, concrete deadlines for individual measures, defined responsibilities with expected outcomes, and any financial framework. Monitoring and reporting obligations were formulated only in general terms. Given that the Strategy expired at the end of 2020, the Ministry of Labour and Social Policy was unable to provide the audit with a final implementation report, despite this being an explicit obligation. The only available assessment stems from an EU-funded project analysis conducted near the end of the Strategy's lifespan. It covered two of the three specific objectives and revealed a very low

level of realisation: for the social protection objective, only partial implementation of five measures and complete non-implementation of nine measures were recorded; for the healthcare objective, five measures were fully or partially implemented while the majority remained unrealised or lacked information on execution. This unsatisfactory degree of implementation, documented at the very end of the strategic period, makes subsequent significant progress highly improbable. The absence of a final report further prevents any other evaluation of overall results achieved.

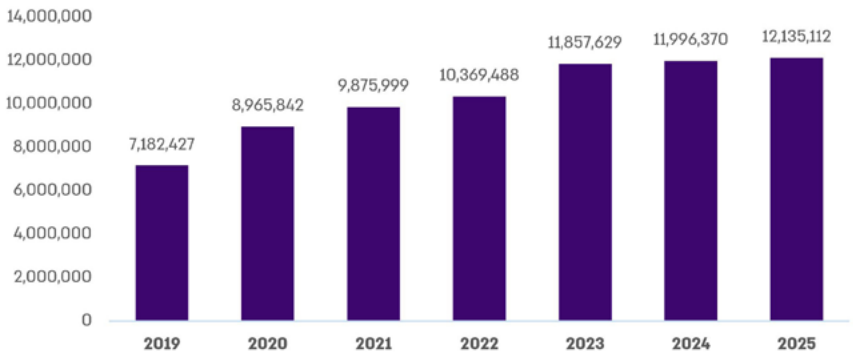
Annual Programmee for the Realisation of Social Protection

Pursuant to the Law on Social Protection, the Government of the Republic of North Macedonia annually adopts the Programme for the Realisation of Social Protection, which defines priority areas, population needs, and the manner and resources for delivering social protection. The audit analysed the Programmes for 2022-2025. They are essentially compilations of ongoing and recently completed activities, without defined measures, responsible entities, deadlines, or any obligation to prepare implementation reports. The narrative sections of the programmes largely repeat the same general areas and sub-areas year after year. The descriptions remain broad, lack specific planned activities, and often serve merely as status reports on the situation at the time of drafting. The Ministry of Social Policy, Demography and Youth prepares annual reports on the realisation of these programmes. However, these reports contain only financial execution data by programme and budget line and provide no information on the degree of achievement of the planned substantive activities.

Through this program, the largest part of the funds for social protection in the country is realized. No special sub-program has been established for issues related to the ageing of the population and the funds for this purpose are allocated in the sub-programs that are an integral part of this program which makes estimating the dedicated budget very difficult. Budget allocations for the Programme for the Realisation of Social Protection increased by 68.82 % from 2019 to 2025, representing an additional 4.943 billion denars. The total expenditures for this programme are presented in the following figure[1]:

1 In denars, exchange rate 1 euro – 61.5 denars

Figure 1: Financial resources for achieving social protection



The dominant share throughout the period (83.2% in 2025) is attributable to sub-programme 50 – Cash Benefits for Social Protection. In 2024, actual expenditure exceeded the plan by 111%, reaching 13.279 billion denars (approximately 216.9 million euro), equivalent to 1.40% of GDP.

The audit established that the Ministry fails to fulfil its statutory obligation to systematically collect, process, analyse, and publish comprehensive statistical data and information on social protection. Although the Ministry's Rulebook on Internal Organisation provides for a dedicated Department for Analysis, Evaluation, and Monitoring of Policies and Programmes with five systematised posts (one head and four advisers), none of these positions were filled at the time of the audit. This persistent failure to establish basic analytical and statistical capacity severely restricts the Ministry's ability to accurately identify real needs, assess the situation in the field, ensure equitable distribution of services, develop evidence-based policies, and adjust the legal and regulatory framework to achieve more effective delivery of social rights and services.

Comprehensive plan

For the entire period covered by the audit, no comprehensive plan has been developed that addresses topics related to the subject of the audit. In this regard, we note a potentially positive shift which occurred on 29 October 2024 with the adoption of the new National Development Strategy 2024-2044 (NDS) as a comprehensive document that defines the main national development goals, strategic areas and priorities for accelerated, inclusive, balanced, gender-equal and sustainable development of the Republic of North Macedonia, especially taking into account the aspiration of the Republic of North Macedonia to join the European Union (EU) by 2030. This comprehensive twenty-year framework correctly identifies demographic decline, population ageing, and youth emigration as existential challenges.

Coverage

This strategy consists of 6 key strategic areas, of which strategic area 3 – Demographic Revitalisation, Social and Cultural Development – includes priorities 3.1 (Balanced and sustainable demographic trends) and 3.3 (Inclusive and efficient social protection and social security system), covering issues related to demography, population migration, ageing and active ageing issues. These points contain objectives that should address the adverse demographic trends in the country and establish an efficient system of social protection and social security taking into account the ageing of the population and active ageing. The first five-year Implementation Programme 2024-2028 has already been adopted. Unlike previous documents, it contains defined leading and supporting institutions, deadlines, estimated costs, funding sources, and measurable performance indicators.

Coordination

In relation to the implementation of this strategy, we have established that the leading role in relation to demographic trends has been taken by the Government, while social protection and social services remain under the leadership of the Ministry of Social Policy, Demography and Youth. The strategy still involves many institutions, and the critical issue of effective inter-institutional coordination remains unaddressed in detail. Given past experience, this represents a continuing risk. While the NDS and its rolling five-year programmes offer a more structured and unified planning architecture that could reduce fragmentation, successful implementation will require sustained political commitment across multiple government cycles, adequate staffing of analytical and coordination functions, and rigorous independent monitoring. Without these preconditions, there is a high risk that the new framework will repeat the pattern of ambitious declarations followed by weak execution observed in all previous strategies.

Conclusion and Plans for the Coming Period

The audit of all strategic documents related to demographic trends and care for the elderly in the Republic of North Macedonia leads to a clear and concerning conclusion: the country has produced an excessive number of strategies, national programmes, and action plans that are highly fragmented, overlapping, and poorly coordinated. The objectives contained in these documents are numerous, overly broad, and frequently duplicated across different strategies. In most cases they lack clearly assigned institutional responsibility, measurable indicators, realistic timelines, and – most critically – any credible financial framework or identified funding sources. Many of the stated goals are complex and their realization requires serious commitments which put doubt concerning their achievability. The absence of a functional analytical unit within the Ministry of Labour and Social Policy means that these objectives were formulated without comprehensive, evidence-based assessments of the actual needs of older persons.

The sheer volume and scope of measures, combined with the involvement of dozens of institutions, has consistently overwhelmed coordination capacity. Where coordination bodies were formally envisaged, they were either never established or remained non-operational. Monitoring, evaluation, and reporting mechanisms were either weakly designed or entirely missing, making it impossible to track progress or enforce accountability. Long implementation horizons (typically ten years or more)

further increased the risk that successive governments and ministerial leaderships would abandon or ignore previous commitments. As a result, despite the existence of multiple strategic frameworks – including the National Strategy for the Elderly (expired 2020), the Strategy for Demographic Policies 2015-2024, National Programme for Development of Social Protection 2022-2032, and Strategy for Deinstitutionalisation 2018-2027 – very limited substantive progress has been achieved. The Strategy for the elderly which expired in 2020 represented the only dedicated policy document exclusively addressing the specific needs of persons over 65. All subsequent strategies and programmes treat the elderly as one segment within the broader social protection system. At the time of the audit, due to the non-adoption of the sub-strategy for the elderly envisaged under the later Deinstitutionalisation Strategy, the Republic of North Macedonia has no active strategic document that systematically and exclusively addresses the needs and rights of citizens over 65 years of age.

Social benefits and social rights for the elderly

Of the established rights to social benefits in the country, in practice, in the part of monetary rights to social protection, only the benefit for assistance and care from another person (other people's care) predominantly applies to persons over 65 years of age. The right to disability benefits applies to encourageing social inclusion and equal opportunities for persons with any form of disability. In addition to this, starting from 2019, social security funds are paid through the ministry to elderly persons who have no income on any other basis and do not have registered property in their name. Basically, this right is the equivalent of a social pension for persons who do not meet the conditions for retirement.

Allowance for assistance and care from another person

The right to this allowance is granted to persons over 26 years of age, with moderate, severe or profound intellectual disability, a person with a more severe and most severe physical disability, a completely blind person, as well as a person with permanent changes in their health condition, who requires assistance and care from another person because they cannot perform basic activities of daily living on their own The aim of this measure is to provide financial support to cover the costs of care, regardless of whether it is provided by a family member, close or professional caregiver, thus enabling a dignified and better quality of life for the beneficiaries. The main aim of the allowance is to compensate for the dependence of persons on assistance from others, facilitating their everyday life and reducing the financial and emotional burden on their families. By reviewing the records of payment of this benefit for all persons, we determined that in the presented figures of beneficiaries, the participation of persons over 65 years of age is dominant. he percentage of their participation in the total figure for the last payment made for 04/2025 is 33,676 persons out of a total of 55.917 persons exercising this right, i.e. about 60.2% or 10.2% of the total number of persons over 65 years of age. In 2024, a total of 64,5 million euros were paid annually on this basis. Starting from 2015 there is a notable increase of beneficiaries of this compensation (29.917 – 2015 to 55.917 – 04/2025).

Informal system for care of elderly people

The payment of the compensation for assistance and care from another person basically represents a replacement for the formal system for care of persons with some form of disability, i.e. it is used to pay informal care providers. In North Macedonia, state authorities do not have records and detailed analyses of the informal care sector for persons with disabilities. Because of this, it is not possible to estimate the percentage of participation of the informal sector in the total volume of care provided for persons in such need, however, judging by the number of persons who receive the above compensation as well as the relatively undeveloped system for formal care of persons in need, it is reasonable to assume that the informal sector is much more prevalent than the formal one. Despite the fact that there is a need to include informal care in the system, the regulatory framework does not contain any measures or services that would directly support informal caregivers and therefore it can be concluded that such a form of support is treated as a replacement for formal care. For the most part, family members appear as caregivers, especially in local and non-urban communities. According to a survey conducted by the Macedonian Red Cross in 2021, informal care in North Macedonia is mainly based on children and spouses. In addition, for people under and over 65 years of age, the spouse appears as the caregiver, while for people over 75 years of age, people in need of care rely more on children than on spouses. A significant problem in this area is that these people are not trained to perform the services they provide, which calls into question the quality of the service, as well as the fact that the people who provide care leave the formal labor market, i.e. an attachment is created between these people and the people in need of care and they become economically unproductive, although in most cases they can still create economic value through participation in the labor market.

Disability allowance

Disability allowance is provided to encourage social inclusion and equal opportunities for a person who is: i. with a severe or profound intellectual disability, ii. with the most severe physical disability, iii. a completely blind person and iv. a completely deaf person. Disability allowance in Macedonia is financial support intended for persons with disabilities, to improve their quality of life and ensure greater social inclusion, i.e. to cover additional costs arising from their condition, such as medical devices, therapies, transportation or personal assistance. To avoid misunderstandings about the purpose of this allowance and the allowance for care, we point out that this allowance is different from the allowance for care, which is paid to persons who need assistance in performing basic life functions. Given that these benefits are essentially intended for two different purposes, they are not mutually exclusive, i.e. persons who receive one benefit can also apply for the other, and if they meet the conditions, they can receive payment of both benefits at the same time. This benefit for the month of April 2025 was paid to 4,807 persons over the age of 65, i.e. 44.5% of the total number of persons over the age of 65 and amounted to a total of 16.9 million euro for the 2024 year. Unlike the previous benefit, no increase has been recorded over the years in the total No of beneficiaries.

Social security allowance for the elderly

The social security allowance for the elderly is a key element in the social protection system in the Republic of North Macedonia, aimed at providing financial support for people over 65 years of age. The social security allowance for the elderly is intended for citizens who meet certain criteria defined in this law as well as in the special rulebook developed in connection with the law. These criteria include reaching the age limit of 65 years, the absence of sufficient means of subsistence and the unfulfilled right to a pension due to unfulfilled conditions for an old-age pension or other regular income. The payment of this allowance began in 2019. In the period from 2020 to 2024, a continuous increase in the beneficiaries of this measure was observed, resulting in a significant increase for this period, i.e. an increase of 66.7%, i.e. from 7,932 beneficiaries to 13,230 beneficiaries. The total amount paid on this basis for 2024 is 21.3 million euros. The increase in payments made for the same period of 114% is notable, which is due to the increase in the number of beneficiaries but also to the amount received monthly by the holders of this measure. The amount paid is twice lower than the amount of the minimum pension, which leads to the conclusion that this amount, at best, only partially helps to improve the financial situation of the persons using the measure and is not sufficient to fully meet the basic financial needs of the beneficiaries.

Social services for the elderly

Home care and assistance

The aim of this service is to enable the user to self-help, i.e. to restore, acquire or maintain the ability to take care of themselves, to continue living in their own home and to lead an independent life in the community, by providing assistance in performing basic activities of daily living for up to 80 hours per month. The users of the service are: people with the most severe disability, i.e. combined disability with the highest degree, completely blind people, elderly people over 65 years of age and other people who need assistance and care at home with reduced functional capacity who cannot take care of themselves.

The development of this service was initiated with the loan agreement for the Social Services Improvement Project concluded between the Republic of North Macedonia and the World Bank on 02.10.2018 in the amount of 28.7 million euros, which is implemented through the Project Unit at the Ministry of Social Affairs and Health. The total amount of contracts concluded for all 34 service providers after the first and second calls amounts to 310,505 thousand denars, or 5,065,574 euros. Of this amount, the providers of social services for the elderly over 65 years of age (20 providers of home care and assistance services and 4-day care centers for the elderly) account for a total of 4,133,184 euros. The home care and assistance service was used by a total of 1,369 users, of which 987 are female, while the day care centers for the elderly were used by 126 users, of which 85 are women. The number of caregivers engaged by these service providers is 467, of which 416 are women, with the number of service users in relation to the number of caregivers being 2.93 users per caregiver, or in a range from 1.7 to a maximum of 4.2 users per caregiver among different service providers. From

an analysis of the total funds paid and the number of users of this service, we determined that the total costs for one user of the home care and assistance service amount to 3,700 euros, or 227,500 denars for the entire duration of the contract, set at 12 months.

In terms of satisfaction with the service received, the respondents from the first call responded that 98.5% were completely satisfied with it, while in the second call this percentage decreased and amounted to 90%, and the remaining users responded that they were generally satisfied. According to the results of the survey, 66% of caregivers were unemployed for a period longer than one year, while some of the caregivers (around 20%) used social assistance before are engaged as caregivers. Even more significant is the response that most caregivers had financial problems before engageing as caregivers and satisfaction with the financial situation after accepting the engagement as a caregiver was expressed by 93% (satisfied and very satisfied). This is particularly important for activating unemployed people in the labor market, especially for caregivers from smaller municipalities where employment opportunities are limited and people have a limited set of work experiences and skills. However, according to the results of this research, about 95% of caregivers are engaged through a contract of employment, i.e. they are not regularly employed and do not pay contributions for health and pension insurance.

After the end of the 12-month period specified in the concluded contracts, service providers have the opportunity to apply for a public call published by the Ministry of Social Affairs and Health, whereby these service providers, if their application is approved by the Ministry, will transfer the provision of the service they offer to funding from the Ministry by concluding administrative contracts with the service providers. With insight into the review of entities that are part of the network, we determined that the number of providers of this service is higher because individual service providers have independently developed the social service without participating in the project for the development of social services. We determined that there are a total of 40 institutions in the field of social protection operating in the country that are licensed and offer assistance and care services in the home for the elderly over 65 years of age. These institutions have registered a total of 969 caregivers. These service providers have reported a total of 2,536 planned service users, or 2.6 service users per caregiver, which is lower than the 2.93 users per caregiver shown by the service providers that are part of the Social Services Development Project.

Current capacity

If we use the highest caregiver/beneficiary ratio presented above to determine the maximum capacity of service providers, which for two service providers is around 4 beneficiaries per caregiver, we determined that the current number of 969 caregivers in the most favorable scenario can provide the service to a maximum of 3,876 beneficiaries, or 40 hours per month per beneficiary.

Using the data for the average number of beneficiaries per caregiver of 2.9 to 3 beneficiaries, we determined that the current number of caregivers in the country can serve around 3,000 beneficiaries and it would be unrealistic to expect a higher coverage of beneficiaries than the stated one without increasing the number of caregivers. Regarding the scope of the service by individual municipalities, by analyzing the information obtained from the register presented to us by the ministry, we determined that at the time of the audit, out of a total of 80 municipalities in the country, it is offered

in 49 municipalities, which means that citizens in the remaining 31 municipalities do not have access to this service at all. We conducted additional analyses and determined that a total of 77,439 people over the age of 65 live on the territory of these municipalities, or in relation to the total number of residents in the country in this age group according to the data shown in the 2021 population census, 24.56% of the population in the country does not have access to any social services for the elderly at all, due to the fact that they are underdeveloped on the territory of the municipality.

In terms of the municipalities where this service has been developed and is provided by licensed service providers, we have determined that a total of 237,892 people over the age of 65 live on the territory of these municipalities and are served by 969 caregivers.

At the national level, there are an average of 245.5 people over the age of 65 per caregiver, which far exceeds the capabilities of one caregiver to provide the service and which, as we estimated above, cannot exceed 4 people. It can be concluded that the situation is worse in larger urban areas where there are a large number of residents of the age in question in relation to a small number of caregivers, which is why most service providers in large urban areas have waiting lists of potential users.

A disadvantage of the system established in this way is the unestablished or insufficiently established competition between social service providers. In the largest percentage of municipalities, where social services are provided, they are implemented by a single service provider, i.e. in conditions of absence of competition, contrary to the principle of plurality promoted in the Social Security Act. We have also determined the inadequate visibility of the social services that have been developed and are available to citizens, the lack of information about their existence and the conditions that should be met, as well as the manner and place where persons in need should apply for their realization. Due to the above, there is a lack of improvement in the quality of services offered in order to increase the satisfaction of users as well as adequate and complete information from the affected persons about the services offered. Therefore, it cannot be said that this measure has been established in a way that completely addresses the needs of the citizens aged 65 and over who need assistance and care at home, which is more pronounced in large urban areas, and it does not point to the efficient implementation of the established service.

Projections for future needs

The process of population ageing has affected our country in the past period. Namely, the elderly population over the age of 65 is constantly increasing both in absolute numbers and as a percentage of the total population whereas for the analyzed period from 2005 to 2024, this age group of the population has increased by 109,517 people, while in percentage terms compared to the total population, this age group is the only one that has increased by 7.2 percent. In the remaining age groups, the number of people has decreased, which further emphasizes the problem of demographic ageing of the population, which will continue in the coming years. In order to confirm these trends, we have conducted an analysis of demographic trends for the coming period based on the population movement projections prepared by the State Statistical Office on data from the Population Census conducted in 2021. They are shown in the following table:

Table 1

Year	Population estimate by age group 2025-2055 (low fertility)					
	0-14	15-64	65+	Population projection including migration and low fertility	Population projection without migrations	% of people aged 65+ (low fertility/ migration included)
2025	288,666	1,144,383	338,215	1,771,264	1,818,849	19.1%
2030	237,158	1,039,297	365,844	1,642,299	1,792,479	22.3%
2035	185,459	942,994	385,920	1,514,373	1,759,020	25.5%
2040	158,074	869,558	400,253	1,427,885	1,724,052	28.0%
2045	147,652	800,869	413,842	1,362,363	1,690,993	30.4%
2050	146,973	731,230	424,443	1,302,646	1,655,462	32.6%
2055	143,333	675,736	426,545	1,245,614	1,616,084	34.2%

According to the projections of population movement until 2055, no slowdown in the trend of population ageing is expected. Namely, according to these projections, the number of people over 65 years of age will increase by 88 thousand people by 2055, while the percentage will increase by 15.1% and will reach an exceptionally high 34.2%, i.e. 426,545 people. With additional analyses, we determined that the percentage of people over 80 years of age who fall into the most vulnerable category of citizens for the period 2025–2055 will increase from 3.3% in 2025 to 11.6% in 2055, when according to projections it will reach 144,101 inhabitants, i.e. an increase of about 87 thousand people. From the data presented, it is evident that the process of population ageing is gaining momentum and that it will result in an increased number of residents of the country in the age group over 65 years of age.

Usually, as in every country, the age group of the population over 65 years of age has the greatest need for care from other people due to health problems that occur more significantly from this age. The 2021 Population Census also offers information about this group of citizens, i.e. for citizens who have some form of disability (physical, mental, etc.). The results are presented in the following table:

Table 2

Age group	Type of disability					
	Total	Movement	Vison	Hearing	Communication	Other
Total	94,412	38,499	12,371	5,947	3,896	33,699
0-14	1,674	258	307	69	385	655
15-65	40,985	13,597	5,678	1,419	2,193	18,098
65+	51,753	24,644	6,386	4,459	1,318	14,946

As can be seen from the table, the highest percentage of disability has been reported by the age group older than 65 years. The percentage of the population from this age group who have some type of disability in relation to the total number of citizens over the age of 65 years is 16.4% of the total number of people over the age of 65, which according to the census results is estimated at 315,331 people. In order to assess the number of people with disabilities in the RSM as well as to make a projection for the next period, we used the Eurostat GALI[2] indicator for activity limitations by age group. For the purposes of this audit, we used only the rates of people who responded that they have serious limitations because they are likely to need social services through appropriate service providers. In the following table, we present the established indicators for our country and the countries of the region in order to show the situation regarding long-term disability of the elderly, which implies the need for help from other people.

In the following table[3], we present the established indicators for our country and the countries of the region in order to show what the situation is regarding long-term disability of the elderly, which also implies the need for help from other people:

Table 3

State[4]	Age		
	65-74	75-84	85+
Bulgaria	4.2	8.2	21.5
Croatia	14.1	24.6	47.1
Montenegro	10.4	21.7	41.7
North Macedonia	11.9	27.7	49.2
Albania	10.3	23.3	37.3
Serbia	5.5	12.8	22
EU avg	10	17.8	34.6

2 GALI (Global Activity Limitation Indicator) is a Eurostat indicator used to measure long-term overall disability. It assesses the extent to which a person has been limited in their usual activities due to a health problem for at least the last six months. It is a basic social variable used in European statistical surveys. GALI is measured through a survey question asking respondents about the extent to which they have been limited in their usual activities due to a health problem. Response options include "severely limited", "limited but not severely" and "not limited at all".

3 Source EUROSTAT: **[link]**.

4 Data is provided for 2022 except for Albania where the latest available data is for 2021.

Based on these indicators, it is possible to calculate the total number of people who have serious difficulties in performing basic life functions. We present this calculation in the following table:

Table 4

	65-74	75-84	85+	Total
Population by age groups 2024	210,235	99,160	21,763	1,826,247
Indicator for population in need of care	11.9%	27.7%	49.2%	
Total elderly people with serious limitations 2024	25,018	27,467	10,707	63,193

According to this calculation, the number of people in the Republic of North Macedonia over the age of 65 who have serious obstacles in performing basic life functions for 2024 is 63,193 people. The study prepared by the Red Cross of the Republic of North Macedonia estimates the percentage of people over the age of 65 who need long-term care caused by a form of disability or severe chronic illness at a higher level, i.e. at 25.6%, which indicates a total number of approximately 84,776 people. Given that the current capacity for formal care for the elderly held by the providers of services for the elderly does not exceed 3,000 people at best, as well as an additional 2,378 beds in nursing homes, it is clear that there is a significant difference in the capacity for formal residential and non-residential care and the quantum of elderly people who need it. This difference is partially compensated by the payment of the care allowance, which in 2024 was paid to 33,676 people, which goes towards stimulating the informal sector for care for the elderly.

According to the aforementioned study prepared by the Red Cross, the percentage of people who use help from a person paid by a public service or who themselves pay a person to help them is around 10%, while the majority of people use help from members of their families (children, spouse), i.e. around 73.4%. The remaining people either manage on their own or use help from neighbors, humanitarian organizations and friends. The above indicates that informal care dominates in the care of the elderly, which clearly highlights the weaknesses and insufficient capacity of the formal system for care of the elderly. It is of crucial importance in the absence of a sufficiently developed public system for care of the elderly, and families appear as the main bearers of informal care. As mentioned, the informal care system is not included in the legal and by-laws in terms of measures and services for support, both financially and for training, of informal caregivers. Given the ongoing process of population ageing, if we make the same calculation based on the projections from the State Statistical Office for the number of elderly people in 2050 (424,443 people) using the activity limitation indicator, i.e. the percentage determined in the Red Cross study (18.1% and 25.6% respectively), the estimated number of people in 2050 who will need assistance from others due to their inability to perform basic life functions will range from 76,764 to 108,544 people, which is an increase of up to 71% from the current level.

Given the extremely limited capacity for formal residential and non-residential care at the country level, the aforementioned increase in the number of elderly people with serious limitations in performing basic life needs will lead to the complete inability of the formal care system to respond

to the increased needs of users, i.e. people in need of care. The Ministry of Social Affairs and Health has not determined the optimal number of caregivers that should be available in the country to fully meet the needs of the elderly. Therefore, we have projected the necessary financial resources solely based on the number of elderly people who, according to the activity limitation indicators for 2024, need help from other people. Given that this number is between 56 and 63 thousand people in conditions of an undetermined required number of caregivers, we have calculated the necessary financial resources that will need to be allocated from the Ministry of Social Affairs and Health's budget in three scenarios by beneficiary coverage.

Table 5

No. of caregivers	Avg. users by caregiver	Total users	Avg. hours per month	Price per hour	No. of months	Total amount (euro)
3,000	3	9,000	140	385	12	31,551,220
5,000	3	15,000	140	385	12	52,585,366
10,000	3	30,000	140	385	12	105,170,732

The projections in all three scenarios indicate a significant increase in the necessary funds in the conditions of increasing the coverage of beneficiaries of the measure of assistance and care at home. At the time of the audit, we did not determine that the Ministry of Social Affairs and Health is actively working towards determining targets for the coverage of beneficiaries, a planned increase in the number of caregivers and the provision of additional financial resources for this purpose. The main drawback of the service for assistance and care at home is the complete absence of services related to health care for the elderly. Namely, basically this service is reduced to helping the elderly with food preparation, eating, basic hygiene needs, shopping, and the like. As a result, the management contracts do not provide for the possibility of care that has a more medical nature, i.e. elementary medical interventions (e.g. receiving an infusion or changing a catheter) in the beneficiary's home, which would eliminate the need to visit a medical institution where these and other interventions would be performed.

In this regard, the legislation in the country also does not provide for such activities in the homes of people who need them and they are referred to medical institutions, which for some of the elderly is a major problem due to reduced mobility for various reasons. From the analyses of the programs, strategies and legal and by-laws, we did not find evidence that the state through the competent institutions is taking activities in this direction, although there is a need for it and these people remain to be cared for through the palliative care system, which has a small capacity, or to be exposed to regular visits to medical institutions. The above, for people who have reduced mobility for various reasons, creates problems regarding visits to medical institutions as well as the engagement of close people for assistance who usually have their own work or other obligations, which negatively affects these people, and interpersonal relationships within these families should not be neglected due to the unequal participation of various members of the same in caring for the elderly.

Day care centers for the elderly

Day care centers for the elderly in the Republic of North Macedonia are intended for a wider category of people – the elderly, children at risk, people with disabilities, marginalized people and people with specific social problems. These centers provide day care, nutrition, personal hygiene, individual activities for acquiring life and work skills, educational, social, cultural and recreational activities, preventive activities, counseling, education, educational support, social support for individuals and their families and other related activities, lasting up to eight hours a day, depending on the needs of the users.

There are a total of 5 licensed service providers as day care centers for the elderly in the country (which can serve a total of 149 people. In addition to this, the Center of social affairs and local municipalities have opened 9 more day care centers that operate in rural settlements. Regarding the development of the network of day care centers for the elderly, with insight into the documentation that was provided to us, we determined that the Ministry of Social Affairs and Health has not conducted an analysis of the needs for centers for the elderly, their optimal capacity, as well as the geographical distribution of these centers on the territory of the country.

Although day care centers for the elderly are designed as facilities in which elderly people can receive a wider range of services, in practice, in most cases, due to a lack of necessary staff, these centers serve as residences and social clubs in which elderly people socialize and exchange information, without providing other services that are provided for in accordance with the Health and Safety Act (e.g. nutrition and maintenance of personal hygiene). This leads to the conclusion that within the framework of day care centers for the elderly, not all potentials are used in accordance with legal possibilities for providing social services in terms of the functioning of these centers, which is why they are not used as provided for by the law in terms of providing all forms of social services and care for the elderly and which, if provided, would reduce the pressure on the social service of assistance and care in the home.

Therefore, it cannot be said that the efficient functioning of these centers in terms of supporting the elderly in the manner described in the LSA is ensured, and the failure to conduct an analysis in terms of the optimal capacities and geographical distribution of these centers creates a risk of uneven access of the elderly to this service or complete inaccessibility to it.

Institutions for the accommodation of the elderly

Despite the activities aimed at developing social services in the community that have been implemented in the past period, there remains a need for accommodation in specialized institutions – nursing homes for the care of the elderly who, for various reasons, are unable to fulfill their basic living needs within their own homes According to the law, the institutions in the country are public and private institutions that must meet appropriate conditions in terms of capacity, housing conditions – the space in which the cared for persons will live, the equipment they should have at their disposal and the engaged staff. In our country, according to information received from the Ministry of Social Policy Demography and Youth, 5 public institutions for the elderly and 45 private institutions for the elderly operate. The capacity of public institutions for the elderly in the country, is 646 beds. The capacity of private institutions is 1,732 beds, or a total of 2,378 beds. These capacities are sufficient to accommodate 0.7% of the total number of elderly people over 65 years of age in the

country, or 7 beds per 1000 inhabitants over 65 years of age. In order to assess the sufficiency of this capacity, we compared this percentage with several European countries and countries in the region[5]:

Table 6

State	Beds per 1000 inhabitants over 65 years old	State	Beds per 1000 inhabitants over 65 years old
Latvia	12.4	Poland	10.7
Czech Republic	34.9	Slovak Republic	46.2
Estonia	41.4	Slovenia	49.5
Germany	53.9	Turkey	9.5
Hungary	42.6	Bulgaria	1.2
Israel	16.5	Croatia	10.7
Italy	21.3	Romania	10.9

According to the data listed in the table, our country, except for Bulgaria, has the lowest accommodation capacity calculated per 1000 inhabitants over 65 years of age. It is evident that our country has a lower number of beds compared to the countries in the region. According to estimates[6], the optimal number of beds in our country is estimated at 15 beds per 1000 inhabitants or double the current capacity. With the process of population ageing, it is realistic to expect that this number will grow in the future due to the growing need caused by the increase in the number of elderly people in the country.

In terms of the occupancy of the capacities of public institutions for the elderly, we determined that the occupancy rate is 87.3%. There are free beds in two homes, while the remaining three are fully occupied. In these three homes, waiting lists have been formed, which, according to information we received from the homes at the time of the audit, include a total of 186 people. These waiting lists indicate the insufficient current capacity of public institutions for the elderly and the need to expand it. The above points to the conclusion that there is an insufficient number of beds at the state level and need to increase capacities. We also determined an uneven geographical concentration of institutions for the elderly, and in some regions the number of available beds is negligible, which creates difficult access to these services for people who need them.

5 Source OECD **[link]**.

6 Source: Analysis of the existing system for institutional accommodation and care of the elderly in North Macedonia, Association for Research and Analysis ZMAI

Projections for future

The current capacity of public and private institutions for the elderly is insufficient to meet all accommodation needs. In conditions of achieving the optimal capacity of 15 beds per 1000 inhabitants, it is necessary to double the current capacity in order to respond to all needs, and the waiting lists that nursing homes have only further confirm the insufficient capacity. As a result of all these facts, in order to gain insight into the future needs for capacities of institutions for the care of the elderly, we have carried out the following projection for the next 25-year period. Given that there is no clear rule for determining the required percentage of beds, it was prepared using the projection of population movement based on the results of the census, using the rate of 15 beds per 1000 inhabitants from 65 to 79 years of age and beds for 4% of the population over 80 years of age. The results of the same are presented in the following table:

Table 7

Year	65-79	80+	Total 65+	15 beds per 1,000 inhabitants aged 65-79	4% beds for inhabitants over 80 years of age	Total
2030	294,316	71,528	365,844	4,415	2,861	7,276
2035	296,867	89,053	385,920	4,453	3,562	8,015
2040	293,942	106,311	400,253	4,409	4,252	8,662
2045	292,455	121,387	413,842	4,387	4,855	9,242
2050	290,386	134,057	424,443	4,356	5,362	9,718
2055	282,444	144,101	426,545	4,237	5,764	10,001

Considering that the capacity of institutions for the elderly in 2025 is 2,378 beds, the data presented in the table imply that in the coming period a significant increase in capacities will be necessary, regardless of ownership (public, private or a combination of both), taking into account the increase in the number of elderly people that is projected in the future. In addition to this, taking into account the current uneven geographical distribution of institutions for the care of the elderly, the differences between the current and the required bed capacity are deepening at the level of planning regions in the interior of the country where at the time of the audit the number of available beds is minimal. The ageing of the population is more pronounced in these regions and they are rapidly losing their young population which will further deepen the care needs of the elderly living in these regions.

Slovak Republic

Introduction

Rationale

The National Active Ageing Programme (NAAP) is a comprehensive strategic document of the Slovak Republic (SR) that sets out the objectives and measures of the state to support dignified, healthy and active living for older people. Its significance lies in the fact that it responds to **the ageing population in the SR, supports the active participation of older people** in employment, volunteering, education and community life, and seeks to **improve the quality of life in old age** through accessible social and health services, the protection of the rights of senior citizens, the promotion of independence and the improvement of intergenerational relations. It represents an investment in a sustainable future for Slovak Republic, where older people are not a burden but a source of wisdom and experience, and where ageing is not seen as a problem but as part of natural social and societal development.

The preparation and implementation of the NAAP is the result **of international commitments in the field of active ageing**, to which the Slovak Republic committed itself at the UN level under the 2002 Madrid International Plan of Action on Ageing (MIPAA) and its Regional Implementation Strategy (RIS), as well as through its involvement in the implementation of the Decade of Healthy Ageing, which the UN declared in December 2020 for the years 2021-2030.

The Ministry of Labour, Social Affairs and Family of the Slovak Republic (MoLSAF SR) acts as the central managing and coordinating authority of the NAAP. It is responsible for developing, implementing, evaluating and monitoring of the Programme. It coordinates an inter-ministerial working group on active ageing, composed of representatives of ministries, local governments, the third sector and the Government Council of the Slovak Republic for the Rights of Seniors and for the Adaptation of Public Policies to the Ageing Population (Government Council for the Rights of Seniors).

The NAAP does not have its own budget, and therefore financial security is one of its weaknesses. There is no indication of the total allocation or the allocation for individual measures, which may jeopardise the achievement of measures and measurable indicators.

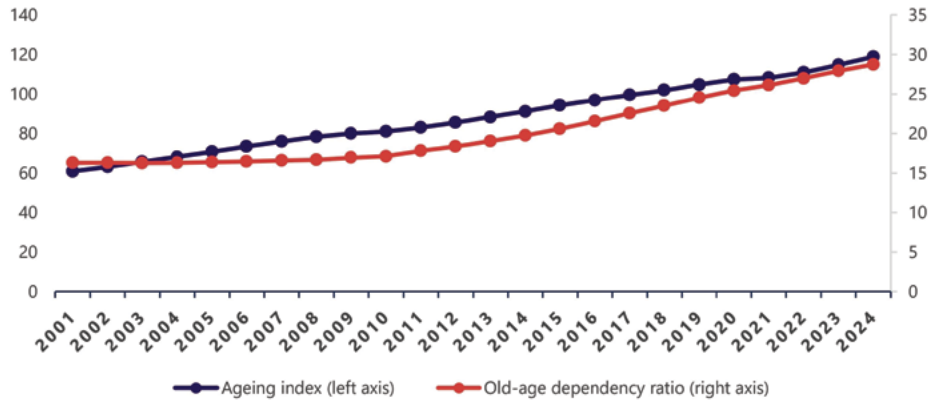
The participation of the Supreme Audit Office of the Slovak Republic (SAO SR) in this international audit resulted from the findings of its audit actions (SAO's Opinions on the Draft State Budget of the Slovak Republic, SAO's Opinions on the Draft State Final Accounts of the Slovak Republic) as well as **analyses, comments and monthly reports** (Impact of the introduction of early retirement after 40 years of service on the revenues of the Social Insurance Agency, Old-age pension savings (Pillar II), Evaluation of Pillar II pension funds, etc.), **in which the SAO SR drew attention to problems related to population ageing. One of the key issues identified by the SAO SR is the growing expenditure on old-age pensions, which has accumulated significantly in recent years. This trend threatens both the long-term sustainability of public finances and the stability of the pension system.**

Additional risks were identified through the SAO's mapping of social policies. These risks have been recurring over several years and include unpreparedness for demographic change, insufficient support for active ageing, underutilisation of the silver economy, pension system sustainability, low quality and insufficient capacity of social services, lack of qualified personnel, inadequate funding of social services, underdeveloped community-based care, etc.

The risks were supported by selected indicators of population ageing in the SR, such as the ageing index[1] **and the old-age dependency ratio**[2] (Figure 1). In 2001, according to the ageing index, more than 60 people of post-productive age corresponded to 100 people of pre-productive age. By 2024, this figure has almost doubled to nearly 117. The old-age dependency ratio increased from 16.3 to 28.7 over the last 25 years, indicating a rising dependency of older persons, on the economically active population. This imposed increased pressure on the social and pension systems and requires robust policy measures to ensure sustainability of public finances and adequate support for the elderly.

1 The ageing index expresses the number of persons of post-working age (65+) per 100 persons of pre-working age (0–14).
2 The old age dependency ratio of older people expresses the number of people of post-productive age (65+) per 100 people of productive age (15–64).

Figure 1: Development of selected indicators of population ageing in the Slovak Republic (in %)



Source: Statistical Office of the SR [om7005rr]. **[link]**; processed by the SAO SR

In the process of mapping risks within social policy, the SAO SR identified the ministries and institutions responsible for addressing issues related to active ageing. These entities act as managers and cooperating partners in the implementation of numerous measures under the NAAP. **The Ministry of Labour, Social Affairs and Family of the Slovak Republic (MoLSAF SR) holds** a central role as the main manager and coordinator of the NAAP.

The institutions involved include the following ministries:

- Ministry of Health of the Slovak Republic (MoH SR): Responsible for healthcare, preventive programmes, and long-term care.
- Ministry of Education, Research, Development and Youth of the Slovak Republic (MoERDY SR): Responsible for lifelong learning, including Universities of the Third Age and promotion of digital literacy.
- Ministry of Finance of the Slovak Republic (MoF SR): Participates in financing measures and ensure sustainability of the pension system.
- Ministry of Culture of the Slovak Republic (MoC SR): Supports cultural and leisure activities for seniors, including intergenerational programmes.
- Ministry of the Interior of the Slovak Republic (MoI SR): Ensures protection of seniors from violence and discrimination.
- Ministry of Transport of the Slovak Republic (MoT SR): Responsible for housing accessibility and infrastructure.
- Ministry of the Environment of the Slovak Republic (MoE SR): Addresses environmental aspects, including climate change adaptation affecting senior citizens.

- Ministry of Investment, Regional Development and Informatization of the Slovak Republic (MIRDI SR): Participates in EU funds management and supports regional development.

Beyond these ministries, the implementation of NAAP measures involves other organisations (the Home Care Service Agencies, universities, the Statistical Office of the SR, the Social Insurance Agency, labour, social affairs and family offices, and others), local governments, non-governmental organisations, senior and pensioner associations, social partners. The Government Council for the Rights of Seniors plays an important role too.

Presentation of the audit questions

Is there a comprehensive plan in place?

Until 2013, the Slovak Republic did not have a strategic document dealing with active ageing. The turning point came in 2013, when the national project Strategy for Active Ageing, financed by EU funds from the Operational Programme Employment and Social Inclusion, was completed. Subsequently, the National Active Ageing Programme (NAAP) for 2014-2020 was drawn up. In November 2021, a new NAAP for 2021–2030[3] was approved for the next period (Table 1). It follows on from the previous NAAP for 2014-2020, which failed to meet all its objectives and targets. The programme failed to respond to unfavourable demographic developments, changes in the economy, families, the digitalisation of society, the need for lifelong learning, the introduction of integrated health and social care, etc.

Table 1: Comparison of basic information on two national active ageing programmes

	NAAP 2014-2020	NAAP 2021-2030
Prepared by	Ministry of Labour, Social Affairs and Family of the Slovak Republic (MoLSAF SR), cooperating organisations	Ministry of Labour, Social Affairs and Family of the Slovak Republic (MoLSAF SR), cooperating organisations
Management	MoLSAF SR	MoLSAF SR
Managers and cooperating partners	Other ministries, self-governing regions and municipalities, other organisations	Other ministries, self-governing regions and municipalities, other organisations
Government law	Resolution of the Government of the Slovak Republic No. 688 of 4 December 2013 The Government approves the NAAP Proposal for 2014-2020	Resolution of the Government of the Slovak Republic No. 657 of 16 November 2021 The Government approves the NAAP proposal for 2021-2030 with comments adopted at the Government meeting
Financing	State budget, EU funds	State budget, Recovery and Resilience Plan, Programme Slovak Republic 2121-2027

3 MoLSAF SR. National Active Ageing Programme. **[link]**.

	NAAP 2014-2020	NAAP 2021-2030
Evaluation of measures	every 2 years evaluations carried out: 2016, 2018, 2020, 2021 total	Every 2 years Planned dates: 2023, 2025, 2027, 2029, 2031 Evaluations carried out: 2023 for the years 2021-2022, 2025 for the years 2023-2024
Target group	people aged 50 and over	All persons actively preparing for ageing or older persons, but especially those who, due to their age, may be disadvantaged in any way in some area of life and social relations and limited in their access to public resources
Areas	1. Protection of human rights, promotion of active independence and civic participation of older people 2. Employment and employability of older people 3. Independent, safe and high-quality life for older people	1. Promoting active ageing from a family perspective 2. Support for human resources throughout the life cycle 3. Healthcare promoting active ageing 4. Support for economic activity from a life-cycle perspective 5. Supporting social participation and inclusion of older people 6. Securing income in old age 7. Promoting dignity and quality of life for older people 8. Active ageing policies closer to citizens and their management 9. Awareness raising, data and research

Source: NAAP 2014-2020, NAAP 2021-2030; processed by the SAO SR.

What areas does the plan cover?

The current NAAP for the period 2021 to 2030 covers **nine areas of support for active ageing** (Table 1, Table 2). Each of the nine areas of the NAAP has its own strategic objective and corresponding sub-objectives; each sub-objective specifies a measure in the following structure: name of the measure, managers, cooperating partners, deadline for implementation, method of financing and measurable indicator.

Objectives – What are the goals, and how are they measured?

Table 2: Overview of NAAP strategic objectives

Area	Objectives
Promoting Active Ageing in the Family Context	Promoting intergenerational solidarity and good intergenerational family relationships as the basis for the functioning of the family and the fulfilment of its tasks in the family life cycle
Support for Human Resources throughout the Life Cycle	Utilising people's potential for active ageing as the basis for sustainable development of society through the sustainable development of continuing education infrastructure
Healthcare Supporting Active Ageing	Accessible, high-quality healthcare that supports people's potential for active ageing
Supporting Economic Activity from a Life-cycle Perspective	Harnessing the potential of older people to participate in paid work as the basis for sustainable development of society from an intergenerational perspective
Supporting Social Participation and Inclusion of Older People	Harnessing the potential of older people to participate in various socially beneficial activities that contribute to the development of individuals, families, neighbourhoods and communities and promote social cohesion and intergenerational exchange
Ensuring Income Security in Older Age	Economic security for older people based on the long-term sustainability of public resources for adequate pensions and other types of support and assistance protecting older people from poverty and severe material deprivation
Promoting Dignity, Independence and Quality of Life for Older People	A dignified, independent and quality life at all stages of the life cycle, including the stage of dependence on the assistance of another person, and in all environments in terms of mobility
Active Ageing Policies Closer to Citizens and Better Governance	Functioning of institutionalised mechanisms for managing active ageing policies and institutions for the participation of senior citizens' organisations and organisations dedicated to senior citizens in their creation and implementation at various levels (national, regional, local).
Awareness Raising, Data and Research	Raising public awareness of active ageing issues and making decisions based on available, high-quality data and research findings

Source: NAAP; processed by SAO SR

Originally, the NAAP set nine strategic objectives for each area (Table 2), 36 sub-objectives and 82 measures, measured by 82 measurable indicators. After the NAAP was updated, the number of measures increased to 83; one measure was added in the fifth area, in objective 2, and one in the seventh area, in objective 2, while the number of measures in the first area, in objective 3, was reduced by one measure.

Indicators and Achievements – Have the objectives been met?

The fulfilment of the objectives and the results achieved by the current NAAP are discussed in the Report on the Implementation of Measures under the National Active Ageing Programme for 2021-2030 for the years 2021-2022 and the Proposal for its Update (Report 1). This is the first report related to the NAAP for the period 2021-2030. Report 1 evaluates the implementation of the measures planned in the NAAP for 2021–2022. It includes an update of the measures as well as new measures proposed for the coming years.

The fulfilment of the objectives is assessed using measurable indicators set out in individual measures in four categories: achieved, ongoing, not achieved and objectives with a later deadline for fulfilment. The assessment used the consolidated version of the NAAP with 83 measures and 83 indicators. Report 1 states that during the period under review, ten measures were fulfilled, 41 measures were in progress, 16 measures were not fulfilled, 12 measures that were not fulfilled had a later deadline, and in the case of four measures, no data on their fulfilment please change the text to was available (Table 3).

Table 3: Overview of the implementation of measures for 2021 and 2022 in the NAAP for 2021–2030

Area	Objectives	Measures	Measurable indicators	Achieved	Ongoing	Not achieved	Later deadline for fulfilment	Data unavailable
Promoting Active Ageing in the Family Context	3	7	7	0	3	4	0	0
Support for Human Resources throughout the Life Cycle	5	9	9	1	5	1	1	1
Healthcare Supporting Active Ageing	4	6	6	0	6	0	0	0
Support Economic Activity from a Life-cycle Perspective	6	15	15	2	2	6	3	2
Supporting Social Participation and Inclusion of Older People	3	9	9	0	5	3	0	1
Ensuring Income Security in Older Age	3	7	7	2	5	0	0	0
Promoting Dignity, Independence and Quality of Life for Older People	8	19	19	0	13	1	5	0
Active Ageing Policies Closer to Citizens and Better Governance	2	4	4	2	0	0	2	0
Awareness Raising, Data and Research	2	7	7	3	2	1	1	0
Total	36	83	83	10	41	16	12	4

Source: NAAP, Report on the implementation of measures under the National Active Ageing Programme for 2021-2030 for the years 2021–2022 and proposal for its update; processed by the SAO SR.

The first evaluation report showed that when preparing a national programme on population ageing, it is very important to formulate objectives and measures responsibly, taking into account financial, personnel, time and competence conditions, so that the objectives and measures can be achieved.

The implementation of the NAAP is also discussed in the second Report on the Implementation of Measures under the National Active Ageing Programme for 2021-2030 for the years 2023-2024 and a Proposal for its Update (Report 2), which was approved by the Slovak Government in October 2025.

Table 4: Overview of the implementation of measures for 2023 and 2024 in the NAAP for 2021–2030

Area	Objectives	Measures	Measurable indicators	Achieved	Ongoing	Not achieved	Later deadline for fulfilment	Data unavailable
Promoting Active Ageing in the Family Context	3	7	7	0	7	0	0	0
Support for Human Resources throughout the Life Cycle	5	9	9	3	5	0	1	0
Healthcare Supporting Active Ageing	4	6	6	1	5	0	0	0
Support Economic Activity from a Life-cycle Perspective	6	15	15	4	8	0	3	0
Supporting Social Participation and Inclusion of Older People	3	9	9	0	8	0	0	1
Ensuring Income Security in Older Age	3	7	7	4	3	0	0	0
Promoting Dignity, Independence and Quality of Life for Older People	8	19	19	3	13	0	3	0
Active Ageing Policies Closer to Citizens and Better Governance	2	4	4	4	0	0	0	0
Awareness Raising, Data and Research	2	7	7	0	6	0	0	1
Total	36	83	83	19	55	0	7	2

Source: NAAP, Report on the implementation of measures under the National Active Ageing Programme for 2021-2030 for the years 2023–2024 and proposal for its update; prepared by the SAO SR.

Report 2 is based on materials provided by managers and cooperating partners. One shortcoming is that not all entities provided materials to the MoLSAF SR. The material documents the fulfilment of tasks for 2023-2024 and includes new measures and updates to some of them. Report 2 states that 19 measures have been completed, 55 are being implemented, seven measures have a later completion date, and no information on the implementation of two measure was available (Table 4).

It is not clear from Report 1 and Report 2 whether the situation of senior citizens has improved or not. Many measures are listed without an assessment of their contribution to active ageing during the four years of implementation of the NAAP and without specifying the financial resources spent on the measures.

It will only be possible to assess the fulfilment of all measures and indicators after the implementation of the NAAP has been completed; the final Report should be prepared and submitted to the Slovak Government for discussion by 30 September 2031.

Timeframe – What is the timeline for implementation?

The NAAP is designed for a period of ten years (2021-2030), during which it should be implemented. It is currently in its fifth year of implementation in the Slovak Republic, which means that it is an appropriate time to evaluate it and assess the results achieved.

Implementation – To what extent has the plan been implemented?

The implementation of the NAAP in Slovak Republic takes place at two levels: at the level of the NAAP implementation management structure and at the level of the implementation of individual NAAP measures. The NAAP implementation management structure has a strategic and coordinating function, which is provided by the MoLSAF SR. The second level is implemented by managers and cooperating partners who prepare calls, projects and activities in practice, while cooperating with the first level of implementation. The NAAP is thus implemented not only from the top down, but also seeks to link strategic objectives with specific needs in the field.

The level of implementation is discussed in reports (Report 1 and Report 2), which evaluate the implementation of measures for the period 2021 to 2024. Both reports were prepared on the basis of data provided by ministries, self-governing regions, organisations representing senior citizens, social partners and many other entities that are managers or cooperating partners in the NAAP. The draft report is undergoing an inter-ministerial consultation process. The report will then be submitted to the Government Council for the Rights of Seniors and subsequently to the Government of the Slovak Republic for approval.

The NAAP implementation timetable also mentions an information campaign on the NAAP. According to representatives of the MoLSAF SR, an information campaign specifically focused on the NAAP has not yet been implemented separately to the extent originally planned in the programme implementation schedule due to capacity, organisational and budgetary constraints.

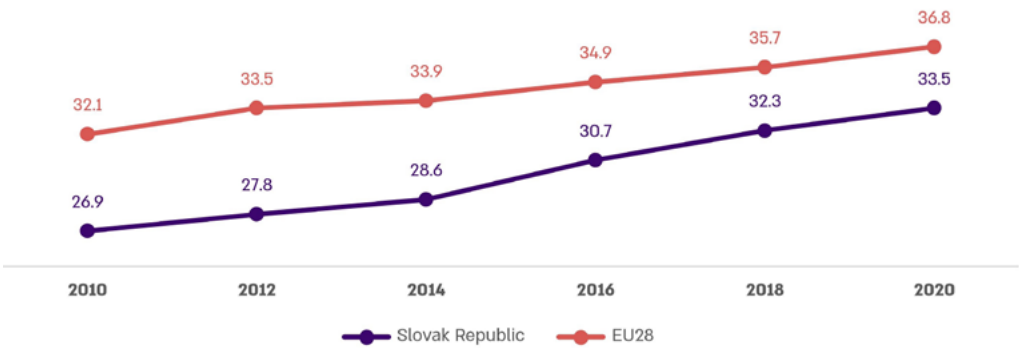
Monitoring and Evaluation – How is progress tracked and assessed?

The monitoring and evaluation of progress in the implementation of the NAAP is carried out in accordance with the methodology approved by the MoLSAF SR and is based on a two-year monitoring cycle.

The managers of the measures regularly collect data on the activities carried out, which are sent to the programme coordinator – the MoLSAF SR, which evaluates them. Based on the collected data, a Report on the Implementation of NAAP Measures is prepared every two years, which assesses progress in individual areas, identifies shortcomings and challenges, and proposes updates to the measures.

One possible way of assessing progress in the implementation of the NAAP is through indicators. The MoLSAF SR is currently working on the introduction of systematic impact indicators that would allow for a better assessment of how the measures affect the quality of life of older people. For the time being, the assessment is based mainly on output indicators such as the number of activities, participants, etc.

Figure 2: Development of the Active Ageing Index in the Slovak Republic and the EU28 between 2010 and 2020

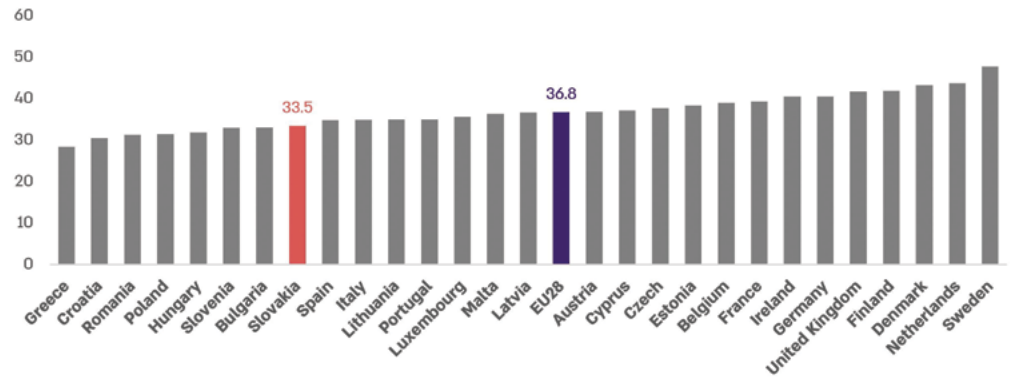


Source: UNECE, **[link]**; processed by the SAO SR.

Another way of assessing progress is through the Active Ageing Index (AAI)[4], which has been used as a summary indicator for assessing active ageing in European countries since 2010. It was proposed by the United Nations Economic Commission for Europe (UNECE)[5]. Slovak Republic lags behind in the Active Ageing Index, although there has been a noticeable positive trend towards increasing the value of this indicator since 2010.

Slovak Republic lags behind in the AAI, although there has been a noticeable positive trend towards an increase in the value of this indicator since 2010, when Slovak Republic ranked second to last among the 28 EU countries assessed (EU28). It has moved from 26.9 in 2010 to 33.5 in 2020 (Figure 2). The gap with the EU28 has gradually narrowed over the ten years under review, and according to the latest data, the Slovak Republic ranks 21st (Figure 3)[6].

Figure 3: Active Ageing Index in the EU28 in 2020



Source: UNECE, [online]; processed by SAO SR.

We can also look at the AAI from a regional perspective as the so-called Regional Active Ageing Index at the county level. The Bratislava County ranks highest and the Košice County ranks lowest. In terms of domains, the Bratislava region dominates in employment and independent, healthy and safe living, while in the other two domains – participation in society and an environment enabling active ageing – the Banská Bystrica region leads (Figure 4)[7].

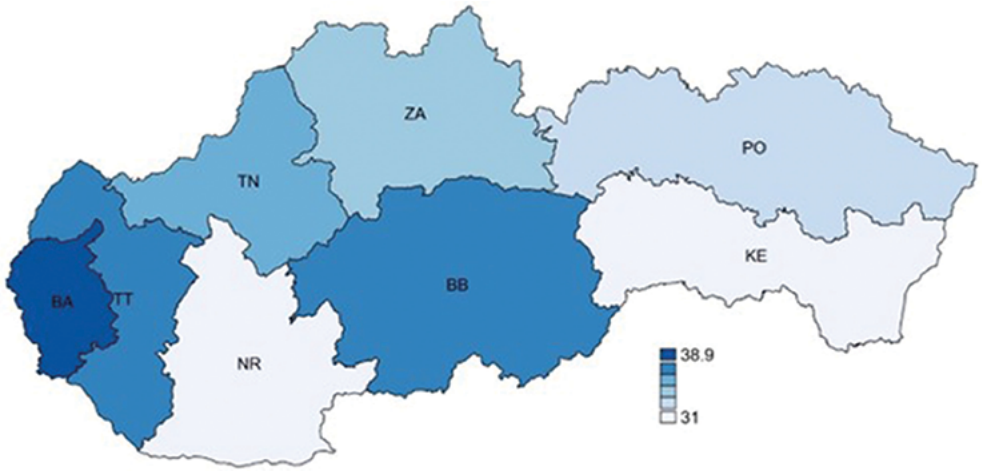
4 The AAI measures the extent to which older people live independently, participate in paid employment and social activities, and their ability to age actively. It consists of 22 individual indicators divided into four domains: employment (4 indicators), participation in society (4 indicators), independent, healthy and safe living (8 indicators) and an environment conducive to active ageing (6 indicators). The results of the index are published every two years.

5 UNECE. Active Ageing Index. **[link]**.

6 UNECE **[link]**.

7 Slovak Statistics and Demography 1/2025; Alena KAŠČÁKOVÁ, Zuzana RIGOVÁ, Faculty of Economics, Matej Bel University in Banská Bystrica, Ľudmila IVANČÍKOVÁ, Statistical Office of the Slovak Republic: Active ageing in the regions of Slovak Republic; **[link]**.

Figure 4: Active Ageing Index in the regions of the Slovak Republic in 2024



Legend: BA – Bratislava Region, TT – Trnava Region, TR – Trenčín Region, NR – Nitra Region, ZA – Žilina Region, BB – Banská Bystrica Region, PO – Prešov Region, KE – Košice Region

Source: Slovak Statistics and Demography 1/2025; Alena KAŠČÁKOVÁ, Zuzana RIGOVÁ, Faculty of Economics, Matej Bel University in Banská Bystrica, Ľudmila IVANČÍKOVÁ, Statistical Office of the Slovak Republic: Active ageing in the regions of Slovak Republic; **[link]**.

According to representatives of the Ministry of Labour, the AAI was used as inspiration in the preparation of the NAAP for the period 2021-2030. When assessing the implementation of NAAP measures, Slovak Republic relies on specific quantitative and qualitative data provided by the measure managers and cooperating partners as part of annual monitoring and the biennial report. Data from the Statistical Office of the SR, Eurostat, the OECD and others are used to compare trends in population ageing. All these sources are combined within the monitoring methodology coordinated by the MoLSAF SR.

Funding Sources – What are the sources of financing?

Most questions arise in relation to the financing of the NAAP. The source of financing is specified for each measure, but generally (state budget, most often from the budget chapter of the MoLSAF SR and the Ministry of Health of the SR, EU funds, the Recovery and Resilience Plan, the Programme Slovak Republic 2021-2027, the local government budget, etc.), without specific amounts that should be spent on the implementation of the measure. In addition, each administrator finances their own measures from their own budget chapter or from EU funds. From this perspective, this part appears to be risky.

More specific information on the financing of certain NAAP measures is provided in the Recovery and Resilience Plan and in the Programme Slovak Republic 2021-2027. In the case of the Slovak Republic's Recovery and Resilience Plan, Component 13, entitled 'Accessible and high-quality long-term social and health care', presents the objective of preparing Slovak Republic for the rapid ageing of its population by ensuring high-quality, accessible and comprehensive support for people of all age groups in need of long-term and palliative care.

In the Programme Slovak Republic 2021-2027, support focuses on active ageing in relation to demographic trends and higher participation of older people in the labour market. This is made possible by a specific objective aimed at supporting the adaptation of workers, businesses and entrepreneurs to change. This covers topics such as active and healthy ageing and a healthy and appropriately adapted working environment that prevents health risks. Other priorities include the intention to contribute to intergenerational cooperation and greater participation of elderly in community life through active and healthy ageing.

Long-Term Planning and Trends – How does the plan address future needs and trends of ageing population?

The NAAP systematically focuses on the future demographic challenges facing Slovak Republic in connection with the ageing of the population. It is based on forecasts that Slovak Republic will be among the fastest ageing countries in the coming decades. The document contains a baseline analysis and summary of the risks of future developments relating to the pension system, healthcare, housing and the labour market.

Data-Driven Planning – To what extent is the plan based on data and evidence?

The NAAP 2021–2030 is largely based on data and evidence, from the preparation phase to the evaluation of its implementation. Overall, the NAAP can be described as an evidence-based programme that draws on a combination of statistical data from the Statistical Office of the SR, Eurostat, the OECD, etc., expert analyses and recommendations from the Institute for Labour and Family Research, practical experience, and field data from managers and cooperating partners.

Geographic Coverage – How does the plan address regional disparities (periphery vs. centre) and the balance between national and local planning?

The NAAP covers the entire territory of Slovak Republic and is implemented in both metropolitan areas and peripheral rural regions for all senior citizens. It seeks to take into account local needs and specificities (e.g. availability of services, demographic structure) and to use local capacities (e.g. community centres, local authorities, non-profit organisations). Implementation thus takes place at regional and local level through local authorities, non-profit organisations and senior citizens' associations, which also contribute to the financing of some measures. According to representatives of the Ministry of Labour, the NAAP has a territorial dimension and its implementation is adapted to regional needs.

Is there an integrative policy or separate sectorial plans by ministries?

The NAAP itself represents an integrative policy; individual ministries do not have their own separate sectoral plans addressing population ageing.

The NAAP has many overlaps with other important documents at the national level, which may cause overlapping of measures with a similar focus in other national documents, which are also addressed by the NAAP, but which focuses primarily on ageing and the lives of older people (Table 4).

Table 5: List of strategic documents related to the NAAP

Strategic document	Responsible
Government Programme Statement of the SR 2020-2024	Government of the SR
Government Programme Statement of the SR 2023-2027	Government of the SR
National Strategy for Deinstitutionalisation of the Social Services and Substitute Care System	MoLSAF SR
National Programme for the Development of Living Conditions for Persons with Disabilities 2021-2030	MoLSAF SR
National Priorities for the Development of Social Services 2021-2030	MoLSAF SR
Long-Term Care Strategy in the SR, Integrated Social and Health Care	MoLSAF SR
National Framework Strategy for Social Inclusion and Combating Poverty	MoLSAF SR
Lifelong Learning and Counselling Strategy 2021-2030	MoERDY SR
Vision and Development Strategy of Slovak Republic until 2030 – Long-term Strategy for Sustainable Development of the SR – Slovak Republic 2030	MIRDI SR
Strategic priorities for Employment Development in the SR with a view to 2030	MoLSAF SR
National Concept for the Prevention and Elimination of Homelessness	MoLSAF SR
Recovery and Resilience Plan	MIRDI SR
Partnership Agreement 2021-2027	MIRDI SR
Food and Basic Material Assistance 2021-2027	MoLSAF SR
National Action Plan for the Transition from Institutional to Community Care 2022-2026	MoLSAF SR
Slovak Republic's Digital Transformation Strategy 2030	MIRDI SR

Source: NAAP; processed by SAO SR.

Are there interactions and coordination between ministries?

The strategic materials of the Slovak Government and ministries are interrelated, for example, the Government Programme Statement for 2023-2027, the Recovery and Resilience Plan, the Programme Slovak Republic 2021-2027, etc., are not in conflict with the NAAP. The managers of strategic materials at the ministries submit these materials for inter-ministerial consultation.

Specific examples can be given. In the case of documents prepared by the Ministry of Labour, such as the "National Priorities for the Development of Social Services for 2021-2030", "National Strategy for Deinstitutionalisation of the Social Services and Substitute Care System", etc., are assumed to be in line with the NAAP, as the MoLSAF SR is the coordinator of the NAAP. In the case of documents prepared outside the Ministry of Labour or in cooperation with the Ministry of Labour, such as "Long-term Care Strategy in the SR, Integrated Social and Health Care", "Lifelong Learning and Counselling Strategy for 2021-2030", continuity with the NAAP was ensured through an inter-ministerial consultation process.

In addition, a working group on the NAAP has been set up, in which all ministries and other institutions are represented. Within this group, regular monitoring and coordination meetings are held between the contact persons responsible for monitoring and evaluating the fulfilment of NAAP objectives and for calculating measurable indicators.

Is there a central body coordinating all plans?

The Ministry of Labor, Social Affairs and Family of the Slovak Republic is responsible for the implementation of the entire NAAP as the managing authority, coordinating all activities in the field of active ageing. The Department of Advisory Bodies has been established within the MoLSAF SR, which falls under the organizational authority of the Office of the Minister of Labor, Social Affairs, and Family of the Slovak Republic. Currently, two employees of the Department of Advisory Bodies are dedicated to active ageing.

In addition, the Slovak Government Council for the Rights of Seniors has been established, which has its own secretary. The Council monitors, comments on and initiates the development of conceptual materials and assesses the implementation of measures resulting from approved concepts for the creation and development of living conditions for seniors in all areas of life and their integration into society. Its activities also include commenting on reports on the implementation of the NAAP.

Ministries and other organisations are involved in the implementation of the NAAP, such as labour, social affairs and family offices, the National Labour Inspectorate, the Statistical Office of the SR, Union of Towns and Cities of Slovakia, the Alliance of Universities of the Third Age, local governments, health insurance companies, the Public Health Office of the SR, Agency for Home Care Services, Slovak Association for Age Management, Conference of Trade Unions of the SR, Republican Union of Employers, Office of the Plenipotentiary of the Government of the SR for the Development of Civil Society, non-governmental organisations acting as managers responsible for the implementation of several measures. Each managers implements their own measures arising from the NAAP. During the reporting period, the MoLSAF SR monitors the fulfilment or non-fulfilment of measures.

Other institutions act as cooperating partners. In addition to the ministries and the above-mentioned organisations, these include the Council for Budget Responsibility, the Social Insurance Agency, social service homes, social service providers, educational institutions, universities, senior citizen organisations, the Forum for Assistance to the Elderly, social partners, and others. They participate in the implementation of measures, monitoring of implementation, data collection, evaluation of impacts and results achieved, and preparation of reports on the implementation of measures. They also present their views during the preparation of the NAAP (Table 6).

Table 6: RACI analysis

Activity	Government of the SR	MoLSAF SR	Managers	Cooperating Partners	Government Council for the Rights of Seniors
Coordination of active ageing	C	R, A	C	I	I
Preparation and approval of the NAAP	R	R, A	C	C	C
Information campaign	I	R	A	C	I
Implementation of NAAP measures	I	R	A	A	I
Monitoring implementation	C	R	A	A	I
Collection of information, data and facts on the implementation of measures	I	R	A	A	C
Report on the implementation of measures arising from the NAAP	A	R	A	A	C
Assessment of impacts and results achieved	C	R	A	A	C

Source: the MoLSAF SR, Statistical Office of the SR; processed by the SAO SR.

Is population ageing addressed within broader national plans?

The NAAP is part of the Vision and Development Strategy of Slovak Republic until 2030, the Government Programme Statement of the SR 2020-2024, the Government Programme Statement of the SR 2023-2027, the Recovery and Resilience Plan, the Partnership Agreement 2021-2027, the National Programme for the Development of Living Conditions for Persons with Disabilities 2021-2030, and the Lifelong Learning and Counselling Strategy 2021-2030.

Examples of good practices

The following examples of good practice can be mentioned from both national active ageing programmes (NAAP 2014-2020 and NAAP 2021-2030):

The existence of the Slovak Government Council for the Rights of Seniors

The Slovak Government Council for the Rights of Seniors is a permanent expert, advisory, coordinating, and initiative-taking body of the Government of the Slovak Republic in the area of seniors' rights, addressing issues related to living conditions, equal opportunities, and equal treatment of seniors, and ensuring closer cooperation among stakeholders in addressing the consequences of a population ageing. The Council's establishment and activities contribute to the active participation of older people in society and, through their representatives, in the preparation and adoption of important legislative and other decisions and documents at the national, regional, local, and organizational levels that concern them.

Universities of the Third Age

Older citizens can study at universities. The active participation of seniors in education increases their awareness, broadens their horizons, and educates them in various areas of life, contributes to the quality of their leisure time, improves their mental condition, and slows down the ageing process.

The education took place not only at the universities' headquarters, but also at their branches, bringing education closer to the regions. The most common educational activities focused on healthy living, healthy food, mental resilience, critical thinking, improving digital skills, cyber security, etc. These activities are planned throughout the entire implementation period of the NAAP.

Active labour market measures

EU funds under the Human Resources Operational Programme were used to finance national projects for older jobseekers, helping them to remain in the labour market, keep their jobs and thus ensure their financial stability. The situation is similar in the 2021-2030 programming period, where projects specifically designed for older people aged fifty and over are being prepared.

Field social services, home care agencies

The system of field and outpatient social and health services, in line with the deinstitutionalisation strategy, supports seniors in remaining in their natural environment, which is important for dignified ageing and autonomy for older people, rather than staying in impersonal institutional facilities.

Digital literacy for seniors

In Area 2, Support for Human Resources throughout the Lifecycle of the NAAP, training courses focused on digital skills for seniors were implemented. The measure was managed by the Ministry of Investment, Regional Development and Informatisation of the SR, which cooperated with the Alliance of Universities of the Third Age, the Digital Coalition, the Slovak Association of Age Management, the Ministry of Education, Research, Development and Youth of the SR and the MoLSAF SR. As part of the project Improving the digital skills of seniors and disadvantaged groups in public administration, implemented through the online platform, a network of trainers was created, 52 training locations throughout Slovak Republic and 521 training courses for seniors who learned how to use computers and smartphones. A total of 13,643 seniors and public administration employees participated in the training. In addition, as part of the project Improving the Digital Skills of Seniors and Distribution of Senior Tablets1, funded by the Recovery and Resilience Plan through the Ministry of Investment, Regional Development and Informatisation of the SR, 11,300 graduates were trained in 2023 and 2024.

Contribution to recreational stays for senior citizens

In 2024, 13,283 seniors took advantage of the €100 contribution per senior, with a total of €1.3 million paid out to increase the availability of recreation and promote the physical and mental health of older people.

Contribution from the Ministry of Tourism and Sport of the SR

From 2025, each regional headquarters of the Slovak Pensioners' Union will receive an annual contribution of €15,000 for sports activities for seniors from the national lottery company Tipos, which falls under the Ministry of Tourism and Sport of the SR. The funds are intended to support sports activities for older people and to organise sports and tourist events, which should improve the physical and mental health of senior citizens.

SAI findings

During the international audit, based on an evaluation of the NAAP, two reports (Report 1 and Report 2), communication with the MoLSAF SR and other entities, the SAO SR identified the following positive aspects (Table 7) and risks of the NAAP.

Table 7: Positive aspects of the NAAP

Positive aspects	Justification
Comprehensiveness of the NAAP	The NAAP covers a wide range of aspects of senior citizens' lives, from health and social care, social participation, intergenerational relations, employment, culture, transport and housing to education and digital skills. Ageing, and even more so active ageing, is not just about retirement, but about the overall quality of life of older people. It is a complex issue that requires a systematic solution. The NAAP thus becomes the basis for a long-term and coordinated response to demographic changes in society.
Focus of the NAAP not only on seniors, but also on active ageing	The NAAP does not focus solely on the target group of senior citizens, but addresses ageing as an important part of life.
Involvement of multiple entities as managers and cooperating partners	Several entities are involved in the implementation of the NAAP as managers or cooperating partners (ministries, state administration bodies, local government, non-profit organisations, senior citizens' organisations, etc.), which were also involved in the preparation and development of the NAAP. Each department has its own area of responsibility, e.g. education, employment, social care, etc., within which it ensures that the objectives, measures and measurable indicators are met.
Measurability of progress achieved in the implementation of the NAAP	The NAAP monitors progress in implementation through measurable indicators using data, which makes it possible to evaluate which measures are working and which are not.

Source: Line should be closer to table.

In addition to the positives, the SAO SR would like to draw attention to the biggest risks of implementing the programme (Table 8):

Table 8: Risks of NAAP implementation

Risks	Justification
Insufficient financial security for the implementation of the NAAP	The greatest risk to the NAAP is the lack of a comprehensive budget. The NAAP is more of a strategic document without the allocation of resources to individual measures, years and totals. The NAAP is financed on an ongoing basis from several sources, referred to only in general terms as the state budget (budget chapters of ministries), EU sources, the Recovery and Resilience Plan, local government budgets, etc., but without specific amounts. Most measures depend on European funds. One shortcoming is that Report 1 and Report 2 do not specify the actual expenditure for each year spent on implementation. It is clear that without clearly allocated and long-term guaranteed resources, the implementation of the NAAP will not be successful, which is indirectly stated in Report 2, where it is noted that some measures have not been implemented due to a lack of financial resources.
Lack of hierarchy or prioritisation of objectives and measures	The NAAP itself has more than 80 measures in nine areas, a number of objectives and measurable indicators. However, not all measures are equally important. There is no clear hierarchy of objectives, which ones are strategic, supportive or complementary. At a time of consolidation, Slovak Republic has limited financial and human resources, so it would be appropriate to focus on fewer but essential measures with concrete results that would contribute most to improving the living conditions of senior citizens.
Complex and administratively demanding monitoring	The programme has a number of measures and measurable indicators, with each measure having a deadline, managers and cooperating partners, which means that the evaluation involves drawing up a long bureaucratic list of measures indicating whether they have been fulfilled or not, which is administratively demanding and is also evident from Report 2, which is 126 pages long.
Incorrectly set qualitative and quantitative measurable indicators	The NAAP has a measurable indicator for each measure, which does not always reflect quality. For example, the number of training courses for seniors in digital skills does not mean that they were satisfied with them and that they benefited them or improved their quality of life.
Insufficient presentation of the NAAP and its results	The information campaign focused on the NAAP has not yet been implemented as originally planned, which is another weakness of the programme. There is no mention of it in Report 2. There is a lack of simple and comprehensible presentation of the specific results of the NAAP to the public.

Source: Own processing by the SAO SR.

Summary

Based on the information obtained, analyses, interviews and findings, the SAO SR proposes the following recommendations for improving the implementation of the NAAP (Table 9).

Table 9: Recommendations of the SAO SR for improving the implementation of the NAAP

Recommendation	Description, justification
Creation of financial security for the NAAP	The financial aspect of NAAP implementation is insufficient, and we therefore propose: Creating a separate budget with the allocation of resources to individual areas, measures, years and the entire period of NAAP implementation. Adding a system for monitoring expenditure in areas, measures, years and throughout the entire NAAP implementation period to the system for monitoring objectives, measures and indicators, in order to determine how much resources were spent on individual measures and what was achieved with them. Create a system of small grants, e.g. up to EUR 10,000, for the implementation of meaningful projects for senior citizens at local level, with a minimum administrative burden, which could be applied for by local authorities, senior citizens' organisations and non-profit organisations.
Setting priorities	For each area of NAAP implementation, set priorities and measures, divide them according to importance into strategic, supportive and complementary, and adapt the responsibility, monitoring and evaluation of these measures accordingly. At a time of consolidation, Slovak Republic has limited financial and human resources, so it is advisable to focus on essential measures that would contribute most to improving the living conditions of senior citizens. For example, supporting the employment of older people through flexible working arrangements would have a greater social and economic impact than conducting research on the impact of active volunteering on the health, social and mental well-being of older volunteers, etc.
Setting not only quantitative but also qualitative indicators	Add qualitative indicators to strategic priority measures and thus evaluate the impact, not just the output of activities. In addition to quantitative indicators such as the number of digital skills training courses for senior citizens or the number of senior citizens trained, add qualitative indicators such as how many senior citizens use information technology after completing the training, how satisfied senior citizens are with the training, etc.
Improving cooperation and coordination during the implementation of the NAAP	Pay due attention to the systematic coordination and cooperation of managers and cooperating partners during the implementation of the NAAP under the leadership of the MoLSAF SR, not only every two years when preparing the Report, but throughout the entire period of programme implementation.
Improving communication with the public	Implement an information campaign on the NAAP Regularly inform the public about the implementation of the NAAP, the measures taken and the specific results of improving the lives of senior citizens.

Source: Own processing by the SAO SR.

Methodology used

- data from freely available sources (Eurostat, Statistical Office of the Slovak Republic, Social Insurance Agency, UNECE, etc.),
- detailed analysis of documents relating to active ageing, mainly the NAAP, Report 1 and Report 2 and other strategic materials,
- working meetings and intensive communication with representatives of the Ministry of Labour, Social Affairs and Family of the Slovak Republic and the Government Council of the Slovak Republic for the Rights of Seniors,
- conclusions from audits, analyses and analytical comments by the Supreme Audit Office of the Slovak Republic,
- Communication with the Office of the State Comptroller and Ombudsman of Israel, conclusions from the meeting in North Macedonia.

Israel

Management of Governmental Preparedness for Population Ageing

Population ageing constitutes one of the challenges confronting the State of Israel. This issue has extensive implications for the healthcare system, the long-term care system, welfare services, and the labor market. Moreover, Israel, similarly to numerous developed nations, is experiencing a significant demographic shift due to the accelerated ageing of its population. This transformation is attributed to increased life expectancy[1] coupled with declining birth rates, which collectively contribute to a continual rise in both the number and proportion of senior citizens[2] within the total population. Within this demographic - which in Israel at the end of 2024 comprised 1.3 million individuals aged 65 and older, representing 13% of the national population[3] - the level of functioning exhibits considerable variability, ranging from full functioning without medical limitations to severely restricted functioning attributable to significant medical and functional impairments.

Addressing this challenge necessitates that the State of Israel engage in comprehensive preparations across multiple domains – from initial policy formulation through strategic and detailed planning, up to equipping senior citizens for the subsequent phase of their lives[4] and enhancing the capacity of supporting systems and infrastructure, including healthcare and welfare services[5]. Fundamentally, preparations for an ageing population require the preservation of optimal functional, health, emotional, social, and occupational conditions among senior citizens, thereby minimizing dependency[6] to the greatest extent possible and preventing deterioration once assistance or treatment becomes necessary. Sustaining such conditions is necessary throughout the ageing process, contingent upon the individual's health status.

This is a summary of the SAI Israel Audit report titled "The State of Israel's Preparedness for an Ageing Population - Managing Government Preparedness for an Ageing Population". The full National Report can be accessed through the SAI Israel website **[link]**.

1 Life expectancy constitutes a statistical estimate of the average number of years an individual from a specified population is anticipated to live at a particular time and location, under the assumption that mortality rates prevailing during the reference period remain constant throughout the individual's life expectancy (Dagan, Michal, 2018). Age-Diversity and Employment: A Concepts Guide, Joint Israel, Jerusalem.

2 According to the Senior Citizens Law, 5750-1989, a senior citizen is "a resident of Israel who, according to registration in the Population Registry, has reached retirement age": 63 for women and 67 for men (according to the Retirement Age Law, 5764-2004).

3 Central Bureau of Statistics, Senior Citizen Month 2025: Selected data on senior citizens of Israel aged 65 and over (September 30, 2025).

4 Yeung DY and Zhou X (2017) Planning for Retirement: Longitudinal Effect on Retirement Resources and Post-retirement Well-being.

5 The National Economic Council, Strategic Socio-Economic Assessment (2015); in the interim report of the joint committee of the Labor, Welfare and Health Committee and the Economics Committee for the discussion discussing the motion for the agenda on the subject of formulating a national master plan in the field of ageing, headed by MK Tali Ploskov, (2018).

6 Central Bureau of Statistics, "National Indicators for Optimal Ageing in Israel 2022" (November 2024), p. 15.

Is there a comprehensive plan in place? What areas does the plan cover?

Long-term strategic planning functions as a framework that transforms a vision into national tasks, goals, and priorities in the present, in order to realize future outcomes[7]. It constitutes a prerequisite for effective governance by establishing priorities, optimizing resource allocation, and fostering accountability through measurable objectives and performance monitoring. Furthermore, it facilitates coordination mechanisms among ministries and entities to ensure that policies align with national objectives[8].

In Israel, two comprehensive national plans have been developed to address the ageing population and its associated social, health, and economic implications: the Strategic Socio-Economic Assessment, which identifies ageing as a principal challenge for the nation, and the Map of National Indicators for Optimal Ageing.

Strategic Socio-Economic Assessment

In 2015, the National Economic Council within the Prime Minister's Office (the Council) identified the ageing population as one of six socio-economic challenges confronting the State of Israel over the forthcoming decades. Within the Strategic Socio-Economic Assessment (the Strategic Assessment), the Council delineated five courses of action for the state to address this challenge[9].

7 Knesset of Israel, Research and Information Center, "Long-Term National Planning – A Comparative Review" (January 30, 2017).
8 Rita Golstein-Galperin and Shai Amit, "The Strategic State 2048: How to Implement Long-Term Strategic Planning in Israel?", Eli Hurwitz Conference on Economy and Society 2025.
9 The National Economic Council, Strategic Socio-Economic Situation Assessment (2015).

Table 1: Courses of action for addressing the challenge of the ageing population as defined in the Strategic Assessment, 2015

Preparedness of the long term care and health systems	The ageing of the population will increase the demand for health and long term care services, and therefore requires early planning and systemic preparation that includes training of the workforce and expanding infrastructure.
Integrating senior citizens in the workforce and in the community	Integrating senior citizens into the workforce and the community contributes to the economy, society and the individuals themselves, and should be promoted through flexible employment, removing barriers and encourageing a change in perception regarding their contribution.
Gradual adjustment of retirement age	To maintain the stability of the pension and national insurance system, the retirement age must be gradually raised, in line with the increase in life expectancy, especially for women. At the same time, a policy is needed that will encourage and enable employment in old age.
Preparedness of the pension systems	Over the past decade, there has been a stable increase in both the proportion of individuals saving for retirement and the average pension savings accumulated. Nevertheless, it is imperative to develop solutions for demographic groups that are not presently engaged in retirement savings. Additionally, it is essential to assess the stability and adaptability of the pension system over time, particularly during periods of crisis and diminished returns.
Addressing the actuarial deficit of the National Insurance Institute	The National Insurance Institute is experiencing an increasing actuarial deficit, attributable to the ageing population and a decreasing ratio of workers contributing insurance premiums relative to benefit recipients. The absence of long-term strategic planning exacerbates this risk, and it is anticipated that expenditures on benefits, particularly old age and long term care, will further augment the deficit in the foreseeable future.

According to the National Economic Council's Strategic Assessment[10].

10 The National Economic Council, Strategic Socio-Economic Situation Assessment (2015)

In Resolution 145 of June 2015, the Government of Israel formally adopted the Strategic Assessment, including the proposed courses of action addressing various challenges, notably those related to population ageing, and assigned government ministers the responsibility of incorporating these courses of action into the work plans of their respective ministries[11]. Concurrently, through Government Resolution 150, also adopted on the same date, the Government resolved to advance the strategic topic of "Preparing for Population Ageing", assigning ministers with corresponding responsibilities within their ministerial domains. It further stipulated that the designated government ministries and their respective ministers should develop outline plans for implementing the courses of action delineated in the Strategic Assessment, coordinating with the Strategy Management Team and integrating these plans into their annual work programs[12].

Despite the passage of a decade since the adoption of Government Resolutions 145 and 150 in 2015, the pertinent government entities, including the National Insurance Institute, the Ministry of Health, the Ministry of Welfare, and the Ministry of Social Equality, have yet to establish a systemic, coordinated, and long-term response – and are unprepared for the ageing of the population, as defined by the Council. For instance, according to the actuarial report of the National Insurance Institute issued in 2025, the projected exhaustion date of the fund was brought forward by nine years[13]. This development indicates potential difficulties for the National Insurance Institute in sustaining benefit payments, such as long term care benefit and and old-age pension, to future senior citizens. Moreover, although the Retirement Age Law elevated the retirement age for women, adjustments commensurate with changes in life expectancy were not implemented[14].

Additionally, the Council does not engage in monitoring the execution of government resolutions arising from the Strategic Assessment. It does not collect progress reports from the general directors of ministries concerning the status of these resolutions, and consequently, it fails to provide the government or cabinet with updates on implementation progress.

It is advised that the governmental entities responsible for addressing the challenges associated with population ageing, including the National Insurance Institute, the Ministry of Welfare, the Ministry of Social Equality, and the Ministry of Health, undertake the implementation of the Strategic Assessment and provide the government with annual updates regarding the progress of implementation within their respective ministries. To achieve this objective, it is further recommended that these entities develop a comprehensive outline plan for executing the prescribed courses of action, alongside the formulation of annual work plans. Moreover, the Council should systematically collect periodic reports from governmental ministries and perform the designated functions assigned to it, which include the regular monitoring of the implementation of the courses of action. It is also recommended that the Council establish a mandatory oversight and reporting framework encompassing elements such as the establishment of multi-year objectives and outcome indicators, the imposition of a quarterly reporting requirement for ministry general directors concerning the status of action plan execution, and the submission of periodic progress reports to the government.

11 Government Resolution 145, "Adoption of the Strategic Socio-Economic Situation Assessment for the 34th Government", (June 28, 2015) (Resolution 145).
12 Government Resolution 150, "Promoting the Strategic Topic "Preparing for Population Ageing as a Derivative of the Strategic Socio-Economic Situation Assessment for the Government", June 28, 2015 (Resolution 150).
13 With respect to the actuarial report of 2020.
14 Retirement Age Law, 5764-2004.

The National Economic Council in the Prime Minister's Office stated in its response to the Office of the State Comptroller from May 2026 (the National Economic Council's response), that it would take steps to implement improved reporting and control mechanisms in the new program, in order to ensure that policy decisions are translated into consistent and measurable implementation.

Map of National Indicators for Optimal Ageing

Optimal ageing is defined as a state in which an older individual experiences good health, a sense of purpose, and has the financial capacity to support their status[15] (Optimal Ageing).

In 2021, a joint work team comprising representatives from government ministries dealing with ageing and the third sector (the Joint Work Team) developed the Map of National Indicators for Optimal Ageing (the Indicators Map)[16]. The Indicators Map is intended to serve as a tool for the government to make evidence-based decisions, thereby enabling efficient management of public resources, addressing disparities and enhancing the processes associated with optimal ageing in Israel. Additionally, it is designed for use by all stakeholders engaged in this domain, including local authorities, the business sector, and civil society.

The Indicator Map delineates two categories of indicators:

1. The first category consists of super-indicators for optimal ageing across three domains: health, sense of meaning, and economic resilience. Improvements in these super-indicators reflect optimal ageing; however, these indicators themselves cannot be influenced directly.
2. The second category comprises predictive indicators for optimal ageing. These behavioral or perceptual indicators have been identified in literature as influential factors in achieving optimal ageing. Intervention targeting these indicators at any age can affect outcomes related to optimal ageing. The CBS 2022 report concerning the Indicator Map included 24 predictive indicators, while the subsequent and final report published in 2024 presented 31 predictive indicators organized into five areas: health management, healthy lifestyle, active social lifestyle, financial preparedness, and digital literacy[17].

The image below illustrates the super-indicators alongside selected predictive indicators within the Indicator Map.

15 Central Bureau of Statistics, "National Indicators for Optimal Ageing in Israel 2022", (November 2024), pp. 18-19.
16 Joint ESHEL, Multi-Annual Work Plan: 2021 - 2025 (Publication date not specified).
17 Central Bureau of Statistics, "National Indicators for Optimal Ageing in Israel 2022", (November 2024).

Table 2: Indicator Map for Optimal Ageing, 2024[18]

SUPER-INDICATORS		
Economic resilience	Poverty	The rate of poor families per households where at least one individual is 65 years old and above
	Ability to manage financially	The self-perception of an individual regarding his/her financial state and ability to cover the household expenses
Meaning	Quality of Life	The personal subjective wellbeing concerning control, autonomy, self-actualization and enjoyment
	Feeling of loneliness	The individual's self-assessment regarding his/her social and emotional condition
Health	Functional Status	The ability of an individual to carry out daily activities necessary for basic functioning or that reduce the extent of dependence
	Healthy life expectancy	The number of years an individual is expected to live without a functional limitation arising from a health-related matter
PREDICTIVE INDICATORS		
Financial Readiness	Pension recipients and average pension amount	
	Recipients of income from work	
	Ability to cope with an unexpected expense	
Active social Lifestyle	Employment rate	
	Rate of people non-voluntarily employed part-time	
	Voluntary activity and individual leisure activity	
Active social lifestyle	Satisfaction with the social network	
	Satisfaction with the relationship with family members and sense of appreciation from them	
	General trust and sense there is someone to rely on	
Healthy Lifestyle	Engageing in light exercise at least once a week	
	Underweight or obesity	
	Summarizing index of health behaviors	
Health management	Self-assessment of health	
	Receiving vaccines	
	Performing tests for early detection of breast cancer (mammography) and colon cancer (occult blood)	
DIGITAL LITERACY		
Using online government services		
Use of the Internet		
Access to a Computer		

According to the Central Bureau of Statistics, processed by the Office of the State Comptroller.

18 Central Bureau of Statistics, "National Indicators for Optimal Ageing in Israel 2022", (November 2024).

In Resolution 127 of July 2021, the government formally adopted the Indicators Map[19] and established, inter alia, the following:

1. The Joint Work Team is required to continue the efforts of the strategic work, within which the necessity of developing new indicators, either supplementary to or as replacements for the previously mentioned indicators, will be assessed; the specific set of complementary indicators to be measured will be elaborated upon; and the necessity of establishing national objectives for optimal ageing will be evaluated.
2. Government ministries, particularly those substantially involved in delivering services to senior citizens, are mandated to orient their actions and intervention methods toward influencing the ageing indicators and mitigating disparities in these indicators among demographic groups.
3. The Central Bureau of Statistics is tasked with publishing a biennial report that delineates the indicators in an international context and in relation to demographic cross-sections, including population groups, age categories, gender, regions within the country, or any other pertinent classification.

Designation of a Responsible Entity for the Promotion of the Indicators

According to the OECD[20], a precise delineation of roles, responsibilities, and competencies constitutes a fundamental component in the provision of person-centered administrative services[21]. Both the OECD and the EU[22] further assert that to guarantee the practical implementation of a strategy, rather than its mere documentation, it is essential to establish clearly defined lines of responsibility[23], among other prerequisites.

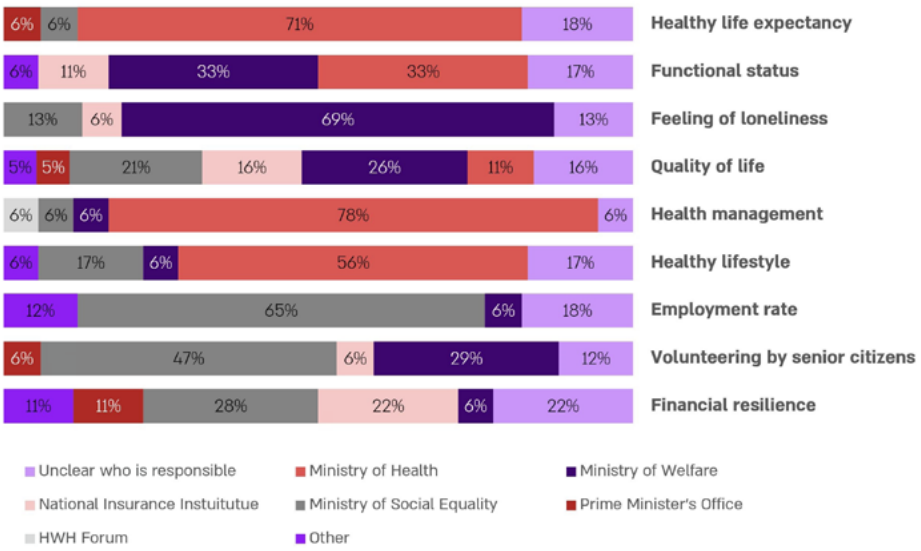
19 Government Resolution 127, "Map of National Indicators for Optimal Ageing", July 19, 2021 (Resolution 127).
20 The OECD (Organization for Economic Cooperation and Development) is an international organization and global policy framework in which governments collaborate to set standards and develop policies to improve economic and social well-being **[link]**.
21 OECD (2025), Government at a Glance 2025, OECD Publishing, Paris.
22 The European Union (EU) is a political-economic organization of 27 European countries, working to promote a common internal market, common policies and legislation in areas such as trade, environment, migration and security **[link]**.
23 OECD, Toolkit for the preparation, implementation, monitoring, reporting and evaluation of public administration reform and sector strategies, Guidance for SIGMA partners, SIGMA PAPER No. 57 (2018).

The audit revealed that neither the Indicator Map nor the 2021 government resolution that adopted the Indicator Map specified the entity responsible for leading each individual indicator and for consolidating all actions undertaken in support of that indicator. This omission persists despite the fact that certain indicators pertain to multiple ministries. The absence of a designated responsible entity for leadership impedes the coordination of actions and the consolidation of accountability for indicator implementation. When multiple ministries simultaneously engage in promoting the same indicator, there is a risk of activity duplication, potentially resulting in resource wastage and inefficiency, or alternatively, ambiguity regarding the entity accountable for the indicator. Moreover, an unclear division of responsibility may cause public confusion concerning the authorized body to contact for information or services, as well as precipitate coordination deficiencies among ministries themselves.

Within the scope of this report, the Office of the State Comptroller approached the headquarters of the government ministries and central bodies addressing population ageing[24] with several standardized inquiries concerning population ageing policy. These inquiries aimed to map the perspectives of professionals in this field for the purpose of gathering structured data (structured data collection). As part of this process, responding officials were requested to answer a series of questions related to the national policy on population ageing. Among other matters, respondents identified which ministry they considered responsible for manageing each indicator within the Indicator Map. The image below presents their responses:

24 The bodies that the audit team contacted as part of the information collection process: the Prime Minister's Office, the Ministry of Social Equality, the Ministry of Welfare and Social Affairs, the Ministry of Health, the National Insurance Institute, the four HMOs, the Federation of Local Authorities, and Joint-ESHEL.

Figure 1: The ministry responsible for each indicator in the Indicators Map, according to the structured data collection[25]



Source: The HWH Forum (Health, Welfare, HMOs) – A joint forum of the National Insurance Institute, the Ministry of Welfare, and the HMOs on the subject of ageing.

Despite the importance of clearly defining responsibility, responses from professional bodies reveal considerable ambiguity regarding the responsible entity in four key indicators: senior citizen volunteering, functional status, economic resilience, and quality of life. In five additional indicators - health management, healthy life expectancy, loneliness, employment rate, and healthy lifestyle - there is broader consensus (exceeding 50%); however, a notable proportion of respondents in all indicators remain uncertain as to which body holds responsibility.

This situation underscores the absence of regulatory clarity concerning the management and consolidation of optimal ageing indicators and highlights the imperative of designating a responsible body for each indicator, given the lack of consensus on the division of responsibility. The absence of clearly defined and mutually agreed-upon authority and accountability for each indicator within the Indicator Map compromises accountability, impedes the establishment of measurable objectives, and complicates coordination among relevant entities. Such deficiencies may result in overlapping initiatives, service gaps, and inconsistencies in both performance monitoring and plan implementation.

25 If more than one answer was given to the indicator, the answer was classified as "unclear who is responsible". Also, in the Senior Citizens Employment Index, the few answers that indicated the Joint were removed (about 5%).

The Ministry of Health stated in its response of May 2026 (the Ministry of Health's response), that it is examining the development and use of a new performance index[26], which examines the level of performance and participation in society, in cooperation with the Joint, the National Insurance Institute and other ministries. In doing so, the Ministry of Health defined the 'Healthy Life Expectancy' index as a super-index and is working tirelessly to promote this matter. The Ministry noted that it is working to promote the topics under its purview, including expanding geriatric services, beds and rehabilitation and hospitalization services, and immunization coverage; it also added that it is setting measurable goals.

It is therefore recommended that the joint working team that formulated the Indicator Map for Optimal Ageing, which included representatives from the Prime Minister's Office, the Ministry of Social Equality, the Ministry of Health, the Ministry of Welfare, and the National Insurance Institute, map all the entities active in relation to each indicator and examine the need to designate a body responsible for each of the indicators in the map. Accordingly, the team should formulate a recommendation to the government for a government resolution, following the July 2021 resolution that adopted the indicators map, which would determine the responsible body for each indicator, in cooperation with all relevant entities. It is further recommended that the resolution define the role of the responsible body, in order to ensure coordination, a clear division of responsibilities, and effective monitoring and evaluation.

26 International Classification of Functioning, Disability and Health Index, ICF.

Establishing Targets for the Indicators of the Indicator Map

Long-term strategic planning encompasses a systematic progression through defined stages: the mapping and analysis of the environment, the articulation of goals and objectives, the formulation of strategic courses of action, the implementation of plans, and, ultimately, the measurement and evaluation of outcomes. The establishment of measurable goals constitutes a fundamental prerequisite for the effective planning of public policy and the informed allocation of resources. In the absence of clearly defined goals, the assessment of whether progress indeed reflects improvement and how such progress aligns with projections or international benchmarks is rendered infeasible[27].

Setting National Goals for the Indicator Map: **In contrast to other strategic frameworks in Israel, the Israeli government adopted the Indicator Map for Population Ageing in Government Resolution 127 without delineating explicit goals. Instead, the responsibility was assigned to the team that formulated the Indicator Map to evaluate the necessity of establishing national goals aimed at promoting optimal ageing**[28].

The audit revealed that the Indicator Map team convened in 2023 and initiated the goal-setting process; however, as of the audit's end date (January 2026), despite the government's resolution and the lapse of approximately four years since the adoption of the Indicator Map, formal goals had not yet been established.

The Prime Minister's Office stated in its response from May 2026 (the Prime Minister's Response) that after the staff work conducted in 2021, it was agreed that at this stage of the process' maturity, desirable trends would be defined and specific targets would not be set. This position was presented to the Ministerial Committee in July 2022, and subsequently, the targets led by the Prime Minister's Office in 2025 were also defined as trends and not as numerical targets.

It is recommended that the team responsible for formulating the Indicator Map complete the process of examining the need to set goals in collaboration with the relevant government ministries, and jointly develop a proposal for a government resolution consistent with the government's July 2021 resolution that adopted the Indicator Map. It is recommended that the proposed framework include national goals for optimal ageing and designate a responsible entity charged with achieving these overarching objectives. The establishment of such goals will facilitate the derivation of subsidiary, interim, and short-term goals, thereby providing a foundation for systematic governmental work planning, prioritization of resource distribution, and evaluation of progress in policy implementation. Furthermore, it is advisable to institute a permanent mechanism for the monitoring, evaluation, and reporting of goal attainment. Such a mechanism would ensure that the government's strategic directives are effectively translated into implementation and produce measurable results over time.

The Ministry of Health stated in its response that there was ongoing work to update and refine the index map within the framework of the government partners' forum, and that it would welcome the passing of a government resolution specifically for the ageing population and the inclusion of the issue in the government's priorities, including an appropriate budget that is commensurate with the

27 Rita Golstein-Galperin and Shai Amit, "The Strategic State 2048: How to Implement Long-Term Strategic Planning in Israel?", the Israel Democracy Institute's Eli Hurwitz Conference on Economy and Society 2025, pp. 19-20.

28 Government Resolution 127, "Map of National Indicators for Optimal Ageing" (July 19, 2021).

projected growth of this population in the coming years.

Formulating Operational and Measurable Goals within Ministry Work Plans: To facilitate the implementation of strategic policy, it is necessary that such policy be translated into operational work plans. The governmental planning guide provides that a ministry work plan shall encompass three tiers: goals[29], objectives[30], and tasks[31]. In conjunction with the goals and objectives, outcome indicators shall be established to delineate the anticipated environmental changes resulting from the implemented actions. The establishment of indicators enables the precise definition of intended achievements and the assessment of actual outcomes. Outcome indicators constitute a systematic and effective instrument for evaluating policy implementation, as well as a mechanism for policy adjustment aimed at enhancing future success[32].

Government Resolution 127 provides that government ministries delivering services to senior citizens shall align their interventions and methodologies with the ageing indicators delineated in the Indicator Map[33]. Due to the absence of explicit goals within the Indicator Map and the lack of designated responsibilities imposed on various ministries for achieving these indicators, ministries were obligated to engage in a systematic strategic planning process. Each ministry was required to develop a work plan examining the indicators pertinent to its operational domains and goals, and identifying strategies to influence these indicators. Furthermore, each ministry was expected to establish measurable goals and to monitor and evaluate their attainment.

The audit revealed that, in the absence of national goals and measurable outcome indicators within the Indicator Map, government ministries addressing ageing-related issues – including the Ministry of Social Equality, the Ministry of Welfare, the Ministry of Health, and the National Insurance Institute – did not establish measurable operational targets for all indicators in the map. Additionally, the ministries' capacity to effect improvements in the indicators was limited, rendering it infeasible to verify whether implemented actions were producing the intended results. Consequently, the formulation of measurable objectives for each indicator constitutes an essential prerequisite for results-oriented management and the continual enhancement of system performance.

The Ministry of Social Equality stated in its response of May 2026 (the Ministry of Social Equality's response) that it mapped its activities according to the key life areas of senior citizens, from a perspective that sees the quality of life of the senior citizen as a measurable and multidimensional goal. This approach would, it claimed, also allow for a direct connection to the index map, setting operational goals, defining clear responsibilities for each area, and enabling ongoing monitoring of progress.

29 The broad achievements that are aimed at. The goals reflect a desired course of action to realize a vision, which takes into account the limitations of reality. At the stage of setting the goals, the focus is on "where we aspire to get to" in all matters concerning the field of activity.

30 The objectives are the intermediate achievements that bring us closer to the goal. The objectives are required to be concrete, measurable and achievable. At the stage of setting the objectives, the focus is on "what we want to achieve", in order to fulfill the goals.

31 The actions that must be taken to achieve the defined goals.

32 The Prime Minister's Office, Government Planning Guide (2010).

33 Government Resolution 127, "Map of National Indicators for Optimal Ageing" (July 19, 2021).

The Office of the State Comptroller points out to the Ministry of Social Equality that although the Indicator Map was formulated in 2021, the Ministry's activities, as indicated by its response, are still in the mapping stages, and do not correspond with the Indicator Map even five years after its formulation.

It is recommended that the joint working team that formulated the Indicator Map examine the need to develop clear, quantitative, and measurable national targets for each of the overarching indicators in the Indicator Map for optimal ageing, and subsequently also for the predictive indicators in the Indicator Map, and submit its recommendation to the government. These targets will serve as an anchor for results-oriented government policy and will enable an effective assessment of the state's progress in preparing for the ageing of the population. It is also recommended that the team examine the need to designate a coordinating body for each of the indicators, to be responsible for achieving the targets, and accordingly formulate a recommendation to the government.

Concurrently, it is recommended that pertinent government entities – including the Ministry of Welfare, the National Insurance Institute and the Ministry of Social Equality – set corresponding secondary objectives for each indicator in accordance with their respective areas of jurisdiction. This process should be conducted with inter-ministerial coordination to guarantee consistency, transparency, and comprehensive monitoring of goal achievement.

The Ministry of Health responded that it concurred with the necessity of establishing clear, measurable objectives to assess success and guide the Ministry's activities. Accordingly, the Ministry has developed a measurement model with targets set for 3, 5, and 10 years concerning the topics delineated in the Indicator Map for optimal ageing, which include incidence of cancer, diabetes, stroke, functional status, health behavior indicators, and obesity. In alignment with these goals, the Ministry of Health formulates policy plans and allocates resources correspondingly.

Is there interaction and coordination between ministries?

Collaboration Among Entities Responsible for Elderly Care

Collaborations constitutes a fundamental prerequisite for establishing a continuum of care and services, for facilitating data-driven planning, and optimizing the allocation of public resources. Numerous issues within public policy necessitate structured collaboration among multiple governmental bodies to achieve effective objectives and outcomes. Such collaborations are particularly important in cross-sectoral matters that impact diverse populations and extensive economic and social processes, exemplified by the issue of population ageing. As previously indicated, the domain of ageing is complex and multidimensional, involving various ministries, which complicates the provision of a comprehensive and coordinated response.

Government Resolution 145 mandates that government ministries implement the strategic directives derived from situation assessments through inter-ministerial cooperation[34], thereby enhancing public services for the elderly and their families. This requirement is similarly emphasized in the Bank of Israel report, which underscores the need to explore methods for augmenting coordination among various community services and institutions to improve service provision to elderly individuals and their families[35]. The Indicator Map further establishes systemicity – particularly the necessity for inter-ministerial and multi-sectoral cooperation – as a guiding principle and framework[36].

Steps Toward Establishing Collaborations

Recognizing the need for multi-system cooperation, inter-ministerial initiatives have been undertaken over several years to promote coordination, implement policy, and enhance service responses.

The Office of the State Comptroller commends the measures enacted to foster cooperation among entities responsible for the ageing population; however, these measures are not mandatory for all ministries, and participation is not universal.

Enhancing Inter-Ministerial Coordination Within the 2025 Government Work Plan: To fortify inter-ministerial coordination and amplify the impact of governmental actions, the Government and Society Division within the Prime Minister's Office initiated an experimental process of joint planning focused on the core issue of optimal ageing in Israel. This pilot project involved the formulation of a unified work plan consolidating key tasks from individual ministry plans pertaining to optimal ageing for 2025. The pilot aims to establish an infrastructure for cross-sector, coordinated planning that links existing plans and objectives, fosters deeper collaboration, and improves the efficiency and effectiveness of intervention measures.

In the course of collecting data from entities addressing population ageing, the audit team examined the positions of ministries involved in the pilot regarding the achievement of its goals – namely joint planning and enhanced inter-ministerial coordination. The gathered information revealed that 35% of respondents were unfamiliar with the joint planning pilot. Among those acquainted with the pilot, 64% reported that it marginally or minimally fosters cooperation and joint planning. Only 18% indicated that it substantially promotes cooperation, and 27% affirmed its role in increasing coordination among ministries.

34 Government Resolution 145, "Adoption of the Strategic Socio-Economic Situation Assessment for the 34th Government", (June 28, 2015).

35 Bank of Israel, Report. 2011, p. 321.

36 The Joint and the Israel Democracy Institute (L. Maman, R. Golstein-Galperin, L. Lisinsky-Fisher, N. Shaked), Indicator Map for Improving the Public Service in Israel (2025). Systemicity is conceptualized as the manner in which the organization or mechanism functions as an integrated whole, characterized by cooperation and information exchange among ministries, collaboration across the entire public sector, and public participation in policy formulation and decision-making processes. Inter-ministerial cooperation is defined as the manner in which the organization or mechanism facilitates information transfer and cooperation with other government ministries, both through formal and informal channels. Multi-sectoral cooperation is defined as the manner in which the organization or mechanism operates with a comprehensive vision and fosters cooperation among all relevant stakeholders within the broader public service.

The Prime Minister's Office indicated in its response that the initiation of an inter-ministerial pilot represents a substantial and innovative measure, establishing a framework for enhancing inter-ministerial coordination and dialogue through a progressive process of maturation and refinement. The pilot's voluntary nature is an inherent aspect of its experimental character, and during its development, additional partners were incorporated in 2026 alongside the inclusion of further tasks. The Office further stated that the outcomes and implications of the pilot would be most appropriately evaluated at a later stage, as part of an ongoing cumulative process of learning and integration.

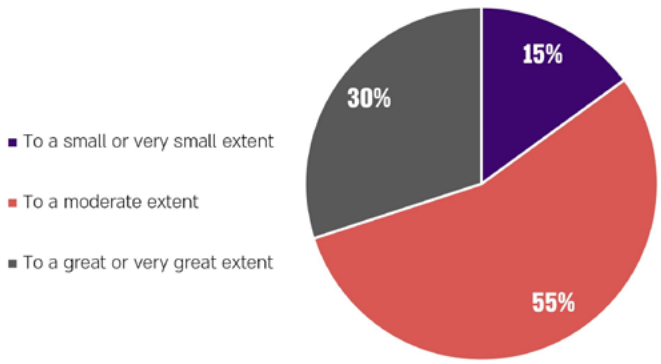
It is recommended that the Government and Society Division of the Prime Minister's Office intensify efforts to raise awareness of the pilot, ensuring all relevant ministry personnel are informed, thereby fostering commitment and meaningful engagement in the collaborative process. Additionally, it is advised that the Prime Minister's Office, as the pilot's administrator, conduct ongoing monitoring of goal attainment throughout the year to evaluate effectiveness and implement necessary adjustments.

Collaboration Among Agencies Responsible for Elderly Care

Numerous entities currently operate within the domain of ageing, frequently functioning in parallel or with overlapping responsibilities, yet lacking comprehensive systemic coordination. This deficiency in coordination engenders a proliferation of uncoordinated initiatives, suboptimal resource utilization, duplication in data collection, challenges in establishing measurable objectives and accountability, as well as difficulties in inter-agency coordination and message unification. Moreover, the presence of multiple service providers may cause confusion among the elderly and their families regarding appropriate points of contact, leading to gaps in treatment and inconsistencies in monitoring and implementation.

As part of the data collection process involving agencies addressing the ageing population, respondents were queried regarding their perceptions of the extent of cooperation among various entities, as well as their primary collaborative engagements. The following image presents their responses.

Figure 2: Responses of agencies addressing population ageing on the degree of inter-agency cooperation



Based on systematic data collection procedures.

The image indicates that approximately 70% of respondents reported that cooperation among agencies dealing with population ageing is moderate or low.

Dedicated Budget for Population Ageing: **The audit further revealed that although various ministries allocate budgets toward elderly care within their respective domains, no unified budget encompassing all relevant ministries exists to comprehensively address the issue of ageing. This absence of a consolidated and dedicated governmental budget for population ageing hinders the provision of systemic and comprehensive interventions, particularly concerning cross-sectoral matters.**

The Budget Division of the Ministry of Finance indicated in its response that, at present, numerous budgets are assigned to the pertinent government ministries to address the challenge of population ageing. It emphasized that the appropriate allocation of existing resources is necessary to attain the desired outcomes. The proper management of resource allocation has the potential to yield the required results for the nation's preparedness in response to the anticipated demographic transition.

The Office of the State Comptroller points out that one potential solution to this issue, as will be elaborated upon subsequently, is the formulation of a multi-year plan for preparing for population ageing. This plan would establish a dedicated budget for addressing the matter, along with the determination of each ministry's respective share of the budget.

Information Transfer Among Agencies for Decision-Making, Service Provision, Planning, and Elderly Rights Enforcement: The transfer of information among public agencies constitutes a critical element in the development and implementation of effective public policies, especially in the context of enhancing citizen services. Government resolutions, the Protection of Privacy Law[37], reports by the Privacy Protection Authority[38], and guidelines from the Deputy Attorney General[39] underscore the necessity of regulating information transfer in an orderly and secure manner, establishing procedures for inter-agency data exchange.

Findings demonstrate that 90% of respondents involved in the structured information mapping exercise (including the Ministry of Social Equality, Ministry of Welfare, Ministry of Health, the National Insurance Institute, the Prime Minister's Office, and the HMOs) believe that information and data exchange occurs insufficiently; 55% reported that such transfer occurs to a limited or very limited extent, while an additional 35% indicated it takes place to a moderate extent. Consequently, despite widespread recognition of the importance of exchanging information about citizens, inter-ministerial data transfer remains inadequate to fully capitalize on the benefits of information sharing, thereby impairing the capacity for effective planning and service provision.

37 The Protection of Privacy Law, 1981.
38 The Privacy Protection Authority, "Transfer of Information Between Public Bodies".
39 Directive of the Deputy Attorney General on the Transfer of Information Between Public Bodies (March 16, 2006).

An Overarching and Coordinating Agency for Optimal Ageing

The implementation of national policy necessitates whole-of-government coordination and a unified strategic vision[40]. The World Health Organization and the United Nations have established that optimal ageing requires leadership and coordination across multiple sectors, including health, welfare, employment, community, planning, and living environments, within the framework of multi-stakeholder collaborations[41]. The United Nations Economic Commission for Europe (UNECE) underscores that coordinated action among government ministries enhances the adaptation of services and reduces fragmentation[42].

Ageing constitutes a domain influenced by numerous factors; to effectively lead related processes, an integrating entity is essential to ensure coordination and cooperation among all stakeholders.

It was found that although optimal ageing demands collaboration across diverse sectors such as health, welfare, and employment, Israel lacks a central authority responsible for leading national policy in this area. In contrast to other systemic domains, such as climate policy or minority sector development, where there are dedicated bodies for planning and integration, the issue of ageing remains without an overarching authority or a systematic strategy. This absence results in suboptimal resource utilization and policy inconsistency, and diminishes the state's capacity to adequately prepare for an ageing population.

It is therefore recommended that the ministries involved in matters relating to ageing, including the Ministry of Social Equality, the Ministry of Welfare, the Ministry of Health, and the National Insurance Institute, under the leadership of the Prime Minister's Office, enact a governmental resolution to designate an overarching body endowed with the requisite responsibilities, coordination, and supervisory powers. Additionally, the establishment of a permanent mechanism for monitoring and evaluating integration activities is advised to guarantee the effective and continuous implementation of policies that benefit senior citizens.

The following summarizes the responses of various stakeholders concerning inclusiveness in the domain of population ageing:

1. The Prime Minister's Office stated that the definition of an integrating body entails policy considerations, including the prioritization of areas of responsibility and allocation of resources. Accordingly, it will evaluate the advantages of establishing an integrating body alongside alternative mechanisms for joint coordination and collaboration, while carefully examining pertinent considerations.

40 OECD, "whole-of -government development co-operation", (2022) [link]; OECD, "Government at a Glance 2025", (June 19, 2025)
41 UN Decade of Healthy Ageing: Plan of Action 2021-2030, page 23.
42 **[link]**.

2. The Ministry of Finance, in its response dated May 2026 (the Ministry of Finance's response), noted the challenges in promoting significant initiatives within this field due to the involvement of numerous actors. The Ministry emphasized the necessity of reducing the separation in the sector and the number of parties engaged therein, recommending the establishment of a singular integrating body charged with ongoing oversight of the issue.
3. The National Insurance Institute, in its response of May 2026 (the NII's response), expressed concurrence with the audit's recommendation advocating for one integrating body. Furthermore, it asserted that, at present, the 'Brak' (Health, Welfare, HMOs) Forum represents the most effective practical mechanism for integration.
4. The Ministry of Welfare, in its May 2026 response (the Ministry of Welfare's response), asserted that the ageing domain necessitates an integrating governmental entity possessing nationwide reach, professional infrastructure, implementation capabilities, supervisory mechanisms, and direct engagement with local authorities and communities. The Ministry further stated that, given its organizational structure and expertise, it is suitably positioned to assume responsibility for this sector at the national level, contingent upon adjustments to authorities, coordination mechanisms, and requisite resources.

Conversely, the Ministry of Health stated in its response that, due to the multifaceted nature of the issue – characterized by numerous stakeholders with distinct and sometimes overlapping jurisdictions – it is not always appropriate or feasible to designate a single responsible entity. The Ministry acknowledged the potential utility of an overarching body to consolidate information, receive reports from various entities, and facilitate coordination among partners. Additionally, it emphasized the importance of differentiating between integration and executive responsibility, noting that previous experience demonstrates that appointing a nominally integrating or responsible body without substantive authority may prove ineffective and constrain its capacity to effect practical change.

The Ministry of Social Equality noted in its response that addressing the issue of ageing surpasses the purview of any single ministry and necessitates the establishment of a permanent mechanism for inter-ministerial cooperation.

In summary, the responses to the audit findings reveal that the Prime Minister's Office, Ministry of Finance, the NII, and Ministry of Welfare concur on the necessity and importance of designating an integrating body to address population ageing, with some ministries expressing readiness to assume this role. In contrast, the Ministry of Health and Ministry of Social Equality raised additional considerations warranting attention in this process. Accordingly, the Office of the State Comptroller recommends that government ministries hold joint discussions to define an integrating body for population ageing and subsequently promote a proposal for decision-makers to regulate this domain.

Multi-annual plans constitute an important instrument through which the Israeli government advances complex socio-economic policies over time, utilizing binding governmental resolutions, allocated budgets, and inter-ministerial coordination. These plans provide stability, a clear division of responsibilities, measurable objectives, and the capacity to implement large-scale measures systematically. In the field of ageing, no multi-year plan has been formulated. Accordingly, the formulation of a multi-year national plan for population ageing is recommended, to institutionalize necessary responsibilities, budgeting, collaboration, and oversight.

The Prime Minister's Office indicated in its response that the recommendation to develop a multi-year national plan addressing population ageing pertains to the determination of overarching government policy and national priorities, which fall within the government's jurisdiction. Consequently, the Office will undertake a study of the recommendations.

The Ministry of Finance stated in its response that it recognized the significant importance of formulating and implementing a national policy on ageing, which would, among other elements, establish a comprehensive framework for the issue and ensure the appropriate allocation of existing resources, thereby achieving the necessary outcomes for the nation's preparedness for the anticipated demographic changes.

The Ministry of Welfare expressed agreement with the audit report's recommendation and proposed to consider the development of an updated government resolution regarding ageing. This resolution would establish a clear division of responsibilities, inter-ministerial coordination mechanisms, measurable objectives, budgetary sources, and effective implementation instruments.

The Ministry of Labor, in its response, emphasized the importance of formulating a multi-year plan delineating the areas of responsibility assigned to the Ministry and identifying an integrative factor. Additionally, it asserted that the Ministry of Labor should serve as the integrative factor specifically within the employment domain.

Leumit HMO, in its response dated May 2026, concurred with the assessment that a disparity exists between the national acknowledgment of the challenges posed by population ageing and the actual execution of multi-year operational plans encompassing measurable goals, resource allocation, and a clear allocation of responsibility. A policy designed to address this gap would also incentivize HMOs to compete for the elderly market segment.

Summary

This chapter examines the extent to which participating countries have developed comprehensive governmental plans and governance arrangements to address the challenges of population ageing. Based on the national audit reports, the following section presents a comparative overview of the countries' responses to the audit questions, highlighting whether comprehensive plans exist, what policy areas they cover, how coordination is structured, and whether good practices or implementation gaps were identified.

Tables 1-7: Audit Questions and Findings by Country

Table 1: Is there a comprehensive plan?

Albania	Republic of North Macedonia	Republic of Paraguay	Portugal	Slovak Republic	Israel
No. Ageing issues are addressed through separate sectoral strategies.	Yes. A new National Development Strategy (2024–2044) was recently adopted.	Yes (Nominally). A National Policy exists, but it lacks short/long-term goals and an approved Action Plan.	Yes. The Action Plan for Active and Healthy Ageing 2023–2026 (APAHA).	Yes. The National Active Ageing Program (NAAP) 2021–2030 is in place.	Yes (Nominally). There are two main national plans, but they remain at a declarative level and are not fully integrated or implemented across government ministries.

Table 2: What areas does the plan cover?

Albania	Republic of North Macedonia	Republic of Paraguay	Portugal	Slovak Republic	Israel
Employment, social protection, youth, active ageing, and migration.	Social protection, deinstitution-alization, and demographic policies.	Protection of rights, social welfare, health, and economic services.	Health and well-being, autonomy and independent living, lifelong development and learning, healthy working life throughout the life course, income and economics of ageing, and participation in society.	Active ageing, human resources, health, economic activity, social participation, income security, dignity and independence.	Health. Long term care, employment, pensions, loneliness, quality of life.

Table 3: Is there an integrative policy or separate sectorial plans by ministries?

Albania	Republic of North Macedonia	Republic of Paraguay	Portugal	Slovak Republic	Israel
Sector-based but integrated within broader strategies like the NSDI.	Highly centralized but consists of fragmented and overlapping sectoral documents.	Segmented. Implementation is fragmented and lacks standardized procedures.	Integrative. APAHA is an integrated cross-sectoral plan, but it does not replace existing sectoral plans or strategies. Portugal has an integrative policy alongside existing sectoral plans.	Integrative. The NAAP serves as the central policy framework for all ministries in support of active ageing.	Segmented. The plan is integrative but implementation is fragmented.

Table 4: Is there interaction and coordination between ministries?

Albania	Republic of North Macedonia	Republic of Paraguay	Portugal	Slovak Republic	Israel
Partially. Formal mechanisms exist but do not ensure consistent or effective cooperation.	Partially. Coordination bodies were often never established or remained non-operational.	Non-operational. The Senior Citizens' Liaison Committee did not function during the audit.	Partially. The plan was prepared under the joint coordination of the Ministry of Labour, Solidarity and Social Security and the Ministry of Health. However, interinstitutional coordination mechanisms were not sufficiently structured or documented.	Partially. An inter-ministerial working group and consultation processes are established. However, their impact on the promotion of active ageing is not sufficiently visible.	Partially. The interactions that exist are sporadic and not well coordinated.

Table 5: Is there a central body coordinating all plans?

Albania	Republic of North Macedonia	Republic of Paraguay	Portugal	Slovak Republic	Israel
No dedicated body; coordination occurs via the Integrated Policy Management Group.	Yes. The Ministry of Social Policy, Demography and Youth leads, but lacks analytical capacity.	Yes. The Ministry of Public Health and Social Welfare (MSPBS) is the governing body.	Partially. APAHA provides for a National Coordinator and an Advisory Council. However, the coordinator has no decision-making authority and the Advisory Council has not been established.	Yes. The Ministry of Labour, Social Affairs and Family (MoLSAF).	No. In practice, there is no single body responsible for coordinating the entire field of ageing.

Table 6: Is population ageing addressed within broader national plans?

Albania	Republic of North Macedonia	Republic of Paraguay	Portugal	Slovak Republic
Yes. Addressed indirectly via employment, migration, and youth strategies.	Yes. Integrated into the existential challenges of the new National Development Strategy.	No. Lacks an approved plan to address future needs within broader national trends.	Yes. Population ageing is addressed through APAHA, a broader National Strategy for Longevity is being developed.	Yes. Part of Vision 2030, the Recovery and Resilience Plan, the Partnership Agreement 2021–2027, Lifelong Learning strategies and etc.

Table 7: Examples of good practices

Albania	Republic of North Macedonia	Republic of Paraguay	Portugal	Slovak Republic	Israel
Digital improvements in employment and tax breaks for families with children.	The new NDS (2024–2044) includes measurable indicators and estimated costs.	The Ministry of Public Health and Social Welfare (MSPBS) developed new care manuals; provided training to community agents, health personnel from various health regions, and caregivers; promoted the Health Club for active ageing; and provided outpatient medical care services to adult patients.	The preparation of APAHA benefited from contributions from a range of actors, including academia and the social sector. The national coordinator established direct and effective collaboration with municipalities and intermunicipal bodies	Universities of the Third Age, digital literacy for seniors, and active labour market projects, The Government Council for the Rights of Seniors as a permanent expert and advisory body in the area of population ageing.	Gradual rise in retirement age. The National Indicators of optimal ageing.

The joint audit reveals a significant gap between declarative national policies and the actual implementation of services for ageing populations. While some countries have established integrative frameworks like the National Active Ageing Program (NAAP) in Slovak Republic or The Action Plan for Active and Healthy Ageing in Portugal, others, suffer from strategic fragmentation where ageing issues are scattered across multiple overlapping sectoral plans. Even when comprehensive policies exist on paper, they often lack approved action plans, measurable goals, or clear designations of responsibility, leaving the strategies at a merely declarative level. This lack of a unified approach leads to a duplication of efforts and an inability to address the multidimensional needs of the elderly in a coherent manner.

Governance and financial instability represent the most critical barriers to effective policy execution. Across almost all audited nations, coordination bodies intended to align inter-ministerial efforts were either never established, remained non-operational, or were severely understaffed. Furthermore, the absence of dedicated, guaranteed budgets is a recurring risk; programs frequently rely on inconsistent state budget chapters or external EU funds without specific allocations for ageing-related measures. This fiscal uncertainty, combined with low budget execution rates, directly compromises the sustainability of long-term care and the achievement of measurable indicators.

Designated funding is required to address these systemic weaknesses. It is therefore recommended that governments move toward financial security by establishing separate, multi-year budgets specifically for ageing programs. This would involve moving away from general sectoral funding and creating a system to monitor expenditures per measure to ensure that resources are actually reaching the elderly population. Additionally, institutional governance must be strengthened by activating and staffing central coordinating bodies with the legal authority to enforce inter-ministerial cooperation and monitor the implementation of the policy and its impact.

Preparing the Health System for an Ageing Population: Community-Based Health Care

Introduction

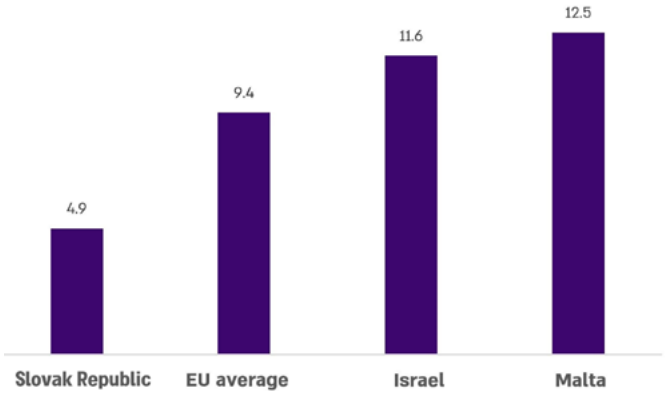
Population ageing constitutes a primary demographic, social, and economic challenge confronting health and welfare systems in numerous countries, particularly those within the OECD. The rise in life expectancy, coupled with declining birth rates in certain nations, has resulted in a continuous increase in the population of older persons and their proportional representation within the overall population. This trend is anticipated to intensify over the coming decades, exerting a direct influence on the demand for health, nursing, and social services, particularly those delivered within community settings and the living environments of the elderly.

In most countries, the elderly population accounts for a disproportionately high consumption of health and hospitalization services, attributable to the elevated prevalence of chronic diseases, increased morbidity, functional decline, and the necessity for ongoing monitoring and treatment. Concurrently, institutional inpatient systems, including hospitals and nursing homes, are subject to structural constraints related to staffing, infrastructure, and the availability of hospital beds, alongside escalating costs.

Healthspan refers to the duration of life characterized by good health, free from chronic disease and the limitations typically associated with old age[1]; in other words, it denotes the expected years of life lived in good health relative to the total life expectancy of an individual[2]. Some researchers contend that the increase in life expectancy may decelerate over time, emphasizing that efforts should prioritize the extension of the healthspan[3]. The figure below presents data on the healthspan at age 65 for the countries featured in this chapter – Malta, Slovak Republic, and Israel.

1 Matt Kaeberlein, "How healthy is the healthspan concept?", GeroScience 40 (2018), pp. 361-36.
2 The Israeli Ministry of Health, "Years of Life in Good Health" (no publication date specified).
3 S. Jay Olshansky, "From lifespan to Healthspan", Scientific Discovery and the Future of Medicine (2018), pp. E1 - E2.

Figure 1: Healthspan at Age 65 for Men and Women in Malta, Slovak Republic, and Israel, 2023



According to data from Eurostat[4] and the CBS[5], processed by the Israeli Office of the State Comptroller.

The figure shows that the healthspan in Slovak Republic (4.9 years) is below the average healthspan observed in European countries (9.4 years), whereas in Malta (12.5 years) and in Israel (11.6 years) it is above.

In this context, community health services – including medical and clinical care provided in patients' own homes, nursing services delivered within the living environments of the elderly, and supportive social services – are increasingly recognized as either an alternative or a necessary complement to institutional hospitalization. These services are considered instrumental in enhancing the continuity of care, quality of life, and systemic efficiency.

The shift from an institutional model to a community-based model represents not only an organizational transformation but also a change in perception and policy. This transition necessitates coordination among multiple stakeholders, including government ministries, local authorities, public and private service providers, health insurance systems, and regulatory agencies. Furthermore, it requires strategic planning, allocation of dedicated resources, the cultivation of skilled personnel, establishment of reliable information systems, and the implementation of monitoring and evaluation mechanisms capable of assessing the scope, quality, and compliance of services with established targets.

4 Eurostat, Healthy life years at age 65 for men and women **[link]**.
5 The Central Bureau of Statistics, Life Expectancy and Healthy Life Years (2024).

In light of these challenges, the present international audit focuses on assessing how the participating countries – Malta, Slovak Republic, and Israel – are preparing to deliver health and community support services to their elderly demographic and whether these systems are adequately equipped to address the anticipated increase in demand[6]. The integrated chapter synthesizes findings from the three participating countries, which differ in terms of health system structure, financing models, and distribution of responsibilities, yet confront comparable challenges stemming from population ageing.

The Healthcare System for the Elderly in the Participating Countries

The healthcare systems responsible for delivering healthcare services to the elderly population in each of the participating countries are delineated below.

Healthcare Services for the Elderly in Malta

The Maltese national health system serves a population of around half a million inhabitants. It is a tax-based system which provides universal health access to all citizens and residents covered by the social security legislation. The system is mixed, with the private sector playing a complementary role in service provision, but the Ministry for Health and Active Ageing (MHAA) is the main actor responsible for the governance, regulation, provision and standards of health services.

Health planning, including resource allocation and procurement, is primarily managed by the MHAA, while capital projects fall under the remit of the Foundation for Medical Services. The National Health Systems Strategy 2023-2030 (Government of Malta, 2022)[7], together with other national public health strategies, provide direction, setting out the main planning priorities in relation to projected population needs. The National Health Systems Strategy has recently been updated and extended to 2033 to reflect changing priorities and needs (Government of Malta, 2024)[8]. Although there are no specific health plans at regional or local levels, the involvement of local government in primary health and community care has increased[9].

Health services are mainly provided by the state and the private sector, with some complementary roles played by voluntary and religious organizations in long-term and chronic care provision.

6 The international parallel audit was scoped to cover home-based medical and clinical services. However, it does not imply that this is the full extent of community-based services in Malta, as a well-developed range of such services is also provided through regional health centers. These are also supported by a range of non-medical and non-clinical support services which are intended to assist elderly persons to live at home for as long as possible.

7 Government of Malta (2022). A National Health Systems Strategy for Malta 2023–2030. Valletta: Government of Malta **[link]**.

8 Government of Malta (2024). A National Health Systems Strategy for Malta 2023–2033. September 2024. Valletta: Government of Malta **[link]**.

9 Azzopardi-Muscat N, Buttigieg S, Calleja N, Merkur S, Forman R, Mauer N, Bezzina A, Grech K, Vincenti K. Malta: Health System Summary, 2024. Copenhagen: European Observatory on Health Systems and Policies, WHO Regional Office for Europe; 2025. Licence: CC BY-NC-SA 3.0 IGO.

The state, which delivers primary care and most secondary and tertiary care, provides access to a comprehensive basket of health services free at the point of access.

Healthcare Services for the Elderly in Slovak Republic

From a legislative perspective, the provision of healthcare and social services is governed by several laws that define patient rights, provider obligations, as well as the system of financing and organization of services (Act No. 576/2004 Coll. on healthcare and services related to the provision of healthcare; Act No. 578/2004 Coll. on healthcare providers, healthcare professionals, and professional organizations in healthcare). Particular importance is attached to Act No. 448/2008 Coll. on social services, which regulates the provision of community-based services and promotes the development of care in the natural environment of clients.

Service provision is ensured by a wide range of entities, including public institutions, local governments, higher territorial units, as well as private and non-profit organizations. The system is characterized by a division of competencies between the healthcare and social sectors, with local governments playing a key role particularly in providing community and residential social services.

The main providers of health and social services for older people in Slovak Republic are public institutions, local governments, private providers, and non-profit organizations. The system is divided between healthcare and social care. An overview of services for older people in Slovak Republic includes healthcare, long-term nursing care, social services, and community support.

Institutional healthcare is provided mainly in hospitals, long-term care facilities, and specialized institutions. These facilities ensure care for patients with serious or chronic health conditions, including palliative and hospice care.

Table 1: Overview of Hospitalizations in Healthcare Facilities

Year	Number of hospitalizations by age group			
	65–74 years	75–84 years	85+ years	Population as of 31 Dec
2020	190,078	129,454	46,381	5,459,781
2021	183,653	119,732	42,217	5,434,712
2022	199,206	131,225	45,675	5,428,792
2023	217,040	145,814	47,506	5,424,687
2024	222,760	154,035	50,336	5,419,451

Source: National Health Information Center

Within outpatient healthcare, older people most commonly use the services of general practitioners, specialists, and home nursing care services. The aim is to prevent diseases, ensure early diagnosis and treatment, and support their independence in their natural environment.

Table 2: Number of Persons Treated by Home Nursing Care Agencies

Year	Number of persons aged 60+	Population as of 31 Dec
2020	48,004	5,459,781
2021	50,615	5,434,712
2022	53,897	5,428,792
2023	55,534	5,424,687
2024	59,486	5,419,451

Source: National Health Information Center

Long-term and nursing care play a significant role, as they bridge the healthcare and social systems. This care is provided both in the home environment and in residential facilities, including facilities for older people and specialized institutions. Social service facilities are obliged to ensure nursing care either through their own staff or via home nursing care agencies. The growing importance of nursing care as a component of comprehensive care for older people is also reflected in the increasing number of recipients.

Table 3: Number of Recipients of Nursing Care in Social Service Facilities for Persons Dependent on Assistance

Indicator	2022	2023	2024
Total number of recipients of nursing care in social service facilities	29,759	31,600	31,654
Recipients of nursing care in facilities for seniors	14,594	15,460	15,373
Population as of 31 Dec	5,428,792	5,424,687	5,419,451

Source: Processed by the Supreme Audit Office (SAO SR) based on data from the ministry Ministry of Labor, Social Affairs and Family of the Slovak Republic.

Healthcare Services for the Elderly in Israel

The State Health Insurance Law, 5754-1994[10] (the Health Insurance Law or the Law), provides that every resident of the State of Israel is entitled to receive health services according to the basket of services established by Law, through one of the four HMOs[11] of their choice. The health services basket functions as a system that ensures equitable access to services for all residents through all HMOs[12]. These HMOs are public-statutory entities that operate both as insurers and as service providers within the insured community, funded publicly and subject to government supervision.

In 2025, among an estimated population of 10.2 million residents in Israel, the number of elderly[13] members registered with the four HMOs approximated 1.3 million, constituting roughly 13% of the total membership of these HMOs, as indicated in the distribution presented in the accompanying figures below:

Figure 2: Proportion of elderly HMO members out of all members of each HMO, 2025 (in percentages and numbers)

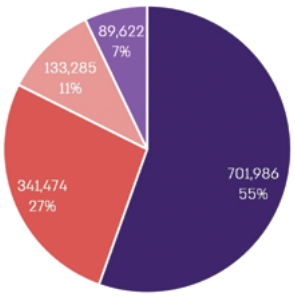
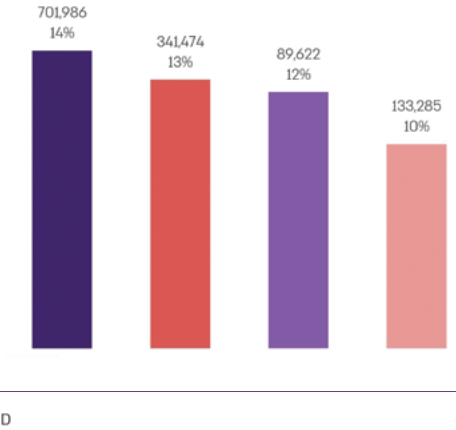


Figure 3: Number of elderly members of each HMO and their proportion of all elderly people, 2025 (in percentages and numbers)



According to the National Insurance Institute data, processed by the Office of the State Comptroller.

10 The National Health Insurance Law, 5754-1994.
11 Health Management Organization.
12 The National Health Insurance Law, 5754-1994, Section 1.
13 The Central Bureau of Statistics, Israel's population at the beginning of 2026.

The figures show that more than half of the HMO members aged 65 and over are affiliated with HMO A, approximately one-quarter are associated with HMO B, and the remainder belong to HMOs C and D. The data further reveal variations among the HMOs in the proportion of elderly members relative to the total membership. This is evidenced by the proportion of elderly members in HMO A (14%), which is 40% higher than that in HMO D (10%), with HMOs B and C falling between these values (13% and 12%, respectively). Such disparities may influence the burden level, medical needs, financial expenditures, and planning requirements for each HMO.

Hospitalization is indicated when a patient's medical condition necessitates continuous medical supervision, advanced diagnostics, intensive treatment, or medical interventions that cannot be administered within the community setting. Hospitalization services are included within the health services basket.

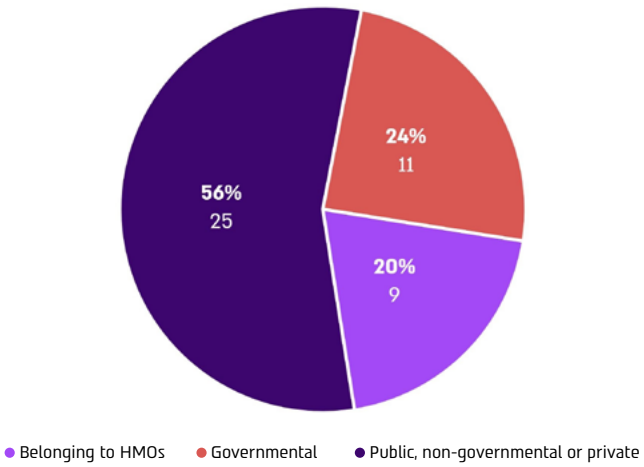
Hospitals are categorized into three primary groups: general inpatient hospitals, mental health hospitals, and hospitals treating chronic illness and rehabilitation.

The general inpatient system in Israel, the focus of this chapter, comprises a network of general hospitals providing acute inpatient services across various medical specialties, including internal medicine, surgery, obstetrics, and pediatrics.

These hospitals operate within a public framework but are classified into several principal types based on ownership and management: government hospitals, fully owned by the state and managed by the Ministry of Health; non-government public hospitals, including facilities owned and managed by HMOs – primarily those to which most insured individuals belong – as well as hospitals operated by local authorities or public associations; and private hospitals, which function on a for-profit basis, predominantly offering elective medical services while remaining subject to oversight by the Ministry of Health. The Ministry of Health serves as the regulatory authority, establishing standards for healthcare professionals, hospital bed allocation, quality and safety protocols, and the monitoring of service quality in hospitals.

The figure below presents the number of general hospitals and their proportional distribution by ownership:

Figure 4: Number of general hospitals and their proportion, by ownership, 2025 (in numbers and percentages)



According to the Ministry of Health data, processed by the Office of the State Comptroller[14].

The figure shows that most hospitals (56%) are public, non-governmental or private, about a quarter are governmental, and about a fifth belong to the HMOs.

14 The Ministry of Health website.

Audit Questions

The key audit questions that formed the basis of the national reports of the participating countries, and which serve as the basis for this chapter, are presented in the following table:

Table 4: Audit Questions and the Countries Addressing Them

The Audit Question	Countries Addressing It[15]
Is the concept of home-based medical services for the elderly a clear and independently recognized function within government's strategic objectives?	Malta Slovak Republic
Are sufficient budgets being allocated for these services?	Malta Slovak Republic Israel
Are sufficient human resources being allocated for these services?	Malta Slovak Republic
Are these services developed and are there any plans for the future?	Malta Slovak Republic Israel

By conducting a comparative analysis across countries, this chapter identifies shared patterns, gaps, and systemic risks, as well as country-specific deficiencies and recommendations. Additionally, it delineates directions for action and principles that may facilitate the enhancement of health services and community care for the elderly, thereby supporting optimal preparation for population ageing over the long term.

15 Each country chose which audit questions to address, according to the context in which the issue is handled in that country and the structure of the system responsible for addressing it.

Malta

Performance Audit: Home-Based Medical and Clinical Services for the Elderly

Summary Report

This is a summary of the NAO Malta Performance Audit report titled 'Home-Based Medical and Clinical Services for the Elderly'. The full National Report can be accessed through the NAO Malta website **[link]**.

Introduction

SAI Profile

The National Audit Office (NAO) is the Supreme Audit Institution of Malta and operates independently of Government through Constitutional and legislative provisions. The NAO follows the Westminster SAI model and conducts financial, compliance, performance, investigative and Information Technology (IT) audits, and reports directly to the House of Representatives on the economy, efficiency and effectiveness with which public resources are used.

In terms of parliamentary oversight, the Auditor General (or his Deputy) presents every report to the Speaker of the House of Representatives. The Speaker lays the document "on the Table" at the very next sitting, at which point it becomes an official parliamentary document.

This audit was carried out as a performance audit, in line with Standards for Performance Auditing, International Standards of Supreme Audit Institutions (ISSAI) 3000.

Overview of Home-Based Medical and Clinical Services for the Elderly in Malta

The Maltese national health system serves a population of around half a million inhabitants. It is a tax-based system which provides free universal health access to all citizens and residents covered by the social security legislation. The system is mixed, with the private sector playing a complementary role in service provision, but the Ministry for Health and Active Ageing (MHAA) is the main entity responsible for the governance, regulation, provision and standards of health services.

NAO Malta focused this performance audit on the provision of medical and clinical services by the Maltese Government to elderly[1] persons, defined for the purposes of this audit as individuals aged 60 and over, residing in their own private homes. In line with the agreed parameters of this international parallel audit, this review focuses on services delivered within the patient's private residence and excludes services provided in community clinics, health centres, and long-term residential care facilities.

All information presented in this report covers the period 2019–2024.

The distinction between *medical* and *clinical* services within this audit follows definitions established in consultation with the involved stakeholders. A medical service is defined as one which sets health-care management plans and is initiated by a warranted health care professional, while clinical services are defined as those which fulfil a prescription or a health-care management plan, and which can be administered by either warranted or unwarranted healthcare personnel. This conceptual distinction underpins the mapping, analysis, and assessment undertaken throughout this report.

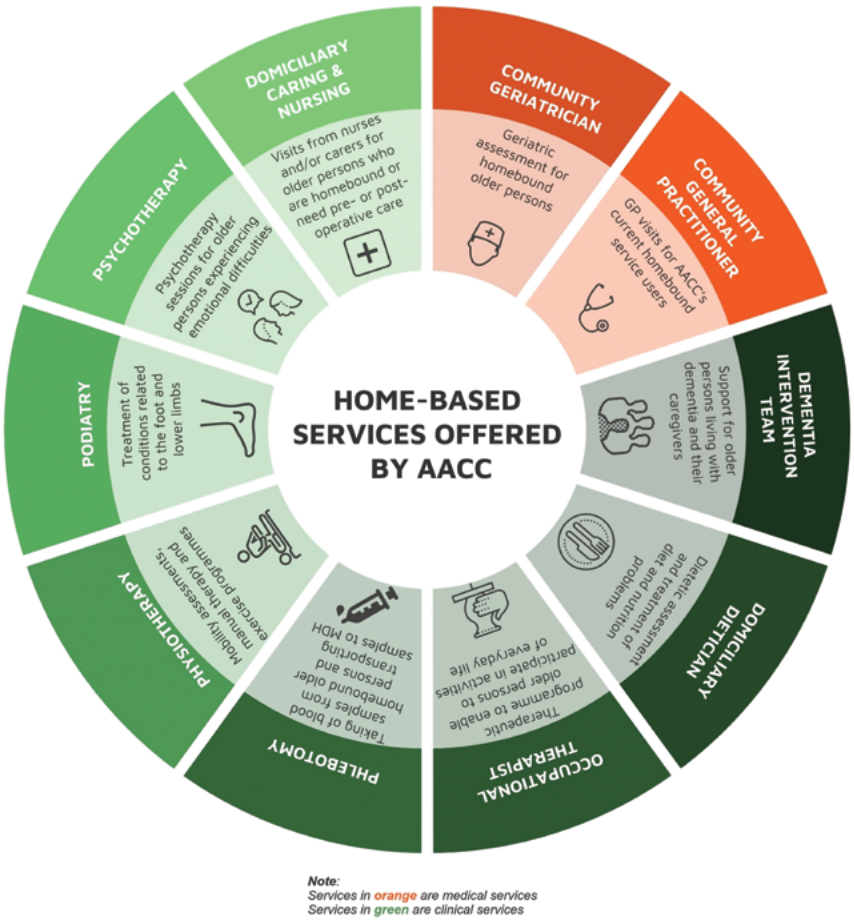
Through a rigorous mapping exercise, the NAO found that in Malta the State provides a well-developed range of free home-based medical and clinical services to individuals aged 60+, under the remit of the MHAA. These services are not delivered through a single programme or authority, but through a dispersion of six[2] different government entities, namely, Active Ageing and Community Care (AACC), Gozo General Hospital (GGH), Mater Dei Hospital (MDH), Sir Anthony Mamo Oncology Centre (SAMOC) – within MDH, Mental Health Services (MHS), and Primary Health Care (PHC). As presented in Figures 1 and 2 below, these entities provide a total of 29 home-based clinical and medical services for the elderly.

The services offered by AACC are focused on providing non-acute care to elderly persons living in the community. AACC's objective is to assist, in particular, elderly individuals to continue contributing to the economy and society (where feasible), as well as to create a support structure with which an ageing individual can delay (or better still, altogether avoid) admittance to elderly residential homes. AACC therefore plays a central role in the provision of home-based services, including those of a medical or clinical nature, to older adults. Most AACC home-based services require an application supported by a medical report from the applicant's GP or consultant, submitted online or by post, with additional evidence where necessary. Figure 1 presents the range of home-based medical and clinical services provided by AACC.

1 For the purposes of this review, NAO resolved to attribute age as the sole qualifier for an individual to be classified as elderly. In line with the eligibility criteria used by the Department of Active Ageing and Community Care, the main provider of services for the elderly, NAO classified individuals aged 60 years and over as elderly to filter out data relating to the elderly from that pertaining to the whole population.

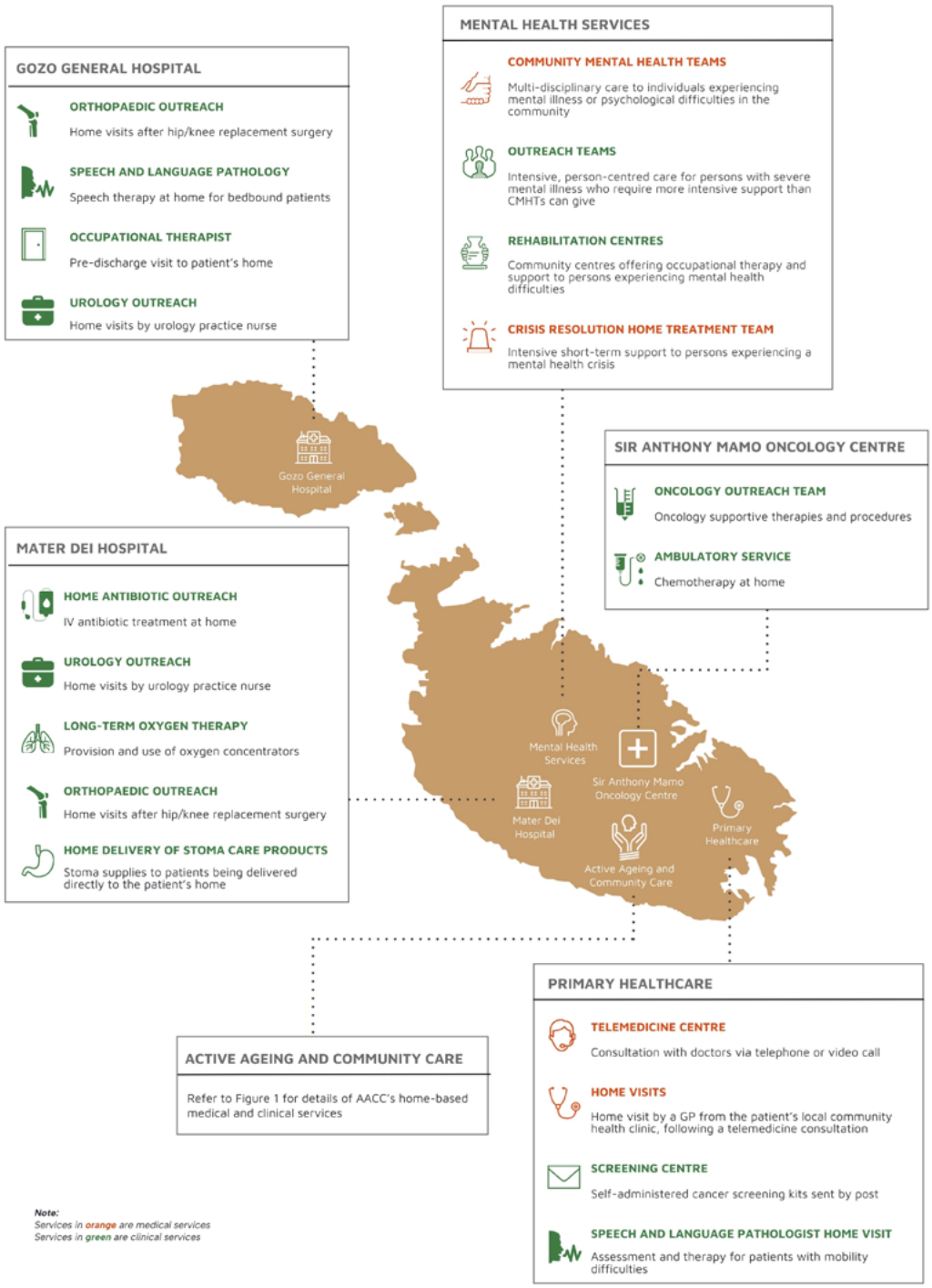
2 While the Directorate of Allied Health Services (DAHS) does not provide services directly to the scoped population cohort, it co-ordinates all allied health professionals providing services in government entities (including in some of the abovementioned entities).

Figure 1: Home-based medical and clinical services offered by AACC



A wide array of home-based medical and clinical services is also delivered by other government entities (refer to Figure 2). Eligibility for these services is generally not age-dependent but is instead based solely on clinical need. Subsequently, unlike AACC services, access to the services provided by the other entities within the scope of this review does not, unless otherwise stated, require the submission of an application form.

Figure 2: Home-based medical and clinical services offered by entities other than AACC



Responses to Audit Set Questions

Recognition of medical and clinical services as a distinct government function/priority

The importance of home-based services is acknowledged in Malta's related national strategies, but these do not lay out clear paths and actionable goals in this regard. Home-based medical and clinical services cannot be considered as a distinct government function.

The audit team referred to relevant national health and active ageing strategies to evaluate planned future integration or cooperation between services and to assess whether these documents set out any future development of the services under review. Four separate strategies were identified and reviewed, namely:

1. A National Health Systems Strategy for Malta (2023-2030);
2. National Strategic Policy for Active Ageing (2023-2030);
3. National Dementia Strategy for the Maltese Islands (2024-2031); and
4. A Mental Health Strategy for Malta (2020-2030).

Through this review NAO noted that, in all these strategies the scoped services were only mentioned peripherally (to varying extents), and that no measurable objectives and specific timeframes for their implementation could be found.

NAO Observation

While the NAO is of the opinion that the range of services as presented in the Introduction is broad and well developed, it is nonetheless concerned that these were only given peripheral attention in the reviewed strategies. The NAO is of the opinion that the further development of services such as those scoped in this audit is hindered if objectives and timeframes set in national strategies are not laid out in an actionable and measurable manner, even if these would intrinsically be high-level. This is also true with regard to securing better coordination between involved entities particularly in view of the decentralised provision of these services.

NAO Recommendations

When considering the stated importance of home-based medical and clinical services for the elderly (together with their probable future demand increase) against the fact that these were only peripherally mentioned in the reviewed national strategies, NAO feels that MHAA may wish to consider developing a specific strategy for these. Should the Ministry choose to adopt this recommendation, this Office suggests that such a strategy could either bring together and encapsulate these services into one distinct and consolidated concept or ensure a single point of access for users, while considering full and seamless entity coordination as a primary priority. In so doing, targeted objectives could be designed so that any resources and efforts invested in these home-based services' further development are done so in the most cost-effective manner possible.

This Office also recommends that any future health strategies are drafted in a manner in which the direction they set is substantiated with clearly laid-out and measurable targets and objectives, together with expected timeframes for the latter to be completed. This would better ensure that any effort invested in the implementation of strategy targets is aligned as closely as possible to its actual aims, while facilitating the tracking of progress thereof.

Budgeting adequacy and/or the allocation of a dedicated budget line

Specific budgeting for the scoped services is not carried out as these are incorporated in the entities' overall budgeting. Comprehensive expenditure analysis by NAO with a view to shed light on relevant financial management was not possible due to significant data filtering limitations.

The NAO enquired whether each entity prepared specific budgets for the services within the audit's scope. None of the interviewed entities were however in a position to forward documentation on specific yearly budgeting processes relating to medical and clinical home-based services intended for individuals aged 60+. The main cited reason for this was that budgeting for individual services is generally incorporated as part of the broader financial planning for larger programmes and initiatives, with specific line items not being allocated to them.

In an attempt to circumvent this situation, the NAO resolved to request from the involved entities the actual expenditure for these services for the period under review. This was done so that, in the absence of budgets, an indication on the overall actual expenditure could be presented in this report (and therefore giving context on overall financial materiality). This however also proved problematic as only two entities supplied NAO with expenditure figures which were specifically filtered for the relevant services they offered to individuals aged 60+ within the scoped period. One other entity provided an estimate of the 2024 expenditure for only one of its services.

This submitted information was not sufficient for the audit team to compute, to any meaningful extent, the overall expenditure incurred to provide home-based medical/clinical services to the elderly in Malta. In view of this, NAO was not in a position to conduct the necessary analysis to address the audit's budgeting objective.

NAO Observation

NAO acknowledges that the budgeting and financial allocation practices adopted by the involved entities are not necessarily expected to align directly with the scope of this audit. Notwithstanding, the fact that this data could not be readily filtered in accordance with the audit requirements by a number of entities, is a cause for concern. From this Office's perspective, this suggests that the significance of data for planning could be better acknowledged, and highlights opportunities to enhance financial data management and reporting systems. The NAO notes that this could present challenges, particularly since such data are needed as inputs for future strategic planning.

The adequacy of Human Resources

Data on human resource allocation for the scoped services as requested by NAO was not reliably and comprehensively received from all entities. From the limited data provided however, evident material HR shortages were observed.

NAO requested from each entity the number of Human Resources (HR), in Full Time Equivalents (FTEs), which were deployed to deliver the services under review throughout the scoped period. This Office also requested that the entities indicate any shortages (also in FTEs) registered between 2019-2024. However, replies to these queries by the different entities featured different formats and levels of reliability and comprehensiveness. While two entities forwarded largely clear and complete related data (which satisfied the reasonableness criteria), the others were not in a position to do the same for a variety of reasons, including data filtering limitations.

While the NAO could not calculate accurate HR deployment and shortages based on the collective information received by the six involved entities for the entire scoped period, it became evident that a material shortage in this respect prevails. From the submitted information related to the staff complement assigned across all the scoped services (and irrespective of designations), it was identified that, at an aggregate level, a shortfall of at least 19.4% relative to the actual deployed FTEs prevailed in 2024.

NAO Observation

HR shortages in any provision of service are cause for concern, not least when it comes to medical and/or clinical services and when considering the identified indicative extent thereof. This situation creates evident risks that the provision of these scoped services could be compromised, particularly (among others) in terms of timeliness, frequency and/or overall coverage.

Once again, this Office reiterates the risks associated with operational data (in this case related to HR) not being stored in a manner in which it can be readily filtered and comprehensively collated. This would invariably prove problematic in the event that such information would be required as input for forward-looking service development, capacity building exercises and possibly for the compilation of future strategies.

NAO Recommendations

The need for better data management systems, particularly with respect to financial budgeting and expenditure as well as human resources allocation, is evident. This Office strongly suggests that all such data is kept rigorously and in a manner through which multiple filters could be reliably applied with a view to facilitating a variety of analytical possibilities. This is of utmost importance as such data is invariably considered as central inputs to any well-informed future plans and/or strategies.

Sufficiency of financial and human resources is pivotal in ascertaining that medical and clinical services are delivered without undue delay, consistently and to the highest standards. NAO therefore encourages all involved entities to ascertain that no shortages prevail in the allocation of such resources towards home-based medical and clinical services for the elderly, without negatively impacting other healthcare areas. This Office also highlights that any future financial allocation and capacity building exercises should ideally be developed on well-informed projections.

Service Development and Future Plans

There is scope for further uptake of home-based medical and clinical services by the elderly, but this is mitigated by the wide range of other community-based services provided by the Government. NAO was not provided with adequately filtered, reliable and/or updated trends and projections for the scoped services but could extrapolate indicative yet evident upward usage patterns.

As already mentioned previously in this report, Malta offers a broad and well-developed range of home-based medical and clinical services, which reflects sustained investment over time. However, in order to assess the extent to which the scoped services are utilised by potential clients, the NAO examined whether service uptake levels could indicate the quantitative success of home-based medical and clinical services. The data made available to NAO in this respect however once again featured significant filtering limitations.

To this end, the audit team resorted to establish a benchmark (against which usage data was to be tested) by referring to calculations by the National Statistics Office (based on EU-SILC data), which shows that between 2019 and 2024, on average 61% of elderly persons living independently suffered from at least one chronic condition, and so would reasonably be expected to require at least one medical interaction annually. This benchmark was applied conservatively, without accounting for acute conditions, multiple illnesses, or repeated interventions.

The usage data analysed by NAO to compare against this set benchmark related to the 2024 home-based medical services only (thereby omitting the clinical services given that these typically follow an initial medical intervention). While acknowledging the probability that usage data received on the scoped services by the involved entities contained duplicate entries, NAO was unable to identify these and opted to treat such instances as individual cases, thereby adopting a prudent approach (that is, leaning towards inflating usage data). This notwithstanding, when this latter number was compared against the total population aged 60+ and living in their own home, it resulted to only 22.19%. This inflated result (which ensures a prudent interpretation) still only amounts to less than half of the cited 61% of the elderly population who suffer from at least one chronic illness (and who would therefore need a minimum of one medical intervention every year).

As part of this review, stakeholders were also asked to submit documentation relating to past trends and future projections for the uptake of the scoped services by individuals aged 60+. The majority of the involved entities confirmed that no such trends and/or projections were/are prepared for these services and specifically with regards to individuals aged 60+. Only one entity provided the audit team with usage projections, and these related to only one of its services. Notwithstanding the above, based on information submitted by the various auditees on past service usage, NAO established that for the vast majority of the scoped services, this registered an evident increase between 2019 and 2024. The NAO subsequently used these figures as roots to rudimentary and indicative projections. While this Office acknowledges that these projections need to be further developed through other informed inputs (which among others could include changes in population composition, any exponential increase in chronic illnesses, policy changes etc) by the respective entities themselves (being the experts in these areas) to enhance their accuracy and reliability, an evident increase in the projected usage of the scoped services emerged.

NAO Observations

If the quantitative success of the scoped services was to be solely assessed against the criteria that, as much as practically possible, medical and clinical services to individuals aged 60+ are to be provided in the client's own home, one would invariably need to conclude that there is significant scope for further uptake. This is in view that even a very prudent computation determined that, as a minimum, there is the potential for this to more than double. Notwithstanding, NAO posits that this result needs to be considered in a context which is materially influenced by external factors. First and foremost, this Office acknowledges that a wide array of community-based services is provided at regional health centres across the country. Given Malta's geographic compactness (resulting in short commute distances to these centres) and considering the availability of other public services which among others include free transportation for the elderly to and from these health hubs, access to these community-based services can be considered as barrier-free to the vast majority of the scoped population. NAO also acknowledges the distinct probability that a segment of the population aged 60+ could harbour preference to avail of medical and clinical services at community health centres rather than in their own home. In view of this, while technically there is scope for the services under review to attract a larger client base, this Office is not in a position to express material concern on the current overall registered uptake of these services.

While this Office positively notes that the overall usage of the vast majority of the scoped services registered an evident increase during the period under review, this Office questions why the scoped entities were not in a position to submit any studies, reports, or analyses which accurately show past trends or comprehensive future projections of service utilisation. The absence of such technically-informed forecasts introduces avoidable risks that services may not be appropriately aligned with evolving demand patterns. This could in turn impact the timeliness, quality, future planning and sustainability of service provision.

NAO Recommendations

While NAO is not materially concerned with the relatively low registered uptake of the scoped services in view of the plethora of other easily accessible community services, it still encourages the involved entities to ascertain that sufficient and ongoing effort is being invested in the awareness about the availability of home-based medical and clinical services for the elderly.

In view of the evident (even if indicative) probable increase in future demand for these services, this Office strongly recommends that the involved entities endeavour to develop accurate and informed projections of service usage. Only in doing so can they undertake any necessary planning, resource acquisition and preparation in an adequate, cost-effective and timely manner which meets the evolving needs of Malta's ageing population, while also serving as pivotal future strategy inputs.

Summary of findings

Government policy/integration regarding community-based elderly services

NAO Malta's review of the existing home-based services covered within this report identified a well-developed range of services available to persons aged 60 and over. These services are delivered in a decentralised manner, through a number of different government entities, amounting to a total of 29 services across six entities. In order to understand the direction for government policy regarding home-based services for the elderly, NAO reviewed the extent to which national health and active ageing strategies address home-based medical and clinical services for the elderly. These services are acknowledged across the strategy documents as contributing to independent living, continuity of care, and reduced reliance on institutional and acute hospital services, however they are generally referenced only peripherally and not as a distinct policy area.

Budgeting and expenditure

Specific budgeting for individual services is not carried out by the audited entities as this is generally incorporated within each entity's overall budget. NAO could therefore not obtain estimates for the budgeted costs relating to the scoped services within this audit. With regard to expenditure data, this was only provided by two entities, with a third entity providing estimates for only one of its services. In the case of the remaining services, specifically filtered expenditure data could not be made available to NAO. A comprehensive expenditure analysis regarding home-based medical and clinical services for the elderly could therefore not be carried out.

Human resources

Data regarding human resource allocation from the audited entities varied considerably in format, levels of reliability and comprehensiveness. While NAO could therefore not calculate accurate staff complements and shortages throughout the audit period, it was identified that, at an aggregate level, an HR shortfall across the scoped entities of at least 19.4% relative to the actual deployed FTEs prevailed in 2024.

Trends and future plans

The audited entities were not readily able to provide trends or projections for the scoped home-based services, from either a usage or a resourcing perspective. Using past usage data as provided by auditees however, NAO observed an evident upward trend in the level of uptake of the scoped services between 2019 to 2024. Based on these patterns, NAO could establish that further increases in service usage over the coming years are also to be reasonably expected.

Slovak Republic

Report on the Audit Results – Community Service for Seniors

We Audited

The Ministry of Labor, Social Affairs, and Family of the Slovak Republic and seven selected senior care facilities.

The audit focused on evaluating the system of providing community-based social services in senior care facilities in relation to the expected increase in demand for these services. The audit was carried out at the Ministry, which is the governing authority responsible for the social services system and oversees the transition of social services to the community level. The conditions for the provision of social services were examined in seven senior care facilities.

How We Proceeded

The audit was carried out by 16 auditors in accordance with the Act on the Supreme Audit Office of the Slovak Republic and the standards based on the fundamental principles of auditing within the International Standards of Supreme Audit Institutions.

During the audit, auditing procedures and techniques were applied, including the examination of records and documents, analytical methods, interviews, and requests for information pursuant to § 22 of the Act on the Supreme Audit Office of the Slovak Republic.

Why We Conducted the Audit

The ageing of the population is a significant demographic trend. According to estimates by the European Commission, the number of pension recipients in Slovak Republic will be 194,000 higher by the end of 2030 than it was in 2022. Conversely, the number of contributors to the pension system is expected to be 94,000 lower in five years.

In 2024, there were 1,018,725 people aged 65+ in Slovak Republic, representing an increase of more than 86,000 since 2020. During the same period, the total capacity of senior care facilities increased by only two thousand places, while in 2024 alone, 8,677 people applied for the provision of social services in senior care facilities.

We expect that, in line with demographic developments, the demand for these services will continue to grow, and it already exceeds the available capacity.

What We Found

- From the total allocation of EUR 160.7 million under the European Integrated Regional Operational Program, almost EUR 104 million remained unused, even though these funds could have contributed to improving the availability of social services.
- The objective aimed at reducing the number of largecapacity facilities, as declared in the strategic documents of the Ministry of Labour, was not achieved.
- A longterm unsustainable economic and financial situation persists among smallcapacity facilities whose operators provide communitybased services for seniors across Slovak Republic.
- The stabilization allowance for employees has temporarily prevented, and will continue to help prevent until 2027, the outflow of personnel. However, it is not a systemic solution that would lead to longterm stabilization of staff in social services.
- he average salary of professional staff, at EUR 1,065, represented only 71% of the average wage in the national economy.
- Weak interinstitutional cooperation persists – community services for seniors must be based on the knowledge and cooperation of local and regional governments, service providers, and the policy guarantor: The Ministry of Labour, Social Affairs and Family.
- There is a lack of highquality and valid data on providers and recipients of social services, as well as risks related to the exchange of information through public administration information systems.

What We Recommend

- preparation of an analysis on the development and sustainable financing of residential facilities for seniors,
- adoption of systemic measures that would ensure the longterm stabilization of personnel in all forms of social services, including in the context of financing nursing services from the public health insurance system,
- assessment of the design of new legislative financing mechanisms for local and regional selfgovernments to ensure the sustainable funding of their original competences in the area of social services, and systematic support for selfgovernments in creating functional groupings of local municipalities for the purpose of developing residential community services and their shared financing.

Purpose of the audit

The purpose of the audit was to verify whether the system of providing social services for seniors is set up in such a way that it can financially sustainably ensure these services at the community level and whether it creates a sufficient supply of these services to meet the demand given the demographic development.

Framework of the audit

The audit focused on residential facilities for seniors, which are currently the most in demand within the broad range of social services for older adults. The audited entities were selected based on the criterion of participation in the transition process toward communitybased care in familytype facilities with low capacity (max. 12 places). Another criterion was the implementation of investments financed from EU sources. These investments were intended to support the development of familytype senior facilities and thus promote the closure of largecapacity institutions – one of Slovak Republic's stated objectives in the area of social services.

We assessed the adequacy of the financing system in ensuring the implementation of measures supporting the deinstitutionalization of social services, as well as whether the adopted measures contribute to securing the availability of social services for seniors at the community level in their natural social environment. At the same time, the provision of social and nursing care in selected senior facilities was verified.

The sample selection was carried out using nonstatistical methods based on the professional judgment of auditors, with significant risk factors including the financing of projects from European sources. During the preparation phase, meetings and interviews with stakeholders were conducted.

The audited period covered the years 2020 to 2024 and related periods. The audit activity was part of an international audit, with auditors from the Israeli office serving as guarantors of the common approach and international auditing standards. The results of the international audit will be used to compare identified risks and findings across participating countries and to support the sharing of good practices.

Results of the audit

Slovak Republic committed in its national concepts to transition from institutional care to a system of social services with a predominance of services and measures provided in the community as early as 2011. The long-term goal in this area is, among other things, the closure of large-capacity facilities and the transition to so-called community-type facilities. The highest number of social service recipients is in senior facilities, which also have the highest number of applicants for social services.

Legislative changes and their impact on financial sustainability

The policy of deinstitutionalization of social services set in 2011 was supported by legislative measures that were aimed, among other things, at the area of financing social services (e.g., the introduction of a state budget contribution), as well as substantive measures that were intended to prevent the creation of large-capacity facilities. Such measures included the introduction of capacity limitations for senior facilities and selected facilities in 2014 (maximum number of 40 clients in one building) and subsequently in 2024 the definition of family-type facilities (up to six or 12 places).

These changes were introduced without prior analysis of the financial sustainability of facilities of such sizes in the conditions of Slovak Republic. Given the strict legislative requirements for the operation of social service facilities, there is a risk of their economic sustainability. The difficulty of economic sustainability of such facilities was demonstrated by the audit, as the costs of all audited entities, except one, for providing social services exceeded the income from contributions and payments from clients. The audited entities secured the financing of costs from additional financial sources, mainly from donations and the founders' own resources. The high costs associated with the operation of family-type facilities may lead to the need to increase their capacity to ensure their economic sustainability, which some audited entities have already indicated. Alternatively, the price of the service may increase to such an extent that it will be available only to a certain, economically secure group of citizens.

Higher operating costs of the audited entities affected the economically justified costs, which represent the actual expenses required to provide social services. For most entities, these costs were higher than the national average for senior care facilities, and the amount of client payments is derived from these costs.

Demand exceeds supply

In 2024, there were 1,018,725 people aged 65 and over in Slovak Republic, an increase of more than 86,000 compared to 2020. Despite this, the capacity of senior facilities increased by only 2,000 places during the same period. In 2024 alone, 8,677 people applied for social services in senior facilities, while 6,361 of them were not provided with any social services at that time. This indicates the under-dimensioning of provided services and the insufficient preparedness of the system for demographic development.

The demand for these services, expressed by the number of applicants, may not represent the real situation. Despite the fact that the law on social services stipulates the obligation to keep records of applicants, in practice, there are situations where senior facilities recorded applications only at the time of admission to the facility when they knew they had a vacant place. Given this, it is possible that the records of applicants do not reflect the real demand for social services in senior facilities, as there is no obligation to keep a "waiting list" for senior facilities. The ageing population, its development, and the resulting demand exceeding the supply of senior facility capacities will create pressure on the availability of these services.

Table 1: Capacity of senior facilities

Form of Social Service	Status as of 31 December				
	2020	2021	2022	2023	2024
Residential – annual	19,070	19,614	20,539	20,758	21,084
Residential – weekly	11	11	11	11	11
Outpatient	120	123	150	150	120
Total	19,201	19,748	20,700	20,919	21,215

Source: processed by the Supreme Audit Office of the Slovak Republic based on data from the Ministry of Labor, Social Affairs and Family of the Slovak Republic

Despite the fact that the share of facilities with a capacity of up to 12 and 40 places increased from 2020 to 2024, in 2024 more than half of the places were in facilities with a capacity of more than 40 places. The policy of deinstitutionalization set since 2011 is not being sufficiently fulfilled, as during the evaluated period there was no significant reduction in the number of large-capacity facilities, and there is no significant assumption that this will happen in the near future.

Table 2: Overview of the number of senior facilities by size

Capacity Category	Year				
	2020	2021	2022	2023	2024
Up to 12 places	68	71	75	90	100
13 to 40 places	296	316	328	327	334
41 to 100 places	98	98	98	98	99
101 places and more	29	29	29	30	28

Source: processed by the Supreme Audit Office of the Slovak Republic based on data from the Ministry of Labor, Social Affairs and Family of the Slovak Republic

Increasing availability was dependent on European sources

The implementation of measures aimed at supporting the transition to community care was dependent on European sources. There was a lack of significant financial support from the ministry, even considering the measures and goals defined in strategic documents, which would financially stabilize the system.

Support for the sustainable transition to community care in low-capacity senior facilities, as well as in home care services, is largely dependent on funding from European sources. During the audited period, three calls were implemented within the Integrated Regional Operational Program with a total amount of 160.7 million euros. Investments made from these calls could have been used, but in reality, they were not, among other things, to expand the capacities of facilities for Slovak seniors.

Table 3: Overview of the use of selected Integrated Regional Operational Program calls

Call Code	Call Allocation	Contracted Amount	Actual Drawdown	Call Code
IROP-PO2-SC211-2017-17	59,763,013.00 €	24,736,039.94 €	16,141,982.00 €	43,621,031.00 €
IROP-PO2-SC211-2018-27	74,779,302.00 €	43,212,301.11 €	27,315,071.01 €	47,464,230.99 €
IROP-PO2-SC211-2021-78	26,183,582.00 €	19,126,045.83 €	13,271,331.36 €	12,912,250.64 €
Total	160,725,897.00 €	87,074,386.88 €	56,728,384.37 €	103,997,512.63 €

Source: processed based on data provided by the Ministry of Investments, Regional Development and Informatization of the Slovak Republic

Within the calls mentioned, a total of 99 projects were supported and completed, of which 80 were projects related to social services. Of the total allocation, only 35% was used, and almost 104 million euros remained unspent, which could have significantly contributed to increasing the supply of social services. These are funds that could have significantly contributed to strengthening infrastructure, improving the quality of provided services, and creating new capacities, thereby mitigating long-term system problems. Given the unfavorable demographic development, the "missed opportunity" of not using such a significant amount intended to support the deinstitutionalization process is evident.

The Ministry of Labour, which is directly responsible for implementing social care policy, was unable to provide a clear explanation of why such a significant amount remained unspent. Auditors also point out that the Ministry of Labour was not responsible for the actual EU fund calls, but another department – the Ministry of Investments, Regional Development and Informatization of the Slovak Republic. This department was responsible for setting the conditions and administering the calls that were supposed to enable the use of financial resources. The fact that such a volume of funds was not used points to systemic deficiencies in the planning and implementation of projects that could significantly improve the availability and quality of community services for the ageing population. This fact also raises questions about the efficiency of management and coordination between individual state authorities.

The Ministry of Labour did not comprehensively monitor progress in the transformation of social

service providers and was unable to clearly evaluate how many entities successfully completed the deinstitutionalization process. Without monitoring progress in the transformation process of social service providers, it is not possible to evaluate and measure progress in the deinstitutionalization process and make appropriate decisions.

The expansion of capacity in community-type facilities and outpatient facilities, aimed at transferring part of the recipients from large-capacity facilities to smaller community-type facilities, is also financed from the Recovery and Resilience Plan, through investments within component 13 – Accessible and Quality Long-Term Social and Health Care. Of the total budgeted amount of 231.98 million euros excluding VAT, 140.79 million euros (excluding VAT) were spent by July 2025. The result of these investments is to create at least 1,823 new capacity places in community-type facilities with a maximum capacity of 12 places per facility and health-social facilities with a maximum capacity of 30 places per facility. Given the ongoing implementation of these investments, their impact on availability was not evaluated, and this finding leads the Supreme Audit Office of the Slovak Republic to include it in the risk catalog, which serves for the preparation of the office's audit activity plan in the coming years.

Personnel unsustainability

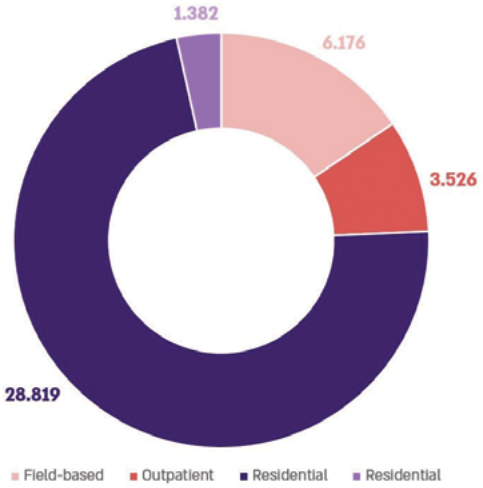
The direct impact on ensuring social services for its recipients to the required extent is the availability of professional staff (caregivers and medical staff). Despite the fact that the audited senior facilities were able to meet the legally required minimum number of employees, all of them identified the most significant problem in their operation as ensuring and long-term retention of qualified staff. The lack of staff is also confirmed by data published by the ministry, as of December 2024, there were 306 vacancies in senior facilities, while the additional need for additional workforce in this sector was identified by the Ministry of Labour to be between 3,840 and 4,040 people by 2025. The lack of workforce is not being mitigated due to the underutilization of the potential of foreign workers, which the Supreme Audit Office pointed out in 2025 in the audit action on the state's integration policy. The lack of staff was also influenced by their insufficient financial remuneration. Despite the fact that wages increased in all audited entities during the audited period, the average wage in 2024 ranged from 809 euros to 1,328.6 euros, which was at the level of 53% to 87% of the average wage in the national economy.

The ministry actively addresses the issue of personnel sustainability in its strategic documents, but despite the identified and acknowledged facts by the ministry that the stabilization of personnel capacities in social services is important, the ministry adopted only short-term ad hoc solutions. This was the stabilization allowance, which was provided from the state budget in the total amount of 45.39 million euros for 687 social service providers and was intended to retain employees in social services during the period from 2023 to 2025. This measure will continue in 2026, with 21 million euros allocated.

The stabilization allowance temporarily prevented staff turnover, but it is not a systemic solution that would lead to the long-term stabilization of staff in social services.

According to the ministry, no other measures aimed at stabilizing staff were planned in the short term due to the ongoing consolidation of public finances and the preparation of new legislation, given the already adopted reform of social service financing effective from the new year 2026.

Figure 1: Number of employees by forms of social services, as of 31 December 2024



Source: processed by the Supreme Audit Office of the Slovak Republic based on data from the Ministry of Labor, Social Affairs and Family of the Slovak Republic

According to the ministry, the systemic solution is the adopted reform of social service financing, which changes the way of payment for providing social services and should cover outpatient, field, and residential services. In the area of residential care, including senior facilities, the current method of financial support will remain unchanged, with the highest number of employees being in residential facilities.

Lack of funds for ensuring nursing care

Nursing care is part of the comprehensive care for recipients of social services in senior facilities. It is crucial for fulfilling the legal obligations of the social service provider, protecting the health of the recipient, and preventing the deterioration of their health condition.

The provision of nursing care is funded from public health insurance. Of all the audited entities, only two facilities had contracts with health insurance companies for the reimbursement of nursing care. The reason why the audited entities did not have contracts for nursing care was, according to their statements, the fulfillment of the limits of health insurance companies. The legislatively set minimum number of beds no longer reflects the needs of recipients in senior facilities.

Another reason was the fact that the audited facilities were unable to meet the qualification and professional conditions set for medical staff. The audited facilities provided nursing care through home nursing care agencies for these reasons.

Table 4: Recipients of nursing care in senior facilities in 2022 to 2024

Indicator	2022	2023	2024
Recipients of nursing care	14,594	15,460	15,373
Provision of facilities for seniors by own employees	10,424	10,920	10,702
Provision of home nursing care by a home nursing agency	1,391	1,431	1,285
Provision of nursing care by a combination of own employees and a home nursing care agency	2,996	3,440	3,482
Revenues of senior care facilities from health insurance companies for the provision of nursing care	3,362,393.29 €	5,374,907.17 €	11,804,314.12 €

Source: processed by the Supreme Audit Office of the Slovak Republic based on data from the Ministry of Labor, Social Affairs and Family of the Slovak Republic

Despite the fact that senior facilities provided nursing care with their own staff in 10,702 cases in 2024 or in combination with home nursing care agencies for 3,482 recipients, the income from health insurance companies amounted to 11.8 million euros out of a total income of EUR 356.9 million, which was only 3.31% of the total income. This indicates insufficient funding for nursing care from health insurance. Despite the increase in income from health insurance companies, the fixed price of 13.20 euros per person per day for nursing care does not correspond to the performance or the real financial demands of providing nursing care in senior facilities. Low reimbursements for nursing care from public health insurance reduced the possibility of providers to hire qualified medical staff permanently, who could provide such services for the facility's clients professionally and also from a long-term personnel or financial perspective.

High-quality data as a basis for decisionmaking

Effective management of public policies requires reliable and highquality data. The data on applicants for the audited period were not mutually comparable. Relevant data were also not reported for the number of recipients to whom social services were provided during the audited period. Without a highquality data foundation, it is not possible to make adequate decisions that would lead to improvements in the current situation.

The assessment of the development of availability – whether in terms of the number of applicants or recipients – was influenced by a change in the method of tracking relevant data. In 2022, the ministry began using the Social Services Information System to collect data with the aim of obtaining more comprehensive information from social service providers. The limited quality of the data was partly due to the gradual filling of data into the Social Services Information System, which affected its completeness and timeliness. For this reason, it was not possible to compare all data with those from 2020 and 2021.

The use of the Social Services Information System as a tool for obtaining more comprehensive data depends on the quality of the information provided by social service providers. The audit carried out in senior facilities also identified shortcomings in the reported data.

Conclusion

Slovak Republic belongs to the fastestageing populations in Europe. The significant increase in the number of people of retirement age will raise the demand for social services provided not only in senior care facilities. Although the capacity of senior facilities increased during the audited period, they are already unable to meet the current demand for these services, which will continue to grow due to negative demographic trends.

The audit demonstrated the economic challenges of sustaining familytype senior facilities under the current financing system. Operating such facilities is financially demanding. Once the project sustainability period ends, it will likely be necessary to accommodate more recipients in buildings designed for 12 people to ensure economic viability, which directly contradicts the intended objective. Otherwise, the provision of services may even be discontinued.

Efforts to transition social service provision in senior facilities were supported by legislative measures that partially encouraged the creation of familytype facilities with a capacity of 12 places, aiming to provide more individualized care and improve service quality. However, these changes were introduced without prior analysis of their financial and staffing sustainability. In addition to available capacity, the availability of personnel also affects the provision of social services. Despite acknowledging the importance of stabilizing staffing levels in social services, the ministry only adopted shortterm ad hoc measures in the form of a stabilization allowance. A potential end to this allowance in 2027 may have a significant negative impact on the availability of social services due to staff shortages.

The transition to communitytype senior facilities, which should support higher service quality and a more individualized approach, is progressing very slowly. Achieving this objective depends heavily on the use of EU funds. There is therefore a risk that without EU funding, the development of community services for seniors will not only stagnate but also jeopardize the availability of social services for seniors. Despite this dependency, Slovak Republic failed to use EUR 104 million out of more than EUR 160 million allocated to support this objective, which we consider a missed opportunity to improve the scope and quality of public policy aimed primarily at seniors.

The current system of financing nursing care in social service facilities can no longer adequately respond to the increased demand for these services. During the audited period, health insurance companies did not conclude contracts for reimbursement of nursing care, even though senior facilities are required to provide it. The reasons included exhausted regional budget limits and failure to meet minimum qualification requirements for professional staff. From the perspective of the Supreme Audit Office of the Slovak Republic, providing qualified nursing care for longterm ill patients in such facilities is economically more advantageous than in institutional healthcare facilities, ultimately creating positive effects in the health insurance system.

Demographic trends in Slovak Republic show a continuing ageing of the population, which will manifest in increasing demand for social services for seniors. Without more effective implementation of measures, there is a risk that the availability of these services will not be ensured in the required scope and quality for the growing number of applicants. At the same time, this will create pressure on public finances, as the cost of providing care in senior residential facilities is nearly double compared to care provided in a home environment.

The further sustainable development of community social services for seniors must be based on a partnership between the state, which creates a legislative environment for functional cooperation with municipalities, service providers, and the public health insurance system.

Israel

Introduction

The increase in life expectancy in Israel, coupled with the ageing of the population, presents a significant challenge to the healthcare system. This is due to the anticipated rise in the number of elderly individuals aged over 65 (the elderly) and their proportional representation within the population, which will consequently lead to greater demand for healthcare services provided by HMOs (Health Management Organizations) and hospitals[1].

The National Economic Council's Strategic Socio-Economic Assessment[2] (the Strategic Assessment) identified the ageing of the population as a significant challenge facing the State of Israel. It was determined, among other considerations, that the health system must adequately prepare for the demographic shift toward an older population, particularly in terms of workforce and infrastructure. This preparation is necessary due to the anticipated increase in the number of elderly individuals and the consequent increase in demand on health services.

In 2015, the government endorsed the Strategic Assessment through the adoption of a government resolution titled "Promoting the Strategic Topic 'Preparing for Population Ageing' as a Derivative of the Strategic Socio-Economic Assessment for the Government"[3] (Resolution 150). This resolution acknowledged the announcement by the Minister of Health and the Director General of the Ministry of Health, indicating commencement of the formulation of a comprehensive plan aimed at preparing the health system for an ageing population.

For further information on the Israeli healthcare system's preparedness for an ageing population, see "The State of Israel's Preparedness for an Ageing Population - Israel's Healthcare System Preparedness for an Ageing Population" **[link]**.

1 The Committee for Planning the National Geriatric System for 2010-2020 and 2020-2030, headed by Prof. Yohanan Shtesman (2011); The National Economic Council, Monitoring Report on the Implementation of the Strategic Situation Assessment (2018).

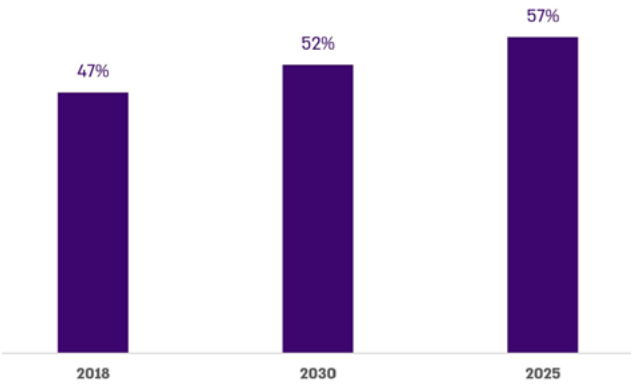
2 National Economic Council, Strategic Economic and Socio-Economic Situation Assessment (2015); The National Economic Council in the Prime Minister's Office is engaged in advising the Prime Minister on economic issues and in formulating and leading strategic processes to advance the Israeli economy and society in cooperation with government ministries, authorities and private entities. The Council is composed of a team of economists with advanced degrees and experience in the public, private and academic sectors, who are engaged in coordinating inter-ministerial staff work on socio-economic issues and accompanying policy implementation processes – all based on economic analysis, while using systematic strategic thinking.

3 Government Resolution 150, "Promoting the Strategic Topic "Preparing for Population Ageing as a Derivative of the Strategic Socio-Economic Situation Assessment for the Government", June 28, 2015.

Hospitalization of Elderly Patients

Hospitalization Costs: The Ministry of Health's budget for the year 2025 was approximately NIS 62 billion[4]. National health expenditure reached NIS 146 billion[5] in 2024[6]. Expenditures related to hospitalization constitute roughly one-third of the total national health spending in Israel[7], amounting to approximately NIS 50 billion. Although the elderly population represents only about 13% of all HMO members, as previously noted in the introduction, this demographic exhibits a considerably high rate of healthcare service utilization. The figure below presents an estimation of the projected increase in hospitalization expenses as a proportion of total hospitalization expenditures, corresponding to the increasing proportion of elderly individuals hospitalized:

Figure 1: Estimated growth in hospitalization expenses for the elderly as a percentage of total hospitalization expenses, 2018-2050



According to the Ministry of Health data, processed by the Office of the State Comptroller.

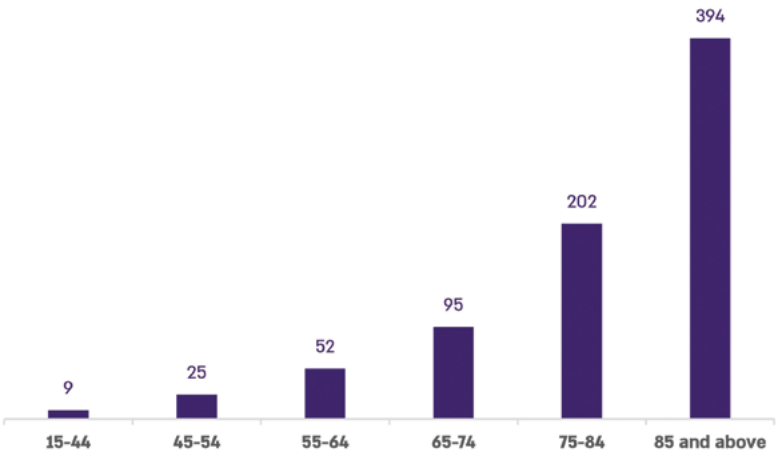
The figure shows that in 2018, the proportion of expenditure on hospitalization for the elderly relative to total hospitalization expenditure was 47%, with a projected increase to 57% by 2050, representing a rise of 10 percentage points.

4 The budget key.
5 Health expenditure includes expenditure on all health services provided in clinics and hospitals, as well as expenditure on private physician and dentist services, expenditure on medicines, medical supplies and medical devices, research and government administration in the health sector, and investment in buildings and equipment in health institutions.
6 The Central Bureau of Statistics, Press Release, National Health Expenditure in 2024 was 7.3% of GDP (2025).
7 The Ministry of Health website.

The Health Insurance Law enumerates the service domains encompassed within the health basket, including general hospitalization[8], psychiatric hospitalization, psycho-geriatric hospitalization, and chronic care nursing hospitalization[9]. The Law mandates that HMOs must provide services of reasonable quality to their members, within a reasonable timeframe, and at a reasonable distance from the members' residences[10], either directly or through other service providers[11].

In 2022, approximately 1.4 million general hospitalizations[12] were recorded, of which about one fifth (21%) occurred in internal medicine wards, totaling 295,000 hospitalizations[13]. The hospitalization rate in internal medicine wards increases with advancing age, as illustrated in the following figure.

Figure 2: Number of hospitalizations per 1,000 individuals in internal medicine wards, by age, 2022



According to the Ministry of Health data, processed by the Office of the State Comptroller[14].

The figure illustrates that as age advances, the frequency of hospitalizations within internal medicine wards correspondingly increases. For instance, among individuals aged 55-64, the hospitalization rate is approximately 50 per 1,000 persons, whereas for those aged 85 and older, this rate is eight times higher, reaching approximately 400 hospitalizations per 1,000 individuals.

8 Hospitalization in a general hospital, that is, in a multidisciplinary inpatient setting that provides treatments and diagnoses in the core specialties – internal medicine, surgery, intensive care, children, women and maternity, and more, as distinguished from other specialized hospitalizations separately defined under the law, such as psychiatric, psychogeriatric, or chronic care nursing hospitalization.
9 The State Health Insurance Law, 5754-1994, Section 6(a)4.
10 The State Health Insurance Law, Section 3(d).
11 The State Health Insurance Law, Section 21.
12 The Ministry of Health, Hospitalization Institutions and Day Hospitalization Units in Israel, 2022 (2024).
13 The Ministry of Health, Hospitalizations in Internal Medicine Wards 2010 - 2022 (2024).
14 The Ministry of Health, Hospitalizations in Internal Medicine Wards 2010 - 2022 (2024).

The National Economic Council's monitoring report[15] on the implementation of the 2018 Strategic Assessment highlighted that the population aged 65 and above, constituting approximately 11% of the total population, accounts for 45% of the volume of hospitalization services in the State of Israel[16]. Furthermore, the report by the Committee for Planning the National Geriatric System for the Years 2010-2020 and 2020-2030 (the Shtesman Committee) emphasized that preparations for population ageing must include considerations of hospitalization due to the substantial proportion of elderly patients among those hospitalized, as well as the anticipated increase in both the proportion and absolute number of elderly individuals within the population. The Committee asserted that, in the absence of developing alternatives to hospitalization within the community, particularly for the elderly, there would be escalating demands on the general hospital system[17].

Additionally, the report observed that the proportion of elderly patients in general hospitals relative to all hospitalizations is several times higher than their representation in the general population. The elderly constitute the vast majority of patients hospitalized in internal medicine wards, and with the anticipated growth in the elderly population, the number of hospital beds they occupy is expected to increase significantly[18]. The following figure presents the proportion of elderly individuals hospitalized in internal medicine wards relative to all hospitalized patients from 2010 to 2022, as well as projections for the years 2030, 2035, and 2040.

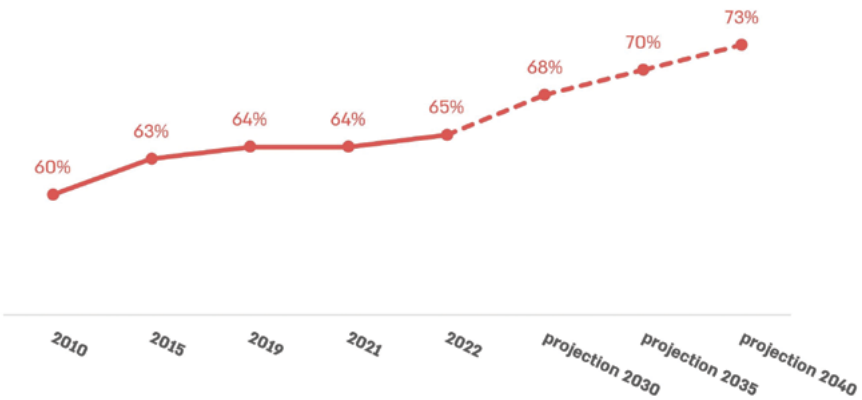
15 The National Economic Council in the Prime Minister's Office was established to meet the need for a professional economic body, with a comprehensive economic and strategic vision and high analytical capabilities, to serve as a headquarters for the Prime Minister. The Council's functions include advising the Prime Minister on economic issues and formulating and leading strategic processes to advance the Israeli economy and society, in cooperation with government ministries, authorities and private entities.

16 The National Economic Council, Monitoring Report on the Implementation of the Strategic Situation Assessment (2018). The monitoring report data presented the proportion of elderly people in 2018, and the introduction to this report presents the proportion of elderly people in 2025; therefore, there is a difference between the two data.

17 The Committee for Planning the National Geriatric System for 2010-2022 and 2020-2030, headed by Prof. Yohanan Shtesman (2011).

18 For example, in the years 2010-2020, in order to maintain the ratio of hospital beds to the elderly population in general hospitals, an increase of approximately 44% in the number of beds for the elderly was required, and by 2030 the increase is likely increase to approximately 84% compared to their number in 2010 (from approximately 5,900 beds in 2010 to approximately 10,800 in 2030); see the Shtesman Committee report.

Figure 3: The proportion of elderly individuals among all hospitalized patients in internal medicine wards during the years 2010–2022, including projections for 2030, 2035, and 2040 (expressed as percentages)



According to the Ministry of Health data[19], processed by the Office of the State Comptroller[20].
*The years for which rate values are presented correspond to those with available data; projected values were derived based on trends observed between 2010 and 2022.

The figure illustrates that approximately two-thirds of patients hospitalized in internal medicine wards are elderly, with their proportion increasing by five percentage points over the examined period, rising from 60% in 2010 to 65% in 2022. Furthermore, assuming the continuation of this trend, projections indicate that the proportion of elderly individuals hospitalized in internal medicine wards will reach 70% by 2035, and further increase to approximately three-quarters (73%) by 2040.

Increase in the Number of Hospital Beds

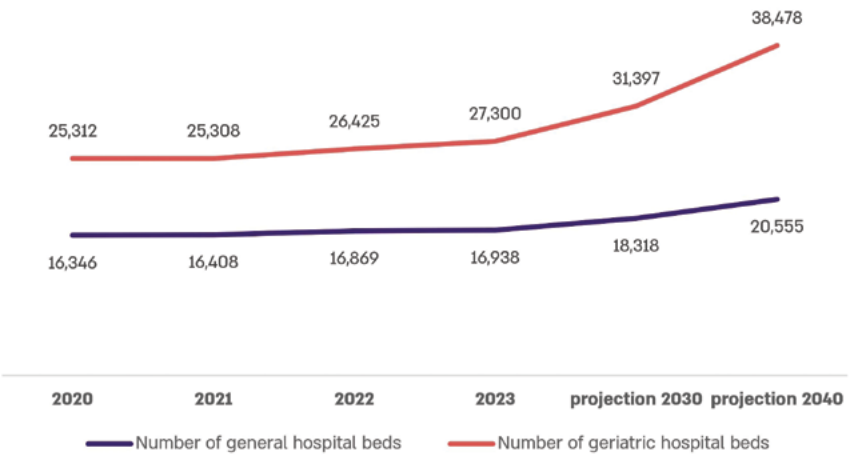
As early as 2011, the State Comptroller's report identified particularly high occupancy rates in general hospital wards and warned of the significant workload burden on inpatient departments[21]. The Shtesman Committee emphasized the necessity of expanding the number of general and geriatric hospital beds to address the anticipated rise in elderly hospitalizations. The Ministry of Health, in its statement recorded in Resolution 150, noted that the issue of hospital beds is being addressed within the framework of the development of a plan for preparing the health system for the ageing population.

19 The Ministry of Health, Hospitalizations in Internal Medicine Wards 2010-2022 (2024).
20 Processing of Ministry of Health data.
21 The State Comptroller, Annual Report 61B (2011), "The Hospitalization Crisis in Internal Medicine Wards in General Hospitals", pp. 169-219.

The Ministry of Health differentiates between two categories of geriatric hospital beds: chronic geriatric beds, designated for patients requiring nursing or cognitively impaired patients, functioning effectively as long-term residential settings for the elderly requiring comprehensive assistance with daily activities; and acute geriatric beds, which represent a continuation of the acute treatment continuum in geriatric rehabilitation, complex nursing, long-term artificial respiration, and subacute wards. These beds are intended for patients requiring short to medium-term hospitalization until their clinical condition stabilizes (Geriatric Hospital Beds).

The figure below presents the number of general and geriatric hospital beds.

Figure 4: Number of general and geriatric hospital beds, 2020–2023, as well as projections for 2030 and 2040



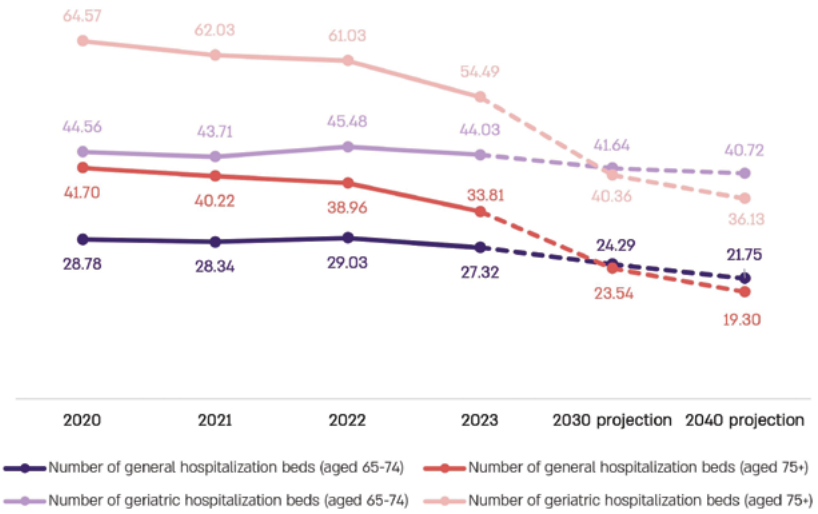
According to the Ministry of Health data, processed by the Office of the State Comptroller[22].

The figure indicates that between 2020 and 2023, there was an increase of approximately 2,000 geriatric hospital beds (rising from around 25,300 beds to 27,300) and an increase of approximately 600 general hospital beds (from approximately 16,300 beds to approximately 16,900). According to estimates prepared by the audit team, this upward trend is projected to persist in the coming decades, with anticipated figures reaching approximately 38,478 geriatric hospital beds and 20,555 general hospital beds.

22 The Ministry of Health, Hospitalizations Beds and Licensed Stations (2023).

The audit analyzed changes in the rate of general hospital beds[23] and the total number of geriatric ward beds[24] during the years 2020 and 2023[25], and projected their rates for the years 2030 and 2040[26], as illustrated in the figure below.

Figure 5: Number of general and geriatric hospital beds per 1,000 individuals, stratified by age, 2020–2023, with projections for 2030 and 2040



According to the Ministry of Health data, processed by the Office of the State Comptroller[27].

The figure demonstrates that between 2020 and 2023, there was a 19% reduction in the number of general hospital beds per 1,000 persons aged 75 and over (declining from approximately 42 beds to approximately 34), alongside a 17% reduction in geriatric hospital beds per 1,000 persons in the same age group (decreasing from approximately 65 beds to approximately 54). The number of general hospital beds per 1,000 individuals aged 65-74 decreased slightly by approximately 7% (from about 29 to about 27), whereas the number of geriatric hospital beds within this age group remained stable.

23 In internal medicine, neurology, intensive care, and surgery departments. It should be noted that some of the beds included in these data are not relevant to the care of the elderly. See: Ministry of Health, Hospital Beds and Licensed Stations (2023), p. 11.

24 See: The Ministry of Health, Hospital Beds and Licensed Stations (2023), p. 6.

25 The last report year.

26 The elderly population estimate is based on Myers, Joint, Brookdale, 65-year-olds in Israel: Statistical Yearbook (2024); the hospital bed estimate was conducted using linear regression analysis.

27 The Ministry of Health, Hospital Beds and Licensed Stations (2023).

Projections for 2030 and 2040 suggest that, at the current rate of change, the number of hospital beds is expected to decline further, with estimates indicating approximately 40 geriatric hospital beds per 1,000 persons aged 75 and over in 2030, decreasing to roughly 36 beds by 2040. Consequently, despite efforts by the Ministry of Health to augment the number of hospital beds, the rate per 1,000 elderly individuals is diminishing and is anticipated to continue declining in the future.

The Ministry of Health stated in its response dated May 2026 (the Ministry of Health's response) that an analysis of acute geriatric beds demonstrates a consistent increase in the rate of beds per thousand individuals (aged over 65). During the period covered by the audit (2020–2023), this rate rose from 3.7 to 4.2 beds per 1,000 elderly persons. This increase reflects designated budgetary support allocated to institutions involved in the construction and establishment of new geriatric wards, with particular emphasis on expanding bed capacity in regions experiencing a relative shortage of these services. Concurrently, there has been a continuous growth in the number of beds dedicated to chronic geriatrics; approximately 800 beds were added between 2020 and 2023.

The Office of the State Comptroller notes that, although the total number of geriatric beds is increasing, the rate of beds per 1,000 elderly individuals is declining due to the rapid growth of the elderly population.

The above shows that, notwithstanding the Ministry of Health's statement in Government Resolution 150 asserting preparation for population ageing in terms of hospital bed availability, there has in fact been a decrease in their rate. As a result, general hospitals may face challenges in accommodating the rising demand for hospital beds consequent to population ageing.

The Ministry of Health claimed in its response that simultaneous efforts were being undertaken to increase the number of patients treated within the community, both through financial support tests for the HMOs and via the National Insurance Institute, grounded in the professional assessment that, whenever feasible, community-based treatment is preferable to hospitalization. Furthermore, the Ministry of Health asserted that it did not anticipate a reduction in the number of geriatric hospitalization beds, considering initiatives by market stakeholders and ongoing and planned investments aimed at augmenting bed capacity. Furthermore, anticipated changes in hospitalization rates intended to enhance supply and responsiveness to geriatric patients, were expected to improve the economic viability of the sector, encourage the establishment of additional wards within existing operating frameworks, and facilitate the entry of new providers and entrepreneurs into the sector, thus supporting an increase in the availability of beds for chronic geriatrics. Additionally, the Ministry of Health noted that the CAP Law[28] for the years 2021-2025 includes a provision that decouples the number of hospitalizations in inpatient wards from the total payment that became global, with the objective of minimizing preventable inpatient hospitalizations.

28 The CAP arrangement establishes the economic rules between HMOs and public hospitals: it defines caps and incentives for purchasing hospitalization and services from hospitals, discount mechanisms when the scope of activity exceeds the cap, and uniform accounting rules that limit excessive competition and regulate the growth in demand. In practice, the arrangement is intended, on the one hand, to ensure the HMOs' continuous availability and service to insured persons throughout the country, and, on the other hand, to maintain financial stability for hospitals, while allowing the state to direct clinical policy through incentive components within the payment mechanism.
The main principles of this law are, on the one hand, setting a ceiling ("cap") for hospitals beyond which they are obligated to sell services to HMOs at a discount, and, on the other hand, setting a purchasing obligation ("floor") for HMOs in each hospital in order to ensure its financial stability and reduce the scope for competition to a desirable level.

As a result, among individuals aged 65 and over, there has been a significant reduction in inpatient ward admissions without a corresponding change in ward inputs, representing in practice an improvement in hospitalization standards for both patients and caregivers.

It is recommended that the Ministry of Health develop a strategic plan to adjust the quantity of general hospital beds, and particularly geriatric beds, in accordance with current requirements and projected needs due to population ageing and the expected increase in hospitalized patients, consistent with the declarations made in Government Resolution 150. Furthermore, it is recommended that this plan establish specific objectives and include mechanisms for monitoring progress toward these goals. Concurrently, it is recommended that the Ministry of Health continue to advance efficient, accessible, and adequate alternatives for geriatric hospitalization within community settings to manage anticipated demand effectively.

Alternative to General Hospitalization – Hospital-at-Home Service

To address the anticipated increase in hospitalizations resulting from the rising elderly population and their growing proportion within the demographic structure, the Shtesman Committee recommended, among other measures, the development of community health services, including hospital-at-home care. Moreover, given the reduction in the availability of general hospitalization beds for elderly patients, the advancement of hospital-at-home services is necessitated as a viable alternative.

Hospital-at-home service refers to medical care administered under the supervision of a physician and nurse within the patient's residence, rather than in a traditional medical institution. This service offers a more comfortable and positive experience for many patients and is therefore recognized as a necessary and effective alternative to conventional hospitalization, potentially enhancing patients' recovery outcomes[29]. According to the Ministry of Health circular[30] outlining criteria for alternatives to hospitalization for patients with acute illnesses[31], it is deemed appropriate for HMOs to facilitate access to hospital-at-home services for suitable cases, provided that an existing community medical system can deliver high-quality care along with a robust safety framework capable of promptly identifying clinical deterioration necessitating hospital transfer, and providing the appropriateness of the patient's condition for hospital-at- home care.

29 The Ministry of Health, Medical Division Circular, Criteria for Hospital-at-Home Alternatives for Patients Suffering from Acute Illnesses (2022).

30 Circulars and Directives from a Division in a Ministry refer to official directives from government ministries (such as the Ministry of Health) containing legal and ethical directives, intended to regulate activities, processes and conduct in subordinate institutions, such as hospitals. They also serve as enforcement and regulatory tools with binding legal force. They are published on official government websites and cover a variety of topics, such as ethics, treatment safety and patient rights, and aim to maintain uniformity and high standards.

31 The Ministry of Health, Medical Division Circular, Criteria for Hospital-at-Home Alternatives for Patients Suffering from Acute Illnesses (2022). An acute illness or medical condition begins suddenly or within a short space of time and requires a rapid medical response to prevent worsening or permanent damage, as distinguished from a chronic condition. Examples of these conditions include: pneumonia, sudden deterioration of heart or lung failure, severe asthma attack, and acute infection with high fever.

Advantages of Hospital-at-Home Care

Hospitalization may be accompanied by emotional and social challenges, since hospitalization takes place in an unfamiliar environment, far from home, and sometimes may lack privacy. By alleviating these difficulties, hospitalization within the home can increase the likelihood of optimal medical recovery. Additionally, this approach confers significant benefits by reducing risks that predominantly affect the elderly population, such as cross-infection[32], functional decline, and episodes of acute confusion[33].

Furthermore, hospital-at-home care contributes to alleviating the burden on hospital facilities and may reduce the economic resources required per patient relative to inpatient hospitalization[34]. Consequently, expanding hospital-at-home services as an alternative to hospital admission can enhance the healthcare system's capacity to manage the ageing population by easing hospital demand, lowering costs[35], and improving patient well-being.

The Bodies Responsible for Hospital-at-Home Services

Regular hospitalization services are typically delivered by hospitals; in contrast, hospital-at-home services for elderly patients are offered by hospitals, HMOs, and private companies that operate under the direction and on behalf of the HMOs.

Development of Hospital-at-Home Services

In order to promote hospital-at-home services in different years, including 2023 and 2024, the Ministry of Health issued financial support tests[36] for HMOs operating hospital-at-home programs[37]. The objective of these financial support tests is to implement a hospital-at-home system as an alternative to inpatient hospitalization within internal medicine wards of hospitals, with the goals of reducing hospital admissions in general hospitals and shortening the duration of hospital stays. These measures aim to enhance the quality and safety of treatment as well as improve the patient experience. The figure below illustrates the budget allocation and its utilization during these years.

32 Cross-infection is the infection of one person with a microorganism (bacteria, virus or fungus) that originates from another person, the environment or equipment – usually through hands, respiratory droplets, surfaces, medical equipment or contaminated protective clothing.

33 The Ministry of Health, Medical Division Circular, Criteria for Hospital-at-Home Alternatives for Patients Suffering from Acute Illnesses (2022).

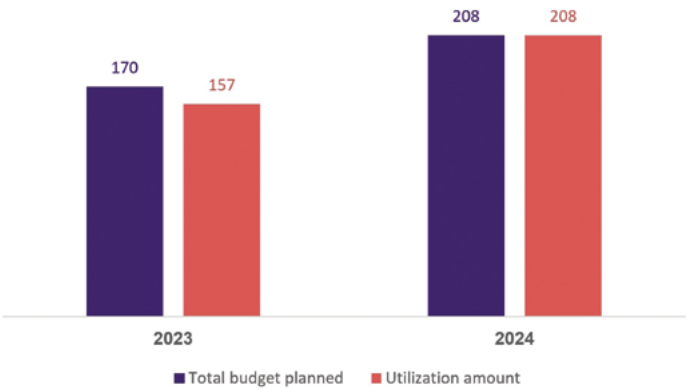
34 The Ministry of Health website.

35 See for example: Boris Punchik at al., The outcomes of treatment for homebound adults with complex medical conditions in a hospital-at-home unit in the southern district of Israel, Israeli Journal of Health Policy Research, 13 (2024).

36 Support tests are fundamental provisions that determine criteria according to which support from the state budget can be provided to public institutions. The Ministry of Health publishes support tests for HMOs for the distribution of support funds from the Ministry of Health.

37 The Ministry of Health, Tests for the Distribution of Support Funds by the Ministry of Health for Support to HMOs Operating a Hospital-at-Home Program (2018); Ministry of Health, Tests for the Distribution of Support Funds by the Ministry of Health for Support to HMOs Operating Hospital-at-Home Program under the Budget Principles Law, 1985 (2025).

Figure 6: Budget allocation of financial support tests to operate hospital-at-home programs and their use, 2023-2024



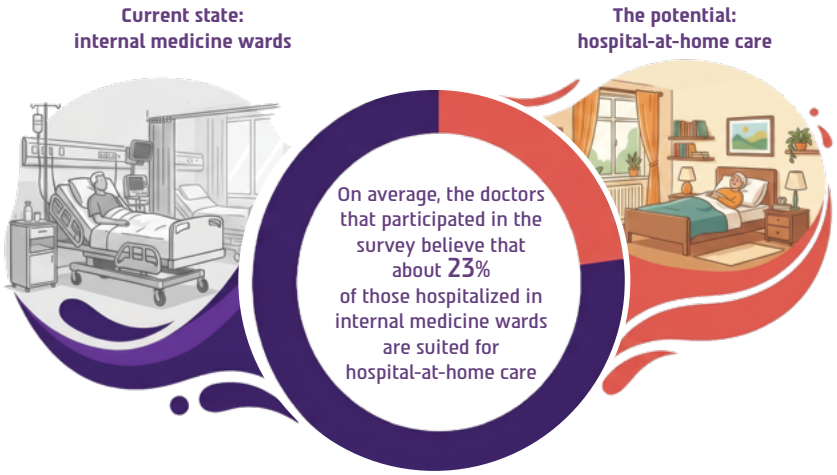
According to the Ministry of Health data, processed by the Office of the State Comptroller[38].

The figure indicates that in 2023–2024, the Ministry of Health allocated approximately NIS 380 million through support tests to develop hospital-at-home programs within HMOs, of which NIS 365 million, representing 96%, was used.

Various estimates both within Israel and internationally suggest that 10% to 20% of patients hospitalized in internal medicine wards could have been accommodated through hospital-at-home programs, provided that adequate community-based settings were available. A survey conducted in 2022 among family doctors and internists[39] yielded the following insights:

38 The Ministry of Health, Support Tests for HMOs 2024 (no publication date specified).
39 The Prof. Gur Ofer21 st Dead Sea Conference, Hospitals/Community: Challenges of the Changing Arena (2022).

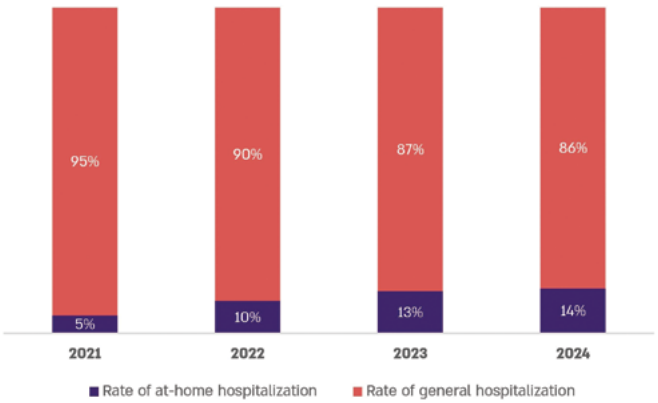
Figure 7



According to the Dead Sea Conference survey data[40], processed by the Office of the State Comptroller[41].

The audit team analyzed the percentage of hospital-at-home cases relative to all hospitalizations among the elderly between 2021 and 2024, as depicted in the figure below.

Figure 8: Rate of hospitalizations in general hospitals and hospital-at-home care among the elderly within three HMOs[42], by year, 2021-2024 (in percentages)



According to the HMOs' data, processed by the Office of the State Comptroller[43].

40 The Prof. Gur Ofer 21st Dead Sea Conference, Hospitals/Community: Challenges of the Changing Arena (2022).

41 A survey conducted in 2022 among family doctors and internal medicine doctors revealed that 43% of them believe that 11%-25% of those hospitalized in an average internal medicine ward at a given moment could be suitable for and receive alternative treatment within the framework of hospital-at-home care, and 32% believe that more than 25% of those hospitalized could be suitable for hospital-at-home care – on average, the doctors who participated in the survey believe that about a quarter of those hospitalized in internal medicine wards at a given moment could be suitable for and receive alternative treatment within the setting of hospital-at-home care. The calculation was made based on a weighted average of the doctors' responses.

42 At of the audit completion date, data had been received from only three HMOs, covering 93% of the elderly.

43 The rate of hospital-at-home care and general hospitalizations.

The figure shows that, among people aged 65 and over, the rate of hospital-at-home care relative to hospitalizations in general hospitals nearly tripled, from 5% in 2021 to 14% in 2024. However, this rate remains very low compared with the hospitalization rate in hospitals, which account for 86% of hospitalizations among the elderly.

The budgeting mechanisms associated with the support tests, including those employed by HMOs operating hospital-at-home programs, exhibit deficiencies that may influence their effectiveness[44]. Specifically, budgeting based on the support tests is not integrated within the health basket framework and is thus more vulnerable to future alterations and reductions. Consequently, HMOs that apply the support test may allocate resources to satisfy eligibility requirements; however, upon the conclusion of the support test period, the Ministry of Health does not guarantee ongoing budgetary support in this domain. Additionally, implementation of the support tests necessitates substantial resource investment by the HMOs for preparation and reporting, an undertaking that smaller HMOs may elect to avoid.

HMO B responded in May 2026 that it agreed with the issues raised regarding the support test and asserted that the absence of a multi-year plan encompassing objectives for the hospital-at-home sector also constitutes a substantial challenge to the service's development.

The Ministry of Health stated in its response that financial support tests constitute a widely utilized tool within the Ministry and are regarded as an effective mechanism for advancing policy within the community. Accordingly, modifications have been implemented to ensure that the service functions as an alternative to hospitalization. The Ministry further clarified that financial support tests are not intended to supplant a structured and fixed incentive mechanism. Consequently, the hospital-at-home service itself is incorporated into the service basket as part of the overall regulation under the CAP mechanisms. Moreover, the new CAP legislation introduced explicit provisions concerning hospital-at-home care, thereby establishing a comprehensive set of incentives related to the subject. Additionally, a designated budget of NIS 30 million was allocated for the year 2026 to facilitate the development of hospital-at-home service by hospitals, and should it become clear that the government's emphasis tends to hospital-at-home care for the elderly, the coefficients and conditions of the financial test will be subject to review.

It is recommended that the Ministry of Health incorporate the hospital-at-home service into its strategic framework for addressing the needs of an ageing population and establish multi-year objectives for the development of hospital-at-home service.

44 The Knesset, Research and Information Center, HMO Budgeting for Mental Health – Sources and Uses (2024).

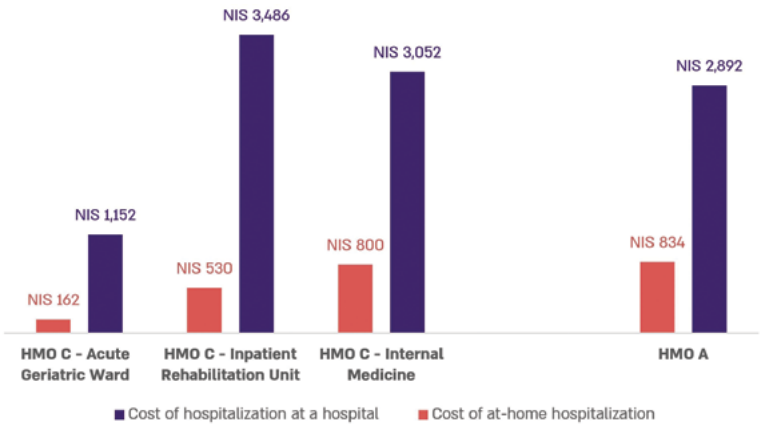
Hospitalization at General Hospitals Costs Versus Hospital-at-Home Costs

Hospitalization of HMO members in general hospitals is financed by the HMOs as part of the basket of services delineated in the National Health Law[45]. The Accounting Between Hospitals and HMOs Law for the Years 2021-2025 (Accounting for Health Services in General Public Hospitals), 2021 (the CAP Law)[46], governs the accounting procedures between hospitals and HMOs concerning the services provided to their members[47].

In order to enhance hospital-at-home care, the law permits a hospital and an HMO to reach an agreement stipulating that certain patients will receive treatment at home rather than being admitted to an internal medicine ward. Should such an agreement be established, the state may impose a reduced "usage cap" for inpatient hospitalizations. This implies that if the number of inpatient hospitalizations exceeds the revised cap, the HMO will be eligible for a discount from the hospital on payments – thereby creating a mutual interest for both parties to increase the utilization of hospital-at-home services[48].

The audit team conducted an examination of the average costs associated with hospital-at-home care compared to general hospitalizations for elderly patients across two HMOs, as illustrated in the following figure.

Figure 9: Average cost per-day of hospital-at-home care and general hospitalization among the elderly in two HMOs, 2019 - 2024 (in NIS)



According to the HMOs' data, processed by the Office of the State Comptroller.

45 HMOs are obligated under the Health Insurance Law to provide insured persons with a basket of health services, and therefore they purchase hospitalization services from any hospital capable of providing the required treatment, even if they do not own it.

46 The Accounting Between Hospitals and HMOs Law for the Years 2021-2025 (Accounting for Health Services in General Public Hospitals), 2021.

47 The main principles of this law are, on the one hand, setting a ceiling ("cap") for hospitals beyond which they are obligated to sell services to HMOs at a discount, and, on the other hand, setting a purchasing obligation for HMOs in each hospital ("floor") in order to ensure its financial stability and reduce the scope for competition to a desirable level.

48 The Cap Law, Section 13; the Ministry of Health website.

The figure indicates that the cost of hospitalization in a general hospital is significantly higher than the cost of hospital-at-home care: by approximately 247% for HMO A (NIS 2,892, about EUR 850, compared with NIS 834, about EUR 245, respectively); and, for HMO C, by 282% for hospitalization in an internal medicine ward (NIS 3,052, about €900, compared with NIS 800, about EUR 235, respectively), by 558% for hospitalization in a rehabilitation ward (NIS 3,486, about EUR 1,025, compared with NIS 530, about EUR 160, respectively), and by 611% for hospitalization in an acute geriatric ward (NIS 1,152, about EUR 340, compared with NIS 162, about EUR 50, respectively).

It therefore follows that, in addition to the benefits that hospital-at-home care offers patients, its cost to the HMO is significantly lower than the cost of hospitalization in a hospital. It is recommended that the Ministry of Health and the HMOs continue developing hospital-at-home services for the elderly, both as an alternative to hospitalization in internal medicine wards and as an alternative to hospitalization in other departments.

The Ministry of Health stated in its response that, as part of the financial support test and the CAP Law, it had established incentives to facilitate the referral of patients from hospitals to the HMO, which was regarded as a significant barrier. The Ministry asserted that expanding the practice of hospital-at-home care and fostering competition among various institutions and entities would advance this service. However, it also highlighted that the reduction in budgets allocated to financial support tests in the domain of at-home hospitalization represents a barrier and an impediment to the expansion or even the maintenance of the current level of activity. Furthermore, budgetary uncertainty constitutes a major obstacle in the market, thereby necessitating the designation of a stable budgetary source for this field.

It is recommended that, beyond the provisions established in the CAP Law, the Ministry of Health undertake a review of the incentive mechanisms to encourage HMOs to develop hospital-at-home services, and following the Ministry of Health's response, it is recommended that it take steps to allocate a budgetary source for the matter. Such measures would facilitate the expansion of these services targeting the elderly population and constitute a critical element of the health system's strategy in preparing for population ageing and the anticipated impacts on the general hospital system.

In view of the gap between the pace at which the needs of the ageing population are growing and the pace at which infrastructure, particularly the number of hospital beds, is being expanded to the levels required to provide an optimal response, it is recommended that, alongside efforts in this area and as part of the strategy for preparing the health system for population ageing, the Ministry of Health establish a process for developing hospital-at-home services as a significant alternative to hospitalization in general hospital departments

Summary

Although the elderly constitute approximately 13% of HMO members, they represent a growing proportion of individuals hospitalized in inpatient wards – approximately two-thirds of those hospitalized are aged 65 and over. The Shtesman Committee cautioned as early as 2011 that, without the development of alternatives in the community to hospitalization at hospitals, particularly for the elderly, increased burdens on the general hospital system are anticipated. Nonetheless, data from 2020 to 2023 indicate a 19% reduction in the number of general hospital beds per 1,000 individuals aged 75 and over (decreasing from approximately 42 beds to 34 beds).

Hospital-at-home care functions as an alternative to inpatient hospital care, combining medical, emotional, and economic advantages: it reduces exposure to infections and confusion, supports the maintenance of functional status and continuity of life, and alleviates pressure on hospital bed availability. The Ministry of Health published criteria for hospital-at-home alternatives and funded supportive tests for HMOs in 2023 and 2024, allocating approximately NIS 380 million. Accordingly, among people aged 65 and over, the rate of hospital-at-home care relative to hospitalizations in general hospitals nearly tripled, from 5% in 2021 to 14% in 2024.

From an economic perspective, the proportion of hospitalization expenses attributable to the elderly is projected to rise from approximately 47% in 2018 to roughly 57% by 2050, underscoring the need to develop more efficient alternatives. The data indicate that the average cost of general hospital care exceeds that of hospital-at-home care; specifically, the average cost of hospital-at-home is substantially lower by approximately 247% for HMO A, and by approximately 282%-611% for HMO C.

In light of the potential to transfer a greater proportion of general hospital care to hospital-at-home care, it is recommended that the Ministry of Health incorporate hospital-at-home care as a fundamental component of the national strategy for preparing for an ageing population, establish multi-year objectives for service expansion, investigate the factors contributing to the partial exploitation of this potential, and adjust the incentive system to motivate all HMOs to systematically invest in the development of hospital-at-home services for the elderly. The implementation of these measures would facilitate the transition of hospital-at-home care from an experimental model to a core service, reduce critical burdens on hospitals, and enhance the quality of life and care for the elderly population in Israel.

Summary

International Comparison of the Audit Questions

The tables below present the findings of the audit reports from Malta, Slovak Republic and Israel regarding the key audit questions.

Table 1: Is the concept of home-based medical services for the elderly a clear and independently recognized function within government's strategic objectives?

Malta	Slovak Republic
Partial recognition necessitating improvement. There is a wide array of home-based medical and clinical services; however, government is currently not actively seeking to encapsulate and cost these scoped services as an overall distinct concept. The audit recommends that MHAA may wish to consider developing a specific strategy for home-based medical and clinical services.	There exists a strategic commitment. The state made a commitment as earsly as 2011 to transition from institutional care to community-based services. These objectives are articulated in Ministry of Labor documents; however, the process of reducing the number of large-capacity facilities is proceeding slowly.

Table 2: Is sufficient budget being allocated for these services?

Malta	Slovak Republic	Israel
• Budgeting and expenditure data are not specific to clinical and medical home-based services but are part of broader budgets within each respective entity. Significant challenges exist in filtering financial expenditure data, proving impractical to extract. • Improved data management systems are required to facilitate effective data filtering, particularly where such data is considered a key input in the development of well-informed future plans and strategies.	• A substantial under-utilization of EU funds is evident, with approximately € 104 million remaining unallocated. • Expansion of capacity in community-based facilities using EU funds totaling EUR 141 million (as of July 2025); the effectiveness of these investments has not yet been evaluated. • The reimbursement rates for nursing care provided by insurance companies are both low and unrealistic. Consequently, although in 2024 senior care facilities delivered nursing care through their own staff in 10,702 instances, and in conjunction with home care agencies for 3,482 patients, the income derived from health insurance companies amounted to EUR 11.8 million, representing only 3.31% of the total income of EUR 356.9 million.	Approximately NIS 380 million, equivalent to approximately EUR 116 million, were allocated for home nursing support tests (2023-2024), with a utilization rate of 96%. However, this budget is not included within the core health basket and remains susceptible to reductions. The cost of hospital at home service was observed to be 247% to 611% lower than that of inpatient hospitalization in a hospital setting.

Table 3: Are sufficient human resources being allocated for these services?

Malta	Slovak Republic
While it was not possible to calculate accurate figures for staff complements and shortages related to these services throughout the audit period, it was identified that, at an aggregate level, an HR shortfall across the scoped entities of at least 19.4% relative to the actual deployed FTEs prevailed in 2024. This situation creates evident risks that the provision of these scoped services could be compromised, particularly (among others) in terms of timeliness, frequency and/or overall coverage. Additionally, the absence of operational data being stored in a manner that allows it to be readily filtered and comprehensively collated would invariably prove problematic where such information is required as an input for forward-looking service development, capacity-building exercises, and the formulation of future strategies.	There is a significant shortage of skilled staff (caregivers and healthcare workers). It has been estimated that approximately 4,000 additional employees will be needed by 2025. In addition, wages for social services employees remain relatively low, at approximately 71% of the average wage across the entire economy. Although one-time retention bonuses have been allocated, these measures do not constitute a systemic solution.

Table 4: Are these services developed and are there any plans for the future?

Malta	Slovak Republic	Israel
While home-based medical and clinical services for the elderly in Malta are already well developed, National Strategies do not lay out clearly defined strategic objectives on the further development, enhancement or expansion of these services. This becomes particularly relevant when one considers that various indicators point clearly at the expected increase in the demand for such services in the future. This audit recommends that government entities providing home-based medical and clinical services should improve coordination, communication, and information sharing, including establishing clearer referral pathways or possibly leading to a one-stop-shop approach which covers all involved entities.	• Since 2011, a trend of deinstitutionalization, characterized by the transition from large institutional settings to community-based care, has been initiated; however, its implementation has proceeded at a notably slow pace. • The disparity between the demand for and the capacity to provide services is widening: from 2020 onwards, the total capacity of institutions providing care for the elderly has increased by only 2,000 places, whereas in 2024 alone, 8,677 individuals submitted applications for social services within institutions providing care for the elderly. • The Recovery Plan (RRP) is projected to augment community care capacity by approximately 1,800 places by the year 2025.	There is formal strategic recognition (Resolution 150). • Among people aged 65 and over, the rate of home hospitalizations relative to hospitalizations in general hospitals nearly tripled, from 5% in 2021 to 14% in 2024, yet remains significantly below the potential rate (25%). • No multi-year objectives have been established, and the service is excluded from the baseline budget.

Summary

Population ageing constitutes an increasing challenge for health systems, attributable both to the rising number of elderly individuals and the considerable complexity of their medical, functional, and social needs. Within this context, the provision of medical care in community settings has emerged as a fundamental element in nations' capacity to ensure continuous, accessible, and appropriately adapted care, while also mitigating dependence on institutional and inpatient services.

A comparative analysis of Malta, Slovakia, and Israel reveals that all three countries acknowledge the importance of strengthening community-based services for the elderly. The audits also indicate that, although the level of development of these services varies between the countries, there remains scope in each country to further improve, expand, or adapt community-based services to meet the needs of the elderly population. In each country, the ageing demographic is already exerting, or is anticipated to exert, increased pressure on health systems, necessitating a transition in care delivery from institutional and inpatient facilities to home and community-based environments. The findings also highlight the importance of ensuring that diverse services, strategic planning, and allocated resources are supported by effective coordination, implementation, and monitoring mechanisms, so that community-based healthcare responses can continue to develop in an accessible, coherent, and sustainable manner.

The audit chapters pertaining to the three countries demonstrate that the advancement of community services for the elderly depends not solely on service expansion but primarily on the government's capacity to administer the sector as an integrated, quantifiable, and coordinated policy domain. In the absence of defined objectives, reliable data, demand forecasting, budgetary oversight, and workforce stabilization mechanisms, even systems with accurately identified strategic directions encounter difficulties in ensuring adequate and enduring responses.

Looking ahead, based on the comparative findings of the three countries, it is advisable that health systems develop a clear and actionable policy for the enhancement of community-based medical services for the elderly. This policy should encompass the establishment of measurable targets aimed at expanding alternatives such as hospital at home services, home medical and clinical services, and multi-professional community services, aligned with the projected growth of the elderly population and anticipated service demand. Furthermore, the creation of a systematic framework for the collection and analysis of data on service utilization, staff availability, costs, unmet needs, and treatment outcomes is recommended, to facilitate informed service planning and timely identification of gaps between needs and actual provision. It is also recommended that the expansion of community services be supported by the dedicated deployment of medical and nursing personnel, including adjustments in the number of positions and the adaptation of training and employment models to effectively deliver care in home and community settings.

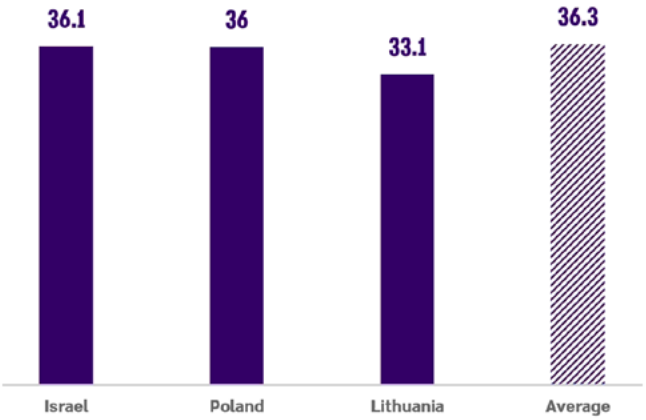
Preparing the Welfare System - Well Being and Quality of Life After Retirement

Introduction

Well-being is defined as a state encompassing physical, mental, and social wellness. It is manifested both subjectively, through experiences of happiness, satisfaction, self-actualization, and emotional equilibrium, and objectively, through conditions of health, functional capacity, and security. While illnesses and physical impairments may hinder functioning and cause discomfort, they do not necessarily determine the individual's sense of inner well-being. For the demographic aged 65 years and older (hereinafter referred to in this report as Senior Citizens), the capacity to maintain autonomy, foster meaningful social connections, and imbue life with significance and purpose facilitates the attainment of a fulfilling and satisfactory existence – characterized by well-being.

The significance of sustaining the well-being of senior citizens is increasingly marked by the rise in life expectancy as well as the extension of healthy life expectancy (Health Span). The latter denotes the duration of an individual's lifespan characterized by good health, absent of chronic illnesses and disabilities associated with advanced age; in other words, the expected years of life lived in good health relative to total life expectancy. This rise in life expectancy and health span implies that senior citizens currently experience a greater number of years in robust health and functional capacity compared to preceding generations. The following figure illustrates the quality-of-life index among those aged 65 and over in the countries examined in this report, alongside the average of the countries participating in the SHARE survey.

Figure 1: Quality of life index among individuals aged 65 and above in Lithuania, Poland, Israel, and the average of the countries participating in the SHARE survey, 2022



According to the SHARE survey, from the data of the Optimal Ageing Index Map, data file for processing 2022, processed by the Office of the State Comptroller in Israel[1].

The figure illustrates that, in both Poland and Israel, the quality-of-life index for individuals aged 65 and over is comparable to the average observed among the countries participating in the SHARE survey. In contrast, Lithuania demonstrates a slightly lower index.

This report, in which Lithuania, Poland, and Israel participated, addresses two primary components that may enhance the well-being of senior citizens: post-retirement employment and the identification of, and measures aimed at reducing, loneliness among senior citizens. Furthermore, the report examines the presence of comprehensive welfare policies for senior citizens within each country, the prevailing trends in these policies, and the strategies each country is adopting to address future challenges related to the well-being of the ageing population.

1 The SHARE survey (survey of health, ageing and retirement in Europe) is an international and multidisciplinary longitudinal study that forms the basis for examining the health, economic and social status of people aged 50 and over in Europe and Israel. The latest data is updated for Wave 9 from 2021-2022.

Post-Retirement Employment

The event of retirement, which signifies a disconnection from the structures that had previously organized one's schedule, responsibilities, social role, and sense of belonging, generates a situation wherein the retiree must reorganize their pattern of activity and sources of meaning in life. The numerous hours freed by retirement may become burdensome if the retiree fails to identify appropriate substitutes for work that will occupy the available time with activities imparting a sense of purpose and satisfaction[2].

In this regard, there is increasing acknowledgment of the significance of processes that foster participation, engagement, and the reinforcement of meaning following retirement and throughout the ensuing stages of life. As early as 2002, the World Health Organization (WHO) defined active ageing as a process aimed at optimizing opportunities for health, participation, and security, with the objective of enhancing quality of life as age advances[3].

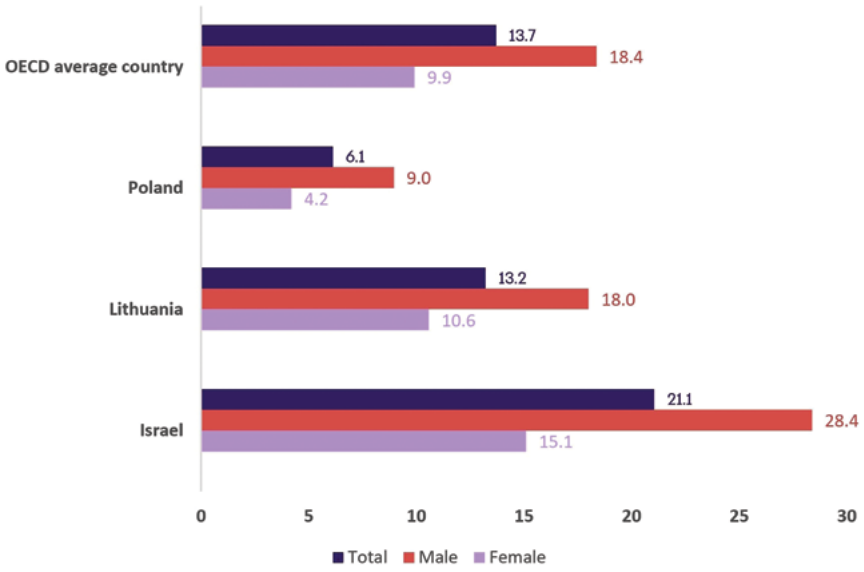
Table 1: Retirement Age

Lithuania	**The retirement age has been rising since 2012, by 4 months each year for women and by 2 months for men. This gradual rise continued until 2026, when the retirement age for women and men became the same and stood at 65.**
Poland	**60 for women, 65 for men.**
Israel	**As of 2026, the retirement age is 67 for men, while for women it ranges from 63 to 64 – due to a gradual rise stipulated in the Retirement Age Law, 2004[4], expected to reach 65 by 2032.**

Notwithstanding the statutory retirement age, the three countries examined in this report permit continued post-retirement employment, recognizing the substantial contributions to mental well-being and quality of life, alongside the economic benefits at both the individual and national levels. The figure below presents the employment rates of individuals aged 65 and over in Lithuania, Poland, and Israel, in comparison to the average rates across OECD countries for the year 2024.

2 Dahan, D., and Nimrod, G. (2016). Leisure patterns of retirees in Israel and their contribution to life satisfaction. Gerontology and Geriatrics 43(3), 63–82.
3 World Health Organization (WHO) (2002). Active Ageing: A Policy Framework **[link]**
4 The Retirement Age Law, 2004.

Figure 2: Employment-to-Population Ratio of Persons Aged 65 Years and Over: Israel, Lithuania, Poland and OECD overage, 2024



Source: OECD, Employment and Employment and unemployment by five-year age group and sex – indicators, Employment to population ratio, population aged 65 years or over, 2024. OECD Data Explorer.

The figure illustrates that in two countries, the employment rates of men and women over the age of 65 fall within the average range (in Lithuania) or exceed the average for OECD countries (in Israel), whereas in Poland, the employment rates of both demographic groups are below this average.

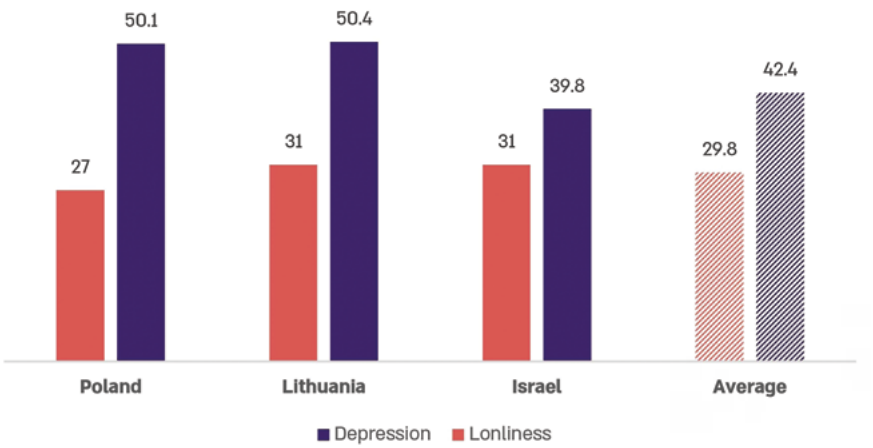
Locating and Addressing Isolation Among Senior Citizens

Loneliness constitutes a subjective experience characterized by an individual's perception of a discrepancy between the desired social connections and those actually accessible to them. Conversely, isolation is an objective condition marked by an absence of social connections. Although a positive correlation often exists between these two states, it is noteworthy that even individuals possessing a substantial number of social connections may still experience loneliness, whereas individuals who are alone, with limited social ties, do not necessarily report feelings of loneliness.

Loneliness is a phenomenon that can manifest across all stages of life; however, in later life it frequently co-occurs with other losses characteristic of this period, such as bereavement of friends and family members, as well as job loss. It is recognized as a principal factor adversely affecting the well-being of the elderly. The intersection of loneliness with these concurrent losses exacerbates mental, physical, and health-related risks, thereby detrimentally impacting the quality of life and potentially reducing longevity in this population. Furthermore, this interplay diminishes the capacity of senior citizens to marshal resources and resilience necessary to cope effectively with such challenges.

The following figure presents the prevalence of loneliness among senior citizens in Lithuania, Poland, and Israel, alongside the proportion reporting feelings of depression, as measured by the SHARE survey conducted in 2021–2022.

Figure 3: Prevalence of reported feelings of loneliness and depression among individuals aged 65 and older in Poland, Lithuania, Israel, and the average of all countries participating in the survey, 2021–2022



Source: SHARE survey data analyzed by the Office of the State Comptroller, Israel.

The figure indicates that rates of loneliness in Israel and Lithuania exceed the average observed across all SHARE survey participating countries, whereas Poland reports lower loneliness rates than the average. Additionally, the percentage of respondents reporting feelings of depression in Lithuania and Poland exceed the average, while in Israel these percentages fall below this comparative benchmark.

The Main Agencies Addressing the Welfare of Senior Citizens in the Participating Countries

Lithuania

The Ministry of Social Security and Labour coordinates policies on active ageing and social inclusion. Active ageing is a cross-cutting area of state policy implemented through cooperation among various ministries and requiring coordinated engagement across social, health, education, cultural, and digital policy areas, encompassing disease prevention, health promotion, lifelong learning, the development of digital and other skills, as well as the inclusion of the elderly in cultural and social life.

Municipalities, non-governmental organizations, and local communities, which provide social services and promote the social participation of the elderly, also have an important role.

Poland

The social assistance system in Poland supports individuals and families who are unable to overcome difficult life situations on their own[5]. Its goals are to meet basic needs, prevent crises, and achieve independence and social integration for beneficiaries.

The central and local governments are responsible for organizing social assistance and collaborating with non-governmental organizations, churches, as well as individuals and legal entities.

The main goals include[6]:

- supporting individuals in overcoming difficulties and achieving independence;
- ensuring a minimum level of income for low-income individuals;
- providing professional assistance to families affected by social problems;
- integrating the marginalized;
- developing a network of social services.

Social assistance encompasses benefits, social work, infrastructure development, needs analysis, and the introduction of new forms of support.

Benefits are provided upon request or ex officio. Decisions on the matter are made after a community interview conducted by a social worker. They take the form of an administrative decision, which may be appealed.

Social assistance is provided to individuals and families, in particular, due to: poverty, homelessness, unemployment, disability, long-term or serious illness, the need to protect mothers or families with many children, helplessness with respect to care, upbringing, and manageing a household, especially in single-

5 Social Assistance Rules - Ministry of Family, Labor and Social Policy.
6 Social Assistance Rules - Ministry of Family, Labor and Social Policy.

parent or large families, alcoholism or drug addiction, unforeseen events and crisis situations.

The right to cash benefits is granted to individuals and families whose income does not exceed the income criteria established based on the social intervention threshold.

There are two types of social assistance activities: community assistance, implemented in the beneficiary's home environment, and institutional assistance, provided in social welfare homes and support centers.

There are two types of social assistance benefits: cash benefits and non-cash benefits (in the form of in-kind or services). Cash benefits include, among others: fixed allowance, periodic allowance, targeted allowance, remuneration for providing care. Non-cash benefits include, for example: social work, meals, specialized care services, including in support centers, stays and services in a social welfare home[7].

The system operates based on the Social Assistance Act[8] of March 12, 2004. The organization and implementation of tasks rests with public administration bodies at various levels:

- Government administration (central level): The Minister of Family, Labor and Social Policy is responsible for general social policy and oversigh.
- Voivodeships (provinces): The voivode's responsibilities include coordination and supervision of facilities within the voivodeship.
- Counties: District Family Support Centers (PCPR) carry out tasks related to family support and foster care, including the organization of childcare and educational facilities. In cities with county rights, these functions are performed by the Municipal Family Support Center (MOPR).
- Municipalities: Municipal Social Welfare Centers (GOPS, MOPS), or Social Service Centers (CUS) are the basic units that have direct contact with those in need and carry out most tasks in the field.

Israel

There are three primary institutions responsible for addressing the welfare of senior citizens:

The Ministry of Social Equality and the Advancement of the Status of Women is tasked with integrating senior citizens into the community, ensuring the exercise of their rights, implementing activities to alleviate loneliness, and promoting employment. These services are delivered either through local authorities or directly by the Ministry[9].

The Ministry of Welfare and Social Security (the Ministry of Welfare) administers services for senior citizens via the Departments of Social Services (DSS) within local authorities. The Ministry establishes policy, supervises DSS activities, and co-finances the services. Its efforts concentrate on the development and provision of community-based services and on housing systems, aiming to enhance the quality of life and respond to the needs of senior citizens in Israel, in accordance with their functional status. Services target social participation, reduction of loneliness, volunteering, exercise of rights, and the prevention of

7 Chaczko, K. (2018). Organizacja pomocy społecznej w Polsce 1918-2018, Wydawnictwo naukowe Scholar.
8 Journal of Laws of 2025, item 1214 as amended; hereinafter: Social Assistance Act.
9 From the Ministry for Social Equality and the Advancement of the Status of Women website.

risk situations[10]. These services are available both to senior citizens known to the welfare system[11] and to the wider senior citizen population.

The National Insurance Institute focuses on safeguarding the rights of senior citizens and providing emotional support[12]. The Institute predominantly operates through volunteers who are themselves senior citizens.

The Audit Questions

a. What is the retirement age?

b. What is the employment rate of retirees in the years 2020-2025?

c. What is the target participation rate?

d. What actions were taken to encourage employment after retirement age?

e. Is loneliness referred to in the national policy for elderly?

f. Is loneliness measured? How?

g. Who is responsible for identifying lonely elderly people, and what methods are used?

h. What percent of lonely elderly participate in treatment programs?

i. Is there a national policy for welfare of the elderly? What topics does it include?

j. What are the budgets allocated?

10 From the Ministry of Welfare and Social Security website.
11 Citizens known to the welfare system are senior citizens for whom a welfare file has been opened.
12 From the National Insurance Institute website.

Lithuania

Audit Results

The Lithuanian national audit report: "Promoting Active Ageing" (17 March 2026) **[link]**.

introduction

Lithuania is one of the countries in the Baltic Sea region, with a population of approximately 2.9 million. Lithuania's welfare system is primarily based on a social insurance model, in which old-age pensions play a central role. In addition to social insurance, the system also includes state-funded social assistance targeted at vulnerable population groups. Active ageing describes a situation in which senior citizens continue to participate in the labour market, engage in voluntary activities, and, as they age, live healthy, independent, and secure lives. Therefore, active ageing policy should create conditions for longer participation in the labour market, ensure social inclusion, promote healthy lifestyles, and provide opportunities for independent living. The Ministry of Social Security and Labour coordinates policies on active ageing and social inclusion. Active ageing is a cross-cutting area of state policy implemented through cooperation among various ministries and requiring coordinated engagement across social, health, education, cultural, and digital policy areas, encompassing disease prevention, health promotion, lifelong learning, the development of digital and other skills, as well as the inclusion of senior citizens in cultural and social life. An important role is also played by municipalities, non-governmental organizations, and local communities, which provide social services and promote the social participation of senior citizens.

Against this background, Lithuania's rapidly ageing population makes both employment and loneliness critical and interconnected issues. In 2026, 28.8% of the population is aged 60+, and this share is projected to reach 43.5% by 2100, while those aged 65+ will make up 37.6% of the total population of Lithuania (compared to 20% in 2022), meaning a growing proportion of society will face challenges related to ageing.

Employment in older age is particularly relevant because many senior citizens remain economically active not only by choice but also out of necessity. Lithuania has one of the higher employment rates among people aged 65+ in the EU context, partly due to a low pension replacement rate and the possibility to combine pensions with work. At the same time, 36.9% of older adults are at risk of poverty, which is significantly higher than the EU average.

Loneliness is an equally important concern. As people age, risks of social isolation increase due to retirement, health limitations, or loss of social ties. In Lithuania, life expectancy is 77.6 years, which is below the EU average (81.7), reflecting ongoing public health and social challenges, while lower healthy life expectancy (60.9 vs. 63.1 years in the EU) further limits opportunities for active social participation.

For these reasons, employment and loneliness are closely linked: staying active in the labour market or in other forms of engagement (e.g., volunteering) can help reduce social isolation, improve well-being, and support financial security.

State policy is not geared towards the activities of an ageing population.

There is no integrated policy to promote active ageing

We assessed whether the areas of senior citizens well-being identified in the defined state policy and the importance of promoting active ageing in addressing issues related to the ageing of society; whether the country's strategic-level documents set at least one goal and/or objective for promoting active ageing and at least one impact indicator measuring the implementation of the goal and/or objective; whether at least one measure provided for in national planning documents for financing senior citizens NGO activities promoting active ageing has been implemented and whether all the indicators provided for in national planning documents for measuring the results of the implementation of such measures have been achieved.

On 25 June 2026, the Parliament of Lithuania adopted the Law on the Fundamentals of the Policy for Older People of the Republic of Lithuania, which establishes the objective, tasks and directions of older people's policy, defines the competences of state and municipal institutions and bodies in this area, provides for advisory institutions, sets out the role of organisations representing older people and organisations working with older people in implementing this policy, and defines the principles and requirements for work with older people. The adoption of the Law represents an important step towards a more systematic framework for older people's policy.

Lithuania's demographic ageing index[1] is constantly increasing and indicates an ageing society (134 in 2022, 148 in 2025). The situation is particularly challenging in some regions. The median age[2] of the country's population at the beginning of 2023 was 44 years (men – 40 years, women – 47 years). Since the beginning of 2013, the median age of the country's population has increased by 2 years. At the beginning of 2023, the median age of men was 7 years shorter than that of women[3]. A rapidly ageing society requires a defined senior citizens's policy.

In its 2025 Economic Survey of Lithuania, the OECD paid particular attention to demographic challenges, emphasizing that, due to the impending demographic shock in Lithuania, it is necessary to ensure the employment of older workers and promote a healthier lifestyle in society in various ways (other necessary actions mentioned include encourageing the return migration of workers of all qualifications and seeking to improve the healthcare system in an economically efficient manner).

1 Demographic ageing index – the number of senior citizens (aged 65 and over) per 100 children under the age of 15 at the beginning of the year.
2 Median age of the population means the age value that corresponds to the middle value of the variation series, i.e., it divides the population into two equal parts so that half of them are younger than the median age and the other half are older.
3 Population ageing - Official statistics portal.

At the international level, the goal of ensuring the inclusion and well-being of senior citizens[4] has been declared since 2002. One of the priorities is employment, which is closely linked to the promotion of active ageing, and the need to enable senior citizens to participate fully in political, social, economic, and cultural activities is also emphasized. The Madrid International Plan of Action on Ageing identifies three priority directions: Older persons and development; Advancing health and well-being into old age; Ensuring enabling and supportive environments. These objectives are broken down into ten commitments covering various areas of life: mainstreaming ageing; integration and participation; economic growth; social security; labour markets; lifelong learning; quality of life, independent living and health; gender equality; support to families providing care; regional cooperation[5]. Well-being of senior citizens is understood as a combination of health, a safe environment, social participation, economic security, learning opportunities, and dignity and rights, which can only function effectively when all these areas are in balance.

Policies do not consistently identify the importance of promoting active ageing in addressing the challenges of an ageing society. The topics most frequently mentioned in national strategic documents are: strengthening social security, quality healthcare, healthy lifestyles, LLL, and intergenerational solidarity. The promotion of active ageing is mainly linked to participation in the labour market. There is a lack of a integrated approach to active ageing that encompasses participation in political, social, economic and cultural activities.

The country's strategic-level documents recognize the impact of demographic ageing and the need to respond to challenges by promoting active participation and employment of senior citizens, but there is a lack of strategic direction, goals, and/or objectives directly aimed at promoting active ageing. Most of the objectives cover the entire population, including senior citizens, e.g., National Progress Plan (NPP) objectives 2.2. "Improve the well-being of people with disabilities and their families, senior citizens, and other vulnerable and socially excluded groups" and 2.7. "Strengthen social activity and social responsibility provisions in society and community spirit" also cover the senior citizens group, but their impact on active ageing is indirect. The Ministry of Social Security and Labour has indicated that the objectives of the NPP are broad in scope, so no specific goal/objective for active ageing has been formulated.

The country's strategic-level documents do not set any impact indicators to measure the implementation of active ageing promotion tasks. The goals and objectives of the NPP cover broad target groups, so no separate indicators for senior citizens were provided. The only relevant indicator is the at-risk-of-poverty rate[6] for people aged 65 and over. It is important, but insufficient to assess all aspects of active ageing. The Ministry of Social Security and Labour acknowledges that the existing indicators (e.g., risk of poverty) are not sufficient to assess the implementation of active ageing objectives. The draft law on the Framework for Senior citizens's Policy proposes to oblige the government to prepare a program for the development of policy on senior citizens, which would set out specific goals and objectives, measures, and indicators aimed specifically at promoting active ageing. This would also involve a review of the NPP and its implementation program to ensure that they adequately reflect the needs of this target group.

4 In 2002, the Second World Assembly on Ageing, held in Madrid, adopted the Political Declaration and the Madrid International Plan of Action on Ageing, which aim to ensure the inclusion and well-being of senior citizens.
5 UNECE regional implementation strategy.
6 Indicator values: 2022 – 39.5%, 2023 – 36.1%, 2024 – 36.1%, 2025 target – 35%.

According to the Senior citizens Survey, 40% of retired respondents had not been active in the last 12 months – they had not worked, volunteered, or participated in any other activities: education (training or lectures, e.g., on history, art, personal finance, war preparedness, computer literacy), cultural (e.g., excursions, performances, concerts, exhibitions), health (e.g., exercise, hiking, lectures on health or nutrition), communication-promoting (e.g., psychological counselling, helplines).

Lithuania has no budget allocated for the implementation of active ageing policies. Funds are distributed horizontally across the programs of various ministries (usually/in most cases without any clear reference to the needs of senior citizens. Most measures are aimed at the entire population, so it is impossible to determine what proportion of the budget is allocated to senior citizens policy. The Ministry of Social Security and Labour has confirmed that funding for senior citizens welfare policy is not consolidated but is spread across different programs and measures. Activities that often receive EU funding, such as education, employment promotion, and community development, contribute to the promotion of active ageing, therefore, there is a risk that the continuity of such activities will be jeopardized as this funding declines, creating a need for a long-term strategy for financing active ageing that is independent of EU support.

Without a clear and directly targeted goal, objective, or indicators for promoting active ageing, the policy is implemented in a fragmented manner: opportunities for long-term, coordinated, and effective planning, implementation, and impact assessment are limited to meet the needs of the rapidly growing senior citizens group.

Lack of coordination between institutions involved in promoting active ageing

We assessed whether the functions of the institution coordinating active ageing had been established and whether the institution was performing those functions.

The Minister of Social Security and Labour is responsible for the areas of social inclusion of vulnerable groups. From September 2024, the provisions of the Regulations of the Ministry of Social Security and Labour stipulate the function of formulating policies for active ageing and the social inclusion of senior citizens (aged 60 and over), organizing and coordinating their implementation, while ensuring opportunities for senior citizens to participate in public life. The regulations set out what the Ministry must do as a coordinating body. From a legal point of view, the established limits of responsibility form the basis for the Ministry of Social Security and Labour to act as the national leader in the area of active ageing, both at the policy-making and implementation coordination levels.

An analysis of the provisions of the Regulations, annual activity plans and reports (from 2022) of the Ministry of Social Security and Labour, and other information provided by the Ministry showed that although the Ministry of Social Security and Labour was assigned the functions of an institution coordinating the active ageing of an ageing society, it did not perform all of them sufficiently during the audited periods.

Table 1: Functions of the Ministry of Social Security and Labour in relation to active ageing and social inclusion policies for senior citizens (aged 60 and over), and the organization and coordination of their implementation

Functions assigned to the Ministry		Performance of functions			
In force until 09/09/2024	In force from 10/09/2024	2022	2023	2024	Q3 2025
Analyse the situation regarding the reduction of exclusion of senior citizens, other vulnerable people, and people experiencing social exclusion.	Analyse the situation of senior citizens (aged 60 and above) in Lithuania.	✔	✔	✖	✖
Prepare and submit to the Government draft legislation on reducing the exclusion of senior citizens (aged 55 and above), other vulnerable people, and people experiencing social exclusion.	Prepare draft legislation on how to promote the social inclusion of senior citizens.	✔	✔	✔	✔
–	Prepare proposals for state and municipal institutions and bodies on how to promote the social inclusion of senior citizens.			✖	✖
–	Submit proposals to state and municipal institutions and bodies on ensuring opportunities for social inclusion of senior citizens.			✖	✖
Coordinate the implementation of measures to reduce social exclusion and poverty.	Coordinate the implementation of measures aimed at promoting social inclusion of senior citizens.			✖	✖

✔- performed, ✖ - performed insufficiently, – - not foreseen.
Source: National Audit Office in accordance with the Regulations of the Ministry of Social Security and Labour, provided and publicly available information.

The performance of the functions of the institution coordinating active ageing in an ageing society assigned to the Ministry of Social Security and Labour was fragmented rather than a consistent strategic process based on the results of systematic monitoring:

- ✔ The Ministry analysed certain aspects of the situation of senior citizens, as necessary, when preparing legislation, reports or information for various institutions. The Ministry of Social Security and Labour conducted a one-off review of the situation of senior citizens for the report on the implementation of the Madrid International Plan of Action on Ageing submitted to the United Nations Economic Commission for Europe, and also participated in the assessment of the promotion of active ageing in Lithuania carried out by OECD experts. However, the process of assessing the situation of active ageing is not defined, the frequency, aspects to be analysed, data sources, etc. are not specified, and no permanent monitoring system has been established that would allow for a systematic assessment of the situation of active ageing at national and municipal levels.

- ✔ The legislation drafted was mainly related to the organization of tenders for NGOs representing the Ministry of Social Security and Labour. In recent years, the Ministry of Social Security and Labour has been participating in the preparation of the draft Law on the Framework for Senior citizens's Policy initiated by the Seimas.
- ✔ Proposals to state and municipal institutions are prepared and submitted in a fragmented manner, responding to the needs expressed by the senior citizens during episodic events and discussions, as the needs assessment process is not consistent and continuous, and remains informal. The Ministry has indicated that it does not have a specific process in place for preparing and submitting proposals on the social inclusion of the senior citizens, so this depends on the situation, form, and deadlines. Certain related proposals are submitted to the Senior citizens Council of the Ministry of Social Affairs and Labour.
- ✔ There is insufficient coordination of the implementation of interinstitutional measures aimed at promoting the social inclusion of senior citizens, even though senior citizens's policy is horizontal, spanning different areas of public administration and involving the activities of different ministries and other institutions. In the opinion of the Ministry, its activities in implementing the coordination function cover only activities in the area of social security and labour, mainly the organization of tenders for NGOs representing senior citizens. The activities of other institutions involved in promoting active ageing – ministries, their subordinate bodies, municipalities – are not coordinated in this area, e.g., the Ministry of the Interior and the Ministry of Agriculture, which contribute to promoting the activity of senior citizens by involving them in community activities.

Although the Ministry of Social Security and Labour is legally responsible for developing and coordinating active ageing policy, the practical implementation of this function remains limited due to insufficient human resources and capacity. The Horizontal Policy and Project Management Group of the Ministry of Social Security and Labour is the unit responsible for the development and implementation of active ageing policy. Its task is to seek to increase the social activity of senior citizens, initiate and submit proposals for legislative initiatives in the area of social inclusion of senior citizens, coordinate the preparation of or participate in the preparation of these initiatives and draft legislation implementing them. An analysis of the job descriptions of this group of employees showed that the functions of three employees are related to social inclusion, policy development, and monitoring, but the functions related to the development and implementation of active ageing policies are assigned to only one employee. OECD experts[7] emphasized that one of the main reasons for the limited capacity to carry out tasks is the lack of a specific division or department responsible for implementing the active ageing agenda. These resources do not ensure that the Ministry can effectively act as the national leader in the field of active ageing.

In the opinion of the Ministry of Social Security and Labour, it would be important to implement a more consistent analysis of the needs of senior citizens at both the national and local government levels. Better coordination of senior citizens's policy and the inclusion of senior citizens in decision-making processes at national and municipal level is planned in the draft Law on the Framework of Senior citizens's Policy. Among other things, it provides for greater attention to be paid to the analysis and monitoring of the situation

7 OECD report "Promoting Active Ageing in Lithuania", 2023.

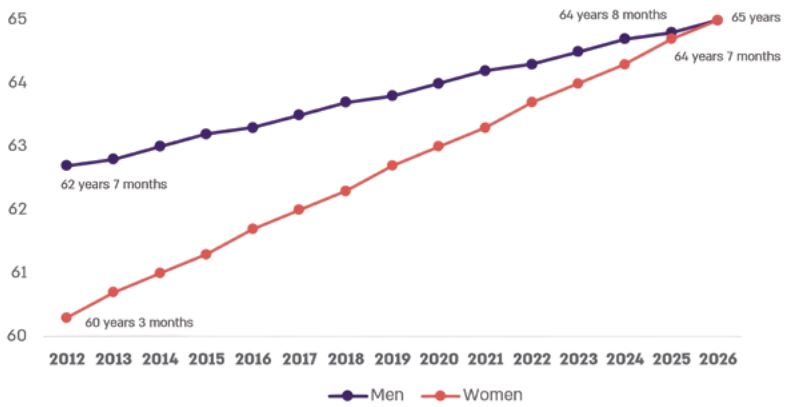
of senior citizens. There are plans to create a system for monitoring the situation of senior citizens, which will provide reliable, informative, and detailed data on the needs of senior citizens, broken down by gender, socioeconomic status, abilities, and other important characteristics at the national and municipal levels.

Coordination of active ageing promotion policies and planned funding – specific allocations for the organization and coordination of senior citizens's policies, would ensure the consistent, integrated, and evidence-based development and implementation of policies focused on the needs of senior citizens at the national and municipal levels.

State actions are insufficient to retain people of retirement age in the labour market

According to OECD data, Lithuania is one of the fastest ageing countries in Europe. With the working-age population declining, the pension system is under increasing pressure. To address this challenge, the retirement age in Lithuania has been gradually increasing since 2012. The retirement age for women is increasing by four months each year, and for men by two months. This gradual increase will continue until 2026, when women and men will retire at the same age – 65. In 2025, the retirement age for men will be 64 years and 10 months, and for women – 64 years and 8 months.

Figure 1: Changes in the retirement age – 2012–2026



Source: National Audit Office based on data provided by SODRA.

State planning documents do not provide for or implement measures to keep people of retirement age in the labour market. The documents emphasize the need to promote opportunities for the unemployed, persons with disabilities, and older persons, excluding the retirement age group, to remain in the labour market. Measures are envisaged for persons below retirement age, as all employment support policies and regulations are oriented towards persons of working age. The group of people of retirement age is left without clear support, and participation in the labour market depends mainly on individual motivation and economic incentives rather than on strategic actions or policies of the state. The Ministry of Social Security and Labour confirmed to the auditors that in in the period between 2022 and the first half of 2025, there were no activities, initiatives, or projects related to retaining people of retirement age in the labour market. No indicators have been planned for the employment of this group of people.

In implementing the 18th Government Program, the Ministry of Economy and Innovation (MoEI) was assigned to develop and implement programs to accelerate entrepreneurship among seniors and provide entrepreneurship training. In view of this, the MoEI's subordinate institution, the Innovation Agency, implemented the business development and creation program "Start at 50" in 2022-2024, aimed at a broader age group – people aged 50+, rather than just senior citizens (i.e., people of retirement age) as planned by the Government of the Republic of Lithuania). The age of participants is not recorded, so there is no data on how many people of retirement age participated in the program, how many of them started a business or remained in the labour market. Without data, it is not possible to assess the impact and benefits of the program for participants aged 60+ or of retirement age. The program was continued in 2025 and 2026.

The 20th Government program envisages to approve and implement a silver economy development strategy tailored to the needs of the older population, which would include measures to keep people of retirement age who are able and willing to work in the labour market, as well as solutions for health promotion, healthcare, rehabilitation, and social assistance relevant to working people of retirement age, and striving for the implementation of silver economy measures tailored to the needs of an ageing society, which would include development of opportunities for people of retirement age to remain in the labour market (more flexible working hours, retraining programs, reducing age restrictions), as well as health, healthcare, rehabilitation, and social assistance solutions relevant to working people of retirement age. As part of the program, the Ministry of Economy and Innovation has been tasked with developing and implementing, by Q3 2028, a silver economy entrepreneurship acceleration program tailored to the needs of an ageing society. This program will support the creation of products that help senior citizens remain active in society.

Pensioners in Lithuania can work without losing their pensions – they do not have to choose between work and retirement. In addition, their pension may increase each year while they are working. The old-age pensions of working pensioners are automatically recalculated each year, taking into account the additional length of service acquired in the previous year and the social insurance contributions paid. This system encourages people of retirement age to remain active, allowing them to work without losing their pension, and their pension increases depending on their work, but in terms of financial incentives, this is a symbolic increase.

In Lithuania, the possibility to fully combine work and old-age pension is the most important pension flexibility mechanism. Early retirement is unpopular due to strict rules, and pension deferral is rare despite relatively generous conditions. According to Eurostat data for 2023, around 45% of new pensioners in Lithuania continue to work on a normal schedule, which is three times higher than the EU average - around 15%. The employment rate among people of retirement age in Lithuania, especially those aged 65-69, is one of the highest in the EU, reaching 30% in 2023, compared to the EU average of 15%. According to researchers, one of the challenges is the availability of information about flexible retirement options, because if people are unaware of the possibilities, the mechanisms do not work.

According to the Senior citizens Survey, the main reasons why respondents worked/are working after reaching retirement age are job satisfaction, the desire to fulfil themselves (49.9%), desire to be busy and feel needed (44.9%), as well as financial reasons – old-age pensions and social guarantees are insufficient for living (41.2%), desire to increase pension, need to support relatives (35.7%).

State planning documents do not provide for or implement measures to help civil servants prepare for retirement (e.g., a mentor before retirement, an information package, consultations on opportunities to participate in education, training, health, culture, voluntary or other activities), although such measures would help people plan and prepare for a new stage in their lives. The Ministry of Social Security and Labour confirmed to the auditors that in the period between 2022 and the first half of 2025, there were no activities, initiatives, or projects related to preparing civil servants for retirement in the Ministry's area of responsibility. A lack of emotional, social, and financial preparedness for retirement may reduce opportunities for active ageing and increase the risk of social exclusion and poverty.

International experience shows that preparing for retirement—especially through information and counselling (financial, emotional, social)—has significant benefits, helps people transition more smoothly into a new stage of life, and reduces the psychological challenges[8] associated with retirement. A 2024 review in the US on how to make the most of one's retirement years indicates that senior citizens counselling prior to retirement can influence attitudes toward this important life change.

According to the Senior citizens Survey, almost a third of respondents are sceptical about the need for services that help prepare for retirement, but this view is more common among people who have reached retirement age. Respondents who have not yet reached retirement age are significantly more likely to recognize the benefits of such services, which indicates greater awareness and a greater need for preparation among this group. Both pensioners and respondents who are still working or have taken early retirement value legal assistance the most, while information about career and volunteering opportunities is the least relevant, especially for those who have already retired.

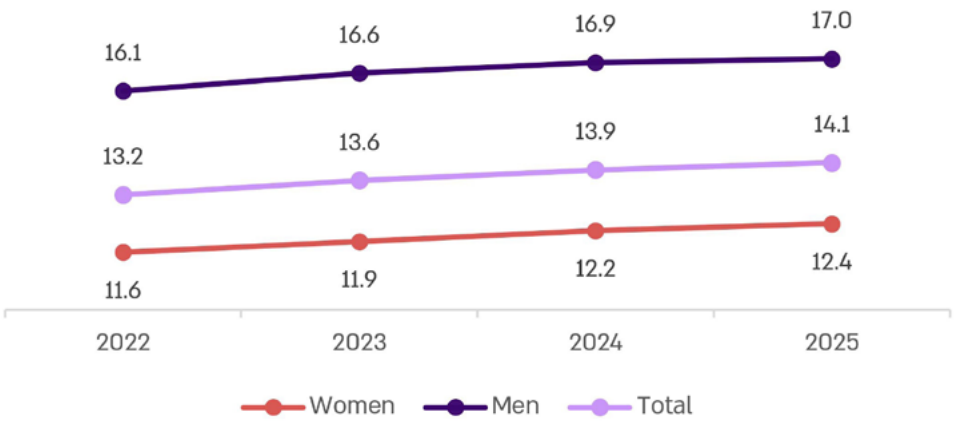
8 The eLeaP® platform specializes in learning, compliance, and performance management in the life sciences, aviation, manufacturing, finance, and technology sectors.

Employment rate of persons of retirement age

There is no target employment rate for people who have reached retirement age in the state, and the indicator is not included in strategic planning documents. National employment policy focuses on the 20-64 age group, who have not yet reached retirement age, as one of the indicators in the 2021-2030 NPP is the employment rate of the population aged 20-64(%) and the target values for 2025 and 2030 are 78.7% and 80.7% respectively. In the absence of a target for the employment rate of people of retirement age, there is a lack of clear strategic direction and the ability to assess progress in this area. This limits the ability to address the challenges of an ageing society and support the inclusion of senior citizens in the labour market.

According to SODRA data, the share of old-age pension recipients working in Lithuania in December 2022-2024 and June 2025 steadily increased from the total number of old-age pension recipients. Over the entire period, the share of men and women combined increased from 13.2% to 14.1%.

Figure 2: Proportion of pensioners working in Lithuania in December 2022-2025 out of all pensioners, %.



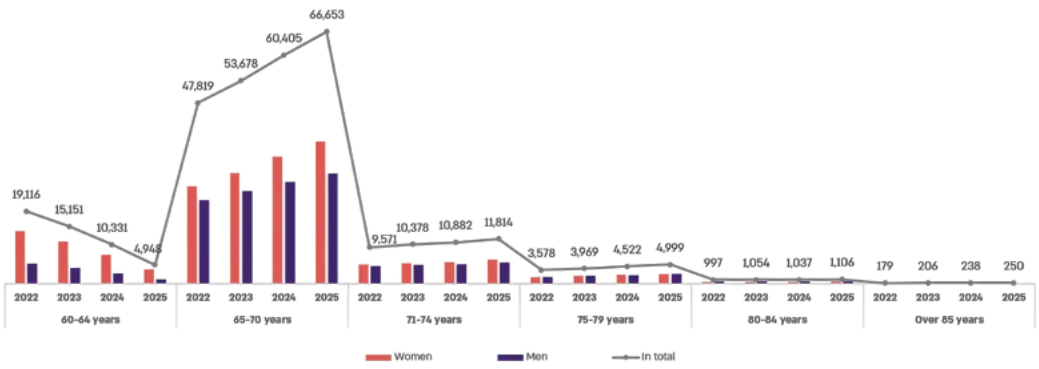
Source: National Audit Office based on data provided by SODRA.

According to SODRA data for December 2024, the proportion of working pensioners out of all pensioners varied between municipalities from 7.2% to 19%. This indicates uneven regional integration into the labour market for various reasons, including regional economic opportunities, accessibility of services, population structure, and differences in local government initiatives.

The Senior citizens Survey showed that more than half of respondents (56.2%) worked or are working after reaching retirement age. 80% of respondents who are working/have worked continued to work without interruption after retirement, and their work was permanent. Education is closely related to employment in retirement – as many as 77.4% of working/previously working pensioners have a higher education, and these individuals are more likely to find opportunities/motivation to continue working.

The largest share of working pensioners is made up of people aged 65–70. According to SODRA data, for example, in 2025 this age group accounted for 74% of all working pensioners. Throughout the year, more women worked in this group – from 17% to 29%. This shows that the most active in the labour market are the "younger" pensioners. According to SODRA data, the number of the oldest working pensioners, those over 90 years of age, is also increasing every year: in December 2022, 10 people (the oldest being 94 years old) were working in this age group, and in 2025, 18 (the oldest being 97 years old).

Figure 3: Number of working pensioners by age group and gender



Note: The significant decline in the number of working pensioners aged 60-64 between 2022 and 2024 may have been caused by the extension of the retirement age.
Source: National Audit Office based on data provided by SODRA.

In Lithuania, people of retirement age choose to remain in the labour market for longer time. On average, men work longer than women after retirement. According to SODRA data, since 2022, the average age of working people of retirement age has increased from 67.4 to 68.2 years. In 2025, the average age of working men of retirement age was 68.5 years, while for women it was 68 years.

According to the Senior citizens Survey data, the majority (37.8%) of respondents who had reached retirement age had worked for 3-5 years, while longer periods of work in retirement were less common. One-third had worked for up to 2 years. About one-fifth (21.9%) of working pensioners who are no longer working indicated that they worked for a longer period of time after reaching retirement age – 6-10 years. Working in retirement is usually a temporary solution related to personal needs or a desire to gradually withdraw from the labour market.

According to SODRA data, working people of retirement age are mostly concentrated in specific professional fields, such as management, education, healthcare, and transportation. These professions require many years of experience and qualifications (e.g., doctors, teachers, company managers), there is a shortage of labour (e.g., healthcare, education, transport), and more flexible working hours are possible (especially in management positions). They are most dependent on the retirement age labour force.

In some professions, pensioners make up a significant proportion of the total workforce – up to a third, according to SODRA data. Certain professions are particularly dependent on older workers, with pensioners making up the largest share of the workforce in professions dominated by physical or unskilled labour (e.g., caretakers, cleaners) and areas requiring many years of qualifications and experience (e.g., doctors, teachers, managers): 29% of caretakers and related professions; 15-20% of cleaners and other unskilled workers; 10-20% of drivers; 10-16% of healthcare workers; 10-12% of education and science workers; 10-11% of managers. Retirement-age workers fill important niches in the labour market that might otherwise remain unfilled, e.g., due to a shortage of new specialists or inadequate working conditions that do not attract younger workers. This points to the potential for targeted policy measures, both to ensure adequate working conditions for seniors and to plan for workforce renewal in these areas.

In order to determine the employment rate of people of retirement age at the national level, it is important to assess their potential ability to work and motivational factors – how much a person can, wants, or must continue to work. According to the Senior citizens Survey, the main reason why respondents work/worked after reaching retirement age[9] is financial. Most say that their pension is not enough to live on, and they want to increase their future benefits or help their relatives – this was confirmed by 61% of respondents of retirement age who are currently working or have worked after reaching retirement age. However, money is not the only reason. Half of those surveyed said that they enjoy/enjoyed working and that it makes them feel meaningful. 45% wanted to remain active and needed, while almost a third sought to maintain social connections.

The non-participation of respondents of retirement age in the labour market is most often determined by health problems (37.2% of respondents), as well as a lack of motivation, fatigue (17.4%), difficult working conditions (work is physically too hard – 20.6%, excessive workload – 15.8%) and social needs (desire to spend more time with family, hobbies or travel).

Most unemployed respondents of retirement age do not plan to return to work and are not looking for work – 99.2%. This situation can be explained by the fact that, according to Eurostat data, healthy life expectancy in Lithuania is 60.9 years, which is lower than the EU average of 63.1 years. Thus, most people reach retirement age already having health problems that limit their ability to work.

In order to encourage the participation of people of retirement age who are willing and able to work in the labour market, it is necessary to prevent discrimination, adaptation of working conditions, application of more flexible forms of work, and retirement planning, based on evidence and international recommendations, which would create the conditions for the full participation of this age group in the labour market and contribute to the country's economic and social sustainability.

9 60% of respondents of retirement age work for financial reasons. 62% of respondents are currently unemployed, but have worked for financial reasons since reaching retirement age.

The problem of loneliness among senior citizens in the state is not being addressed

Loneliness is not identified as a separate social problem

We assessed whether at least one strategic document of the state identifies the problem of loneliness among senior citizens and sets a goal for addressing it; whether the impact of loneliness among senior citizens (on individuals and/or the state) has been assessed in the country.

Loneliness is a subjective feeling arising from a lack of social relationships; it is not the act of being alone, but rather the negative feeling of being alone. It differs from "social isolation," which has an objective meaning—it describes the absence of relationships with other people or a small number of meaningful relationships—and from "solitude," which means voluntarily being alone[10].

Sociological studies confirm that nearly one-third of senior citizens worldwide experience loneliness and/or social isolation. Data on their impact show significant and long-term negative consequences for people who are considered lonely and/or socially isolated. Although this experience can occur throughout a person's life, it has been found that half of people over the age of 60 are at risk of social isolation, and a third will experience some degree of loneliness later in life[11].

The problem of loneliness among senior citizens is not identified in any of the state's strategic documents, nor is there a goal set for addressing this problem[12]. Aspects related to loneliness can be seen in the areas of health, social protection, culture, and non-formal education, e.g., social inclusion, emotional well-being, and strengthening community spirit, but loneliness is not identified as a problem to be addressed.

The Ministry of Social Security and Labour presented its opinion to the auditors that loneliness is not identified as a separate problem in national strategic documents but is integrated into programs or measures related to the development of health, social security, and active ageing policies. Given that ageing policy is horizontal, covering many areas and topics, the problem of loneliness can be addressed in the context of a broader goal related to the social inclusion and participation of senior citizens. This allows for the development of comprehensive solutions to this problem, covering the emotional, social, and physical well-being of senior citizens. In view of this, the Ministry of Social Security and Labour believes that there is no need to single out the problem of loneliness as a separate area.

10 Technical report by the European Commission's Joint Research Centre (JRC) entitled "Risk factors for loneliness," 2022. The JRC is the European Commission's science and knowledge service, whose purpose is to provide evidence-based scientific support to European policy-making.

11 Berg-Weger M., Morley J. E. (2020). Loneliness and social isolation in senior citizens during the Covid-19 pandemic: Implications for gerontological social work; Fakoya et al., 2020.

12 National progress strategies Lithuania 2030 and Lithuania 2050, National Progress Plan for 2021–2030, 18th, 19th, and 20th Governments programs and their implementation plans.

Research conducted by the EC shows that policy responses to loneliness must be based on a clear understanding of the phenomenon and its main determinants. Policy makers need to know which population groups are more prone to loneliness and why, so that they can propose effective solutions and target measures to address this problem.

The Senior citizens Survey reveals that feelings of loneliness are a widespread problem among senior citizens. Over the past 12 months, 34.5% of respondents felt lonely very often, often, or sometimes.

The feeling of loneliness is a particularly pressing problem for senior citizens: one in ten people aged 85 and over often feel lonely, and almost one in five, almost half (48%) of people aged 75 and over, feel lonely very often, often or sometimes. The proportion of men and women who feel lonely very often is similar, but twice as many women as men feel lonely often. Frequent feelings of loneliness are particularly common among the least educated groups: more than a third (36%) of those with primary education and almost half (43%) of those with no education experience loneliness. One-fifth of people who live alone and more than a quarter of those who live with people with whom they have no family ties often feel lonely.

After analysing the country's strategic documents and the documents of the Ministry of Social Security and Labour and the Ministry of Health, we can conclude that no systematic analysis or research has been conducted in the country to assess the impact of loneliness on the health and well-being of individuals and on the state (health and social security systems, economy). This is also confirmed by representatives of the Ministry of Social Security and Labour, the Ministry of Health, and the Health Insurance Fund. According to the Ministry of Social Security and Labour, such an assessment would provide a better understanding of how loneliness affects the mental and physical health of senior citizens, their social activity, and their quality of life. In addition, it would help to assess the consequences of loneliness for the state health care system and social services. Based on the results of such an assessment, it would be possible to develop targeted prevention programs, strengthen community spirit, and reduce social exclusion.

Research shows that loneliness is not only an emotional burden, but also a physical and economic one, which promotes disease, impairs mental health, increases mortality and government spending on healthcare, and hinders economic activity.

Strategic government documents do not identify the problem of loneliness among senior citizens, do not set specific goals for reducing the problem, or assess the impact of loneliness on individual health and well-being, government spending, or the social system. As a result, no long-term and coordinated solutions are being developed, no funding is being allocated, no specific measures to reduce loneliness are being planned, and the problem of loneliness among the senior citizens may remain unresolved, increasing the social and economic burden on the state.

Loneliness is not systematically measured

We assessed whether the indicator for measuring the level of loneliness among senior citizens in the country and the criteria for identifying lonely senior citizens had been established.

An analysis of the country's strategic documents, the 2022-2025 strategic and annual activity plans of the Ministry of Social Security and Labour and all 60 municipalities, SDA Data Agency (SDA) and Institute of Hygiene (IH) data showed that Lithuania has not established or monitored an indicator to measure the level of loneliness in the country or municipalities. This limits the formation of effective, targeted, and evidence-based policies.

The prevalence of loneliness in Lithuania is assessed in separate international and national studies. The data from these studies show that some senior citizens do not have close social ties, live alone, experience a lack of emotional connection, and remain socially inactive. Although there are certain alternatives for communication (e.g., telephone calls or the internet), they only partially compensate for live communication (example).

Examples of studies covering aspects related to loneliness

SHARE survey (2021, wave 9)

One in ten people aged 65+ in Lithuania feel lonely and live a secluded life. The difference in loneliness levels between the 50-64 and 65+ age groups is one of the largest in the EU. Four out of five seniors do not have a single close non-relative. A small network of significant people leads to feelings of isolation and a lack of companionship.

OECD study "Promoting Active Ageing in Lithuania" (2023)

One-third of senior citizens sometimes feel lonely, and one in ten feel lonely often. Only <30% of older Lithuanians meet with family or friends at least once a week (EU – >50%). However, communication often takes place by telephone or e-mail – this indicator is one of the highest among OECD countries in Lithuania. Social connections are small and homogeneous, with communication most often taking place with <2 people of a similar age. In Lithuania, more than 40% of people aged 65+ live alone, which is higher than the average for OECD countries in Europe (32%). An example of good foreign practice is the Danish model, which operates a one-stop shop system with a case manager who visits the elderly person at home. Not only nursing care issues are addressed, but also loneliness and other social problems. Case managers are specially trained to identify risk factors, including loneliness.

European Commission study (2022)

Approximately 12-13% of Lithuanian residents surveyed felt lonely most of the time or constantly during the four weeks prior to the survey (the countries ranged from 9-10% – the lowest level of loneliness, to 18-20% – the highest level of loneliness).

Silver Line Interviewee Survey (2023)

Typical interviewee: a widow over 75 years of age, a woman with a higher education, living alone in a city. >40% do not have close friends or family with whom they can talk openly. Most communicated with 1-4 people, but as many as 75% communicated with a Silver Line volunteer. The survey reveals that those who consciously recognize their loneliness are the ones who seek help.

In the opinion of the Ministry of Social Security and Labour, it would be useful to create and continuously monitor a loneliness indicator, as this would contribute to the development of data-based senior citizens policy, better planning of support measures, and assessment of their impact. The level of loneliness is assessed on the basis of individual studies, most often through surveys, based on subjective responses about emotional connection, lack of communication, or feelings of isolation. Loneliness is a complex phenomenon related to both objective social exclusion and subjective experience.

Lithuania has no legally established definition of loneliness and no criteria for systematically identifying lonely senior citizens at the national or municipal level. Aspects related to loneliness are assessed as one of the aspects of social independence and social risk when a person applies for social services (example). Those who do not apply remain unnoticed. Without data on how many lonely senior citizens there are and who they are, services to reduce loneliness cannot be planned and targeted effectively, and they do not reach those who need them most. This increases social exclusion and self-isolation and exacerbates health problems (mental and physical).

In the opinion of the Ministry of Social Security and Labour, it would be difficult to define the criterion of loneliness in a legal act, because defining and listing the criteria would not constitute an exhaustive list and would leave room for interpretations arising from personal, subjective experience.

In Lithuania, the single person's allowance is also focused solely on physical loneliness and is granted according to criteria clearly defined in legislation relating to family status (e.g., no spouse, widowed) and health or age aspects. Therefore, the number of people receiving the single person's allowance does not reflect the actual number of single senior citizens in the country. According to SDA data, in 2024 there were 235,000 recipients of such allowances (147,000 women and almost 88,000 men). In addition, the data on allowance recipients is not broken down by age group, so it is not possible to determine exactly how many of them are senior citizens.

There is no institution in Lithuania responsible for identifying vulnerable senior citizens who need assistance. NGOs play an important role in identifying vulnerable senior citizens. For example, the Lithuanian Pensioners' Union "Bočiai," other NGOs representing senior citizens, Lithuanian Caritas, the Maltese Order's relief service, and the Lithuanian Red Cross are able to identify lonely individuals through dialogue and community involvement. Their approach is flexible and based on an assessment of individual situations, taking into account the person's living conditions, emotional and social state.

The Senior citizens Survey showed that 87% of respondents who felt lonely very often, often, or sometimes did not seek help. There is a psychological and informational barrier to seeking help – one-third of people who have experienced loneliness have never considered seeking help, and almost as many know where to turn but have never done so. This shows that knowledge alone is not enough – there is a lack of motivation, trust, or a prevailing sense of shame and stigma. Another fifth do not acknowledge the problem, stating that they do not need to seek help (even though they felt lonely). This shows the need to expand information channels tailored to different audiences (especially the senior citizens), reduce the stigma associated with asking for help, and strengthen the role of local communities in disseminating information and organizing assistance.

Measuring loneliness is a complex process, as it is a subjective and personal feeling that is not always easy to reveal or assess objectively. Therefore, two main methods are used in practice: direct self-assessment and indirect scales. The EC Joint Research Centre indicates[13] that in the case of direct assessment, respondents are asked how lonely they felt during a certain period of time. Since loneliness is still socially stigmatized in society, this method may not adequately reveal the true extent of loneliness. Indirect assessment methods are based on scales of several statements that deliberately avoid the words "lonely" or "loneliness". This allows the topic of loneliness to be depersonalized and the prevalence of this phenomenon to be assessed more accurately. Therefore, in order to reliably identify lonely individuals and formulate effective policies, it is necessary to apply validated, sensitive, and context-appropriate assessment methods.

It is important to establish clear criteria and data collection procedures that would enable the identification of isolated senior citizens and the assessment of their situation at the national and municipal levels. Without such a system, decisions on services to reduce loneliness are not based on data, and assistance does not reach those senior citizens who need it most. Monitoring would provide a better understanding of the extent and impact of loneliness on health and emotional well-being and would also enable the development of more effective interventions to reduce social exclusion and loneliness.

Individual measures to reduce loneliness are being implemented

We assessed whether at least one measure provided for in the state planning documents to address the problem of loneliness among senior citizens had been implemented; whether at least one such measure had been implemented by each municipality or its PHO; and whether all the indicators set to measure the results of such measures had been achieved.

Based on an analysis of government and ministry planning documents and the information provided, individual initiatives are being taken to help address the problem of loneliness among senior citizens. In 2022-2024, one targeted state measure was implemented – an NGO project to provide emotional and psychological assistance services to senior citizens by telephone was funded. A total of EUR 0.7 million from the state budget was used for the project in 2022-2024, and EUR 0.2 million is earmarked for 2025.

For the measure implemented in 2022-2024 to address the problem of loneliness among senior citizens, the indicator "Number of senior citizens who have received emotional, psychological, and informational assistance (persons)" was set, and its value has been achieved and exceeded every year: the annual target was 3,000 persons, but the actual value significantly exceeded it (1.6 times in 2022, 2 times in 2023, and as much as 3.5 times in 2024). This indicates a high demand for such assistance, but without knowing the number of single senior citizens, it is unclear what proportion of those who need this assistance receive it.

Other measures related to addressing the problem of loneliness and social isolation among senior citizens have also been implemented: promoting community spirit and intergenerational dialogue, volunteering, cultural, health, and non-formal education activities, but their impact on reducing loneliness is unknown. There are no indicators to help assess the impact of state actions on reducing loneliness among senior citizens. This limits evidence-based decision-making and the targeted planning and implementation of activities.

13 Technical report by the European Commission's Joint Research Centre (JRC) entitled "Risk factors for loneliness," 2022. The scientific information presented in this publication does not reflect the official policy position of the European Commission.

One of the measures related to reducing loneliness among senior citizens is the Social Prescription initiative, which was initiated and coordinated at the national level (by the Ministry of Social Security and Labour and the Ministry of Culture) for 2023–2025 and is being implemented by municipal PHOs. The activities of the initiative (culture, health, non-formal education, or other activities available in the community and municipality) are not specifically aimed at reducing loneliness, but targeted groups — people of retirement age who experience loneliness, isolation, loss, etc. — should help to reduce it by involving them in such long-term activities. The initiative will cost the state budget EUR 0.3 million in 2023-2025: EUR 60,000 in 2023, EUR 151,000 in 2024, and EUR 80,000 in 2025. The amounts do not include funding for Social Prescription coordinator positions, as the Ministry of Health does not have data on the exact number of such positions.

In 2023-2025, more and more municipalities joined the Social Prescription Initiative: 4 in 2023, 17 in 2024, and 18 in 2025. The initiative was implemented in at least one year by 18 municipalities (out of 60), while the remaining municipalities did not implement the initiative.

In 2023-2024, the Social Prescription initiative was implemented in 17 PHOs, but only quantitative indicators were collected – the number of activities and participants, rather than the impact. In 2023, 731 people participated in the initiative (the planned values were set). In 2024, the overall indicator for the number of people participating in the Social Prescription initiative was exceeded (achievement of 164%), as there were 3,226 participants, while 1,970 people were planned. However, 4 out of 17 PHO indicators were not achieved: 3 achieved 90-99%, and 1 only 34%, because the municipality did not receive a sufficient number of participants. It was not assessed and there is no data on whether the project reached the target group based on the participant selection criteria, so it is not possible to assess the impact of the initiative in reducing the loneliness of senior citizens. The indicators were not set in either the municipalities' or the PHO's planning documents. In 2025, 2,541 participants are planned, which is 21.2% less than the actual number of participants in 2024.

The institutions involved in the implementation of the initiative – MoC, MoH, IH, PHOs – face significant systemic and organizational challenges. The main problems identified are: difficulty in reaching the target group (lonely, passive seniors), lack of participation and referral by family doctors, limited geographical accessibility, etc. The implementation plan for the provisions of the Program of the 20th Government stipulates that by the Q4 of 2027, the Ministry of Culture, together with the Ministry of Social Affairs and Labour, the Ministry of Health, and the Ministry of Education and Science, must create an interinstitutional mechanism for the implementation and efficient coordination of the Social Prescription Program in order to improve the inclusion of vulnerable social groups.

The description of the procedure for implementing the Social Prescription initiative sets out the criteria for selecting participants, one of which is "Visits the family doctor's team or the primary outpatient mental health care team more often than necessary for psychosomatic reasons." Based on the information provided by the 17 PHOs that participated in the initiative in 2024, in practice, the PHOs do not systematically assess participants' compliance with the criterion. Only three municipalities used partial assessment by doctors or coordinators. Participants are usually selected on the basis of voluntary participation, direct registration, or invitations from coordinators, rather than referrals from doctors. The main reasons for this are data protection restrictions, undefined assessment methodology, lack of involvement of family doctors, and practical and ethical difficulties in assessing the criterion "more often than necessary".

Another criterion for participant selection is that "the person experiences loneliness, isolation, loss, poor well-being due to chronic diseases or other physical or mental health disorders, or has a disability." According to the information provided by the participating PHOs, they most often rely on the coordinator's subjective assessment and the participant's self-reflection rather than a formal assessment of health or psychological condition. This allows more participants to be reached but makes it more difficult to identify the target group according to the Social Prescription description. Individual PHOs used a more structured initial interview or psychologist's recommendations. Most others emphasize that there are no methodological guidelines or requirements for formal assessment of criteria, so all motivated participants of retirement age are included in the initiative.

In 2022-2025, most of the measures implemented by the PHOs were aimed at strengthening mental health and preventing suicide. The measures are related to addressing the problem of loneliness, but they are aimed at people of different age groups, without distinguishing senior citizens.

The measures implemented by the PHOs related to mental health promotion or suicide prevention are assessed collectively, without distinguishing senior citizens. Since people of different age groups participate in the activities, and it is not intended to collect data on their age or experience of loneliness is collected during registration, it is not possible to determine what proportion of senior citizens participate in them or which of them are lonely. Therefore, it is impossible to assess the impact of these activities on reducing loneliness among senior citizens, and without a clearly defined target group, the activities cannot systematically address the problem.

The 2023-2024 MoH data on the values of the assessment criteria for the provision of basic public health care services by municipalities (functions transferred from the state to municipalities) show that the organization of psychological well-being and mental health promotion services in municipalities is very uneven – in some municipalities, implementation reaches only 2-3%, while in others it exceeds 200%. Such differences show that equal access to services is not ensured, and that the population's opportunities to receive mental health support depend on the municipality in which they live.

Senior citizens Survey data show that 52% (179 out of 345) of respondents who felt lonely very often, often, or sometimes in the past 12 months did not participate in cultural, educational, health, social, communication-promoting or volunteer activities that could help reduce feelings of loneliness.

Most respondents who felt lonely and participated in at least one activity chose cultural activities. Of the 48% who participated, as many as 34% participated only in cultural activities, while some of them combined cultural activities with others (health, education, volunteering). This shows that cultural activities are the main and most accessible means of reducing loneliness, while the potential of education, wellness activities, and volunteering to reduce loneliness is less exploited.

The Senior citizens Survey data shows that people most often reduce feelings of loneliness through passive activities or activities in their immediate environment – watching television, listening to the radio (51.6%) or communicating with family and relatives (51%). Active forms of social engagement, such as volunteering, learning, or seeking professional help, remain unpopular, with only a few percent of respondents choosing them. This leads to the conclusion that society still lacks incentives and conditions for active social participation, which could more effectively reduce loneliness.

In Lithuania, the problem of loneliness of senior citizens remains complex and is not being systematically addressed. Although initiatives are being implemented, there is a lack of a strategic approach at the national level. The responsibilities of the state, municipalities, and NGOs in terms of preventing loneliness, ensuring the availability of assistance, and changing public attitudes have not been defined. As a result, assistance remains fragmented and dependent on the initiative of individuals and communities. Caritas Lithuania, the Maltese Order's relief service, and the Lithuanian Red Cross have provided examples of good practices, challenges, and suggestions for change related to addressing the problem of loneliness.

Loneliness in Lithuania is not monitored or measured, the problem is not assessed/considered a priority, the target group of lonely senior citizens has not been identified, there is no data on the number of lonely senior citizens in municipalities, it is not known which individuals experience loneliness, measures are fragmented and do not reach the target group, and it is not known whether and to what extent lonely senior citizens participate in the measures. It is not possible to assess the impact of the activities – how much they contribute to solving the problem of loneliness.

Recommendations

To the Ministry of Social Security and Labour

To ensure that state policy is oriented towards the active participation of an ageing society:

1. Define the state policy on active ageing by identifying the areas of well-being, objectives, tasks, measures, impact indicators, and a sustainable budget for senior citizens.
2. Adopt a decision on the institutional framework to ensure the consistent performance of functions related to the formulation, implementation, and coordination of policies promoting active ageing.

To increase the employment rate of people of retirement age who are willing and able to work by allowing them to combine work and retirement:

1. Submit proposals to the relevant institutions regarding the removal of age limits for employment in the Laws on Civil Service, Courts, and Science and Studies, and work toward their implementation by actively participating in the legislative amendment process.
2. Make a decision regarding the implementation of flexible working arrangements, additional safeguards, health promotion, or other support measures for senior citizens, taking into account their identified needs.

3. Identify and implement comprehensive measures to help people approaching retirement prepare for retirement, addressing financial, psychological, social, and professional issues, which would facilitate a smooth transition to this new stage of life and enable them to remain active in society and/or the labour market.
4. Set a target employment rate for people of retirement age in strategic planning documents and monitor changes in that rate to ensure that people of retirement age who are willing and able to work participate in the labour market.

To address the issue of loneliness among senior citizens and ensure they receive the necessary assistance:

1. To assess the impact of loneliness on individuals' mental and physical health, their quality of life, and the state's social and health care systems; and to establish a target for the prevention and reduction of loneliness, an indicator of the level of loneliness among senior citizens, and its target value.
2. Establish criteria for assessing loneliness, use them to identify lonely individuals (including participants in the "Social Prescription" program), and plan measures to reduce loneliness.
3. Provide measures to encourage single people to seek help.

Poland

SUPREME AUDIT OFFICE OF POLAND

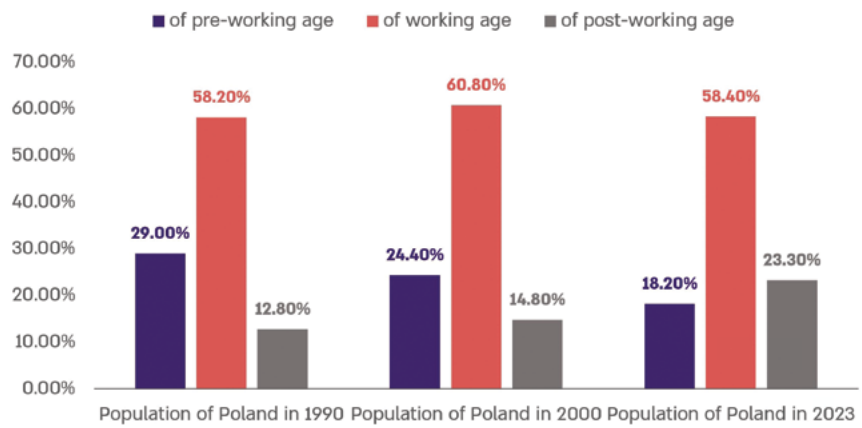
Introduction

Poland is a country located in Central Europe, with an area of 312,685 km², bordering Germany, the Czech Republic, Slovak Republic, Ukraine, Lithuania, and Russia. Warsaw is the capital, and Polish is the official language. It has a population of 37,489,000, including 22,276,000 urban residents and 15,213,000 rural residents. The country is divided into 16 voivodeships, with 314 counties (powiats), 66 cities with county rights, and 2,479 municipalities (including 302 urban municipalities, 718 urban-rural municipalities, and 1,459 rural municipalities). In Poland, 59% of the population lives in urban areas. The ratio of women to men is 107 (in urban areas, 112/100, and in rural areas, 101/100). In addition, the population:

- under 17 years of age constitutes 18.2%;
- of working age (women aged 18 to 59 and men aged 18 to 64) constitutes 58.4%;
- of post-working age (women aged 60 and over and men aged 65 and over) constitutes 23.3%.

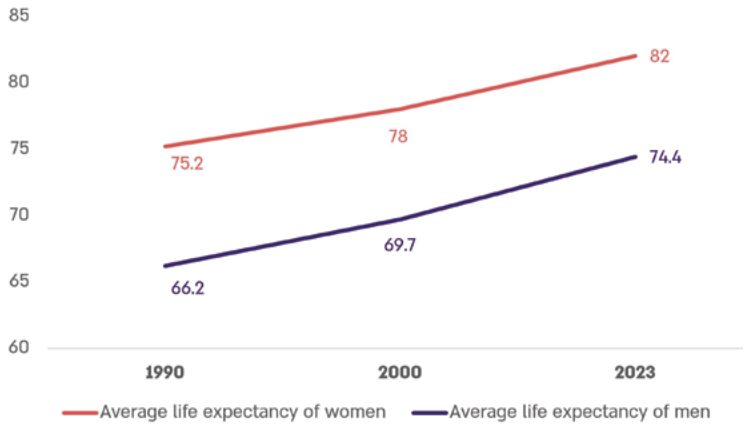
For comparison, in 1990, these figures were 29%, 58.2%, and 12.8%, respectively, and in 2000, 24.4%, 60.8%, and 14.8%. The figure below shows how the age structure of the population in Poland has changed over the last 35 years. It is worth noting that the post-working age population in 2023 increased by over 10% compared to 1990. However, the number of people of pre-working age is decreasing: from 29.0% in 1990 to 18.2% in 2023. This indicates a rapid ageing process of the Polish population

Figure 1: Age structure of the population in Poland



The old-age dependency ratio (i.e., the non-working-age population per 100 working-age people) was 72 in 2024. Life expectancy increased from 66.2 years in 1990 to 74.4 years in 2023 for men and from 75.2 years to 82 years for women. The fertility rate in 2023 was 1.158, having decreased from 1.991 in 1990. The average age of women at the birth of their first child was 22.7 years in 1990 and 29 years in 2023. The average number of people per household in 2023 was 2.43. The median age in 2024 was 41.7 years for men and 44.9 years for women. In 2023, the median age in Poland was 43 years, the share of people aged 65 and over in the total population was 20.5%.

Figure 2: Average life expectancy in the years 1990–2023



The average monthly nominal gross pension and disability pension from the non-agricultural social insurance system amounted to PLN 4,253 in September 2025, i.e. approximately EUR 1,000 with an average monthly gross salary in the national economy of PLN 8,772 (i.e. approximately EUR 2,000) and with an average salary in the economy in 2024 of PLN 8,182 gross (i.e. approximately EUR 1,900).

A Concise Overview of the Social Welfare System of Poland

The social assistance system in Poland supports individuals and families who are unable to overcome difficult life situations on their own[1]. Its goals are to meet basic needs, prevent crises, and achieve independence and social integration for beneficiaries.

The central and local governments are responsible for organizing social assistance and collaborating with non-governmental organizations, churches, as well as individuals and legal entities.

The main goals include[2]:

- supporting individuals in overcoming difficulties and achieving independence;
- ensuring a minimum income for low-income individuals;
- providing professional assistance to families affected by social problems;
- integrating the marginalized;
- developing a network of social services.

Social assistance encompasses benefits, social work, infrastructure development, needs analysis, and the introduction of new forms of support.

Benefits are provided upon request or ex officio. Decisions are made after a community interview conducted by a social worker. They take the form of an administrative decision, which may be appealed.

Social assistance is provided to individuals and families, in particular, due to: poverty; homelessness; unemployment; disability; long-term or serious illness; the need to protect motherhood or having many children; helplessness in matters of care, upbringing, and manageing a household, especially in single-parent or large families; alcoholism or drug addiction; unforeseen events and crisis situations.

The right to cash benefits is granted to individuals and families whose income does not exceed the income criteria established based on the social intervention threshold.

There are two types of social assistance activities: community assistance, implemented in the beneficiary's home environment, and institutional assistance, provided in social welfare homes and support centers.

1 Social Assistance Rules – Ministry of Family, Labor and Social Policy **[link]**.
2 Social Assistance Rules – Ministry of Family, Labor and Social Policy.

There are two types of social assistance benefits: cash benefits and non-cash benefits (in the form of in-kind or services). Cash benefits include, among others: : permanent allowance, periodic allowance, targeted allowance, remuneration for providing care. Non-cash benefits include, for example: social work, meals, specialized care services, including in support centers, stays and services in a social welfare home[3]. The system operates based on the Act of March 12, 2004, on Social Assistance[4]. The organization and implementation of tasks rests with public administration bodies at various levels:

- Government administration (central level): The Minister of Family, Labor and Social Policy is responsible for general social policy and oversight.
- Voivodeships: The voivode's responsibilities include coordination and supervision of facilities within the voivodeship.
- Counties: District Family Support Centers (PCPR) carry out tasks related to family support and foster care, including the organization of childcare and educational facilities. In cities with county rights, these functions are performed by the Municipal Family Support Center (MOPR).
- Municipalities: Municipal Social Welfare Centers (GOPS, MOPS), or Social Service Centers (CUS) are the basic units that have direct contact with those in need and carry out most tasks in the field.

Report Input

How is work after retirement promoted?

Reaching retirement age in Poland does not automatically mean that an employee must retire and cannot take on any additional work. The desire to continue working after the age of 60 for women and 65 for men can lead to two different situations:

- a retiree can continue working but suspend their retirement (which will increase their future retirement benefit);
- they can also retire (i.e., collect benefits) and continue working.

What is the retirement age?

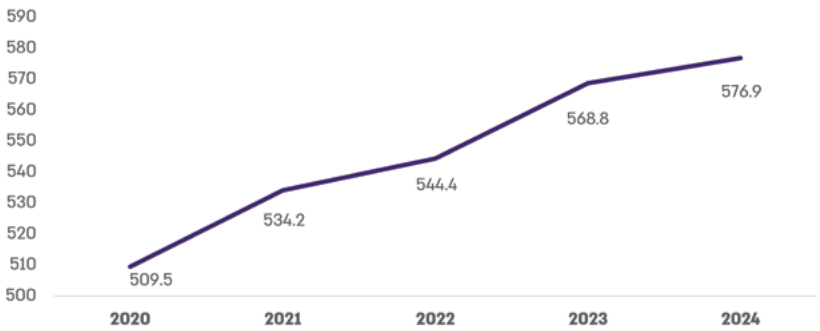
The retirement age is 60 for women and 65 for men.

3 Chaczko, K. (2018). Organizacja pomocy społecznej w Polsce (Organization of social welfare in Poland) 1918–2018, Wydawnictwo naukowe Scholar.
4 Journal of Laws of 2025, item 1214 as amended; hereinafter: Social Assistance Act.

What is the employment rate in the labor market after reaching retirement age in 2020–2025?

Working pensioners (i.e. persons working with an established right to a pension) are an important element of the labor market in an ageing society. According to the results of a survey of persons working in the national economy, their number in 2024 increased by 13.23% compared to 2020[5].

Figure 3: The number of employees aged 60 and over who also have the right to a pension (in thousands) in 2020–2024 (as of December 31)



According to data from the Social Insurance Institution (ZUS), the actual average retirement age in 2023 was approximately 60.7 years for women and 65.0 years for men[6], meaning that the employment rate after reaching retirement age practically coincides with the retirement age. In 2023, 95.8% of women received their pension between the ages of 60 and 64, and 98.4% of men received their pension at 65 or older. The average pension amount as of March 31, 2024[7], is presented in the table below:

Table 1: Average pension for women and men

Average pension for women and men	PLN 3,790
Average pension amount for men	PLN 4,675
Average pension amount for women	PLN 3,209

5 Data obtained from the following documents: 'The situation of senior citizens in Poland in 2020'; 'The situation of senior citizens in Poland in 2021'; 'The situation of senior citizens in Poland in 2022'; 'The situation of senior citizens in Poland in 2023'; 'The situation of senior citizens in Poland in 2024' prepared by the Central Statistical Office, Statistical Office in Białystok. The data concern persons who have informed their contribution payer that they have an established right to a pension. The data do not include information on pensioners insured in KRUS (Agricultural Social Insurance Fund – a state institution responsible for social insurance for farmers, their household members and farmhands).

6 Old-age pensions – ZUS **[link]**.

7 Average amount calculated based on the arithmetic mean.

Half of the beneficiaries received a pension[8] of up to PLN 3,312, of which:

- half of the men received a pension of up to PLN 4,259.41,
- half of the women received a pension of up to PLN 2,823.61.

As of March 2024, 6.8% of people received pensions below 50% of the median (below PLN 1,656), while 22.1% received pensions above 150% of the median (above PLN 4,968).

The number of persons covered by pension and disability insurance who are of retirement age or older, broken down by gender, has been presented in the table below[9].

Persons covered by pension and disability insurance who are of retirement age or older, by gender – as of 31 December in 2020–2024 and 28 February 2025.

Table 2: Persons covered by pension and disability insurance who are of retirement age or older, by gender - as of 31 December in 2020–2024 and 28 February 2025

As of:	Number of insured persons in thousands	
	women aged 60 and over	men aged 65 and over
December 31, 2020	552.5	297.6
December 31, 2021	560.0	309.8
December 31, 2022	577.6	323.5
December 31, 2023	591.7	332.3
December 31, 2024	608.2	336.8
February 28, 2025	617.9	342.2

More women than men of retirement age remain professionally active – one of the reasons for this may be lower pensions for women.

Is there a target participation rate?

Poland has not set a target employment rate for people of retirement age.

What measures are being taken to encourage employment after retirement age?

Incentives for employment after retirement age include various tax breaks, wage subsidies, and the implementation of various government and departmental programs, such as the "Active+" program, which funds non-governmental organizations and other entities that work to increase the involvement of senior citizens in the labor market, as well as their digital integration and social participation.

8 Amount calculated based on the median.
9 According to ZUS data.

It should be emphasized that legal regulations allow retirees to begin or continue working without losing their entitlement to benefits (pensions). This means that seniors who choose to become economically active do not have to choose between retirement and employment. This solution allows for a gradual transition into retirement and the utilization of the experience and skills of older workers. The main tax benefits include:

- tax relief of PLN 85,000 PLN for selected retirees who, despite becoming eligible for a pension, temporarily waive their right to receive it and remain professionally active (the relief was introduced in 2022);
- salary subsidies: up to 50% of the minimum wage for employing a retiree, paid for two years, with the obligation to keep the employee employed for an additional 12 months (the relief was introduced in 2025).

Additionally, if the elderly person settles under the general rules[10], the tax-free allowance is PLN 30,000 per year. In practice, this means that individuals who meet the requirements for receiving a pension but do not actually receive it and who continue to work professionally can benefit from personal income tax exemption (so-called "PIT-0") up to PLN 115,500 of annual income (PLN 85,500 under the relief + PLN 30,000 tax-free allowance). This means that their net salary will be higher.

Loneliness - How are lonely older adults recognized and treated?

Does the national policy for older adults address the issue of loneliness?

The problem of loneliness among older adults is addressed in the government document outlining state actions for older adults in Poland until 2030, "Social Policy for the Elderly 2030. Safety – Participation – Solidarity"[11].

According to this document, approximately 60% of people aged 80 and over live alone in their households. Demographic forecasts indicate that this number will grow rapidly. Providing care for lonely seniors in their homes will be another challenge for public administration and social partners. In 2023, 71,500 people aged 60 and over received permanent benefits worth a total of PLN 369,900,000, of which 95.6% went to seniors living alone.

10 Taxation under general rules is the most common method of calculating PIT on income from business activities of natural persons. The tax base is the income earned during the calendar year, i.e. the amount resulting from deducting costs incurred from revenues earned.

11 This is a government document adopted by the Council of Ministers on October 26, 2018; hereinafter: Safety-Participation-Solidarity Policy.

Is loneliness measured? How is it measured?

In Poland, there are no official indicators for measuring loneliness among older adults. Validated psychometric tools in statistically representative studies (e.g., research laboratories: Kantar, SHare) are used to measure loneliness – especially among seniors – along with indicators of mental health and social support.

Were lonely older adults identified? How? By whom? What methods were used?

In Poland, there are no legal regulations that explicitly mandate the study of loneliness among older adults. Such studies are conducted by government or local government bodies as part of expert opinions or by specialized research centers. One example is the report "Loneliness among people aged 80+" prepared by the "Mali Bracia Ubogich" Association. Among the surveyed group of people over 80, 58.0% lived alone, and 26.0% felt lonely. Lonely people were much more likely to struggle with crisis situations, such as health problems, loss of loved ones, isolation, loss of independence, feeling of being unwanted, or lack of security.

Audit No. P/25/030: Care for the Elderly in Rural and Urban-Rural Municipalities

In the third and fourth quarters of 2025, NIK conducted audit No. P/25/030: Care for the Elderly in Rural and Urban-Rural Municipalities. The audit was undertaken, among other reasons, due to the ageing population and varying access to care, including for single people, in large cities and in urban-rural and rural municipalities. In Poland, pursuant to the Social Assistance Act, municipalities play a key role in providing care for the elderly[12]. Within municipalities, social assistance tasks are performed by their organizational units – social welfare centers or social service centers – pursuant to Article 110, paragraph 1 of the Social Assistance Act.

In 2022, 290 municipalities (approximately 12%) did not provide support to seniors in the form of in-home care services, which are mandatory for municipalities. NIK audited social welfare centers[13] in 19 municipalities. The audit covered the period from January 1, 2022, to November 14, 2025.

One of the issues examined during the audit was loneliness among senior citizens. The audit activities aimed, among other things, to answer the following questions:

a. Were lonely senior citizens identified (recognized) in the municipality? If so, how? By whom?

b. To what extent did the social welfare center collect data on lonely senior citizens? How frequently is this data collected?

c. Did the social welfare center survey the feeling of loneliness among senior citizens in the audited municipality?

12 Article 17(1)(11) of the Social Assistance Act stipulates that mandatory tasks include organising and providing care services, including specialist, at a place of residence with an exclusion of specialist care services for persons with mental disorders and neighbourhood services.

13 Social Service Center.

d. To what extent did the social welfare center implement the tasks included in the social policy for senior citizens, regarding loneliness?

e. Did the strategy for addressing social problems (or its draft)/social welfare needs address the situation of senior citizens, including their loneliness? What actions were planned in this regard, and what actions were implemented? Were any measures adopted regarding loneliness among older adults, and if so, what were they and to what extent were they implemented?

f. To what extent did the social welfare center provide support to lonely older adults to improve their quality of life? Is the scope of support provided sufficient? Were any needs of lonely older adults met?

The evaluation included activities of social welfare centers implemented under government programs for the elderly:

- "Senior+" – this program involved financial support for local government units in implementing their own tasks, consisting of operating and providing places in support centers;
- "Personal Assistant for Disabled Persons" – this program aimed to ensure access to personal assistance services, i.e., support in performing daily activities and functioning in social life for people with disabilities;
- "Active+" – the main goal of the program was to increase the participation of senior citizens in all areas of social life. The program aimed to contribute to increased engagement of seniors in social interactions by enriching the options available to them for manageing their free time;
- Care for 75+" – its strategic goal was to improve access to care services, including specialized care services, for people aged 75 and over who are single or manage their own households, as well as those living with families. The program provided financial support to municipalities with a population of up to 60,000 for the provision of care services and specialized care services for individuals aged 75 and over who met the eligibility criteria specified in the Social Assistance Act.
- "Senior Support Corps" – the program aimed to provide financial support to municipalities in organizing care services provided through neighborhood services and in providing care services through access to so-called "remote care," aimed at improving the safety and independence of senior citizens in their place of residence.

None of the 19 social welfare centers examined specified in their regulations or other separate documents a method for identifying lonely elderly people living within their jurisdiction, nor did they have a separate database of the total number of lonely elderly people. This identification was performed as part of the daily duties of employees employed in social welfare centers – lonely elderly people were identified by social workers, employees administering family benefits (when applying for other benefits provided by social welfare centers), village heads, municipal councilors, police, paramedics, and priests[14]. According to the managers of social welfare centers, such people also self-reported their need for assistance by telephone. These centers only had data on the elderly (including lonely individuals) under their care. None of the examined 19 social welfare centers recorded clearly defined, specified, and specific data on lonely elderly people. The centers collected information solely as part of routine community interviews and updated them at least once every six months[15]. The data covered the functioning of senior citizens in their communities, their health, social and living conditions, financial and family situation, as well as their emotional well-being[16].

Social welfare centers had limited knowledge of the number of lonely older adults who needed assistance, even though the Polish legal system does not obligate social welfare centers to actively identify lonely older adults. As indicated by the managers of social welfare centers themselves, the Social Assistance Act does not mandate the collection of data on the level of loneliness or subjective feelings of social isolation. Therefore, no separate records were kept in this regard. Consequently, individuals in need may not receive assistance: they may be unaware of the benefits they are entitled to, have limited mobility, health problems, or avoid social welfare centers out of fear or distrust. Based on the results of the NIK audit, it was determined that a social welfare center only responds when, for example, a family member reports the situation, a neighbor notices the elderly person's poor condition, or the police or ambulance arrives at the senior's home. By operating in this manner, social welfare centers deprive themselves of the opportunity for early intervention. The lack of obligation to identify lonely older adults and record data may result in a lack of awareness of the true scale of this group's needs.

It is true that regular background checks conducted by social welfare center staff allow for the verification of whether the individual still meets the criteria for benefits or whether new needs have emerged. However, these activities are undertaken for an already established group of people in need of assistance. Based on the daily social work of social welfare center staff, information about lonely elderly people who were not receiving assistance but who did need it was generally not obtained.

14 For example, in the Mniów municipality.
15 Social welfare center in Lubochnia.
16 There was no separate database on single elderly persons.

According to NIK, the failure to identify lonely elderly people and the lack of collecting information about such individuals stems from the lack of systemic solutions at the national level. The applicable law does not identify lonely elderly people as a group particularly in need of assistance, nor does it specify what such assistance would look like. This is also indicated by the opinions of the heads of the audited units. As one of the heads of the social welfare centers pointed out, the provisions of the Social Assistance Act do not require the collection of data on the level of loneliness or the subjective feeling of social isolation. Therefore, the social welfare centers did not maintain separate records in this regard[17]. Analysis of the phenomenon of loneliness can only be indirect, for example, based on data on the number of people running single-person households, but this is not a legally defined category in the social assistance system. Furthermore, the Polish legal system does not provide a definition of "feelings of loneliness" or "feelings of isolation" in terms of emotional state – the only reference to loneliness is the definition of a single person, which primarily refers to one's living situation and household.

According to Article 6, Section 9 of the Social Assistance Act, a single person is a person running a household alone, unmarried, and without ascendants or descendants. This definition serves, among other purposes, to establish income criteria (which are different for single people than for families) and, based on these, to determine the fee for specific forms of support (such as care services). However, it does not address emotional loneliness. This concept remains subjective and is not standardized in law. One of the social welfare center managers pointed out that social workers providing assistance to single-person households were unaware of whether these individuals were emotionally lonely, as loneliness is a subjective condition that is not a subject of social worker research. According to the manager, loneliness is a subjective and negative experience of a lack of meaningful social or emotional connections, regardless of the actual number of people around. This information is not collected by social workers during a community interview.

The audit results also indicate that social welfare centers did not take the initiative to examine the feeling of loneliness among seniors: no community meetings were organized, nor were individual interviews or surveys conducted. If a social welfare center did undertake any activities in this area, these were done in conjunction with other activities, for example, ad hoc surveys of loneliness among senior citizens during the intake of application forms for the "Personal Assistant for Persons with Disabilities and Senior Support Corps" programs. Even if such surveys were conducted, they were still limited to senior citizens using the social welfare center's services or applying for such assistance. Social welfare centers did not take the initiative to examine loneliness among senior citizens "outside", meaning among those who had not previously used the services provided by social welfare centers. Furthermore, in no case were such surveys documented, which makes it impossible to assess their actual value[18]. The heads of the audited units indicated that communities of lonely senior citizens are identified by social workers as part of their social work activities, where they respond to reported problems. However, they lack a separate document on loneliness assessment. The efforts undertaken by the centers to measure loneliness among seniors demonstrate the lack of a coherent, systemic approach to this problem at the national level. The practices employed by social welfare centers vary greatly – in scope, methods, and often even the

17 One of the heads of the social welfare centre pointed out that being a single-person household does not always equate to experiencing loneliness, as this is a subjective factor depending on the individual's life situation, family and social relationships, as well as their level of activity, which is difficult to clearly identify within standard social welfare procedures.

18 As indicated by the head of the social welfare center in Lubochnia, these surveys were only for informational purposes for the social welfare center.

understanding of the phenomenon itself. Consequently, there is no uniform, systematic plan that would allow for comprehensive monitoring of the scale of loneliness among senior citizens or the development of effective, comparable preventive and supportive measures across the country.

Meanwhile, loneliness is a real problem among senior citizens, as indicated by numerous publications. In the Commissioner for Human Rights' report[19], "Accessibility of social services for senior citizens living in rural municipalities",[20] in the absence of children (usually due to migration), many senior citizens with disabilities are left to their own devices, which leads to feelings of loneliness. Among the numerous problems faced by senior citizens, the report highlights, among others:

- the growing number of people living alone, for example, due to increasing life expectancy;
- the increasing number of younger generations taking up jobs outside their homes, which contributes to the loneliness of senior citizens; seniors living even in multigenerational homes are alone in these homes all day;
- the lack or insufficient availability of social services, including psychological support for lonely seniors.

The previously cited Safety-Participation-Solidarity Policy is a set of actions, strategies, and directions of state intervention aimed at ensuring decent living conditions, safety, health, and active participation in social life for seniors. It encompasses issues related to care and support, as well as, more broadly, quality of life and combating social exclusion in this age group. The implementation of tasks included in the social policy for senior citizens, in the area of combating loneliness, by social welfare centers included enabling senior citizens to participate in social life through organized integration meetings, participation in programs run by the Ministry of Family, Labor and Social Policy, creating spaces for contact and integration for senior citizens, participation in workshops for seniors on the topic of combating violence, organizing Christmas Eve gatherings, and providing individual emotional support through social work in the form of face-to-face and telephone conversations with senior citizens in need of support. The social welfare centers implemented tasks included in the social policy for senior citizens, in the area of combating loneliness, in a general manner. In practice, none of the audited social welfare centers directly referenced this document in their activities. According to NIK, this stems from the fact that this strategic document on social policy, in its content towards senior citizens, does not impose specific, clearly formulated obligations on social welfare centers.

19 Newsletter of the Commissioner for Human Rights in Poland 2024, No. 4; The Principle of Equal Treatment. Law and Practice, No. 36; Accessibility of social services for senior citizens living in rural municipalities.

20 **[link]**.

Strategic documents in force in the municipalities where the social welfare centers were audited, i.e., in the strategy for addressing social problems/social assistance needs, always addressed the situation of senior citizens, but loneliness was not always mentioned as a problem for this group. Municipal authorities are best acquainted with the needs of senior citizens living in their area – they have the closest contact with the local community and are best placed to perceive changes occurring in its structure and the daily lives of residents. However, it is worth emphasizing that when assessing these needs, the issue of loneliness cannot be ignored, which for many seniors is becoming as acute as health or financial problems. Addressing it as a real and growing challenge is crucial to developing actions that will truly improve the quality of life of the municipality's oldest residents. Meanwhile, one social welfare center concluded that there was no basis for distinguishing the needs of seniors living alone from those living in families, as each person, whether living alone or in a family, was provided with assistance tailored to their needs[21].

In one case[22], although loneliness was listed as one of the main problems affecting senior citizens, no measures were proposed to counteract it. The head of the social welfare center explicitly stated that the issue of loneliness among senior citizens in the municipality had not been sufficiently recognized, and until now, the focus had been primarily on individuals who self-reported a need for help or were recommended by village heads, clergy, non-governmental organizations, or neighbors. In four cases, the strategy for addressing social problems did not include provisions directly addressing the issue of counteracting feelings of loneliness. According to the heads of the social welfare centers, this was due to the complexity and subjective nature of the phenomenon, as lonely people often do not identify their feelings as "loneliness".

Social welfare centers undertook a variety of activities to counteract loneliness among senior citizens, including: organizing team-building events for municipal residents and classes and training for seniors; workshops with medical professionals (nurses, orthopedists, physiotherapists); Respite care support, volunteer services, developing care staff, developing community support systems, and sports activities. Indicators for assessing the implementation of these activities included, among others, the number of training sessions/activities conducted for seniors, as well as the number of recreational and integration events organized. According to the Supreme Audit Office (NIK), this demonstrates the uneven perception of the problem of loneliness among older adults by social welfare centers.

Social welfare centers provided support to lonely older adults to improve their quality of life, including through providing in-home care services and personal assistance services, providing safety wristbands as part of the government's Senior Support Corps program, assisting in the placement of those in need in medical care facilities after hospitalization, conducting mediation with family members of older adults to remind them of their responsibilities to their elderly parents, conducting supportive conversations during community interviews, and as part of ongoing social work. One of the head managers of a social welfare center[23] indicated that, in his opinion, the scope of support provided to older adults was sufficient, as it met the needs reported in this regard. Elderly people receiving specific forms of assistance were provided not only with the care they requested but also with the opportunity for contact, including conversation, which

21 Explanations provided by the director of the social welfare center in Mniów.
22 Social welfare center in Serock.
23 Director of the social welfare center in Mniów.

positively impacted their emotional and mental well-being and prevented feelings of loneliness. Another social welfare center manager emphasized that the goal of supporting lonely senior citizens was to ensure that the assistance was activating, counteracting loneliness, and ultimately improving the quality of life for seniors holistically.

NIK points to the positive aspects of support provided under existing ministerial programs: "Senior+", "Active+", "Personal Assistant for Persons with Disabilities", "75+ Care", and "Senior Support Corps". One form of support for lonely people provided by social welfare centers was participation in Senior Clubs and Senior Day Care Centers[24], which not only stimulated participation but also enabled them to establish relationships with peers, overcome loneliness, and maintain intellectual and social activity. These centers provided services such as social, educational, cultural, sports, and recreation, physical activity and kinesiotherapy, social activation, occupational therapy, artistic, and culinary classes. The "Senior Support Corps" program, on the other hand, provided support services for seniors who struggled with independent living due to health conditions, managed households alone, or lived with loved ones unable to provide sufficient support.

However, the support offered by social welfare centers to lonely older adults was, in practice, no different from that offered to seniors who do not experience loneliness. This means that loneliness although a distinct, significant challenge affecting the functioning and well-being of older adults was not treated by social welfare centers as a condition requiring a specific, individualized approach. Support remained universal, not focused on the specific needs resulting from living alone. NIK points out that being elderly and lonely are not mutually exclusive; on the contrary, an older person can be lonely.

To obtain detailed information on the situation of older adults, auditors distributed surveys to older adults who used various forms of care provided by social welfare centers. The survey focused on their sense of connection with others and social relationships, as well as the effectiveness of the assistance they received. Five hundred older adults living in 19 municipalities participated in the study, providing a comprehensive picture of their experiences. The collected responses provide a valuable source of information on the quality of life of seniors, including their feelings of loneliness. The characteristics of the respondents are presented in the tables below:

24 Operated in 18 municipalities.

Table 3: Age

Description	Number[25]	Percentage
Up to 70 years of age	134	26.8%
From 71 to 80 years of age	158	31.6%
From 81 to 90 years of age	164	32.8%
Over 90 years of age	43	8.6%

Table 4: Gender

Description	Number	Percentage
Female	370	74.0%
Male	130	26.0%

Table 5: Living/housing situation

Description	Number	Percentage
single persons/persons living alone (i.e. running a household on their own)	188	37.6%
persons with family in the same town or nearby	181	36.2%
single persons with extended family in a distant town	44	8.8%
single persons living with another family member who is also single and ill	37	7.4%
persons declaring a different housing situation	50	10%

The majority of respondents (347 out of 500) positively assessed the impact of the services they received (residential care services, including neighborhood care, specialized care services, as well as programs such as "Senior+," "Active," "Personal Assistant for Persons with Disabilities," 75+ Care, and Senior Support Corps) on their ability to live independently in their own home or apartment:

25 One respondent did not provide their age.

- 235 respondents (47.0%) indicated that the aforementioned services significantly enabled them to live independently and allowed them to avoid the need for 24-hour care/institutional care;
- 112 respondents (22.4%) stated that the services provided to them rather helped them avoid the need for care;
- 66 respondents (13.2%) were unable to provide a clear answer.

According to 455 respondents (91.0%), social care workers took steps to learn about seniors' living conditions (living, financial, housing), including through visits to their homes. However, 39 respondents (7.8%) stated that such steps were not taken.

Respondents were also asked about the possibility of talking to others about everyday problems. Responses were varied: 287 respondents (57.4%) strongly agreed that they always had someone to turn to, while 163 respondents (32.6%) responded "rather yes". At the same time, 40 respondents (8.0%) stated that this was probably not possible, and seven respondents (1.4%) responded "definitely no". Three respondents did not respond to this question.

Regarding the sense of belonging to a group of friends or family, 276 respondents (55.2%) stated that they definitely felt part of it, while 161 respondents (32.2%) stated that they rather did. Another 45 people (9.0%) indicated the opposite answer ("probably not"), and 17 people (3.4%) stated that they definitely did not feel part of any group. One person did not answer this question.

Regarding being well-known by others, the results were as follows: 59 people (11.8%) believed that no one knew them well, while 163 respondents (32.6%) stated that no one probably knew them well. At the same time, 181 people (36.2%) stated that someone probably knew them well, and another 88 (17.6%) stated that someone definitely knew them (nine respondents did not provide any answer).

Responses regarding the lack of a close friend were divided: 229 respondents (45.8%) indicated that they did not feel the lack of a close friend, while 106 (21.2%) stated that they definitely did not. At the same time, 95 people (19.0%) admitted that they rather miss a close friend, and 68 people (13.6%) said they felt this lack strongly. Two people did not answer this question.

When asked about the lack of companionship, 227 people (45.4%) said they rather don't feel it, and 136 people (27.2%) said they definitely don't. Meanwhile, 94 people (18.8%) indicated that they rather miss contact with others, and 43 people (8.6%) said they felt this lack very strongly.

Another aspect concerned the ability to ask for help when needed. Of the respondents, 164 people (32.8%) had absolutely no doubt that there is always someone there, while 171 people (34.2%) did not feel a lack of support. However, 67 respondents (13.4%) admitted that they definitely have no one to turn to, and another 98 (19.6%) said they felt they lacked support. The responses regarding the number of people with whom they felt close were similar: 204 respondents (40.8%) said they definitely had enough close people, while 194 (38.8%) said they had enough close people. Eighty-one respondents (16.2%) admitted that they didn't have enough close people, and 20 respondents (4.0%) said they definitely lacked them. One survey was left blank.

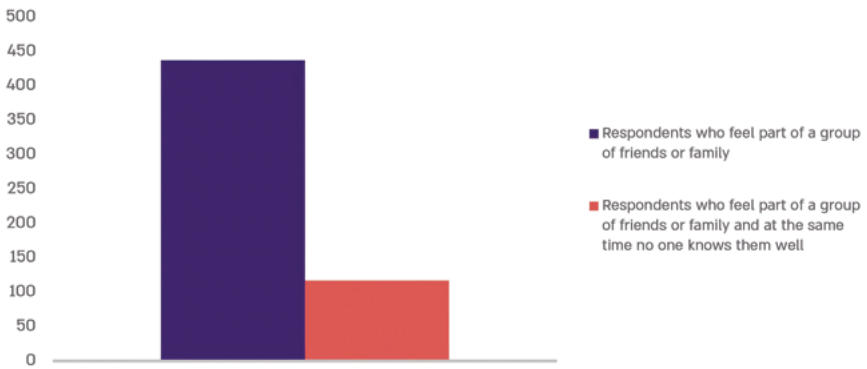
Regarding feelings of isolation, 209 respondents (41.8%) said they felt they didn't feel isolated, while 202 (40.4%) said they definitely didn't feel isolated. However, 65 people (13.0%) indicated that they felt somewhat isolated, and 23 people (4.6%) indicated that they definitely experienced isolation (one respondent did not answer this question). Similar results were found in the question about exclusion: 209 respondents (41.8%) indicated that they definitely did not feel isolated, and 213 (42.6%) indicated that they probably did not. At the same time, 57 people (11.4%) indicated that they felt somewhat isolated, and 18 people (3.6%) indicated that they definitely felt isolated. Three people did not answer this question.

Finally, the survey asked about the possibility of counting on support from friends and family. Of the 500 respondents, 287 (57.4%) strongly agreed that they could always count on it, while another 164 (32.8%) indicated that they probably did. However, 29 people (5.8%) felt they could not count on support from loved ones, and 19 people (3.8%) felt they had absolutely no one to rely on in this regard (one respondent did not respond to this question).

Analysis of the study results

Analysis of the study results shows that although the majority of respondents reported a sense of belonging to a group of friends or family, there is a distinct group of people who experience a lack of emotional support and have limited opportunities to seek help. As many as 117 respondents who stated they definitely felt part of a group of friends or family also indicated that no one truly knew them well[26]. This illustrates the high level of lack of deep relationships, despite the fact that senior citizens may maintain superficial contacts with their surroundings.

Figure 4: Belonging to a group of friends or family, and a deeper relationship with at least one person



26 71 " rather yes" and 46 "definitely yes". Of all 500 respondents, 222 people believe that no one really knows them well.

The possibility of a group of people potentially at risk of loneliness and exclusion may be indicated by the responses to the question about the possibility of talking to someone about everyday problems and about having a close friend: as many as 450 people (90%) declared that there was always someone with whom they could talk about everyday problems, but 64 of them also stated that they lacked a truly close friend[27]. Taken together, these responses may indicate that although senior citizens maintain contact with their surroundings, at least some of them do not develop deeper relationships, so having people "around them" does not necessarily mean having a close person they can fully trust.

Another important aspect of the study results is the percentage of people who declared that they lacked someone they could turn to in times of need – this figure is 165 people (33%), of whom:

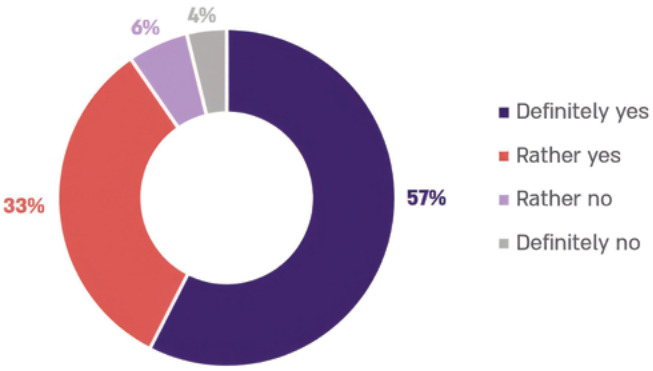
- 45 people feel isolated and lack people around them[28];
- 44 people feel excluded.

Across all respondents, a total of 88 (17.6%) feel isolated, and 75 (15%) often feel excluded. The survey results in this area show that the absence of someone to whom an older person can turn in times of need may be more common than the broader concept of "social isolation".

The survey results show that the vast majority of respondents can count on the support of loved ones. As many as 287 people (57.4%) report full, reliable support from family and friends, while a further 164 (32.8%) also assess this positively, though with slightly less certainty. This means that a total of 451 respondents (90.0%) feel they have support from their immediate environment, which is crucial in preventing the negative effects of isolation. At the same time, the results highlight a significant group of people who lack this support: 29 people (5.8%) believe they can't count on their loved ones at all, and 19 respondents (3.8%) report a definite lack of it. This means that almost one in ten people feels deprived of reliable or full support from family or friends. Although this is a minority, their situation is particularly significant – a lack of support from close circles can significantly impact a person's sense of isolation and security. According to NIK, people deprived of the emotional support of family or friends may be particularly at risk of loneliness, which is why they may be most in need of additional attention and action from social welfare centers.

27 44 "rather yes" and 23 "definitely yes", with 163 people (32.6%) out of all 500 respondents declaring that they rather or definitely feel their absence.
28 30 "rather yes" and 15 "definitely yes".

Figure 5: The possibility of obtaining support from family or friends



In light of the results, it is justified to focus the activities of social welfare centers on strengthening social relationships and building an environment conducive to bonding among older adults. Implementing activities targeted at individuals experiencing emotional loneliness – those who have social contacts but lack deeper, trust-building relationships – is particularly important. According to NIK, individualized interventions, such as providing access to a psychologist or volunteer, are worthwhile, especially for those who declare they are unable to seek help. Social welfare centers should develop preventive measures (such as telephone surveys among older adults living in the municipality) and activities that would strengthen mental resilience and help reduce feelings of isolation. According to NIK, appropriate recommendations include:

a. Strengthening the support system for individuals deprived of certain or complete support from family or friends. This group should receive special attention. It would be advisable to develop supportive activities, such as individual consultations.

b. Early identification of individuals at risk of social exclusion and isolation, as well as those deprived of support. From the perspective of social welfare centers, it is crucial to have tools and procedures in place to quickly identify these individuals. This could include, for example, regular surveys or collaboration with medical facilities or non-governmental organizations.

c. Individualizing the assistance provided. Older adults may have diverse needs, both emotional and material. It would be advisable to develop personalized support plans, including psychological support for building relationships.

d. Education about the importance of social support in combating loneliness among older adults. According to NIK, information campaigns emphasizing the importance of relationships with family and friends can encourage the maintenance of relationships and address the needs of lonely older adults.

What percentage of older adults who live alone participate in treatment programs?

Poland does not keep statistics in this area.

Social Policy for the Elderly

Is there a national policy on the well-being of older adults? What topics does it cover?

Strategic Framework

Poland has a comprehensive national policy on elder care, coordinated primarily by the Ministry of Family, Labor and Social Policy[29]. The Safety-Participation-Solidarity Policy is based on a strategic framework and dedicated programs aimed at improving the quality of life of seniors. The Safety-Participation-Solidarity Policy defines the directions of action in senior policy, focusing on three main pillars:

- Safety - ensuring access to healthcare, preventing elder abuse, and increasing physical safety;
- Participation - supporting the social, educational, cultural, and professional activities of older adults, including their integration into the labor market; Solidarity – promoting intergenerational cooperation and social solidarity;
- Solidarity - promoting intergenerational cooperation and social solidarity.

The Safety - Participation - Solidarity Policy also addresses the needs of dependent individuals, proposing, among other things, easier access to services that increase independence and adapting the living environment to their functional capabilities by implementing a range of activities for all senior citizens within the following areas:

a. Shaping a positive perception of old age in society;

b. Participating in social life and supporting all forms of civic, social, cultural, artistic, sporting, and religious activity;

c. Creating conditions enabling the utilization of senior citizens's potential as active participants in economic life and the labor market, adapted to their psychophysical abilities and family circumstances;

d. Health promotion, disease prevention, access to diagnostics, treatment, and rehabilitation;

e. Increasing physical safety – counteracting violence and neglect against senior citizens;

29 Polish: Ministerstwo Rodziny, Pracy i Polityki Społecznej; hereinafter: MRPiPS.

f. Creating conditions for solidarity and intergenerational integration;

g. Actions promoting education for the elderly (care and medical staff), for the elderly (the entire society), through the elderly (from the youngest generation), and education in the elderly (senior citizens).

Another document addressed, among others, to the elderly is the "Social Services Development Strategy, Public Policy until 2030 (with an outlook until 2035)"[30], one of the main objectives of which is to prepare a system for the implementation of social services for people who require support in everyday functioning, including due to old age or disability, so that they can function safely and independently in their place of residence for as long as they wish. Planned activities focus on five social areas: family – children, including children with disabilities; the elderly; people with disabilities; people with mental disorders and in mental health crisis; and people experiencing homelessness. The second strategic objective, building an effective and sustainable system for providing social services to people who need support in their daily lives, includes:

a. Implementing a social service delivery system and standardizing services provided to older adults;

b. Supporting families providing care for older adults;

c. Developing community-based forms of support for older adults;

d. Supporting and developing staff providing social services.

e. It is also worth noting that the aforementioned social services development strategy does not directly address the issue of loneliness among older adults.

Programs Aimed at Seniors

As part of senior policy, various programs dedicated to older adults have been implemented in Poland in recent years. In addition to the previously mentioned programs, such as "Senior+" (multi-Year Program for 2021–2025), "Active+" (multi-annual program for 2021–2025), Senior Support Corps (implemented between 2024 and 2026) and the "75+ Care" program (has been implemented since 2018), a new program will be launched in Poland in 2026 – Active Senior – Aces, which incorporates findings from the "Active+" and "Senior+" programs. This program is intended to combine the ideas of both programs. The program is planned for 2026–2030. The strategic goal of the program is to improve the quality and standard of living of older adults through active participation in social life and education. The program will target older adults, aged 60 and over. The program includes five priority areas of action: developing strategic concepts for senior policy; educating older adults; social participation of older adults; intragenerational integration; and developing daytime support programs.

30 This strategy is official Polish public policy, adopted by a resolution of the Council of Ministers on 15 June 2022.

Geriatric services

The quality of life of seniors is significantly influenced by the provision of geriatric services. The number of geriatric hospitals in Poland remains low. In 2022, it reached 57, increasing to 60[31] between 2023 and 2024. The number of beds in geriatric hospitals was 20,377 in 2022 and 21,146 in 2023[32]. The number of beds per geriatric hospital decreased from 357.5 to 352.4. This indicates a slight improvement in the number of geriatric hospitals and the number of beds in these hospitals. However, this trend is offset by a significant increase in the number of senior citizens between 2022 and 2024[33]. The number of geriatric wards operating in hospitals was 57 in 2022, 60 in 2023, and 61 in 2024[34]. The number of beds in geriatric wards was 1,264 in 2022 and 1,266 in 2023.

Number of geriatric staff per elderly population

The need for geriatricians in Poland is defined by the Act on Special Geriatric Care of August 17, 2023[35], according to which care for geriatric patients should be provided in hospital geriatric wards, 75+ health centers, and primary health care.

The total number of beds in geriatric wards within a Polish voivodeship should not be less than 50 beds per 100,000 people over 60 years of age residing in this voivodeship as of December 31 of the previous year, which, according to data from the end of 2023, amounts to 4,950 beds. According to data from the end of 2023, there were actually 1,316 geriatric beds, which constituted only 26% of the required number.

For the total number of elderly people, which amounted to 9,893,721 in 2023 and 9,978,984 in 2024, there were 70,417 and 71,579 physiotherapists, 558 and 559 geriatricians, and 231,263 and 230,750 nurses, respectively. Therefore, the number of employed staff per 100,000 seniors amounted to:

- in 2023: 711.7 physiotherapists, 5.6 geriatricians, and 2,337.5 nurses;
- in 2024: 717.3 physiotherapists, 5.6 geriatricians, and 2,312.4 nurses.

What budgetary resources are allocated?

Estimating how much Poland spends on seniors and senior policy is complicated because it covers various categories: pensions and disability benefits, benefits (e.g., 13th and 14th pensions), long-term care, social programs, and senior activation.

31 Source: National Health Fund accounting data.
32 Data for 2024 is currently being compiled.
33 In 2024, the number of people in this age group increased by 2.2% compared to the previous year, and their share in the elderly population reached 21.6% (compared to 21.3% a year earlier).
34 Source: National Health Fund accounting data.
35 Journal of Laws of 2024, item 1666.

According to information provided by MRPiPS, approximately PLN 44 billion[36] was allocated for "all activities addressed to seniors" in 2022. At the same time, in 2025, total spending on "social protection benefits"[37] in Poland will amount to approximately PLN 683,200,000,000, of which the largest amount was allocated to the "old age" function, PLN 285,700,000,000[38].

Below are examples of planned budget expenditures for government programs in 2025:

a. "Senior+" Program (2025 edition): total budget: PLN 60,000,000, including Module I: up to PLN 16,000,000 for the creation of new facilities ("Senior+" Community Centers and Clubs) and Module II: PLN 44,000,000 for the operation of existing facilities;

b. "Active+" Program (2025 edition): total budget for 2021–2025: PLN 200,000,000, annual budget: PLN 40,000,000;

c. "Senior Support Corps" Program (2025 edition): total budget: PLN 65,000

The planned expenditure for the "Active Senior – Aces" program for 2026-2030 is PLN 610,000,000 It is difficult to precisely answer the question posed: "Senior policy" encompasses a very broad set of activities from pensions, through healthcare, social services, and activation programs. Data is often scattered across various budgets/funds.

Summary

Poland is grappling with the problem of an ageing population. Low birth rate is forcing the establishment of new long-term care facilities and the development of local support systems. The fundamental values and principles of social policy for senior citizens are outlined in the Safety – Participation – Solidarity Policy. Loneliness among senior citizens is a growing social challenge, highlighted by both research and practitioners, such as managers of social welfare centers. Audit results show that social welfare centers do not always have full knowledge of the scale of this phenomenon among seniors, which makes it difficult to respond precisely. At the same time, social welfare centers lack appropriate tools and procedures to systematically measure loneliness, further complicating the planning of effective interventions. This may require the development of new, systemic solutions at the national level to more effectively support those struggling with loneliness. In recent years, Poland has implemented numerous programs aimed at improving the quality of life for older adults, but an ageing society presents the Polish social welfare system with increasingly demanding challenges.

36 Summary of 2022. Additional PLN 44 billion in support for seniors – Ministry of Family, Labor and Social Policy – Gov.pl.
37 "Social protection benefits" is an even broader category – it includes social assistance, benefits, healthcare – so not everything goes directly to seniors.
38 Central Statistical Office.

Israel

Well-Being & Quality of Life After Retirement

Is there a national policy for welfare of the elderly? What topics does it include?

The State of Israel has acknowledged the importance of safeguarding the well-being of senior citizens. In 2015, the National Economic Council published a strategic socio-economic assessment[1] (the Strategic Assessment) that identified population ageing as a critical challenge confronting the state. This assessment emphasized, among other points, the necessity of implementing measures to facilitate the integration of senior citizens into the workforceand the community, thereby yielding benefits for both the national economy and the senior population[2].

Subsequently, through Government Resolutions 145 and 150 in June 2015, the government formally endorsed the Strategic Assessment. Furthermore, in Government Resolution 127 of July 2021, titled "Map of National Indicator for Optimal Ageing"[3], the government adopted the Indicators for Optimal Ageing (the Map of Indicators). This Map of Indicators includes indicators related to dimensions such as perceived loneliness, active social participation – including employment and volunteering – and indicators pertaining to economic resilience and preparedness[4].

The audit revealed that despite the Strategic Assessment and the Map of Indicators, which the government adopted in 2015 and 2021, respectively[5], explicitly recognizing the importance of maintaining the well-being of senior citizens, no designated or leading authority in Israel has been assigned responsibility for key domains, including preparation for retirement, volunteerism among senior citizens, and the identification of loneliness within this demographic. Responsibility for these issues remains unregulated, with multiple entities engaged in related activities without centralized integration or coordination. Moreover, there are no established national objectives for these areas.

1 The National Economic Council, Strategic Socio-Economic Situation Assessment (2015).
2 The National Economic Council, Strategic Socio-Economic Situation Assessment (2015); Government Resolution 145, "Adoption of the Strategic Socio-Economic Situation Assessment for the 34th Government", (June 28, 2015) (Resolution 145).
3 Government Resolution 127, "Map of National Indicators for Optimal Ageing", July 19, 2021.
4 CBS, Indicator for Optimal Ageing in Israel 2022, (2024).
5 The National Economic Council, Strategic Socio-Economic Situation Assessment, 2015; Government Resolution 145, "Adoption of the Strategic Socio-Economic Situation Assessment for the 34th Government", (June 28, 2015).; Government Resolution 127 on the subject of "Map of National Indicators for Optimal Ageing" dated July 19, 2021.

This is a summary of the SAI Israel Audit report titled "The State of Israel's Preparedness for an Ageing Population - Safeguarding the Well-Being of the Ageing Population". The full National Report can be accessed through the SAI Israel website [link].

In light of the critical importance of maintaining the well-being of senior citizens, particularly post-retirement, and considering the general increase in life expectancy alongside healthy life expectancy, it is recommended that a responsible body be designated for each domain aimed at sustaining the well-being of senior citizens. These domains include preparation for retirement, volunteering, and combating loneliness. It is further recommended that these entities develop comprehensive policies, establish mechanisms for inter-organizational cooperation and coordination, and delineate specific goals for each respective area.

What is the retirement age?

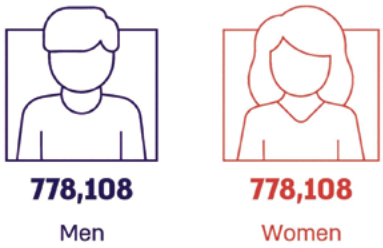
Retirement Age: The Retirement Age Law, 2004 defines retirement age as the age at which an individual is entitled to retire from employment based on their age, and, provided that the conditions established by law or agreement are satisfied, to receive benefits attributable to retirement from employment. The mandatory retirement age is 67 for men and 65 for women. However, there are transitional provisions for women born up to December 1969, whose retirement age is set gradually according to their month of birth. As of 2026, the retirement age is 67 for men, and for women, it is between 63 and 64, with a projected increase to age 65 by 2032 (Retirement Age).

Mandatory Retirement Age: The Law further specifies that the mandatory retirement age is the age at which an employee may be compelled to retire from employment on the basis of age. In effect from 2026, this age is uniform for both men and women, set at 67 years (Mandatory Retirement Age).

The National Insurance Law, 1995, utilizes the retirement ages prescribed by the Retirement Age Law to determine old-age pension eligibility. A senior citizen is defined as an individual who has reached retirement age and is entitled to old-age pension subject to an income test. Upon arriving at the age of 70 – designated as the age of absolute eligibility for both women and men – entitlement to old-age pension is granted irrespective of income levels and independent of retirement status.

The following figure illustrates the number of senior citizens who have reached the statutory retirement age, disaggregated by gender.

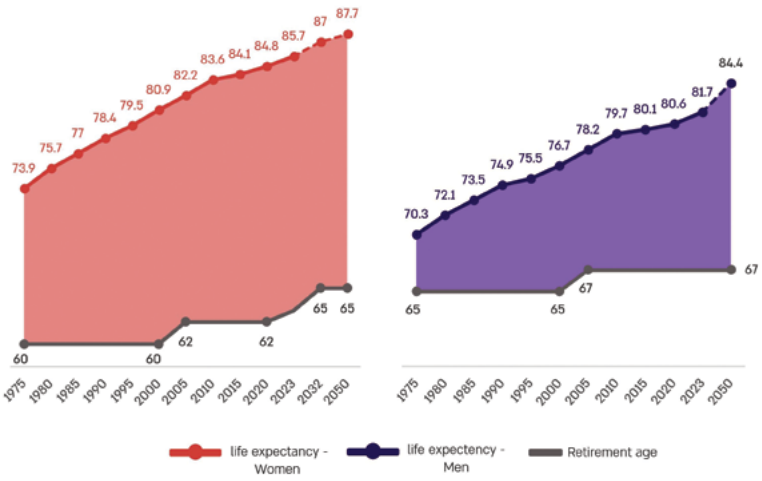
Figure 1: Number of senior citizens above the retirement age established by Law (63 years for women and 67 years for men), by gender, 2025



Source: National Insurance data, as processed by the Office of the State Comptroller. The data is current as of December 31, 2024

Increase in the Gap Between Life Expectancy and Retirement Age: The rise in both life expectancy and healthy life expectancy, as previously noted, has resulted in an expanding discrepancy between the legally mandated retirement age and life expectancy (both overall and healthy life expectancy in particular). The subsequent image illustrates the gap between life expectancy at birth and the statutory retirement age, disaggregated by gender, for the years 1975 through 2050 (forecasted).

Figure 2: Life expectancy at birth by gender, and the gap between it and age 65[6]



Source: Data from the Central Bureau of Statistics, processed by the Office of the State Comptroller[7].

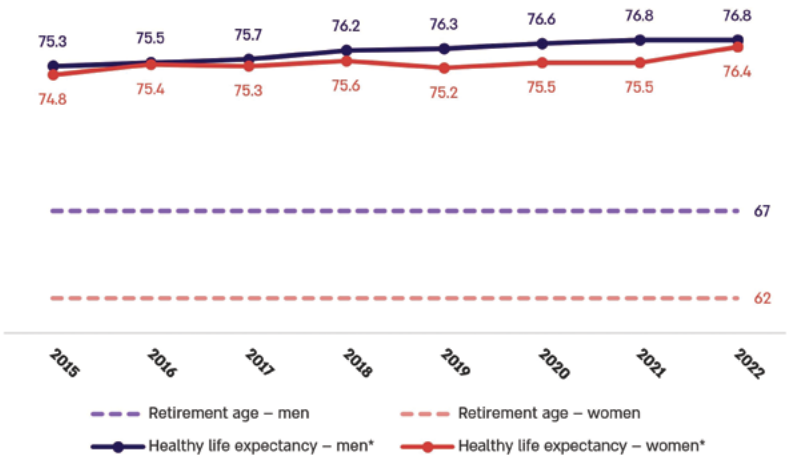
6 The life expectancy shown in the figure is calculated at birth, and does not reflect the expected life expectancy of a person who actually reached retirement age in that year. Therefore, the comparison between the lines is intended for illustrative purposes only.

7 Myers Joint Brookdale, 65+ in Israel Statistical Yearbook 2024; Forecast from United Nations, World population prospects 2024.

The figure demonstrates that from 1975-2023, life expectancy at birth increased from 74 years to 86 years for women, and from 70 to 82 years for men. Furthermore, the gap between retirement age and life expectancy widened over this period; for women, the gap expanded from 14 years in 1975 to 23 years in 2023, representing an increase of approximately 64%. For men, the gap increased from 5 years to 15 years during the same timeframe, reflecting a 200% increase. Notably, projections for men suggest that this gap will continue to widen, reaching 17 years by 2050, which corresponds to a 13% increase relative to 2023.

The subsequent image depicts the gap between healthy life expectancy at age 65 (calculated by adding the expected number of additional healthy years to age 65), and the statutory retirement age, by gender.

Figure 3: Healthy life expectancy (at age 65) and retirement age, by gender, 2015–2022



Source: Data from the Central Bureau of Statistics, processed by the Office of the State Comptroller[8].
*Note: The figure presents age adjusted for healthy life expectancy, computed as the sum of expected healthy years remaining at age 65.

This figure indicates that healthy life expectancy at age 65 increased by approximately 2% for both men and women between 2015 and 2022, whereas the statutory retirement age remained unchanged during this period[9].

Historically, retirement marked the onset of a comparatively brief life phase, characterized by declining functional capacity and health. In contrast, contemporary increases in life expectancy have extended this stage to approximately two decades. Given the concurrent rise in healthy life expectancy, retirees today generally maintain good health and high functional capacity[10], thereby entering a new extended life phase.

8 Central Bureau of Statistics, Life Expectancy and Healthy Life Years (2024) Data Analysis.
9 For women, as mentioned, there was a gradual increase in the retirement age; until 2022 it remained around age 62 (and at most it was extended for some women by only a few months).
10 Report of the Public Committee to Examine the Retirement Age for Women (2016), Appendix B, p. 65.

What is the employment rate of retirees? And what is the target participation rate?

Employment in advanced age presents numerous advantages, including economic benefits manifesting in the maintenance of senior citizens' income[11] and the augmentation of pension benefits[12], the reduction of National Insurance support benefits (such as supplementary income for a senior citizen's benefits)[13], the increase of state revenue through taxes (income tax, National Insurance, and indirect taxes)[14], and the preservation of purchasing power[15]. Beyond these economic benefits, post-retirement employment also confers health advantages, as it helps prevent deterioration in senior citizens' health and mitigates increases in healthcare[16] and nursing care expenditures. Additionally, wellbeing advantages are evident through the maintenance of a sense of belonging and purpose, the preservation of social connections, and enhanced life satisfaction[17]. Moreover, employment among senior citizens benefits employers by ensuring employment stability, fostering organizational loyalty, and retaining professional and organizational knowledge[18]. Consequently, the updated 2022 Map of Indicators determined that participation in employment at older ages contributes substantively to the Israeli economy and constitutes a critical factor in optimal ageing by strengthening and sustaining social relationships.

Notwithstanding these multifaceted benefits associated with continued employment beyond retirement age, not all senior citizens express a desire to continue working, even if they meet eligibility criteria and are not legally constrained from doing so. In 2017, the Ministry of Social Equality estimated that the untapped employment potential among senior citizens approximates 18% of the population aged 60-74, excluding those already employed[19].

11 According to data from the Brookdale Institute, the household income (of an individual or a couple with at least one spouse aged 65 or over) stands at NIS 14,676, which is about a third lower (NIS 7,300) than the household income of the general population (which stands at NIS 22,013). See the 2024 Census of People Aged 65 and Over in Israel, Brookdale Institute, Table 3.14.

12 Continuing employment allows for continued savings deposits, accumulation of additional return on the money accumulated, and shortening of the period for utilizing pension savings (reducing the coefficient). The conversion coefficient is the ratio between the accumulation of capital over the years of savings from employment, and the expected number of years of life after retirement. The longer the postponement of the retirement date, the higher the decrease in the coefficient, since the number of years after retirement decreases. Also, for each year of deferment of retirement from work, the pension benefit may increase by more than 6%. See the Ministry of Social Equality, Conclusions of the Committee for the Integration of the Elderly in Employment and the Community, 2014 Axelrad, H., Eckstein, C., & Larom, T., The Economic Benefit of Employing Older Workers (2021); Retirement Age and Flexible Retirement Mechanisms in the Pension System (2019), p. 24.

13 According to the Brookdale Institute, 30% of household income for persons aged 65 and over comes from benefits and support. See the 2024 Annual Report for People Aged 65 and Over in Israel, Brookdale Institute, Table 3.14. Also see Axelrad, H., Eckstein, C., & Larom, T., The Economic Benefits of Employing Older Workers, (2021). Axelrad, H., Regulatory Barriers to the Employment of the Elderly: An Analysis and Proposals for Solutions, 2023.

14 Axelrad, H., Eckstein, C., & Larom, T., The Economic Benefits of Employing Older Workers, (2021).

15 Kimchi, A. (2019), Is there a decrease in consumption after retirement from work? The National Insurance Institute and Shoresh Center for Socio-Economic Research.

16 Axelrad, H., Eckstein, C., & Larom, T., The Economic Benefits of Employing Older Workers, (2021).

17 Harel Harari, K., Golan, Z., (2012) Senior Citizens: The Largest Pool of Untapped Human Resources. Ministry of Senior Citizens, Conclusions of the Committee for the Integration of the Elderly in Employment and the Community (2014). p. 25. Axelrad, H., Eckstein, C., & Larom, T., The Economic Benefits of Employing Older Workers (2021).

18 Axelrad, H., Levin Epstein, N., Kalev, A., Employing Workers After Retirement Age: The Employers' Perspective, (2021) p. 23. Ministry for Senior Citizens in collaboration with the National Economic Council, Conclusions of the Committee for the Integration of the Elderly in Employment and the Community (2014).

19 It should be noted that this estimate does not take into account the number of senior citizens who are motivated to work. Summary presentation of the Employment Strategy of the Ministry of Social Equality and Deloitte 2019, p. 23.

As part of the audit process, the Office of the State Comptroller conducted a survey addressing retirement preparation, post-retirement employment, volunteering, and experiences of loneliness. This questionnaire was completed by a representative sample of 403 senior citizens aged 60-75 (the Survey of the Senior Citizen Population)[20]. The survey was conducted using an online questionnaire, with sampling derived from online panels – databases of respondents who had previously consented to participate in surveys. Data were collected from August to September, 2025.

The audit team's Survey of the Senior Citizen Population revealed that prior to retirement, a substantial proportion of senior citizens – 75% (77 respondents) – expressed interest in working after retirement. Despite this, only a minority (22%) reported actual continued employment after retiring; however, a majority of those not working after retirement (64%) remained interested in employment. These findings point to a significant employment potential within the senior citizen demographic.

Recognizing the importance of employment among senior citizens, the Israeli government established targets in Government Resolution 198 of 2021[21] to increase the employment rate among men aged 67-74 from 33.5% in 2020 to 43.5% by 2030, and to increase the employment rate among women in the same age group from 18.5% in 2020 to 28.5% by 2030[22]. Additional government resolutions have facilitated the employment of senior citizens within the civil service, governed by designated standards[23].

20 Confidence interval of ±4.9%, p = 95%.

21 Government Resolution 198, The Economic Plan for 2021 - 2022. In accordance with this resolution, an increase of 1% is required each year, in order to achieve the set goals.

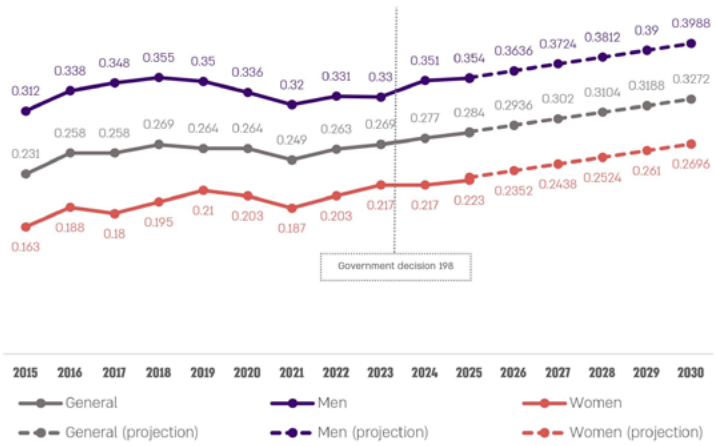
22 The government resolution adopted the recommendations of the Committee for the Advancement of Employment for 2030, which was established by the Minister of Labor, Welfare and Social Services in 2017, with the aim of formulating policy and practical recommendations intended at increasing employment among demographics that are underrepresented in the labor market. The Committee consisted of 20 members from various fields, and was headed by Prof. Zvi Eckstein.

23 Government Resolution 2239, "Promoting the Employment of Senior Citizens in the Civil Service", Government Resolution 592, "Promoting the Employment of Senior Citizens in the Civil Service" Government Resolution 834, "Promoting the Strategic Issue of Preparing for an Ageing Population – Integrating Seniors into Employment".

Employment of senior citizens aged 67-74

The following image illustrates the actual overall employment rate of citizens aged 67-74, disaggregated by gender, for the years 2015-2025, alongside an employment rate forecast developed by the audit team extending to 2030.

Figure 4: Employment participation rate of senior citizens aged 67-74, by gender, 2015-2025, with forecast to 2030



According to the Central Bureau of Statistics, processed by the Office of the State Comptroller[24].
*In 2021, Government Resolution 198 was adopted, establishing employment targets for the year 2030.

The figure shows that the actual employment rate among citizens aged 67-74 increased from 23.1% in 2015 to 28.4% in 2025. This increase was observed among both men and women: from 2015 to 2021, there was a discernible upward trend in employment rates, with the exception of a 1.5 percentage point decline between 2020 and 2021, which appears attributable to the labor market impacts of the COVID-19 pandemic outbreak in 2020. Specifically, male employment rates rose by 0.8 percentage points during this period (from 31.2% to 32%, averageing an increase of 0.13 points annually), while female employment rates increased by 2.4 percentage points (from 16.3% to 18.7%, averageing 0.4 points per year).

24 According to CBS data – tracking government employment targets.

Furthermore, the image demonstrates that between 2021 – the year the government resolution was adopted – and 2025, the employment rate exhibited a continuous upward trajectory. Male employment increased by 3.4 percentage points (from 32% to 35.4%, averageing 0.85 points annually), and female employment rose by 3.6 percentage points (from 18.7% to 22.3%, averageing 0.9 points per year).

Consequently, it can be inferred that since the 2021 government resolution, the employment rate among senior citizens aged 67-74 has consistently increased at a rate surpassing that observed prior to the government resolution. Nonetheless, the magnitude of this acceleration is modest, particularly among women, who experienced an average annual employment increase of 0.9 percentage points post-resolution compared to 0.4 percentage points beforehand.

It is important to note that excluding the years affected by the COVID-19 crisis (2020-2021), the analysis reveals that the employment rate for individuals aged 67-74 increased by an average of 0.8 percentage points annually between 2015 and 2019, prior to the government resolution. Conversely, in the post-pandemic and post-resolution period, 2022 to 2025, the employment rate grew by an average of 0.7 percentage points per year. This suggests that the rate of employment growth was higher before the government resolution than after it.

Additionally, the image shows that the estimated forecast, based on existing trends since 2015, projects that the employment rate for senior citizens aged 67-74 in 2030 will be 32.7%; with men expected to attain an employment rate of 39.9% and women 27%.

Hence, despite the benefits of post-retirement employment and the willingness of many senior citizens to remain in the workforce, only a relatively small proportion are currently employed (22.3% of women and 35.4% of men in 2025). Furthermore, if the current trend persists and the projection materializes, in 2030 the employment rate of men aged 67-74 (39.9%) will fall 3.6 percentage points short of the government's target of 43.5%, and the employment rate among women in the same age group (27%) will be 1.5 percentage points below the target of 28.5%. Therefore, there is substantive concern that the government's targets regarding senior citizen employment may not be attained. This shortfall holds considerable economic significance, estimated at approximately NIS 862 million annually[25].

25 The calculation is based on the number of people aged 67-74 from National Insurance data, and an estimate of the population growth rate as of 2030, calculating the expected gap in employment rates compared to the government target. The estimate includes employment volume rates and is based on the minimum wage in 2025 without the higher wage levels, and without adjusting the expected wage for 2030. The rate of part-time jobs was calculated in accordance with the estimate in the Indicator Map for ages 65-74.

What actions were taken to encourage employment after retirement age?

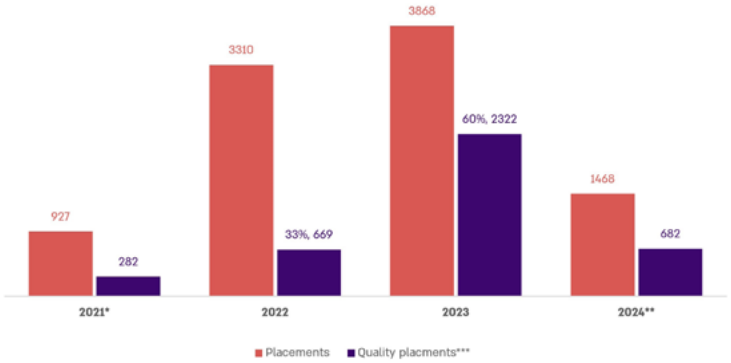
Increasing Employment Among Senior Citizens Over 60 - "Seniors at Work" Program

In addition to Government Resolution 198 focusing on the employment of senior citizens aged 67-74 (in addition to other designated populations), the government has adopted additional resolutions regarding the employment of adults over 60: Government Resolution 150 of 2015 tasked the Minister of Senior Citizens with submitting, in coordination with the Budget Department of the Ministry of Finance, a program designed to promote the integration of adults aged 60 and above into employment and the community. Additionally, Government Resolution 834 of 2015, which was adopted following Resolution 150, assigned the Ministry of Social Equality the responsibility to develop and implement programs encourageing employment among senior citizens.

In 2021, the Ministry of Social Equality formulated the "Seniors at Work" program (the Program), with the objective of effecting a shift in societal perceptions within the employment market regarding senior citizens and fostering equitable opportunities for their integration into the labor market. This Program targets individuals aged 60 and over interested in labor market integration by matching suitable job opportunities to senior citizens and providing the necessary tools and skills for job search and labor market assimilation. The Program establishes quantitative goals for the number of placements and the proportion of quality placements (defined as those lasting more than six months) and was allocated a budget of approximately NIS 37,578,000 for the years 2021 through 2025.

The Program's objectives stipulate that the proportion of quality placements shall constitute 30% of the total placements conducted annually. The accompanying image illustrates the number of placements and quality placements executed between 2021 and 2024 within the framework of the Program.

Figure 5: Placements and quality placements of senior citizens, carried out under the Seniors at Work Program, August 2021-2024



According to data submitted to the Office of the State Comptroller by the Ministry of Social Equality in February 2026[26].
* The data for 2021 reflect data commencing in August, with the actual months shown in the image. It should be noted that, when estimating annual figures based on actual data, the number of placements per year amounts to 2,225, of which 676 are quality placements.
** The Ministry of Social Equality has not yet provided an estimate of the rate of quality placements for 2024.
*** It is important to point out that the rate presented alongside the number of quality placements, referring to placements lasting at least six months, does not necessarily represent the success rate for all placements within that year, since placements initiated in the latter months may only fulfill the six-month criterion in the following year.

The data reveal that both the rate of senior citizen placements and the rate of quality placements increased by approximately 51% and 242%, respectively, from the Program's inception in 2021 through 2023. However, a decline in both rates was observed in 2024. Furthermore, during 2022 and 2023, the Ministry of Social Equality did not achieve the targeted 30% threshold for quality placements.

It consequently follows that the number of senior citizens aged over 60 who applied to the Ministry of Social Equality's "Seniors at Work" program during the period 2021–2024 and received placements in the program, amounted to 9,573 participants. The number of quality placements within the program during these years was 3,955. Considering the employment potential of citizens aged 60 and above in 2024, which stood at 408,728 individuals, the total placements over the four years of the program's operation represent an approximate rate of 2.34%, while the rate of quality placements is approximately 1%.

Additionally, the annual increase in the number of employed senior citizens peaked in 2023, reaching 3,863 senior citizens and 2,322 quality placements, representing only 0.9% and 0.6% (respectively) of the total employment potential among those aged 60 and above.

26 Information sent via emails from the Ministry of Social Equality to the Office of the State Comptroller on February 19 and February 24, 2025.

The Ministry of Social Equality responded that the placement of approximately 50% of all applicants to the program constitutes a significant achievement. It further elaborated that, within the framework of the program and its supplementary activities, personal employment guidance is provided in accordance with the individual preferences of the senior citizens; consequently, the effectiveness of a qualitative placement process is manifested in the establishment of an infrastructure that enables the citizen to make decisions aligned with their needs and offers an opportunity for reintegration into the workforce, while ensuring that the placements are appropriate and tailored. The provision of care, guidance, and placement services, even if brief, is regarded as a success and a meaningful contribution to the citizen. Additionally, the Ministry highlighted that the years under review were marked by a series of crises, including the COVID pandemic and the Swords of Iron War, which disrupted stability and continuity in the employment market, alongside preexisting challenges related to the employment of senior citizens.

The Office of the State Comptroller notes that, as indicated, the scope of the "Seniors at Work" program is limited with respect to the employment potential within the target population defined in government resolutions – namely, citizens aged 60 and above.

It can further be inferred from the above that the Ministry of Social Equality's Seniors at Work Program, by itself, is unlikely to generate the requisite change needed to meet the targets set by Government Resolution 198. According to this resolution, an annual increase of 1% in the employment rate among individuals aged 67-74 is required in order to reach the government target of 43.5% employment among men and 28.5% among women in this age group by 2030.

The Ministry of Social Equality responded that the employment targets for those aged 67-74 are national macro-goals that do not replace the overarching goal of the "Seniors at Work" program, but the program certainly contributes to achieving them.

It is recommended that the Ministry of Social Equality, in coordination with the Ministry of Finance, endeavor to expand the "Seniors at Work" Program and augment both the number of placements and the number of quality placements among senior citizens. Furthermore, it is advised that the Ministry conduct comprehensive analyzes of the Program's objectives and outcomes according to age segmentation, thereby enabling an assessment of compliance with all government employment goals.

Employment of Senior Citizens in the Civil Service - Senior Citizen Positions

The Civil Service Commission (CSC) is responsible for manageing human capital and organizational structure within the civil service, and is entrusted with the initiation, leadership, direction, imparting, and control of the human capital management system within the civil service. Government Resolution 834 of 2015 mandated the CSC, in coordination with the Ministry of Social Equality, the Ministry of Finance, the Ministry of Justice, and the National Economic Council, to develop a plan for a designated employment track within the civil service for senior citizens beyond retirement age.

Subsequently, the "Senior Citizen Positions at the Civil Service" Program was developed as a designated employment track enabling individuals beyond retirement age to integrate into various positions within the civil service, regardless of prior civil service employment. At its inception, the program was classified as a pilot; however, over time it evolved into a fully implemented initiative. The positions within this framework expanded to encompass 400 positions by 2021, with an anticipated increase to 1,000 authorized positions by 2030.

From the above it can be inferred that despite the expansion of the Senior Citizen Positions at the Civil Service Program and the increase in the number of positions, its practical scope remains limited, offering employment opportunities to fewer than 0.1% of the senior citizen population.

The Ministry of Social Equality admitted in its response that the implementation processes concerning this matter are prolonged; however, in collaboration with the Civil Service Commission, it has been able to consistently increase the availability of jobs, the number of actual placements, and the diversity of government ministries that employ senior citizens.

The Civil Service Commission reported in its response that in 2025 there was an improvement in the integration of senior citizens within the civil service. By August 2025, 562 positions had been filled, and the proportion of ministries that did not employ senior citizens stood at 42% (44 ministries and government units). Furthermore, it was noted that several options currently exist for integrating and continuing the employment of senior employees in the civil service, beyond the senior citizen position, including the extension of employment beyond retirement age.

It is recommended that the Civil Service Commission, in cooperation with the Ministry of Social Equality and the Ministry of Finance, extend the number of positions within the employment track of the Senior Citizen Positions.

Does the national policy for the elderly address loneliness?

Loneliness constitutes a subjective experience characterized by an individual's perception of a discrepancy between the desired social connections and those actually accessible to them. Conversely, isolation is an objective condition marked by an absence of social connections. Although a positive correlation often exists between these two states, it is noteworthy that even individuals possessing a substantial number of social connections may still experience loneliness, whereas individuals who are alone, with limited social ties, do not necessarily report feelings of loneliness[27].

27 Joint Israel ESHEL, Report of the Committee to Examine Ways of Coping with Loneliness Among the Elderly (2014), pp. 9-12.

Loneliness is a phenomenon that can manifest across all stages of life; however, in later life it frequently co-occurs with other losses characteristic of this period, such as bereavement of friends and family members, as well as job loss. It is recognized as a principal factor adversely affecting the well-being of the elderly. The intersection of loneliness with these concurrent losses exacerbates mental, physical, and health-related risks, thereby detrimentally impacting the quality of life and potentially reducing longevity within this population. Furthermore, this interplay diminishes the capacity of senior citizens to marshal resources and resilience necessary to cope effectively with such challenges[28].

Both loneliness and social isolation have been acknowledged by the World Health Organization as significant public health concerns and strategic policy priorities across all age demographics, particularly within the framework of the "UN Decade of Healthy Ageing" (2021–2030)[29]. In alignment with this global perspective, the State of Israel has designated the mitigation of loneliness as a key super-indicator of successful ageing in its **Map of Indicators for Optimal Ageing**.

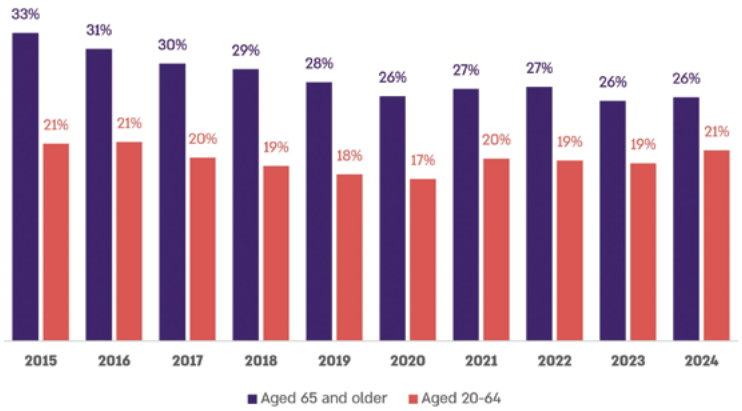
Is loneliness measured? How?

Given that loneliness constitutes a subjective experience, it is assessed through a self-report question answered by senior citizens. At present, there exists no singular, unequivocal administrative dataset that directly indicates a sense of loneliness among the population.

In the annual social survey conducted by the Central Bureau of Statistics (CBS), which examines the living conditions and well-being of the Israeli population[30], respondents are queried regarding situations in which they experience loneliness[31]. Within the National Indicators for Optimal Ageing report, published biennially by the CBS as part of the implementation of Government Resolution 127, a senior citizen is classified as lonely if they respond to the loneliness question in the social survey with either "often" or "occasionally". The image below presents data on the prevalence of feeling lonely among individuals aged 65 and over compared to those aged 20-64 over the past decade, as derived from the CBS Social Survey.

28 Joint Israel ESHEL, Report of the Committee to Examine Ways of Coping with Loneliness Among the Elderly (2014), pp. 9-12.
29 World Health Organization, Social Isolation and Loneliness (link)
30 The CBS, Social Survey.
31 The CBS, 2025 Social Survey Questionnaire on Attitudes Towards Government Services in Israel and Civil Defense.

Figure 6: Prevalence of loneliness among citizens aged 20-64 and aged 65 and over, 2015-2024



According to data from the CBS Social Survey, processed by the Office of the State Comptroller[32].

The figure demonstrates that throughout the years 2015 to 2024, the prevalence of loneliness was consistently higher among those aged 65 and over than among individuals aged 20-64, with the difference ranging from 12 percentage points in 2015 to 5 percentage points in 2024. Furthermore, loneliness rates among the 20-64 age group remained stable between 2015 and 2024, whereas loneliness rates among the senior population decreased by 7 percentage points during this period, reaching approximately 26% in 2024. Despite this reduction, approximately one quarter (26%) of senior citizens in Israel continue to report feelings of loneliness.

The audit reveals that the vast majority of lonely senior citizens (82%, approximately 310,000 individuals) are not identified, and although monitoring is more prevalent among at-risk groups (such as solitary senior citizens[33]), a significant portion of these individuals (70%, approximately 15,000 people) remain unidentified by the professionals who engage with them[34].

32 The data was calculated using the CBS Social Survey panel generator.

33 Senior citizens without a spouse and without children according to National Insurance records.

34 "Identified" means that it is explicitly stated in one of the authorities' systems that the citizen is solitary. There are solitary senior citizens who are known to the authorities and may even be treated, but they are not registered as solitary.

Who is responsible for identifying lonely elderly people, and what methods are used?

Government Resolution 127 of July 2021, which adopted the Indicator Map, identified loneliness as one of the indicators for optimal ageing; however, it did not assign responsibility to any specific ministry for locating and providing care to lonely senior citizens.
Nevertheless, it is noteworthy that the Ministry of Welfare has independently established a target for 2026, set at 21% for the reduction of loneliness.

In order to effectively locate and provide care for senior citizens experiencing loneliness, interventions must be implemented at multiple levels. These include raising public awareness of the issue among both the general population and senior citizens themselves, to ensure recognition of the problem and encourage help-seeking behavior; developing accessible and appropriately adapted social activities that mitigate loneliness and enhance a sense of community belonging, such as community clubs, classes, and intergenerational gatherings[35]; and conducting proactive outreach efforts[36] aimed at identifying lonely senior citizens and offering tailored supportive services[37]. In practice, various professionals regularly engage with senior citizens and address issues related to loneliness, as will be elaborated below.

As part of the audit, the State Comptroller administered a questionnaire to professionals involved in addressing loneliness among senior citizens and in implementing policies related to the ageing population. The survey received responses from 957 professionals working in the field of ageing, including social workers and officials from social services departments within local authorities (242), senior citizen advisors in local authorities (34), volunteers and social workers from the Counseling Service for the Elderly at the National Insurance Institute (655), and community supervisors in the Senior Citizens Administration at the Ministry of Welfare (10) (the Professionals Survey). Additionally, the Office of the State Comptroller conducted a survey targeting family doctors involved in promoting healthy life expectancy, preventive medicine, health promotion, and addressing loneliness among senior citizens; approximately 240 doctors participated in this survey (the Family Doctors Survey).

According to data derived from the Professionals Survey, 93% of respondents (947) affirmed that it is feasible to identify senior citizens experiencing moderate or greater levels of loneliness. Moreover, a majority of these respondents (66%, equating to 619 individuals) were of the opinion that the responsibility for such identification should be collectively assumed by all entities that engage directly or indirectly with senior citizens, including social services departments within local authorities, the health system, the National Insurance Institute, the Ministry of Social Equality, and the Ministry of Welfare.

35 Joint Israel ESHEL, Report of the Committee to Examine Ways of Coping with Loneliness Among the Elderly (2014), p. 14.
36 Outreach is a proactive approach to people or groups who are not receiving treatment or services in order to establish contact between them and social services.
37 State Comptroller, Annual Report 65C (2015), "Non-Exhaustion of Social Rights", pp. 3-46.

The Ministry for Social Equality, the National Insurance Institute, the Ministry of Welfare, and the HMO's emphasized in their responses the importance of identifying and addressing loneliness among senior citizens. They noted that they operate a range of services and programs intended, directly or indirectly, to alleviate loneliness and strengthen senior citizens' sense of belonging. One of the HMO's also addressed in its response the medical implications of failing to identify and treat loneliness, as well as the associated economic costs. Accordingly, it noted the importance of establishing an organized mechanism for identifying, documenting, and providing systemic treatment for the phenomenon.

The Office of the State Comptroller commends the actions taken by the Ministry for Social Equality, the National Insurance Institute, the Ministry of Welfare, the Ministry of Health, and the HMOs to identify and assist lonely senior citizens, even though they have not been assigned direct responsibility for the issue. It is recommended that the government, and in particular the joint working team that formulated the Map of National Indicator for Optimal Ageing — which included representatives of ministries dealing with ageing, such as the Prime Minister's Office, the Ministry for Social Equality, the Ministry of Health, the Ministry of Welfare, the National Insurance Institute, and the Central Bureau of Statistics — examine the need to designate a lead entity for the issue of loneliness and, accordingly, formulate a recommendation for the government.

The subsequent table presents the responses of participants from both the Professionals Survey and the Family Doctors Survey concerning the proactive identification of senior citizens experiencing loneliness.

Table 1: Responses of participants in the Professionals Survey and Family Doctors Survey regarding the proactive identification of senior citizens experiencing loneliness

	Social workers in social services departments	Family doctors in HMOs	Volunteers in the Counseling Service for the Elderly at the National Insurance Institute
Type of contact	Social workers in the social services departments of the Ministry of Welfare, which operate in local authorities, come into contact with senior citizens who are registered with the department, or those who consume welfare services	The family doctor at the HMO provides the primary line of care for the family and comes into contact with the entire population	The volunteers conduct proactive conversations with senior citizens who may be in a state of transition, loss, crisis or risk, or with populations who seemingly do not exercise all their rights[38], and inquire about feelings of loneliness, among other things
Percentage of professionals who stated that they believe this sector should detect moderate or higher levels of loneliness	87% (833)	77% (737)[39]	83% (794)
Percentage of respondents from the same sector who responded that they proactively identify senior citizens suffering from moderate or lower levels of loneliness	58% (122)	44% (104)	67% (186)

The table shows that 77% to 87% of professionals consider that family doctors (77%), National Insurance Institute volunteers (83%), and social workers in social services departments (87%) should identify loneliness among senior citizens. However, in practice, many of these professionals do so to a moderate or lesser degree (48%, 67%, and 58%, respectively).

38 These are the following populations: 100 years old and older; 85-99 years old, recipients of a long-term care allowance/without a foreign worker, who do not visit daycare centers and are defined as "solitary" in the long-term care system (living alone or with another long-term care person); senior citizens who have been widowed in the past year; spouses of beneficiaries of the Long-Term Care Law - at the higher levels (4,5,6) who do not go to a daycare center and do not have a foreign worker (so the entire burden of care falls on them as spouses); 80 years old and older who, according to the records, are apparently childless and unmarried.

39 93% of the doctors themselves (218 out of 236) responded in the Family Doctors Survey that they believe it is moderately or more important for them to know that their patient suffers from loneliness.

Among the barriers reported by professionals as impeding the detection of loneliness among senior citizens are workload, lack of appropriate tools, insufficient professional knowledge, absence of guidelines, and the difficulty of addressing the issue in conversations[40].

In response, HMO A indicated that the issue of loneliness is addressed in professional lectures for caregivers, although not in a systematic manner. HMO D reported that efforts are underway to enhance medical and clinical training in age-appropriate medicine within primary care, targeting all personnel including physicians, nurses, and other healthcare professionals.

The Ministry of Social Equality responded that it conducts training sessions for advisors working with senior citizens and local authorities who address loneliness. Additionally, representatives of the Ministry of Social Equality hotline (*8840) receive instruction and training to identify these challenges among applicants.

The NII acknowledged in its response that there are challenges warranting attention and committed to intensifying its focus on this issue in future training sessions, while continuously striving for improvement.

Notably, 95% of senior citizens who participated in the survey (356 respondents out of 391) indicated that no professional had engaged them in discussions regarding loneliness. This suggests that a substantial number of senior citizens are not queried about loneliness by the professionals with whom they interact, thereby diminishing the likelihood of meaningful and proactive detection.

The Ministry of Welfare indicated in its response that local authorities implement a variety of community initiatives aimed at enhancing social bonds, community engagement, and volunteerism, within the framework of fostering a sense of belonging and social participation among senior citizens. The Ministry's policy is grounded in a comprehensive professional framework encompassing interventions at the individual, group, and community levels. It posits that broadening the scope of interventions related to belonging, the prevention of social isolation, and community participation will necessitate augmented resources, increased professional personnel, and more substantial investment in community services for senior citizens.

The Ministry of Health articulated in its response that the community health systems and hospitals have considerable potential to function as pivotal agents in the early identification of loneliness, attributable to their continuous and frequent interactions with the senior citizen demographic. Consequently, social work systems within the HMOs are presently spearheading various initiatives and programs in this domain, emphasizing the identification of social risk factors, fortification of support networks, coordination of treatment, and mediation with community stakeholders. Comparable efforts are underway within general and geriatric hospitals. Nevertheless, systemic challenges persist, notably the absence of standardized documentation and structured tools within clinical information systems that would facilitate systematic identification, monitoring, and data generation concerning loneliness and isolation. Accordingly, a principal strategic focus currently under development is the enhancement of capacities for detection, documentation, and proactive intervention in this field.

40 The barriers that professionals noted as making detection moderately or more difficult are: among social workers - overload (89%), lack of tools and professional knowledge (58%), and lack of guidelines (51%). Among National Insurance volunteers, the main barriers are - the sensitivity of the issue (63%), lack of tools and professional knowledge (58%), and the circumstances of the conversation (47%).

In its response, HMO B reported having multiple programs specifically aimed at mitigating loneliness and noted that social workers at Maccabi HMO maintain collaborative interfaces with the departments of social services and the National Insurance Institute. It also acknowledged that addressing loneliness necessitates allocation of resources.

HMO D responded that it was formulating models of multidisciplinary care within the community, incorporating social workers and fostering collaborations with social welfare agencies. Furthermore, it emphasized that the capacity to expand these measures, including outreach to social and geographical peripheries, is contingent upon regulatory and budgetary provisions.

HMO A responded that it was assessing aspects of support and social connectivity among patients and that it develops tailored intervention plans in partnership with the social welfare agencies affiliated with the HMO. Additionally, it is engaged in developing standardized documentation pertaining to solitary patients.

In its response, the NII pointed out that the responsibility for identifying senior citizens has not been designated to it and that it holds no specific official objectives in this regard. It further noted that, given the constraints of available manpower and budget, it is not feasible to locate all lonely senior citizens.

It is recommended that the Ministry of Welfare, the Ministry of Social Equality, the National Insurance Institute, and the Ministry of Health, through HMOs, develop and implement a mandatory protocol for the proactive identification of loneliness among senior citizens. To ensure optimal implementation of this protocol, it is further recommended to design targeted training programs for the diverse professional groups involved (including social workers, National Insurance volunteers, family doctors, and call centers within the Ministry of Social Equality) to enhance their ability to recognize signs of loneliness and engage in sensitive and appropriate discourse on the subject.

Additionally, the establishment of a clear referral system to connect individuals with community services, support groups, and programs aimed at reducing loneliness is advised. The formulation of performance and monitoring indicators to assess the extent of proactive detection is also recommended. The adoption of these measures may facilitate earlier identification of senior citizens experiencing loneliness, enable timely and appropriate interventions, and ultimately contribute to the enhancement of their well-being and quality of life. Where such a protocol and training groups exist, and in light of the findings presented, it is recommended to examine the need to expand and deepen the training and guidelines, and to embed them among employees and volunteers.

Summary

Well-being is defined as a state encompassing physical, mental, and social wellness. The general increase in life expectancy, and particularly in the health span, has resulted in a longer post-retirement period of life. Consequently, the maintenance of well-being among senior citizens has gained increasing significance.

This report is collaboratively presented by three countries: Lithuania, Poland, and Israel. It examines two principal components essential for promoting the well-being of senior citizens: post-retirement employment and the identification and care of isolated senior citizens. Furthermore, the report explores the existence of comprehensive welfare policies within each country, delineates the prevailing trends within these policies, and assesses how each country is preparing to address future challenges associated with an ageing population.

The tables below provide a comparative analysis of the three countries participating in the audit, organized according to the audit questions examined.

A Comparative Situational Analysis of Policies Related to the Welfare of Senior Citizens

Table 1: Is there a national policy for the welfare of the elderly? What topics does it include?

Poland	Lithuania	Israel
A comprehensive national policy for senior citizens exists, focusing on three pillars – security, participation, and social solidarity. This policy encompasses various aspects, including health, prevention of harm and neglect, physical security, social, educational, cultural, and professional activities, as well as integration into the labor market. Nevertheless, challenges in implementation persist at the local level and within the social services system, with certain areas exhibiting deficiencies in tools, procedures, and systematic data.	There is no defined and integrated policy for active ageing; furthermore, no designated welfare areas for the elderly have been identified, and there exists no unified strategy or legislation delineating the welfare of the elderly. Additionally, the issue remains split across various ministries. Nonetheless, a bill for a framework concerning policies for the elderly is presently under consideration, aiming to establish a more integrated approach and to define objectives, the roles of institutions and organizations, as well as relevant indicators.	A policy exists; however, its implementation remains incomplete. Government resolutions have been enacted on several issues, including the formulation of strategic directions to address the challenges of ageing, the integration of the elderly into employment and community spheres, and the adoption of a set of indicators for optimal ageing, encompassing measures related to the quality of life and well-being of senior citizens. Nonetheless, gaps persist in the execution of these government resolutions, resulting in only partial implementation. For instance, there is an absence of a comprehensive governing body, and for the majority of issues, no responsible entity has been designated, nor have specific targets been established.

Table 2: What are the budgets allocated?

Poland	Lithuania
Expenditures are allocated across multiple categories, encompassing pensions, benefits, long-term care, health services, social services, and employment programs for senior citizens. Furthermore, there exist specialized government programs, including those designed to provide financial support to local authorities.	No dedicated budget exists for the implementation of active ageing policies. Funding is allocated across programmes administered by various ministries, including pensions, benefits, long-term care, healthcare and social services. Consequently, it is not possible to identify the exact share of funding dedicated to active ageing policy.

The reports indicate that the three countries acknowledge the challenge posed by population ageing, yet differ in the extent of policy regulation and their capacity for implementation. In Poland, a comprehensive policy framework for senior citizens exists, grounded in the principles of security, participation, and solidarity, encompassing aspects such as health, security, and social participation. Nevertheless, gaps persist in implementation, particularly at the local authority level and in the translation of policy into binding guidelines. In Lithuania, an integrated policy to promote active ageing is absent; no specific welfare domains have been delineated, and initiatives are dispersed across the sectors of welfare, health, education, and employment. However, Lithuania is advancing toward the development of a framework law for a policy concerning the elderly, which aims to regulate objectives, indicators, and monitoring mechanisms. In Israel, government resolutions have been enacted to promote optimal ageing; however, no overarching framework has been established, no national goals determined, and no designated responsibility assigned for addressing key issues related to the well-being of senior citizens post-retirement, such as retirement preparation, volunteering, and loneliness.

Furthermore, it is noteworthy that, in the absence of centralized budgeting or a specific budget classification, Lithuania and Poland face challenges, as reflected in their reports, in preparing to address the well-being of senior citizens as a comprehensive domain; in measuring the costs of programs and interventions for this demographic and their associated benefits; and in evaluating whether resources are adequately aligned with the anticipated growth of the elderly population.

A Comparative Situational Analysis of the Employment of Senior Citizens

Table 3: What is the target participation rate?

Poland	Lithuania	Israel
No target for post-retirement employment has been set.	No target for post-retirement employment has been set.	Target set for 2030 for ages 67-74: Men – 43.5% Women – 28.5%

Table 4: What actions were taken to encourage employment after retirement age?

Poland	Lithuania	Israel
Economic incentives: Tax breaks, wage subsidies, employment incentive programs.	Economic incentives: The possibility for persons of retirement age who remain in employment to receive both their salary and the full old-age pension, while continuing to increase the pension through further employment	Two primary programs aim to increase employment rates: Senior Citizens at Work, which supports individuals aged 60 and over wishing to enter the labor market by matching them with appropriate jobs and providing the necessary tools and skills for job searching and market integration; and the Civil Service Senior Citizen Position, a designated employment track that enables individuals beyond retirement age to assume various positions within the civil service.

The situation assessment demonstrates that, although Lithuania and Poland have not established explicit targets for post-retirement employment, they effectively promote continued employment after retirement through economic incentives. Conversely, Israel has established specific targets for post-retirement employment and actively encourages employment among older individuals via government programs; however, there remains concern regarding the likelihood of achieving these targets.

A Comparative Situational Analysis Concerning Loneliness Among Senior Citizens

Table 5: Is loneliness referred to in the national policy the for the elderly?

Poland	Lithuania	Israel
Within the framework of government policy for 2030, loneliness is acknowledged, particularly in relation to senior citizens living alone; however, this acknowledgment is not operationalized into an official indicator, a mandate for identification, or a standardized intervention mechanism.	Loneliness is not explicitly recognized as a distinct social issue within the strategy documents. However, the matter of loneliness is indirectly addressed within the contexts of health, social protection, culture, and informal education.	Loneliness is delineated within the Indicators Map as one of the super-indicators for optimal ageing. Nonetheless, no accountable entity has been assigned the responsibility of identifying and addressing loneliness, nor has a quantitative objective been established for the reduction of loneliness prevalence. Notably, the Ministry of Welfare has established a target for 2026, set at 21%.

Table 6: Is loneliness measured? How?

Poland	Lithuania	Israel
There is no national metric for assessing loneliness. Loneliness is evaluated in research utilizing validated measurement instruments in conjunction with various indicators related to mental health and social support.	There is no national metric for assessing loneliness. Loneliness is evaluated via surveys and studies as a subjective matter.	A national metric exists. Loneliness is evaluated through a direct question in the CBS Social Survey .

Table 7: Who is responsible for identifying lonely elderly people, and what methods are used?

Poland	Lithuania	Israel
No official agency is tasked with the detection of loneliness. In practice, identification is conducted by professionals, including social workers, within welfare centers as part of their routine duties.	No official government agency is tasked with the detection of loneliness. In practice, this issue is addressed by various non-governmental organizations through their respective activities. Additionally, the welfare system identifies loneliness among those receiving services from it as a component of social risk assessment.	No official government agency is tasked with the detection of loneliness. In practice, various professionals who come into contact with senior citizens carry out proactive identification.

Table 8: What percent of lonely elderly participate in treatment programs?

Poland	Lithuania	Israel
Due to the absence of data concerning the rate or number of senior citizens experiencing loneliness, it is not feasible to determine the percentage of this population that receives assistance. Nonetheless, data obtained from a survey conducted by the Comptroller's Office among 500 senior citizens receiving services at welfare centers reveal that 17.6% (88 senior citizens) report feelings of isolation, while 15% report feelings of exclusion.	Due to the absence of data regarding the rate or number of lonely senior citizens, it is not feasible to determine the percentage of this population that receives assistance. Nevertheless, available data indicate that 87% of individuals experiencing loneliness have not sought any form of help, and 52% have not engaged in activities that might alleviate their loneliness.	There is no data regarding the number of lonely senior citizens who engage in loneliness intervention programs. Nonetheless, it is established that the majority of lonely senior citizens are not identified at all. Among the 26% of lonely senior citizens, comprised of approximately 380,000 individuals, only 18% (approximately 70,000 individuals) have been identified. Consequently, most of this demographic (82%, approximately 310,000 individuals) has not been identified by the agencies responsible for this issue, including the Ministry of Welfare, the NII, and the Ministry of Social Equality.

The three countries confront a fundamental challenge characterized by a discrepancy between the acknowledgment that loneliness constitutes a phenomenon with significant welfare, health, and social implications, and the absence of an effective mechanism for identifying and addressing loneliness among senior citizens. In Israel, a national measurement exists; however, there is no designated governmental agency responsible for this issue. In Lithuania, neither a national measurement nor a formal recognition of loneliness as a distinct policy domain is present. In Poland, although policy documents reference loneliness, this acknowledgment has not been operationalized into formal obligations, indices, or databases. Consequently, it remains difficult to ascertain the number of senior citizens experiencing loneliness who receive intervention, as well as to evaluate whether current programs effectively mitigate loneliness in practice.

The Well-being of Senior Citizens in a Future Perspective, an International Perspective

Table 9: Trends and Future Plans – What trends have been identified so far, and what are the current or planned strategies for further development

Poland	Lithuania	Israel
Commencing in 2026, an integrated program "Active Senior – Aces" aims to enhance the quality and standard of life through active engagement in social life and education. This program will concentrate on the elderly across five domains of activity: the development of strategic policy concepts for the elderly, adult education, social participation among adults, intergenerational integration, and the formulation of support programs.	• On 25 June 2026, the Lithuanian Parliament adopted the Law on the Framework of Older Persons Policy, establishing a comprehensive framework for the implementation of older persons policy. The Law strengthens policy coordination at national and municipal levels, provides for the establishment of the Council for Older Persons Affairs, and clarifies institutional responsibilities. Further implementation will focus on strengthening social inclusion, participation, accessibility of digital services, and the promotion of active ageing. • Loneliness – by the fourth quarter of 2027, an inter-ministerial mechanism is planned to support the implementation and effective coordination of the Social Prescription Programme, which aims to improve the inclusion and social participation of vulnerable groups in society	Israel has acknowledged the significance of addressing the well-being of its senior citizens; in 2015, the National Economic Council published a strategic socio-economic assessment that identified population ageing as a major challenge confronting the country. The Indicators Map for Optimal Ageing, adopted by government resolution in 2021, encompasses indicators related to mental well-being, quality of life, and economic resilience. Regarding employment – targets have been established for labor force participation among men and women aged 67 to 74 by the year 2030. Retirement age – according to the Retirement Age Law the retirement age for women is projected to reach 65 by 2032.

This chapter demonstrates that, given the demographic challenge posed by population ageing, it is of considerable significance for the state to address the well-being of senior citizens post-retirement, with particular emphasis on promoting post-retirement employment, as well as identifying senior citizens experiencing loneliness and providing various solutions to mitigate this condition. This significance is further amplified in light of anticipated future challenges associated with changes in life expectancy, particularly the health span.

Despite the critical importance for the state to address senior citizens' well-being and to formulate regulated policies on the matter, and notwithstanding the fact that each country faces unique challenges and implements distinct welfare policies, the reports from the three countries examined in this chapter (Lithuania, Poland, and Israel) reveal several analogous deficiencies. While policy formulation and implementation are at varying stages across these countries, a shared challenge lies in the state's capacity to transform responsibility for this matter into effective, individualized solutions. Regarding post-retirement employment, the measures undertaken by the state to encourage employment appear insufficient to significantly enhance employment participation among senior citizens, who are willing and able to work. Concerning the state's approach to loneliness, none of the three countries engage in proactive national-level identification of lonely senior citizens, nor is there data concerning the proportion of lonely senior citizens participating in programs designed to alleviate loneliness. Thus, although various stakeholders who interact with senior citizens may attempt to identify loneliness on a practical level, there exists no singular entity responsible at the national level, and the overall approach to this issue lacks comprehensiveness.

It is recommended that these countries develop and advance a national policy concerning the well-being of senior citizens and endeavor to implement such policy to enhance their quality of life and well-being. Furthermore, in consideration of the numerous benefits associated with post-retirement employment, it is advised to promote increased employment participation among senior citizens through multiple avenues: raising awareness of employment opportunities after retirement, removing barriers, and providing economic incentives to encourage employment. Additionally, it is recommended that countries proactively identify senior citizens experiencing loneliness, with particular attention to populations at elevated risk, such as those living alone. Governments should also strive to elevate public awareness of loneliness, aiming to diminish shame and stigma surrounding the issue and to increase the engagement of senior citizens, especially those living alone, in community programs designed to alleviate loneliness.

Preparing the Pension System

Introduction

The pension system constitutes a fundamental tier of social security and economic stability within contemporary societies. Its function extends beyond the mere disbursement of benefits; it serves as a strategic mechanism to ensure the welfare of citizens throughout their entire life course. This report examines the pension systems of three distinct countries, each facing comparable challenges related to fiscal sustainability, equity, and efficiency.

Basic Terms in the Pension System

The following section clarifies several fundamental terms that appear in the reports concerning the pension systems of the respective countries featured in this chapter:

Retirement Age

Retirement age (also referred to as the "normal retirement age") denotes the age at which an individual is eligible to receive a full pension benefit without reduction, provided that the individual has completed a full career span[1].

Old Age/Senior Citizen Pension

This pension, together with the Survivors' Pension, forms the first pillar of social and universal security, aimed at guaranteeing a basic standard of living and preventing entry into poverty for residents who have attained the statutory retirement age. It is disbursed as a monthly benefit and, in cases of low income, may include an income supplement to secure a minimum standard of living[2].

Survivors' Pension

A Survivors' Pension is a benefit extended to the family members of a deceased insured individual (e.g., widows and orphans), intended to provide economic protection and ensure continuity of income subsequent to the loss of the primary earner. Survivors' coverage exists both as a basic social right within the first pillar and as an insurance feature integrated into the comprehensive pension funds of the second pillar[3].

1 OECD, Pension at a glance 2025, page 12.
2 Cambridge Dictionary: old-age pension.
3 European Union, Survivors' pensions and death grants.

Structural Reforms

These refer to fundamental and comprehensive modifications to the legislative and institutional frameworks of the pension system, undertaken to guarantee the fiscal and actuarial sustainability[4] of the system over extended periods. Notable examples include the transition from a budgetary pension model[5] to an accrual pension scheme (Israel), the adjustment of retirement age in response to demographic shifts and increased life expectancy (Slovak Republic), and the implementation of a three-pillar pension system (North Macedonia).

Long-term Savings

This concept pertains to the accumulation of assets and capital accrued over decades of employment within savings instruments such as pension funds or provident funds, with the objective of financing the individual's consumption and well-being during retirement.

Insurance Coverage

Insurance coverage is a component within pension funds designed to provide financial protection to the insured individual and their survivors against risks such as disability (loss of work capacity) or premature death. This component ensures that, upon occurrence of a qualifying event, the insured or their family receive a monthly pension exceeding the amount accumulated through savings to that point.

Dependency Ratio

The dependency ratio is defined as the ratio between the number of employed persons contributing insurance premiums and the number of pensioners receiving benefits, in addition to the number of children not of working age. This ratio serves as an indicator of the economic burden imposed on the working-age population due to the need to support both the young and ageing populations.

Pension Provision Rate

The pension provision rate refers to the proportion of salary regularly allocated into pension savings during an individual's working years to finance post-retirement income. Provisions are typically made jointly by the employee and employer, and occasionally by the state, and are transferred to a pension fund or alternative pension savings instrument. The provision rate directly influences the total savings accumulated over time and the eventual pension amount; therefore, it constitutes a critical factor affecting post-retirement income levels and the overall stability of the pension system.

4 Fiscal sustainability refers to the government's capacity to finance its obligations over time without generating unsustainable deficits, whereas actuarial sustainability denotes an equilibrium between the future obligations of a pension system and its funding sources.

5 A budgetary pension refers to a pension disbursed from the employer's allocated budget to its employees, for instance, from the state budget to state employees.

The following table compares several key indicators in the pension systems of the different countries.

Table 1: Comparison of Key Indicators in the Pension Systems, 2024-2025

	Slovak Republic	North Macedonia	Israel	OECD Average
Statutory retirement age (men/ women)	M-64 W-64[6]	M-64 W-62-64	M-67 W-62-65	M-64.7 W-63.9
Fertility rate (children per woman)	1.46	1.5	2.9	1.46
Life expectancy in the general population (at birth)[7]	78.4	75.3	83.2	81.1
Length of time receiving pension in years (men/ women)	M-17.7 W-23	M-9.1 W-15.6	M-17.3 W-21.4	M-18.7 W-22.8
Public spending on pensions (% of GDP)	9.5%	12.1%	5.8%	9%
Mandatory pension provision rate (of total salary)	24.0%	18.8%	12.5%	18.8%

According to the countries' reports and OECD data[8]

The table illustrates that the retirement age, life expectancy, and birth rate in Israel exceed the OECD average as well as those observed in Slovak Republic and North Macedonia. In North Macedonia, the rate of public expenditure on pensions is 12.1%, which surpasses the OECD average of 9%, and is higher than the corresponding rates in Israel and Slovak Republic (5.8% and 9.5 % respectively). Furthermore, the table indicates that Slovak Republic exhibits a pension provision rate of 24%, which is greater than the OECD average of 18.8% and exceeds the rates recorded in Israel (12.5%) and North Macedonia (18.8%).

The Goals of the Pension System

A pension system is designed to accomplish several interconnected social and economic objectives:

Social security

The fundamental aim is to provide individuals with a safety net that prevents poverty in old age and ensures a dignified existence following the conclusion of active employment.

6 The retirement age in Slovak Republic is automatically updated according to life expectancy.
7 Life expectancy at birth reflects the average number of years a person is expected to live, at the time of their birth.
8 OECD, Pension at a glance 2025, page 12 and table 8.1, Figure 6.15 Health at a Glance 2025 figure 3.1, Pension spending 2020, OECD. Minor differences between sources may occur due to methodological differences.

Maintaining a standard of living after retirement

The system strives to enable individuals to preserve a standard of living as close as possible to that enjoyed during their professional life. This objective is commonly assessed by the "Replacement Rate", defined as the ratio between the pension and the final salary.

Reducing disparities

Through a standardized public sector framework, the system endeavors to guarantee a minimum income for those who earned relatively low wages during their working lives, thereby mitigating inequality among the elderly population.

Protection against risks

Beyond retirement savings, contemporary pension systems incorporate insurance components addressing disability or death, thereby safeguarding the family unit against economic shocks.

The Importance of Long-Term Pension Policy

Pension planning necessitates a long-term perspective spanning several decades. Effective policy formulation must consider the following variables:

Demographic trends and population ageing

Numerous countries are undergoing a process of "accelerated ageing", characterized by declining fertility rates and increased life expectancy. This phenomenon results in a reduced dependency ratio and imposes a substantial burden on national budgets.

Macroeconomic trends

Variations in growth rates, labor force participation, and inflationary fluctuations impact pension fund returns. Favorable economic indicators, such as elevated growth rates and high labor force participation, contribute to increases in the value of stocks and bonds held within pension fund portfolios, thereby enhancing the future monthly allowances for savers in the second and third pillars. Moreover, these indicators augment state tax revenues and the fiscal resources available for financing pension benefits under the first pillar. Conversely, inflationary fluctuations adversely affect the real returns of savers and the purchasing power of pension recipients.

Fiscal stability

Prudent policy ensures that the financial burden on future generations for funding retirees' pensions remains reasonable, while preserving savings levels. Without appropriate adjustments aligning retirement age with life expectancy and balancing benefit levels with the scope of available resources, public pension funds risk incurring actuarial deficits that could jeopardize the state's capacity to honor its obligations.

The Different Pension Pillars

The pension framework prevalent in the countries examined adheres to a three-pillar model, which distributes risk among the state, the market, and the individual:

First Pillar: State Public Pension

This pillar constitutes a mandatory scheme administered by governmental entities such as the National Insurance Institute (NII)[9] in Israel, the Social Insurance Agency (SIA)[10] in Slovak Republic, and the Pension and Disability Insurance Fund (PDIF)[11] in North Macedonia. Its financing mechanism is typically predicated on the Pay-As-You-Go (PAYG) method, wherein contributions from current employees fund the benefits of contemporary retirees. This pillar is characterized by its progressive and egalitarian nature, ensuring a basic pension ("old-age pension") for all residents regardless of their prior income levels.

Second Pillar: Mandatory Occupational Pension

This pillar comprises personal savings linked to employment, which were mandated in Israel (since 2008), North Macedonia (since 2000), and Slovak Republic (since 2005). The financing operates on a "defined contribution" basis, whereby the ultimate pension amount is contingent upon the accumulated contributions and the investment performance within capital markets. Management of this pillar is conducted by private firms under governmental oversight. This structure shifts actuarial risks, such as increased life expectancy, to the saver while providing potential for higher returns.

Third Pillar: Voluntary Private Pension

This pillar involves private savings voluntarily undertaken by individuals to augment their retirement income beyond legally mandated levels. In certain contexts, the state incentivizes this savings behavior, frequently through substantial tax advantages. This pillar facilitates individualized adjustment of risk levels and savings contributions, serving as a crucial mechanism particularly for high-income earners seeking to sustain their pre-retirement living standards.

9 National Insurance Institute.
10 Social Insurance Agency.
11 Pension and Disability Insurance Fund.

Republic of North Macedonia

Main audit question – Sustainability of the pension system in connection with the population ageing in the country

First specific question – overview of the pension system and what is the current situation

Structure of the Pension System in the Republic of North Macedonia

The pension system in the Republic of North Macedonia is composed of pension and disability insurance based on generational solidarity and fully funded pension insurance, the main purpose of which is to provide citizens with material and social security.

The structure of the pension system is based on three types (pillars) of insurance, namely:

- Mandatory pension and disability insurance based on generational solidarity (first pillar);
- Mandatory fully funded pension insurance (second pillar) and
- Voluntary fully funded pension insurance (third pillar).

The pension system in the Republic of Macedonia, as a significant part of social insurance, has existed for more than 60 years, first within the framework of the former SFRY, and since 1993 as an independent system. The importance of pension and disability insurance in the Republic of North Macedonia is reflected in the number of insured persons who pay contributions and the number of pension beneficiaries who live off their pensions, as well as in the amount of pension insurance expenditures and their share in the gross domestic product. The current structure of the pension system is the result of the pension system reform, which was prepared for several years, and its legal framework was established in 2000.

Mandatory pension and disability insurance based on generational solidarity (first pillar) is insurance organized according to the principle of current financing (pay-as-you-go), which means that the contributions paid by current insured persons are immediately spent on paying the pensions of current pensioners. The rights from pension and disability insurance, i.e. the pensions provided by the first pillar, depend on the invested funds determined by the amount of the insured person's salary during his working life, length of service and the method of investment. The first pillar ensures the realization of rights from pension and disability insurance in the event of old age, disability and death, which means that the old-age pension, disability pension, survivor's pension, as well as the lowest amount of pension are paid.

Mandatory fully funded pension insurance (second pillar) differs from the pay-as-you-go (PAYG) system in terms of the treatment and recording of the contributions paid and in terms of the determination and payment of the pension. In this case, members of the second pillar have their own account in which their contributions are recorded. These funds are accumulated and further invested, and the return on investments, reduced by the operating costs of the companies, is added to the funds accumulated in the accounts. In this way, a connection is ensured between the funds accumulated in individual accounts and the future pensions that will be realized by the persons included in the fully funded pension insurance. This insurance ensures the realization of the right to pension insurance in the event of old age, i.e. payment of the remaining part of the old-age pension. Two of the three active private pension companies started operating and receiving the first payments in 2006, while the third in 2019.

Voluntary fully funded pension insurance - the third pillar is also insurance based on the capitalization of assets, on the principle of defined contributions. Basically, the third pillar of the pension system is organized in the same way as the second pillar, but on a voluntary basis. It is significant for this insurance that it can include all persons who want to ensure a higher level of material security in addition to mandatory insurance, as well as all persons who are not covered by mandatory insurance (in the first and second pillars).

The bearer of the activities for the payment of pensions from the first pillar is the Pension and Disability Insurance Fund of the Republic of North Macedonia (PDIF), the second pillar is represented by three private pension fund management companies that are operating, and the third pillar is represented by four private pension fund management companies. Since its establishment, PDIF has been facing problems related to its financial situation caused by the transitional changes to a market economy - decline in the volume of production, the closure of a large number of enterprises and an increase in the number of unemployed. The decrease in the number of active insured persons (employed persons) on the one hand and the increase in the number of pensioners on the other hand, led to a decrease in the ratio between insured persons and pensioners, and due to the non-payment of salaries to insured persons, problems related to the inability to regularly collect contributions as the main source of financing for pension and disability insurance also emerged. Although these problems have largely been overcome today, in recent years a new major problem affecting the Fund's operations has been the process of accelerated demographic ageing of the population, which has led to a stagnating number of employed persons paying pension insurance contributions and an increase in the number of pensioners.

Major pension and disability insurance rights in the Republic of North Macedonia are:

- old-age pension;
- disability pension;
- family pension;

Old-age pension - The insured person acquires the right to an old-age pension when he/she reaches the age of 64 (male), or 62 (female) and at least 15 years of pensionable service. However, the effective retirement age is lower and is 62 years for men and 61 years for women. As of december 2024 there are 245.929 pensioners in this group.

Family pension is granted to the family members of a deceased person who was an insured person or a pension beneficiary in cases where the family members do not provide a pension or income, or the provided pension is less favorable than the pension of the deceased person. There are a total of 74.294 beneficiaries in this group.

Disability pension is intended for persons who, due to physical or mental disability, are assessed to have reduced working capacity, based on medical documentation confirming the disability. The conditions for receiving a pension depend on age, length of service and type of disability. A total of 25.571 people receive this type of pension.

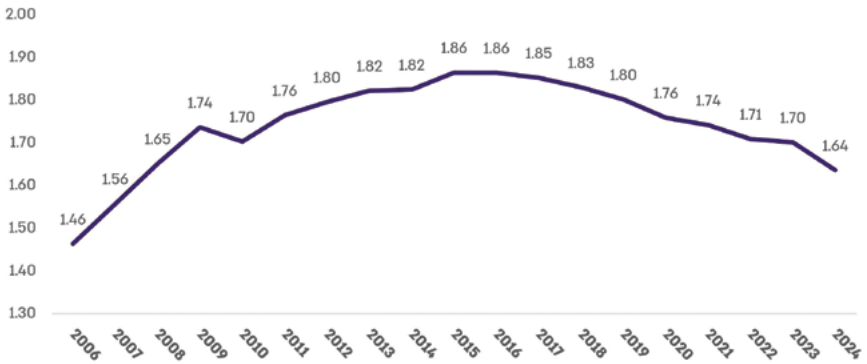
Key data about the pension system

Number of contributors and pensioners

Starting from 2006 to 2016, because of the improved conditions in the domestic economy, the number of employed persons/insured persons has been continuously increasing. For the duration of this period the total No of people paying pension contributions increased from 394.882 to 570.168. From 2016 to 2024, a stagnation in the number of employed persons has been observed and a decrease to 556.294 people was recorded in 2024. On the other hand, the number of pensioners benefiting from the first pension pillar has been on an increasing trend, which is a result of the effect of the accelerated ageing of the population in the country, starting from 269.681 pensioners in 2006 to 339.955 in 2024.

For the analyzed period, the ratio between the number of insured persons and pensioners starts with 1,46 and increased until 2015 reaching its highest level of 1.86 insured persons per pensioner. After this, a period of decline in this ratio begins and in 2024 it decreases to 1.64, which is a result of the decrease in the number of insured persons in this year as well as the increase in the number of pensioners caused by the demographic ageing of the population. It is evident that the movement of the number of insured persons who pay contributions is not in a direction that will ensure the maintenance of this ratio. The movement of this parameter is shown in the following graph:

Figure 1: Ratio employed per one pensioner



According to a study prepared by the World Bank for the assessment of the state of the public finance system in the Republic of North Macedonia a detailed projection of the movement of the pension system is forecast. In line with the above, this study also contains a projection of the movement of the ratio between insured persons and pensioners. The projection predicts a decline in this rate to a level of 1.04 in the interval from 2060 to 2070, which is extremely unfavorable and would greatly burden the pension system.

Average duration of receiving a pension

The average duration of receiving a pension is defined as the period in which a pensioner receives pension payments from his retirement until his death. The burden on the pension system with payments also depends on the length of this period, since with the increase in the average life expectancy of the population, the number of people receiving pensions also increases. As a result, it is of particular importance to determine this data, which is calculated as the difference between the legal age of exercising the right to retirement in the country (for the Republic of North Macedonia 64 years for men and 62 years for women) and the average life expectancy in the country.

The figures for North Macedonia and other counties are shown in the table below:

Table 1

State	Life expectancy			Retirement age		Difference	
	Total	Men	Women	Men	Women	Men	Women
North Macedonia	75.3	73.1	77.6	64	62	9.1	15.6
Serbia	76	73.2	78.9	65	63.5	8.2	15.4
Kosovo	72.2	70.5	74.1	65	65	5.5	9.1
Albania	78.3	76	80.8	65	61.7	11	19.1
Croatia	78.9	76.6	81.1	65	63.7	11.6	17.4
B&H	77	74.5	79.6	65	65	9.5	14.6
Austria	81.3	79.1	83.6	65	61	14.1	22.6
Slovak Republic	77.8	74.9	80.8	63	63	11.9	17.8
Israel	83	81.5	84.5	67	62	14.5	22.5
Norway	83.2	81.5	85	67	67	14.5	18
Germany	81.1	78.8	83.3	66	66	12.8	17.3

The average age of receiving a pension in our country is lower than in most European countries where, due to the longer life expectancy in these countries, the average duration of pension payments is longer, which puts these pension systems at a disadvantage. We note that legislators in some countries (Austria, Albania, Israel.) have adopted legislative amendments aimed at gradually equalizing the legal retirement age of women (usually in the long term by increasing the retirement age by 3 months per year) or gradually increasing the retirement age of both men and women also in the long term by increasing the retirement age by 3 months per year. The above is caused by the financial problems that national pension systems have or are projected to have in the coming period, caused by the continuous ageing of the population and the increase in the average life expectancy of the population, i.e. the increase in the number of pensioners and the duration of pension payments. In this regard, the first pillar of the pension system of the Republic of North Macedonia is in a more favorable situation given the lower average life expectancy and shorter period for payment of pensions but despite this, the domestic pension system still faces financial difficulties.

Contribution rates

The payment of pension and disability insurance contributions is made by the contribution debtor, i.e. the employer, on behalf and for the account of the employee, i.e. with the employee's (insured) funds as a percentage of his gross salary. The contribution rate in North Macedonia is among the lowest in Europe and it is positioned at a rate od 18,8% out of which 6% is paid to the second pillar of the pension system.

Minimum pension amount

The minimum pension amount belongs to pension beneficiaries whose pension earned only from the first pension pillar or the sum of the pension earned from the first and second pension pillars is less than the lowest pension amount and it is paid in three groups depending on the pensionable service. As of 2024, according to data from the Fund, a total of 137,216 persons were registered as recipients of the minimum pension amount out of a total of 345,794 pension recipients or 39.6% of pensioners in the country are recipients of the minimum pension. The ratio of mimimum pension vs minimum sallry of the country is 74,6% as of 2025 year and I increasing startig from 2021 when it is estimated at 65,7%.

Average pension and adjustment of pensions

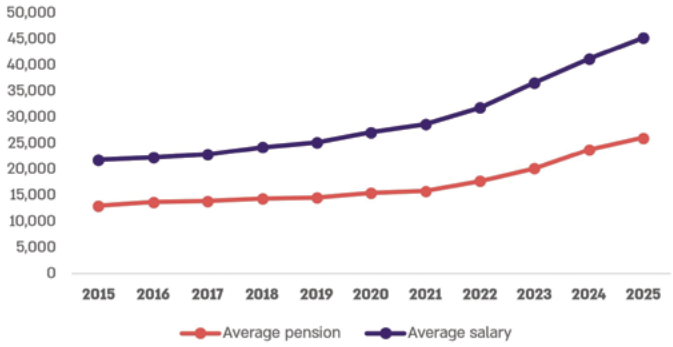
Pension adjustment is an instrument of pension and disability insurance through which the real value of pensions is preserved according to the increase in the average salary of employees in the Republic. In the Republic of North Macedonia, the so-called Swiss model of pension adjustment is used, whereby the adjustment is carried out twice during a year, in such a way that the increase in the cost of living index participates in the correction of pensions by 50% and the increase in the average paid salary of all employees in the Republic of North Macedonia by 50%. As a result of using this model for pension adjustments, a continuous upward trend in the amount of the average pension in the country is noticeable for the analyzed period from 2015 to July 2025.

Table 2

Year	Average pension[1]	Average salary	Ratio pension/salary
2015	13.095	21.906	59.78%
2016	13.754	22.342	61.56%
2017	13.954	22.928	60.86%
2018	14.445	24.276	59.50%
2019	14.602	25.213	57.91%
2020	15.483	27.182	56.96%
2021	15.876	28.718	55.28%
2022	17.727	31.859	55.64%
2023	20.195	36.614	55.16%
2024	23.785	41.239	57.68%
2025	26.166	45.276	57.68%

1 Exchage rate 1 euro – 61,5 denars

Figure 2: Average salary and pension



In absolute figures for the analyzed period, the average pension has doubled, while the ratio to the average salary has recorded a slight increase in recent years, from the lowest 55.28% to 57.68%, or 61.4% if only the average old-age pension is taken into account. In this regard, due to the differences that prevail in the organization of pension systems, various benefits and tax incentives, there is an objective impossibility to compare this data between our country and European countries. For the purposes of this audit, we made a comparison with the so-called pension replacement rate. According to OECD data, the replacement rate varies significantly from country to country and ranges from 28% in Estonia to over 80% in Greece and Spain, with the average at the OECD level being 62%. The above points to the conclusion that the amount of the average old-age pension in the Macedonian pension system has a satisfactorily high ratio in relation to the average salary in the country, especially with the latest pension increases implemented in 2024 and 2025 as well as those planned for the future period. Therefore, from this aspect, it can be concluded that in this period the Macedonian pension system is realizing an adequate replacement of the earnings of employees who retire, with income from pensions.

Current financial position of the pension system (first pillar)

The financial balance of the pension system, i.e. the difference between the original revenues of the first pillar (revenues from pension and disability insurance contributions) and the expenditures for pension payments, is a key indicator of its sustainability. The stability of this system depends on the ratio between the number of employees paying contributions and the number of pensioners. When this ratio deteriorates due to an ageing population, a declining birth rate or high unemployment, the pension fund may enter a deficit. A deficit is a negative balance, which means that pension expenditures exceed contribution revenues, which forces the system to seek additional sources of financing. In many countries, including the Republic of North Macedonia, the negative balance of the first pension fund is often covered by transfers from the state budget. These transfers usually come from general tax revenues, such as VAT, excise duties or income tax, which means that the burden of financing pensions falls on all taxpayers, not just on those who pay contributions. In this regard, a significant indicator for

assessing the self-sustainability of the first pillar of the pension system is the participation of funds from the Central Budget as a supplement to the revenues generated by the first pillar.

For the analyzed period 2014-2024, the share of contributions in total revenues was increasing for the entire analyzed period, with the exception of 2024, when, as a result of the increase in pensions, the slight increase in the number of pensioners, as well as the decline in the number of insured persons, it changed the positive trend and decreased by a high 4.6% from 65.7% to 61.1%, and the share of funds from the Central Budget in total revenues increased from 32.6% to 36.7%. In absolute terms, the share of the central budget in the total revenues of the first pillar of the pension system in 2024 amounts to 42,474 million denars or 690 million and 634 thousand euros, which is an increase of 11,095 million denars or 35% and in absolute terms is the historically highest amount of intervention from the central budget in the work related to the timely payment of pensions. Considering that during 2025 the amount of pensions increased twice, which was not followed by an equivalent increase in the salaries of the insured and an increase in the number of insured persons paying contributions, it is realistic to expect that by the end of 2025 the share of revenues from the central budget in the total revenues will additionally increase to a projected amount of about 800 million euros. The above situation also contributes to changes in the share of pension payments in total GDP and the share of transfers to the Fund in the total Budget. For the period 2014 - 2024, this ratio is shown in the following table.

Table 3

Year	Total expenditures for PDIF	Share of funds from Central Budget	Total GDP	Total revenues of the state Budget	% of share of PDI expenditures in GDP	Share of transfers to the PDIF in the total budget of the country
2015	56.789	23.861	552.286	161.207	10.3%	14.8%
2016	61.488	26.599	579.646	169.356	10.6%	15.7%
2017	65.149	28.457	630.859	179.673	10.3%	15.8%
2018	68.544	29.392	660.308	188.505	10.4%	15.6%
2019	73.122	28.098	697.431	203.822	10.5%	13.8%
2020	77.213	29.852	664.010	189.554	11.6%	15.7%
2021	80.147	30.580	723.239	218.021	11.1%	14.0%
2022	87.607	28.588	831.733	243.085	10.5%	11.8%
2023	99.466	31.379	894.727	277.127	11.1%	11.3%
2024	115.251	42.474	948.904	305.553	12.1%	13.9%

Figure 3: Share of pension expenditure in GDP

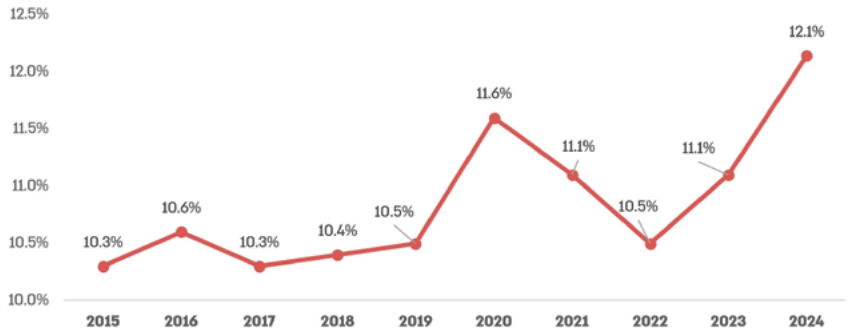
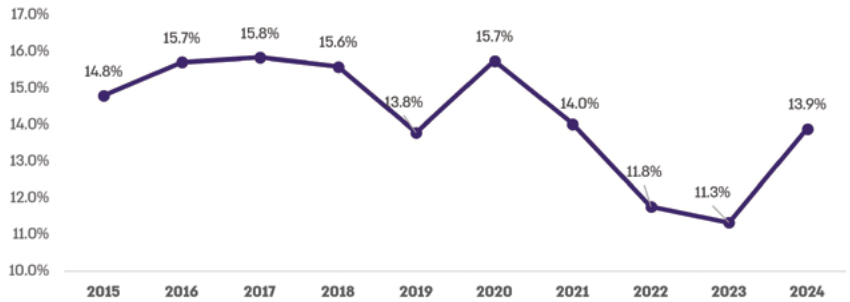


Figure 4: Share of funds from the state budget as transfers for pension payments



In order to make a more reliable assessment of this percentage, we compared our country with the EU member states and with the countries of the region. In doing so, we determined that in the EU member states this percentage varies significantly from a minimum of 3.9% in Ireland to a maximum of 15.4% in Italy. In general, the share of pension expenditures in total GDP is high in countries with a high net pension replacement rate, such as Spain, Greece, Austria and France, which is expected, while it is lower in the member states of Central and Eastern Europe, where this ratio does not exceed 9%. At the level of the entire EU, this percentage is 12.21% and it has decreased compared to the years during the pandemic. In the countries of the region that are not members of the EU, this percentage is lower both in relation to the EU and in relation to our country and ranges from 6.1% in Albania to 8.46% in Bosnia and Herzegovina, i.e. comparatively significantly lower than in our country. This situation indicates a high participation of our pension system in the national economy as well as a high dependence of the Fund on transfers from the Budget of the Republic of North Macedonia, which stems from the inability

of all the Fund's expenditures to be serviced from the generated income from contributions. The above has the effect of reducing the possibilities of financing projects from other areas with budget funds.

Second and third pillar of the pension system

In 2025, three private licensed pension companies operate in the Republic of North Macedonia, which manage the funds paid into the mandatory pension funds, and there are also four private pension companies from the non-mandatory pension funds. The number of insured persons in the three mandatory pension companies has been continuously increasing since their establishment to date and reached 610.855 as of 2024. As of December 2024, the three private pension companies have earned a total amount of 162,853 thousand million denars or 2 billion and 648 million euros based on contributions paid by the insured, i.e. 17.16% share in the country's GDP. The amount is continuously increasing due to the realized returns on invested funds. During 2024, the three companies have realized contributions from pension insurance from the insured in the amount of 15,476 thousand million denars (251 million and 642 thousand euros) or 1.63% share of the country's GDP.

Private pension companies are obliged to invest the paid-in funds in order to achieve the highest return solely for the benefit of the members and retired members of the pension funds and to minimize the risk of losses through diversification and financial analysis. Although these companies basically function as classic investment funds, they also have their own specificity, that is, a social component, which should provide secure and stable pension income for all members of the companies after their retirement. Taking this into account, the investment strategy of these companies is conservative and is implemented based on legally established restrictions on the type and amount in percentages of financial instruments in which these companies have the right to place the paid-in funds of the members of the companies.

Portfolio of the second pillar

By analyzing the portfolio, we determined that the dominant share of placements on the domestic market is where an average of 67.38% of the total assets of these companies are placed. In this percentage, the largest share is held by government bonds issued by the Republic of North Macedonia, which participate in this percentage with 64.93% at the level of the three companies. The bonds have different maturity dates ranging from 2025 to 2050, and the largest part, between 86.2%-97%, is due for payment in the period between 2030 and 2039, when the first significant wave of payments for pensioners from the second pillar of the pension system is expected. The yields on government bonds vary depending on the interest rate at which they are issued and range from 2.5% to 6.15% for bonds issued in 2023. Given that the principal of the companies' assets is mostly placed in government bonds, the yield that pension companies achieve on an annual basis largely depends on the interest rate at which government bonds are issued. This part of the portfolio, together with the part of the portfolio placed in bonds issued by foreign countries, constitutes the risk-free part of the portfolio because these issued financial instruments are guaranteed by the state.

Private pension companies have placed most of the rest of the portfolio in shares in foreign investment funds. The share of these shares in the total placed assets ranges from 20.64% to 29.73 In addition to this, one private pension company has placed assets in shares of reputable foreign companies in the amount of 7.14% of the entire portfolio. The above indicates a concentration of the portfolio in domestic bonds and shares in foreign investment funds, with a particularly high share of domestic bonds in the total portfolio, which has not been fully addressed in terms of diversification of placements by the companies. Given the size of the portion of the portfolio concentrated in domestic government bonds, the liquidity of these financial instruments is low, taking into account the absolute value that exceeds 105,326 thousand million denars (1 billion and 712 million euros) and the lack of capacity on the domestic market, which is unable to absorb bonds in such an amount. As a result, private pension companies are left with the obligation to collect these domestic bonds on their maturity date without the ability to sell them in larger quantities before the maturity date should such a need arise.

Portfolio return

The main reason why the funds paid by the members of private pension companies are invested is to achieve higher returns than the paid funds. These returns, together with the paid funds, are then accumulated and reduced by the amount of fees charged by the private pension company after the exercise of the right to retirement, are paid to the pensioners. The returns are calculated for the last 7 years, reduced to an annual level in nominal and real amounts. The return in real amounts represents the annual rate of nominal return and the change in the cost of living for the same calculation period. By analyzing the movement of returns since the beginning of the system's operation, it can be determined that as of 2019, the pension companies achieved satisfactorily high rates of return in both nominal and real amounts. Since 2020, as a result of the Corona pandemic, and later the war in Ukraine, which caused significant economic disruptions at a global level and especially as a result of high and continuous inflation, real rates of return have been declining. Although the real returns of two companies are still above 0%, (0,7% and 0,8% respectively) in one company this indicator is in a negative amount, which means that the paid-in funds adjusted for the inflation rate are losing value. The decline in real rates of return in all three companies highlights the problem of high inflation that is eroding the value of funds paid by users, which is an irreversible process.

Still, the above does not provide a definitive answer to the impact of the portfolio structure of domestic pension companies on the level of returns. For this reason, we also conducted an analysis of the portfolio structure of OECD member countries as well as selected countries from the region for which data were available, as well as the level of returns achieved in these countries. From the results of the analysis it can be concluded that the selected OECD member countries have a wide diversification of the portfolio. In addition to the traditional three classes of investment placements of assets (shares and investment funds, bonds and deposits), some countries also investments in other investment classes such as investments in real estate as well as energy and road infrastructure, which are not represented at all in the structure of domestic companies since they are not provided for as an investment class in the legal regulations in this area. These investments are undertaken in the direction of portfolio diversification and as a way of dealing

with the effects of high inflation, given that investments in these investment classes bring stable income from rent collection or energy sales and collection for the use of the built infrastructure. It is evident that in OECD member countries the share of bonds in the total portfolio is significantly lower with 40.8% of the total invested assets.

By analyzing the returns of the investments, it is evident that countries that express a high share of investments in stocks and investment funds achieve higher rates of return on investment - Poland, Lithuania, Latvia. On the other hand, countries that have a dominant share of bonds in the portfolio - Czech Republic, Albania for 2023 achieved a negative increase in the return on investment given that the yield on bonds (interest) is in a fixed amount and does not change depending on inflation movements. This situation emphasizes the need for broad diversification of the portfolio in different investment classes in order to achieve the greatest possible protection of assets from price increases, i.e. inflation. We can conclude that domestic private pension companies in the last few years have been facing the problem of high inflation, i.e. the increase in retail prices, which affects the reduction of their real rates of return. This represents a major danger and challenge in the operations of companies, given the negative impact that inflation has on the future income of company members, which emphasizes the need to address and mitigate the effects of inflation on the real value of invested assets.

Second specific audit question – Are the demographic and economic trends in the country driving toward improving of the state of the pension system

Demografic indicators

In recent decades, the Republic of North Macedonia has faced numerous challenges arising from the existing economic and social conditions that have a direct impact on the population. While birth rates are decreasing, and thus the participation of young people in the overall population structure is decreasing, the number of elderly people is increasing. The Republic of North Macedonia also faces a pronounced regional population imbalance between urban and rural areas. The demographic trends in the country are shown in the following table:

Table 4

Year	Population in 000	Life births	Deaths	Population increase
2005	2.037	22.482	18.406	4.076
2010	2.055	24.296	19.113	5.183
2015	2.070	23.075	20.461	2.614
2020	2.073	19.031	25.755	-6.724
2021	1.837	18.648	28.516	-9.868
2022	1.832	18.073	22.459	-4.386
2023	1.828	16.737	20.187	-3.450
2024	1.824	15.662	19.808	-4.146

There are two main reasons for this population decline. The first is the continuous decline in the population's reproduction rate and the second is the migration movements and emigrations that have affected the country in the past period. The fertility rate is the average number of children that a woman would give birth to during her reproductive period (usually from 15 to 49 years). Ideally, this indicator should be above 2.1 in order to ensure a stable population without reductions in the absence of migration movements. In 2024, the reproduction rate in North Macedonia is 1.5 and the last recorded year with a reproduction level above 2.1 was 1994.

There is a noticeable continuous trend of increasing average age, which for the period analyzed from 2000 to 2024 ranges from 32.3 years to 41.8 years. Compared to European countries, our country has a lower average age compared to the EU average (41.8 years MKD, 44.7 years – EU) as well as most European countries. Of the countries in the region, the best situation is in Montenegro with an average age of 40.1 years, while for the other countries the average age of the population is higher than North Macedonia.

As a result of the ageing of the population, the structure of the population by age group is also changing. Namely, the participation of young categories up to 14 years of age as well as the age group from 15-64 years is decreasing, while the age group over 65 years is increasing. This situation is shown in the following table:

Table 5

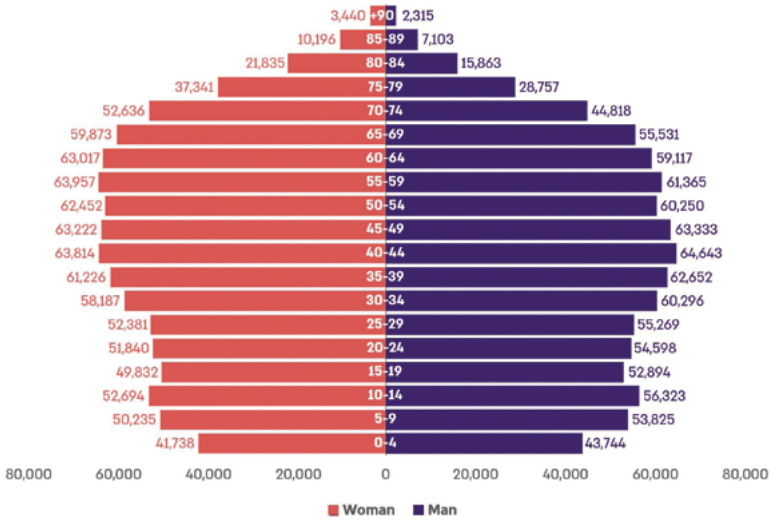
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Total population	2.068	2.071	2.074	2.076	2.078	2.077	2.069	1.837	1.832	1.828
Population 0 - 14	349	347	344	342	340	337	334	312	310	306
Population 15 - 64	1.461	1.459	1.456	1.450	1.446	1.439	1.431	1.211	1.204	1.195
Population 65 +	259	266	275	284	292	301	306	316	320	327
% 65+/total population	12.5%	12.8%	13.3%	13.7%	14.1%	14.5%	14.8%	17.2%	17.5%	17.9%

Compared to the EU average, the average life expectancy lags behind by 6.7 years, which is realistic to expect given the differences in quality of life, level of medical services, general habits of the population, environmental conditions, etc. The comparison of the average life expectancy between North Macedonia and European countries is shown in the following table:

Table 6

	Average life expectancy		
State	Total	Male	female
North Macedonia	75.3	73.1	77.6
Serbia	76	73.2	78.9
Kosovo	72.2	70.5	74.1
Albania	78.3	76	80.8
Croatia	78.9	76.6	81.1
BiH	77	74.5	79.6
Austria	81.3	79.1	83.6
Slovak Republic	77.8	74.9	80.8
Israel	83	81.5	84.5
Norway	83.2	81.5	85
Germany	81.1	78.8	83.3
EU avg	81.7	79.2	84.4

Figure 5: The age pyramid of the Republic of North Macedonia by five-year age groups



The situation with the above analyzed parameters indicates that the demographic trends in our country are unfavorable, however, the comparison with European countries indicates that our country is not an isolated case, i.e. demographic ageing is occurring in most countries in Europe. North Macedonia is in a process of accelerated demographic ageing of the population and according to all analyzed data, which currently shows no signs of slowing down.

Projections 2025-2055

In this regard, based on the available information, we have also conducted an analysis of the projections for demographic development for the next 30-year period, given that it is of great importance for the situation with the pension system in the country, as well as the need for care for the elderly.

Table 7

	Population projection with migrations and low fertility included	Population projection without migrations
2025	1.771.264	1.818.849
2030	1.642.299	1.792.479
2035	1.514.373	1.759.020
2040	1.427.885	1.724.052
2045	1.362.363	1.690.993
2050	1.302.646	1.655.462
2055	1.245.614	1.616.084

The figures published by official state institutions do not show a large immigration wave of emigration from our country has repeatedly proven to be inaccurate given that there are objective difficulties in recording people who leave the country for a longer period and who are considered to have emigrated, which was proven by the results of the Population Census conducted in 2021 In order to determine a more realistic situation with migration movements in the country, we analyzed the number of children born and the number of children who completed primary and secondary school, taking into account that these two cycles of education in the country are mandatory for all children. In doing so, we determined that the number of children who enrolled in primary education has decreased by 13%, while the number of children who graduated from secondary education has decreased by 34.6% compared to births, which can only be explained by migration movements and departures from the country.

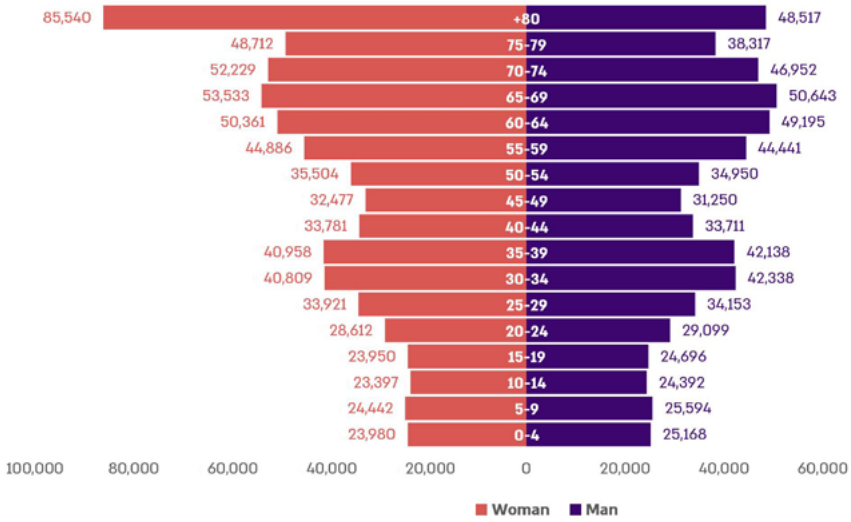
This situation creates multiple negative effects. Namely, first of all, the population in the country continues to further decrease, and at the same time, with the emigration of young categories of citizens, the country is deprived of the fertile base that should create new generations in the future, which will further reduce the reproduction rate in the coming years from the already low rate of 1.5. The negative effects will also be felt in the reduction in the number of employed people in the coming years, which are the basis for filling the pension system through the payment of pension insurance contributions and through a long-term decrease in productivity and wage growth. The conditions by age categories are presented in the following projection

Table 8

Year	0-14	15-64	65+	0-14 % in total pop	15-64 % in total pop	65 % in total pop
2030	237.158	1.039.297	365.844	14.44%	63.28%	22.3%
2035	185.459	942.994	385.920	12.25%	62.27%	25.5%
2040	158.074	869.558	400.253	11.07%	60.90%	28.0%
2045	147.652	800.869	413.842	10.84%	58.79%	30.4%
2050	146.973	731.230	424.443	11.28%	56.13%	32.6%
2055	143.333	675.736	426.545	11.51%	54.25%	34.2%

The negative effects associated with this decline relate to the reduction of the fertile base in the country, which increases the further decline of the population, and in the age group of 15-64 years, given that this is the economically active population in the country that creates new value in society, the decline will also cause negative consequences for economic trends, productivity, as well as a decline in the number of employed persons who pay contributions for pension insurance. On the other hand, the increase in the oldest category of citizens - over 65 years of age will cause an increase in the number of pensioners in the country, followed by an increase in expenditures for the payment of pensions, which will additionally burden the pension system in the country.

Figure 6: The age pyramid of the Republic of North Macedonia by five-year age groups for 2050



As a result of these analyses, it can be concluded that in the country and in the coming years, if measures are not taken, the demographic crisis and the ageing of the population will continue unabated. Moreover, although the public pays great attention to the decline in the birth rate, the analyses still show that the main reason for the demographic decline is migration movements and the emigration of the population from the country, given that the scenarios in which migration is not included as a factor show a much lower decline in the number of the population in the country in the next 30 years. The situation is particularly worrying that some of the people who have left the country in recent years are not leaving due to a lack of employment opportunities, but because of better living conditions abroad, the level of salaries in our country, which are among the lowest in Europe, as well as the better education system, health system, etc., which are areas whose reform and modernization requires a longer period of time.

Taking the above into account, in the absence of specific measures to stop or mitigate the conditions related to the decrease in the reproduction rate and the reduction in migration movements in the country, it is unrealistic to expect an improvement in these conditions in the near future.

Economic parameters

In pay-as-you-go (PAYG) systems, where pension contributions finance current pensions, GDP growth and inflation are important factors in maintaining the balance in the pension system. GDP growth generates higher tax revenues and social contributions as well as higher wages due to increased employee productivity, while conversely, economic recession or stagnation leads to a decrease in wages and contributions, increasing fiscal pressure and potentially reducing the real value of pensions. In conditions of high inflation, fixed pensions quickly lose their real purchasing power and lead to the impoverishment of pensioners. The movement of GDP and inflation in our country is shown in the following table:

Table 9

	GDP (in million denars)	GDPIncrease in %	GDP (in million euros)	GDP per capita (in euro)	Inflation
2010	437.296	3.4	7.109	3.459	1.6
2011	464.186	2.3	7.544	3.665	3.9
2012	466.703	-0.5	7.585	3.680	3.3
2013	501.891	2.9	8.150	3.948	2.8
2014	527.632	3.6	8.562	4.141	-0.3
2015	558.954	3.9	9.072	4.382	-0.3
2016	594.795	2.8	9.657	4.659	-0.2
2017	618.106	1.1	10.038	4.839	1.4
2018	660.878	2.9	10.744	5.175	1.5
2019	692.683	3.9	11.262	5.423	0.8
2020	669.280	-4.7	10 852	5 236	1.2
2021	729.445	4.5	11.836	6.443	3.2
2022	816.084	2.8	13.243	7.230	14.2
2023	897.694	2.1	14.583	7.978	9.4
2024	948.904[2]	3.0	15.430	8.588	3.5

2 Претходен податок

Due to the way PAYG pension systems are financed, the number of employed people in society as a share of the working-age population in the country is of particular importance for the stability of this system. The table below shows these parameters:

Table 10

Year	Total work age pop	Workforce	% workforce	Employed	% employed	Unemployed	Inactive pop
2017	1.517.619	860.686	56.7%	668.958	44.1%	191.728	656.933
2018	1.508.844	856.447	56.8%	680.064	45.1%	176.383	652.397
2019	1.497.380	858.252	57.3%	711.082	47.5%	147.170	639.128
2020	1.480.320	839.332	56.7%	703.733	47.5%	135.600	640.988
2021	1.468.735	819.893	55.8%	693.494	47.2%	126.398	648.842
2022	1.464.493	808.078	55.2%	692.034	47.3%	116.045	656.415
2023	1.515.106	791.647	52.3%	688.296	45.4%	103.351	723.459
2024	1.515.306	792.779	52.3%	694.506	45.8%	98.273	722.527

The labor force in the country in absolute numbers for this period is in constant decline and has decreased by 4.4%, while the opposite is the case with the inactive population, which is continuously increasing. Given the decline in live births in the country, it follows that the growth of the inactive population stems from the increase in the number of pensioners in the country. The number of employed persons has slightly increased for the period analyzed, while in the last 4 years the number has stagnated. In order to confirm these conclusions, we conducted an analysis of the activity and employment rates of the working-age population by age groups. There is a noticeable increase in all age groups, including the youngest group of 15-24 years of age. In addition to this, the unemployment rate has recorded a continuous decline throughout the analyzed period and although it is still among the highest in Europe at 11.9%, it is at its lowest level in the past period.

However, although activity and employment rates are increasing while unemployment is decreasing, this increase is not accompanied by an increase in the number of people employed, which has stagnated for the same period. There is also an obvious difference between the number of persons paying pension insurance contributions and the total number of employed persons, and the same in 2024 amounts to 138,212 persons, who according to official data are employed, but for various reasons do not pay pension and health insurance contributions. In addition, the total number of unemployed persons in the country is 98,273 thousand persons. The above indicates that there is room for improvement in the total number of people who are employed and who pay pension insurance contributions, which would also increase the income in the first pillar of the pension system.

Third audit question - What are the projections for the movements of the pension system in the coming period related to the ageing of the population?

Projections and forecasts for the movement of the pension system

The pension system is a fundamental pillar of social security and economic stability in any modern society, providing financial support and a dignified life for citizens after the end of their active working life. In conditions of rapid demographic changes, such as population ageing and declining birth rates, as well as economic challenges particularly pronounced in recent years, projections for the next 25 years (from 2025 to 2050) are becoming an indispensable tool for assessing long-term sustainability. These projections are not just statistical predictions based on actuarial models but are an essential instrument for creating informed public policies, reforms and strategies that will ensure fiscal stability, intergenerational equity and the resilience of the system to future shocks.

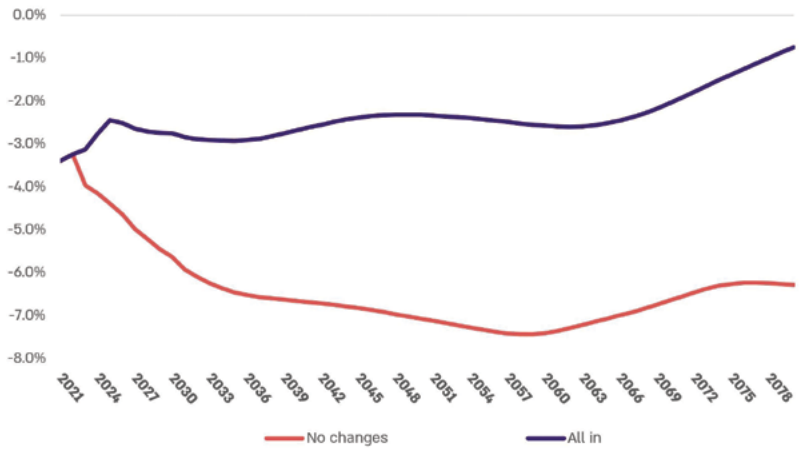
For the purposes of this report, we used two projections - the first is a projection from the World Bank prepared according to the PROST[3] model, and in order to confirm the projections highlighted in it, we also engaged an expert who prepared a separate projection.

For the purposes of the projection, several scenarios have been developed. The "status quo" scenario assumes that for the entire observed period until 2050-2055 there will be no changes in the current parameters of the pension system, i.e. the contribution rate will remain at 18.8%, the retirement age will remain at 64 years for men and 62 years for women, without abandoning the so-called Swiss system of annual adjustment of pensions. The remaining scenarios focus on an individual change in one of the above-mentioned parameters, while the so-called "all in" scenario refers to a change in all three parameters and the effects of these changes on the stability and sustainability of the pension system. In the absence of corrections to the above parameters (status quo), the share of budget funds in servicing the liabilities of the first pension pillar (PAYG) in the period until 2055 will increase both in absolute numbers and as a % of participation in GDP, reaching a high negative 7.4% of GDP in 2057. In the scenario of changing only one of the parameters while the others are unchanged from the current the abandonment of the Swiss model and performing a correction of pensions only based on the increase in the retail price index without correction for the increase in the net salary in the country shows the best results. However, in all observed scenarios, the share of budget funds in servicing the liabilities of the first pillar of the pension system deepens.

3 Pension Reform Options Simulation Model (PROST) is a sophisticated microsimulation model developed by the World Bank to assist policymakers in the analysis and design of pension reforms. It allows users to project the long-term financial sustainability of pension systems by simulating contributions, entitlements, revenues, and expenditures over an extended period, typically 50–100 years. PROST is particularly valuable in addressing challenges such as ageing populations, low fertility rates, and the maturation of pay-as-you-go (PAYG) schemes, which can strain public finances.

This clearly indicates that they are ineffective in terms of stabilizing and reducing the need for budget funds, which is an undesirable situation. As a result of this, the World Bank projection also gives the so-called "all in" scenario in which all three mentioned parameters are changed simultaneously, i.e. gradually increasing the retirement age to 67 years for men and women, increasing the pension insurance contribution rate to 21% and abandoning the Swiss model of pension adjustment, i.e. increasing them only for the change in the retail price index. The increase in the retirement age to 67 years in this scenario is done gradually and it follows the increase in the expected average life expectancy in the country by three or 1.8 months for women and men and it would be realized by 2044. The results of this scenario are presented in the following graph:

Figure 7: Share of budget funds in the first pension pillar (as percentage of GDP)



A combination of changes in all parameters in the manner described above, provides the most effective response to the problem of the increase in funds paid from the budget to support the servicing of financial obligations of the first pillar of the pension system. The effects of the changes are immediately visible in the first few years, followed by a decline in the share of budget funds both in absolute numbers and as a % share in the country's GDP. In the subsequent period, the projection indicates a complete stabilization of the need for budget funds expressed as a % share in GDP at a level of about 2.5% for the analyzed period until 2055. After this, a further decline in the share of budget funds is expected.

Reforms in the pension system / Conclusion

The ageing of the population, the stagnant dynamics in the number of employees, as well as the emigration of working-age people, especially young and qualified ones, have a negative impact on the ratio between contributors to the fund and pension recipients. Increased transfers to the pension fund "crowd out" budget funds that could be used for other priorities such as health, education, infrastructure or climate investments, thus limiting development opportunities. Due to all of the above, in the coming

period, without taking measures to reform the pension system, it, especially in the first pillar, will maintain the current trajectory of increasing amounts of funds that will need to be transferred from the country's Central Budget to service obligations to current pensioners, while the low rate of the pension base adversely affects the benefits of future pensioners. In this regard, there are several possibilities for action aimed at implementing reforms that would improve the self-sustainability of the pension system in the country.

In this direction, it is first necessary to ensure an increase in the revenues of the first pillar of the pension system. The reforms are related to the correction of the rate of contributions paid by employees, increasing the retirement age and abandoning or reducing the share of pension correction by the percentage of average wage growth. Both analyzed projections indicate that partial reforms of only one of these parameters provide limited and insufficient results, and noticeable progress is provided only by a combination of changes in all the listed parameters. It should be borne in mind that, for humane reasons, changes, especially to the retirement age, should be implemented gradually, in increments lower than the annual increase in the average age of the population in the country, and attention should be paid to risky professions that cannot be covered by this measure, such as professions with benefited work experience. In connection with potential reforms, inconsistent policies in the pension system that are characteristic of the past period also pose a risk. If reforms are undertaken in the system in the coming period, given the long period that will be needed for these reforms to have a noticeable effect, a consensus of all political actors in the country is needed in order to avoid future ad hoc or discretionary changes that will undermine the reforms, especially considering that the price of all these changes will be paid by the citizens.

Additionally, in this regard, we point out the possibility of increasing the number of employees who are pension insured, taking into account the difference between the number of people who pay contributions and the number of people who are employed, which is estimated at 138 thousand people, by appropriately motivating at least a part of these people to join the pension system. The above would increase the number of people who pay contributions, followed by an increase in the revenues of the pension system and a reduction in the need for transfers through the Central Budget.

Regarding the second pillar of mandatory pension capital insurance, despite the negative effect that inflation had on real rates of return, the prospects for the second pillar remain positive. Given that real rates of return for the seven-year period ending in 2024 have fallen to 0.5%, this inflationary episode leaves an important lesson for the need for more appropriate diversification of the portfolio, which at the time of the audit is concentrated in government issued bonds, and emphasizes the need for flexibility towards financial instruments that are more resistant to inflationary movements and market shocks, while respecting the conservative nature of these pension funds as well as market momentum.

The third optional pillar is still underdeveloped with a relatively small number of participants in voluntary pension insurance companies, which is not unusual for post-socialist countries and countries with a developed PAYG pension pillar and a second mandatory pillar. There is also the problem of low awareness among employees of the existence of this opportunity, as well as giving preference to more liquid types of savings or real estate investments. It can be concluded that this type of pension insurance has room for improvement in terms of attracting new participants through the promotion of pension funds.

Slovak Republic

The pension system in Slovak Republic

State pension policy – responsibility, actors

State pension policy is primarily carried out by the Ministry of Labour, Social Affairs and Family of the Slovak Republic (MoLSAF SR). It has a decisive role in the areas of social insurance, old-age pension savings and supplementary pension savings. It develops strategies and concepts, proposes and implements legislative changes, monitors and evaluates the results achieved, exercises state supervision over old-age pension savings, and cooperates with the Social Insurance Agency (SIA), other ministries, the National Bank of Slovak Republic (NBS) and other public institutions.

The **SIA** plays an important role, as it is responsible for collecting insurance contributions, acquiring and processing information, awarding benefits, paying benefits, performing control activities and providing information support. The NBS supervises pension savings (Pillar II, Pillar III). **Pension management companies (PMCs)** establish and manage pension funds in the Pillar II. **They are required to manage one bond-based guaranteed pension fund and one index-based non-guaranteed pension fund. The Association of Pension Management Companies (APMCs)** protects the rights of savers and pensioners to ensure that their savings provide them with a decent standard of living in retirement. It informs the public about the performance of pension funds. **Supplementary pension companies (SPCs)** establish and manage supplementary pension funds in the third pillar (Table 1).

Table 1: RACI analysis* (Pension system in Slovak Republic)

Critical activity	MoLSAF SR	SIA	NBS	PMCs	APMCs	SPCs
Management and coordination activities in the area of social insurance, pension savings and supplementary pension savings	R	R	I	I	I	I
Administration of social insurance	A	R	I	I	I	I
Supervision and control of pension savings	R	C,I	R	I	I	I
Establishment and management of pension funds (Pillar II)	C	I	I	A	C,I	-
Establishment and management of supplementary pension funds (Pillar III)	C	I	I	-	-	A
Providing information on the performance of pension funds	I	I	A	R	R	R
Proposing measures to improve the pension system	R	R	C	C	C	C

Source: MoLSAF SR, SIA, Social Insurance Act No. 461/2003 Coll., NBS, APMCs, SPCs; processed by SAO SR.
*Note: R – Responsible: the entity that performs the task, A – Accountable: the entity that is ultimately responsible for the outcome, C – Consulted: the provider of information and consultation, I – Informed: the entity that is continuously informed about the process

Pillars

The pension system in Slovak Republic consists of three pillars: Pillar I - compulsory pension insurance, Pillar II - old-age pension savings, and Pillar III - supplementary pension savings.

In addition to these three pillars, there is also a separate pension system for the armed forces, which includes police officers, soldiers, intelligence services, etc., and a pre-retirement system for municipal police, which applies to members of municipal and local police forces (Table 2).

Table 2: Pension system in Slovak Republic

Pension system	Participation of the insured/ saver	Ownership	Form	Dependency	Administrator	Establishment
Pillar I	mandatory	public	defined benefit	Insured person's income	SIA	from 1 January 1995, from the establishment of pension insurance
Pillar II	mandatory/ voluntary	private	defined contribution	income of the insured person/saver	PMCs	1 January 2005
Pillar III	voluntary; mandatory for hazardous occupations	private	defined contribution	voluntary contribution	SPCs	1 January 2005
Armed forces pension system	mandatory	public	defined benefit	income of the insured person/saver	SIA, Ministry of Defence of the Slovak Republic	from 1 January 1995, from the establishment of pension insurance
Pre-retirement system for municipal police	mandatory	public	-	Income of the insured person/saver	SIA, Ministry of the Interior of the Slovak Republic	1 April 2020

Source: MoLSAF SR, SIA; processed by SAO SR.

Currently, compulsory participation of insured persons is required in the first and second pillars.[1] Participation in the third pillar is voluntary, and becomes mandatory only in the case of high-risk occupations.[2] Ownership of funds is public only in the first pillar; funds in old-age pension savings and supplementary pension savings are private and are invested in pension funds managed by the respective pension companies. Benefits from the first and second pillars depend on the income of the insured person or saver, whereas a saver's benefit from the third pillar depends on the saver's voluntary contribution. In addition to the contributions paid by the saver, the amount of benefits also depends on the investment performance of the pension funds and the chosen method of benefit withdrawal.

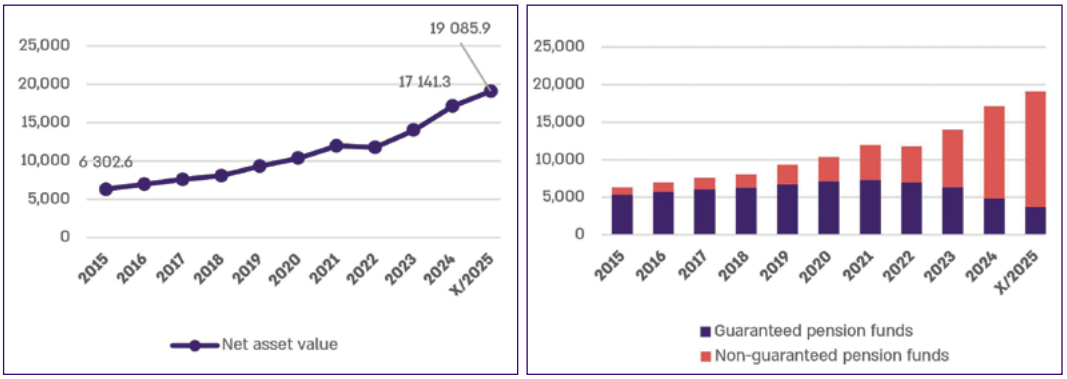
1 Participation in the second pillar has evolved in various ways; since its inception in 2005, participation was mandatory, with no option to opt out. In 2008, it became voluntary, and in 2012, it became mandatory again, with the option to opt out within two years of joining. In 2013, it returned to being voluntary, with the option to defer entry until the saver reaches the age of 35. In 2023, it became mandatory once more, with the option to opt out within two years and re-enter until the age of 40.

2 Hazardous work refers to work classified by a decision of the state administration authority in the field of public health into category 3 or 4 according to a special regulation, as well as the work of employees performing the profession of a dancer, regardless of style and technique, in theatres and ensembles, or of employees who are musicians performing as wind instrument players.

Yields and portfolio structures of the different pillars

Old-age pension savings (Pillar II) are an important part of the pension system in Slovak Republic, despite the numerous legislative changes that have accompanied it during its twenty-year existence.

Figure 1: Net asset value of savers in Pillar II between 2015 and 2025 (in million EUR)



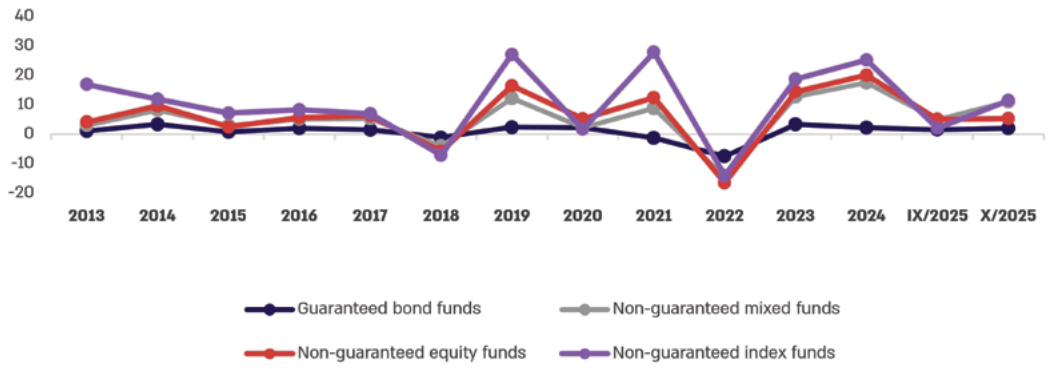
Source: APMCs, processed by SAO SR

At the end of October 2025, more than 2 million savers were contributing to old-age pension savings (Pillar II), with their number having increased almost 1.5 times over the past ten years. The value of assets in the Pillar II reached EUR 19.1 billion, of which 80.7% was held in non-guaranteed pension funds and 19.3% in guaranteed funds (Figure 1). Currently, five **PMCs**[3] manage five guaranteed and 12 non-guaranteed pension funds, including six index funds, four equity funds, one mixed fund and one innovative pension fund. Since 2023, savers have been classified into so-called DIS savers with a default investment strategy, who currently account for 40.9%, and non-DIS savers, accounting for 59.1%, who do not follow this strategy.

The performance of non-guaranteed pension funds usually exceeds that of guaranteed funds. Over the last ten years, non-guaranteed index funds have shown the greatest variation in returns, ranging from -14% in 2022 to 27.8% in 2021. In contrast, guaranteed bond funds recorded the lowest growth of -7.5% in 2022 and a maximum of 3.3% in 2023. Although their growth is stable, it is very low and typically ranges between 1% and 2%. In terms of performance, 2023 was the most successful year for guaranteed pension funds, while 2024 was the best year for non-guaranteed funds. The worst year for both guaranteed and non-guaranteed funds was 2022, when fund performance fell into negative territory (Figure 2).

3 The PMCs currently operating are: Allianz – Slovak PMC, a. s., KOOPERATIVA, p. m. c., a. s., NN PMC, a. s., UNIQA p. m. c., a. s. and VÚB Generali p. m. c., a. s.

Figure 2: Average annual return on pension funds in the second in the second pillar (2015 to September 2025, in %)



Source: APMCs, processed by SAO SR

These fluctuations meant that from the inception of the second pillar until October 2025, the performance of non-guaranteed pension funds averaged 8.1% p.a., with index funds achieving 11.4%, equity funds 5.3% and mixed funds 3.8% p.a. In contrast, the return on guaranteed funds was 1.5% p.a.

In voluntary pension savings (Pillar III), the net asset value (NAV) of EUR 4,385.9 million (as of 30 June 2025) is managed by four SPCs[4]. Over the last ten years, NAV has increased 2.7-fold (Figure 3). A substantial portion, 95.5%, is held in contributory pension funds, with the remaining 4.5% in pay-as-you-go pension funds. SPCs invest savers' contributions in equities and unit trusts (64%) and bonds (27.2%) (Figure 4).

Figure 3: Net asset value in the Pillar III between 2015 and 2024 (in %)

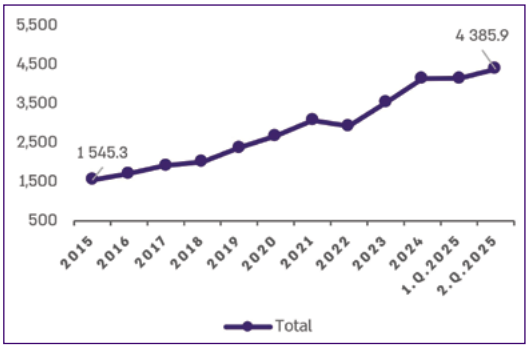
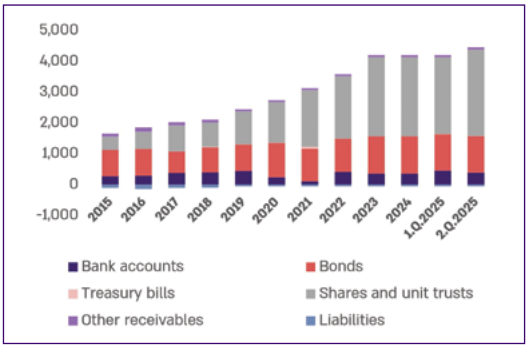


Figure 4: Structure of SPCs investments in Pillar III between 2015 and 2024 (in thousands EUR)



Source: NBS; processed by SAO SR.

4 Source: APMCs, processed by SAO SR

Financing of the pension system, pension contributions (pension insurance revenues and expenditures, deficit management of the basic old-age insurance fund, etc.)

The pension system in the Slovak Republic is primarily based on pension insurance in the first pillar, which is financed through contributions from employees, employers, self-employed persons, voluntarily insured persons, the state and the SIA according to statutory contribution rates (Table 3). It consists of old-age pension insurance and disability pension insurance, which form the basic funds into which insurance contributions are paid.

Table 3: Insurance rates in 2015 to 2025 (in %)

	Employee	Employer	Self-employed persons	Voluntarily insured persons	State	SIA	Minimum AB	Maximum AB
Old-age pension insurance	4	14	18	18	18	18	50% of $AMW_{(t-2)}$	* x times $AMW_{(t-2)}$
Disability pension insurance	3	3	6	6	6	-	50% of $AMW_{(t-2)}$	* x times $AMW_{(t-2)}$
Special social insurance for municipal police officers	3**	-	-	-	-	-	-	-
TOTAL	7 or 10	17	24	24	24	18	-	-

Source: SIA; processed by SAO SR.
* Notes: The minimum assessment base (AB) applies only to self-employed persons, voluntarily insured persons and self-payers. It does not apply to employees and employers. The minimum AB is at least 50% of the average monthly wage from two years prior. The maximum AB is calculated as multiple of the average monthly wage from two years prior. From 1 January 2025, it is calculated as 11 times the average monthly wage (AMW) from two years prior (AMW(t-2)).
** Special social insurance for municipal police officers has been in effect since 1 April 2020. For municipal/city police officers as employees, the pension insurance contribution is paid at 10.0%, whereas for other employees it is 7.0%.

Contributions to pension insurance from insured persons are part of the budget of the SIA, which administers them. Over the past ten years, these contributions have doubled, reaching more than EUR 11 billion. In 2024, 79.7% of this amount was allocated to the basic fund for old-age pension insurance, and the remaining 20.3% to the basic fund for disability pension insurance (Figure 5).

Figure 5: Creation of basic pension insurance funds between 2015 and 2024 (in thousands EUR)

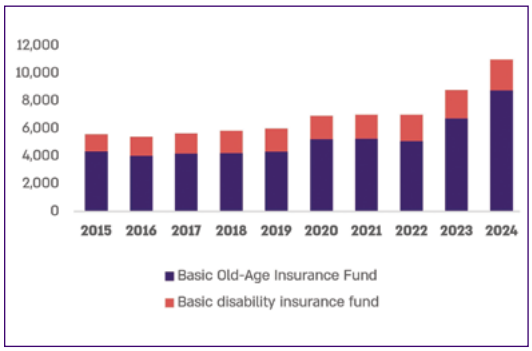
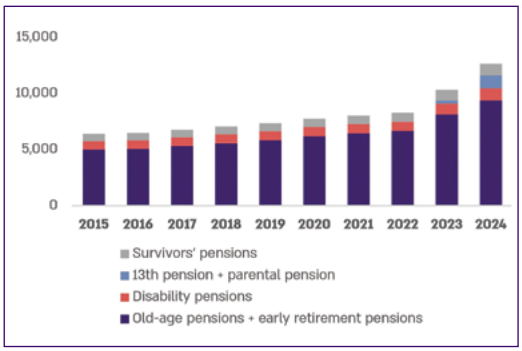


Figure 6: Pension insurance expenditure on pensions between 2015 and 2024 (in million EUR)

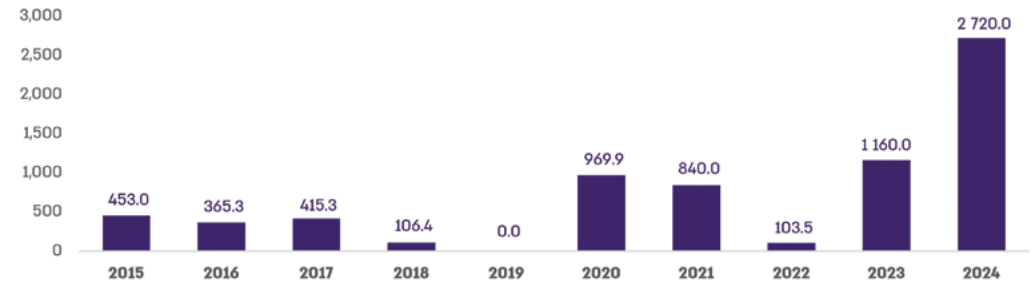


Source: SIA; processed by SAO SR.

During the same period, pension insurance expenditure doubled, reaching EUR 12.6 billion. A substantial portion of this, 74.2%, was allocated to the payment of old-age pensions and early old-age pensions, as well as the 13th pension and parental pension (9%) (Figure 6).

Insufficient funding for pension insurance leads to a deficit in the SIA, which is covered by transfers from the state budget (Figure 7) and reallocations from other surplus funds of the SIA, primarily to finance old-age pension payments.

Figure 7: Transfer from the state budget to the SIA (in million EUR)



Source: SIA; processed by SAO SR.

Types of pensions

Pension insurance provides old-age pensions, early old-age pensions, disability pensions, survivor's pensions (widow's pension, widower's pension and orphan's pension), 13th pension[5], i.e. Christmas allowance for pensioners, and, for 2023 and 2024, also parental pension[6]. Payment from the basic fund (BF) of old-age and disability insurance is shown in Table 4.

Table 4: Types of pensions paid from pension insurance

Type of pension	Old-age insurance BF	Disability insurance BF
Old-age pension	✔	-
Early old-age pension	✔	-
Disability pension	-	✔
Widow's pension	✔	✔
Widower's pension	✔	✔
Orphan's pension	✔	✔
13th pension	✔	✔
Parental pension	✔	-

Source: MoLSAF SR, SIA, processed by SAO SR.

Tax incentives and benefits

The Slovak pension system provides only limited tax incentives for insured persons. However, all pensions paid are exempt from income tax as well as from social and health insurance contributions. Pensioners working under agreements for work performed outside an employment relationship may claim a monthly contribution relief of up to EUR 200, on which they are not required to pay social insurance contributions.

There are no standard tax incentives for savers in the second pillar. In the third pillar, a tax deduction of up to EUR 180 per year is available, allowing savers to reduce their taxable income and lower their annual tax liability by up to EUR 34.20. However, this incentive is relatively modest and has only a limited impact on participation.

5 The 13th pension is paid at the end of the year to recipients of old-age pensions, early old-age pensions, disability pensions and survivor's pensions.
6 Parental pension – a special type of pension, paid in addition to the old-age pension.

Possibility to work while receiving a pension

After receiving an old-age pension, disability pension, or survivor's pension, the recipient may continue working. A special regime applies to early retirees, whose pension payments may be suspended by the SIA. Early retirees must choose between engaging in gainful employment or receiving a pension. The only exception is work performed under agreements for work carried out outside an employment relationship, from which they may earn a maximum income of EUR 200 per month or EUR 2,400 per year. If this income is exceeded, pension payments are suspended and resumed in the following year. Once the statutory retirement age is reached, this no longer applies, and pensioners may work without limitation. Working while receiving a pension also benefits pensioners, as their pension is automatically adjusted each year following recalculation by the SIA.

Pension entitlement – conditions for obtaining a pension

The conditions for entitlement to a pension are specified in the Social Insurance Act and vary depending on the type of pension (Table 5). Generally, a minimum period of pension insurance and attainment of a certain age are required.

Table 5: Conditions for entitlement to different types of pensions

Type of pension	Eligibility conditions
Old-age pension	✔ Reaching retirement age (The general retirement age for the relevant birth cohort, reduced by 6 months if the insured person has raised 1 child, 12 months for 2 children, and 18 months for 3 or more children, e.g. for the 1966 birth cohort, the general retirement age is set at 64 years) ✔ Insurance period (The insured person is entitled to an old-age pension if they have been covered by pension insurance for at least 15 years)
Early old-age pension	✔ Age (At least 2 years before reaching the statutory retirement age, or having completed the required number of insurance years for the relevant cohort, e.g. 41 years of insurance for the 1966 birth cohort) ✔ Insurance period (The minimum required period of pension insurance is 15 years) (The insured must not be employed under pension insurance on the date of entitlement to the early old-age pension) ✔ Minimum amount of early old-age pension (The sum of the early old-age pension payments from Pillar I and Pillar II must exceed 1.6 times the subsistence minimum for one adult) ✔ Pension reduction (by 0.5% for each month of receiving early old-age pension until reaching the statutory retirement age)
Disability pension	✔ Health condition (A decrease in work capacity by more than 40%, determined by a medical assessor of the SIA based on diagnoses) ✔ Insurance period (Depends on the age at the onset of disability, e.g. 15 years of insurance are required at age 45) ✔ Regular reassessment of health condition (The SIA regularly evaluates the health status and may increase, reduce or cancel the pension)
Widow's/ Widower's pension	Entitlement arises after the death of a spouse who was entitled to an old-age or disability pension
Orphan's pension	Entitlement applies to dependent children after the death of a parent

Source: Social Insurance Act No. 461/2003 Coll.; processed by SAO SR.

Participation of the population in the pension system – number of insured persons

As of September 2025, the majority of social insurance contributors were employees, numbering 1.8 million. At the same time, 240 thousand self-employed persons were paying contributions to the SIA.

Basic data on the pension system such as: number of pensioners, average period of receiving a pension, average pension, minimum pension, average salary, ratio of average pension/average salary

Number of pensions paid

At the end of September 2025, the SIA paid more than 1.8 million pensions of various types, with old-age and survivor's pensions being the most common (Figure 8). While the number of old-age pensions has increased only slightly over the past two years, the number of early old-age pension recipients rose significantly in 2024 due to legislative changes benefiting them and pension indexation in 2023 and 2024. After the conditions for obtaining an early old-age pension were tightened, their number began to decline. The number of disability pension recipients, on the other hand, has been decreasing since 2020, with a slight rise in 2025. The number of survivor's pensions has remained stable, with a minor decline in September 2025.

Figure 8: Development of the number of pensions paid by the SIA from December 2020 to September 2025

Source: SIA; processed by SAO SR.

Average period of receiving a pension

According to the latest available data from 2024 (OECD)[7], men receive a pension for an average of 17.7 years and women for 23 years. Compared to the OECD average, men spend fewer years in retirement than the OECD average (18.6 years), whereas the duration of pension receipt for women is slightly above the OECD average (22.8 years).

Average pension

The average amount of all types of pensions increases every year due to legislative changes and regular indexation. This increase was supported by the introduction of the 13th pension, equal to the average old-age pension, the payment of parental pensions for 2023 and 2024, and an extraordinary indexation in 2023. In September 2025, the average early old-age pension reached almost EUR 732, followed by the old-age pension at nearly EUR 703. Disability pensions averaged EUR 412, widow's pensions EUR 385, widower's pensions EUR 322, and orphan's pensions nearly EUR 211 (Figure 9).

Figure 9: Average pension amounts in euros from December 2020 to September 2025 (in euros)

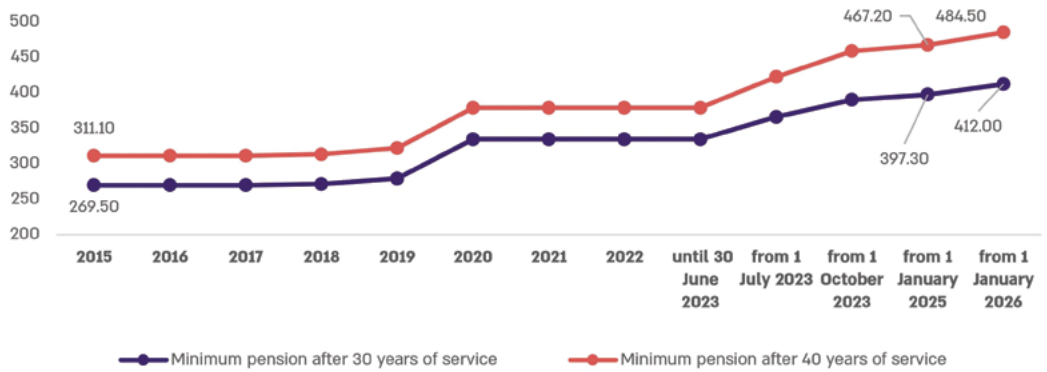
Source: SIA; processed by SAO SR.

7 OECD, 2025. Pensions at a Glance 2025. **[link]**.

Minimum pension

The minimum pension was introduced in Slovak Republic in July 2015. Over the past ten years, the minimum pension amount has increased in line with the subsistence minimum and the number of years of pension insurance. From January 2025, the minimum old-age pension is EUR 397.30 for 30 years of contributions and EUR 467.20 for 40 years (Figure 10).

Figure 10: Minimum old-age pension for 30 and 40 years of service in the period 2015 to 2026 (in euros)



Source: SIA; processed by SAO SR.

Average salary and average pension

According to available data, the ratio of the average solo old-age pension to the average wage declined between 2015 and 2022 (Figure 11, Figure 12). A change occurred in 2023, when the ratio increased to 45.4%, which was due both regular and extraordinary indexation that year. According to the latest available data for 2024, the average monthly solo old-age pension (OP) accounted for 44.8% of the average nominal monthly wage (Figure 12).

Figure 11: Average nominal monthly wage and average monthly solo OP from 2015 to 2024 (in euros)

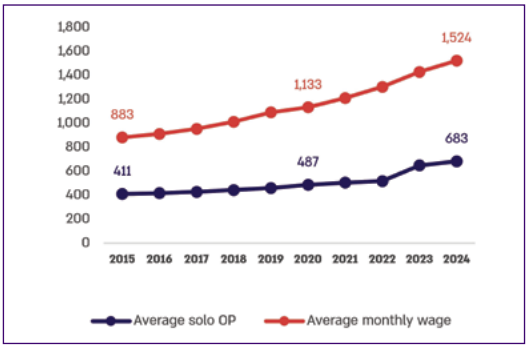
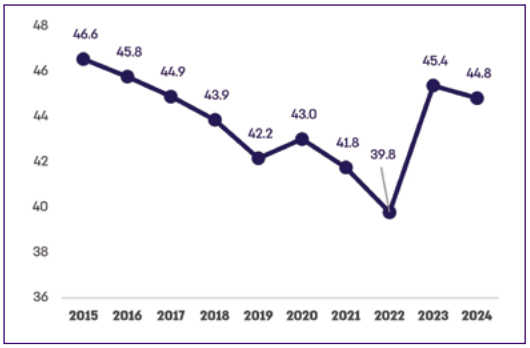


Figure 12: Ratio of the average monthly solo OP to the average nominal monthly wage in 2015 to 2024 (in %)



Source: SIA; processed by SAO SR.

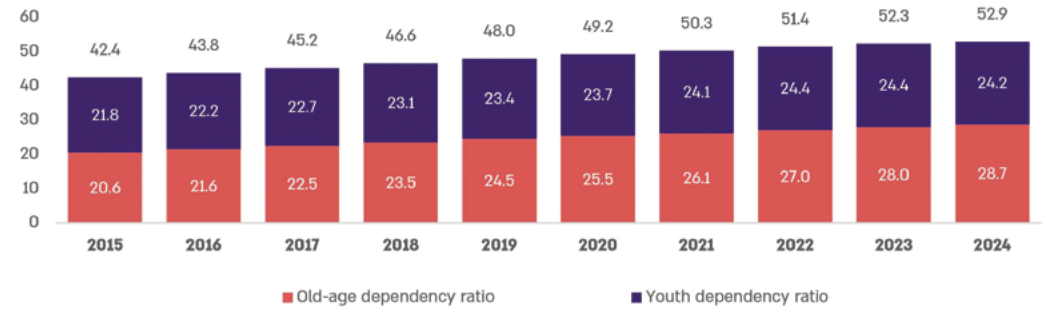
Supplying comprehensive assessment of the financial situation of our respective pension funds in the future

Indicators and data

Dependency ratios

In recent years, the demographic and economic burden on society has risen significantly, intensifying pressure on the working population (Figure 13). Between 2015 and 2024, the economic dependency ratio increased from 42.4% to 52.9%, an increase of almost a quarter. A particularly important factor is population ageing: the share of seniors (65+) in the productive population grew from 20.6% (2015) to 28.7% (2024), deepening the long-term demographic burden and placing growing demands on public finances, the pension system and healthcare. Although the increase in the youth dependency ratio was less steep, it remained notable, rising by 2.4 percentage points (p.p.) during the period under review.

Figure 13: Economic dependency ratio (in percentages)



Source: Statistical Office of the Slovak Republic (SO SR), processed by SAO SR

Demographic data and indicators

Demographic developments in Slovak Republic between 2015 and 2024 confirm the gradual ageing of the population, accompanied by low birth rates and only slight changes in the total population (Table 6). The population peaked in 2020 and fell to approximately 5.4 million by 2024, with the number of women consistently exceeding the number of men and the difference slightly increasing. The age structure is shifting in favour of older age groups: the proportion of children remains almost unchanged, the working-age population has decreased by approximately five p.p., and the proportion of seniors has increased by more than four p.p.

This shift is mainly due to long-term low fertility, which remained below 1.7 children per woman during the period under review, well below the replacement level of 2.1. The number of live births remained relatively stable until 2021, peaking at almost 58 thousand (2017), but has declined since then: 2023 saw the lowest number of live births since 1996[8] and 2024 breaking that record. The decline in fertility was also reflected in negative natural population growth after 2020.

The pandemic temporarily deepened population losses, particularly in 2021, due to increased mortality, especially among women. It also interrupted the long-term increase in life expectancy, erasing nearly a decade of progress. In the following years, life expectancy figures recovered and even slightly exceeded pre-pandemic levels, although this development may be distorted by the selective impact of the pandemic, which left a more resilient population. A similar pattern of increase, decline, and partial recovery is visible in healthy life expectancy, with gender differences persisting.

8 DATAcube. SO SR. **[link]**.

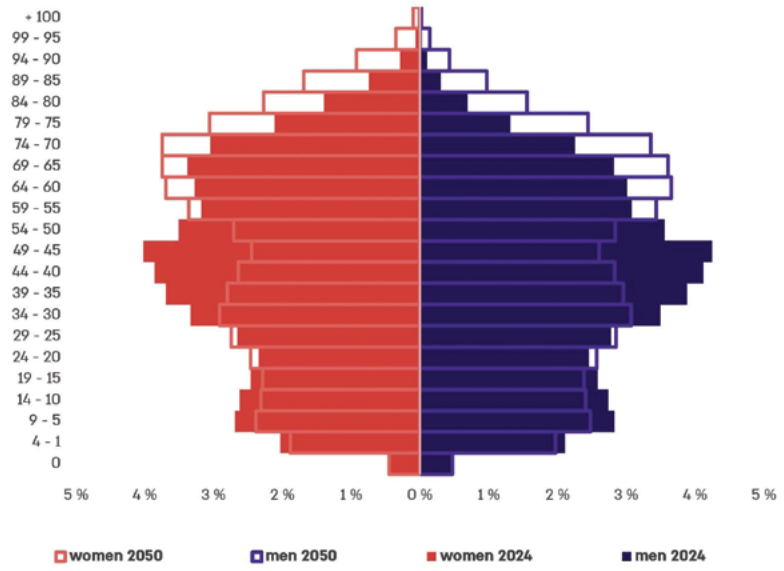
Table 6: Development of selected demographic indicators

		2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	
Population (thousands)	All	5,423.8	5,430.8	5,439.2	5,446.8	5,454.1	5,458.8	5,442.0	5,431.8	5,426.7	5,422.1	↓
	Women	2,779.6	2,781.9	2,785.1	2,788.0	2,790.9	2,792.9	2,780.4	2,775.3	2,772.6	2,770.0	↓
	Men	2,644.2	2,648.9	2,654.1	2,658.8	2,663.2	2,665.9	2,661.6	2,656.5	2,654.2	2,652.1	↑
Age structure (%)	Pre-productive age	15.32	15.40	15.53	15.68	15.78	15.86	15.99	16.07	16.04	15.90	↑
	Working age	70.47	69.89	69.21	68.54	67.90	67.31	66.79	66.31	65.86	65.53	↓
	Post-productive age	14.20	14.72	15.26	15.78	16.31	16.83	17.22	17.62	18.10	18.57	↑
Population growth rate (%)	All	0.10	0.13	0.16	0.14	0.14	0.09	-0.31	-0.19	-0.09	-0.09	↓
	Women	0.06	0.08	0.12	0.10	0.11	0.07	-0.45	-0.18	-0.10	-0.09	↓
	Men	0.13	0.18	0.20	0.18	0.17	0.10	-0.16	-0.19	-0.09	-0.08	↓
Population growth in absolute numbers	All	4,903	9,091	7,777	7,301	7,452	1,908	-14,558	-5,920	-4,105	-5,236	↓
	Women	1,149	3,489	2,947	2,738	3,179	772	-7,085	-3,111	-2,228	-2,968	↓
	Men	3,754	5,602	4,830	4,563	4,273	1,136	-7,473	-2,809	-1,877	-2,268	↓
Total fertility rate		1.40	1.48s	1.52	1.54	1.56	1.59	1.64	1.57	1.49	1.46	↑
Live births (person)	All	55,602	57,557	57,969	57,639	57,054	56,650	56,565	52,668	48,627	46,241	↓
	Women	26,934	28,078	28,196	27,965	27,911	27,722	27,804	25,623	23,712	22,547	↓
	Men	28,668	29,479	29,773	29,674	29,143	28,928	28,761	27,045	24,915	23,694	↓
Life expectancy at birth (years)	Women	79.73	80.41	80.34	80.35	80.84	80.17	78.13	80.3	81.35	81.64	↑
	Men	73.03	73.71	73.75	73.71	74.31	73.47	71.16	73.57	74.73	75.02	↑
Life expectancy at 65 (years)	Women	18.24	18.87	18.71	18.8	19.28	18.58	17.05	18.66	19.63	19.89	↑
	Men	14.83	15.15	15.19	15.2	15.69	14.72	13.17	15.01	15.86	16.09	↑
Healthy life expectancy at birth (years)	All	66.7	67.1	67.1	67.2	67.5	66.9	64.9				↓
	Women	68.7	69.0	69.0	69.1	69.4	68.8	66.9				↓
	Men	64.5	65.1	65.1	65.1	65.5	64.9	63.0				↓

Source: SO SR; processed by SAO SR.

A comparison of age pyramids (Figure 14, Figure 15) shows that the population is ageing in two dimensions: ageing from below – the proportion of children (0–14 years) is declining due to low fertility rates, and ageing from above – the proportion of seniors (65+) is increasing due to longer life expectancy. While in 2024 Slovak Republic still had a relatively balanced structure with a robust productive component, the projection for 2050 indicates a transition to a stationary and subsequently regressive type according to Sundbärg's classification[9] – the pre-productive population is shrinking while the post-productive population is expanding. By 2070, this trend is expected to intensify: the 70–84 age cohorts will expand significantly, whereas younger age groups will decline noticeably. At the same time, gender differences in older age are projected to decrease, indicating a reduction in male excess mortality.

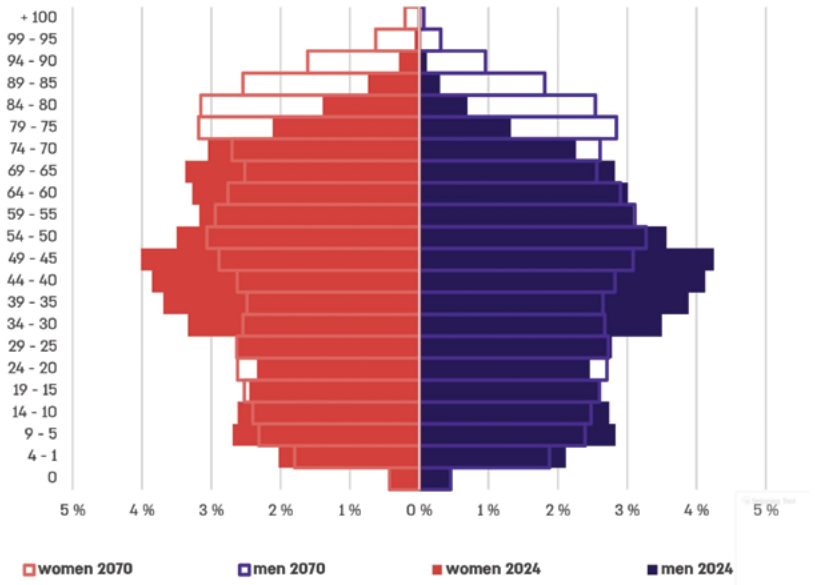
Figure 14: Age pyramid 2024 vs 2050



Source: SO SR, Eurostat; processed by SAO SR.

9 Sundbärg's classification divides the population based on the ratio of young to the older population. A progressive type is dominated by children, a stationary type is balanced, and a regressive type is dominated by older people, indicating population ageing.

Figure 15: Age pyramid 2024 vs 2070



Source: SO SR, Eurostat; processed by SAO SR.

Macroeconomic indicators

The Slovak economy has grown since 2015 mainly due to higher prices (Table 7). Although nominal gross domestic product (GDP) grew at a rate of 4-6% p.a. between 2015 and 2019 and jumped to 12.5% after the pandemic (2023), real GDP, expressed in constant prices (based on 2020 prices), followed a much more moderate path. It only recorded a notably higher growth rate in 2015 (5.2%) and 2021 (5.7%), but after the pandemic it slowed to around 0.4–2.2% p.a. The same pattern is evident in GDP per capita: nominally it grew rapidly, while in real terms it fluctuated between weak growth and slight decline. This confirms that in recent years, economic growth has reflected mainly inflation rather than an expansion of production capacity.

Table 7: GDP development

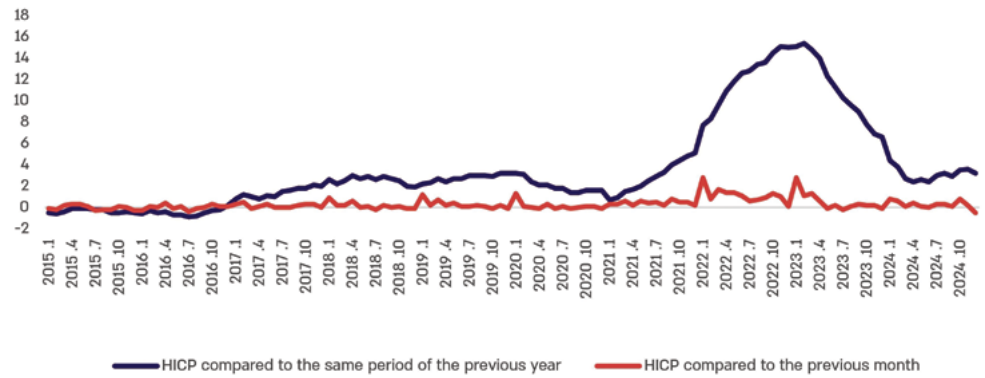
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	
Change in GDP at current prices (%)	4.99	1.54	4.09	6.26	4.73	-0.24	8.07	7.97	12.52	5.78	↑
Change in GDP at constant prices (2020=100,%)	5.18	1.95	2.87	4.07	2.27	-2.58	5.70	0.43	2.17	2.06	↓
Change in GDP per capita at current prices (%)	4.88	1.42	3.93	6.15	4.58	-0.40	8.45	7.69	12.49	5.73	↑
Change in GDP per capita at constant prices (2020=100,%)	5.12	1.75	2.76	3.89	2.19	-2.76	6.08	0.16	2.18	2.03	↓

Source: SO SR, Eurostat; processed by SAO SR.

Between 2015 and 2024, inflation in Slovak Republic shifted from a period of nearly zero price growth to significant price shocks, followed by stabilisation (Figure 16). The beginning of the observed period (2015–2016) was characterized by deflation. From 2017, inflation began to rise gradually, peaking at around 15% in 2021–2022, driven by the energy crisis and the pandemic. From mid-2023, the pace of price growth slowed significantly, and by early 2024, inflation had stabilised at roughly 3%.

Monthly changes provide further insight into short-term fluctuations: during 2021–2022, volatility was high, often exceeding 1%, whereas during periods of deflation and low inflation, changes were smaller or negative. In 2024, monthly changes hover around low positive values with slight declines, reflecting a moderation of price fluctuations.

Figure 16: Development of the harmonised index of consumer prices (HICP) (in percentages)



Source: SO SR; processed by SAO SR.

Labour market indicators

Between 2015 and 2024, the labour market situation developed favourably overall (Table 8). The employment rate gradually increased across all age groups, most significantly among people aged 55–64, where it rose by more than 17 p. p. The total employment rate for the population aged 15–64 increased by almost 8 p. p., with a temporary decline in 2020–2021 due to the pandemic. Unemployment decreased for most of the period, with only a short-term rise in 2020. In 2024, unemployment reached its lowest level in the observed period, falling by nearly 6 p. p. for the 55–64 age group. Although the number of people of working age (20–64) declined by over 250 thousand, the size of the labour force remained stable due to higher participation rates – the proportion of economically active people rose from 76% to 82%, an increase of 6 p. p.

Table 8: Development of selected labour market indicators

		2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	
Employment rate (%)	15–64	64.53	66.70	68.08	69.55	70.43	69.48	69.45	71.35	71.98	72.43	↑
	15–74	58.15	59.83	60.90	61.88	62.40	61.25	60.83	62.15	62.63	63.08	↑
	55–64	48.35	50.50	54.65	55.95	58.83	60.18	60.65	64.08	66.58	66.03	↑
Unemployment rate (%)	15–64	11.53	9.72	8.14	6.58	5.80	6.75	6.90	6.20	5.95	5.45	↓
	15–74	11.47	9.64	8.08	6.49	5.72	6.66	6.85	6.15	5.85	5.35	↓
	55–64	9.29	8.94	5.99	5.36	4.66	4.84	5.40	4.53	3.95	3.40	↓
Effective labour market exit age (years)	Women	58.8	59.1	58.9	59.6	59.6	59.8	60.6	61.7	61,5	61,2	↑
	Men	60.4	60.2	60.1	60.6	60.1	60.2	60.6	61.7	61,6	62,7	↑
Working-age population (20–64 years, in thousands)		3,533.3	3,513.50	3,490.64	3,465.93	3,439.76	3,411.76	3,375.20	3,339.06	3,306.91	3,280.02	↓
Labour force (20–64 years, thousands)		2,700.38	2,716.58	2,704.80	2,690.75	2,685.08	2,657.48	2,697.98	2,716.25	2,707.70	2,692.53	↓
Participation rate (20–64 years,%)		0.76	0.77	0.77	0.78	0.78	0.78	0.80	0.81	0.82	0.82	↑

Source: SO SR, Eurostat, OECD; processed by SAO SR.

Fiscal prognosis considering population ageing

Forecasting selected indicators for the next 20-25 years

The projections are based on the national document for the Slovak Republic, which is part of an official publication by the European Commission (EC) assessing the economic and budgetary impact of population ageing in the long term.[10] The national document was prepared by the Institute for Financial Policy of the Ministry of Finance of the Slovak Republic (IFP MF SR) in cooperation with experts from other EU Member States and the EC within the Ageing Working Group (AWG) and contains long-term projections for almost 50 years – until 2070, with 2022 as the base year.

The population of Slovak Republic is expected to decline from 5.5 million (2022) to approximately 4.8 million in 2070, i.e. by approximately 700 thousand (Table 9). This forecast reflects the long-term demographic decline, which is also driven by persistently low fertility rates. Total fertility is expected to rise only slightly – from 1.60 children per woman in 2022 to 1.66 in 2070, still well below the replacement level of 2.1. Despite the population decline, life expectancy is projected to increase: life expectancy at birth is expected to rise by 10.7 years for men and 8.7 years for women by 2070. Even at the age of 65, both men and women are expected to live on average about 7 years longer than in 2020.

Table 9: Projections of selected demographic indicators

		2022	2025	2030	2035	2040	2045	2050	2055	2060	2065	2070	
Population (in millions)		5.48	5.51	5.44	5.36	5.3	5.23	5.17	5.10	5.02	4.92	4.82	↓
Total fertility rate		1.60	1.60	1.61	1.62	1.62	1.63	1.63	1.64	1.65	1.65	1.66	↑
Life expectancy at birth (years)	Men	73.4	74.5	75.8	77.0	78.1	79.2	80.3	81.3	82.3	83.3	84.1	↑
	Women	80.4	81.4	82.4	83.4	84.3	85.2	86.0	86.9	87.7	88.4	89.1	↑
Life expectancy at age 65 (years)	Men	15.1	16.0	16.7	17.5	18.2	18.9	19.6	20.3	21.0	21.6	22.2	↑
	Women	19.0	19.9	20.6	21.3	22	22.7	23.4	24.0	24.6	25.2	25.8	↑

Source: IFP MF SR; processed by SAO SR.

10 EC, 2023. 2024 Ageing Report: Economic & Budgetary Projections for EU Member States (2022-2070) **[link]**.

After 2022, GDP growth is expected to slow gradually due to demographic ageing and a decline in the working population, which presents a significant challenge to the sustainability of public finances (Table 10). While GDP growth is expected to exceed 2% in the mid-2020s, it will decrease to 1.5% after 2030 and stabilize around 1.3% in the long term. Per capita GDP growth is expected to remain more stable, with an annual rate of 1.9-2.0% until 2033, indicating favourable productivity developments. By 2050, growth is expected to slow slightly to 1.5%, but will pick up again and remain at 1.7-1.8% until 2070. After sharp price increases in 2022-2023 (HICP 12.1% and 10.9%), inflation is projected to gradually ease. In 2025, it is expected to fall to 4.5% and then stabilize at the target level of 2%, which will be maintained until the end of the forecast period.

Table 10: GDP and HICP projections (in percentages)

	2022	2025	2030	2035	2040	2045	2050	2055	2060	2065	2070	
GDP growth rate (%)	1.94	1.62	1.63	1.66	1.51	1.41	1.25	1.13	1.23	1.35	1.31	↓
GDP growth rate per capita (%)	1.34	1.87	1.92	1.92	1.75	1.64	1.50	1.42	1.60	1.78	1.72	↑
HICP (%)	12.13	4.47	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	↓

Source: IFP MF SR; processed by SAO SR.

In the coming decades, Slovak Republic will face a gradual decline in its working-age population and total labour force, which presents a significant challenge for the labour market and economic activity (Table 11). By 2070, the working-age population is projected to decrease by more than 27%, and the number of economically active persons by 25%. A slightly positive development is indicated by the growth in the labour force participation rate, which, after a temporary decline until 2040, is expected to rise again from 81.7% (2022) to 84.8% in 2070. In this context, working life is also expected to be extended, with the average retirement age increasing from 62.4 years in 2022 to 64.8 years in 2050, and reaching 66.4 years in 2070. Employment in the 20–64 age group will show a slight increase, from 76.8% (2022) to 79.6–79.7% after 2040. In contrast, the trend in the 20–74 age group is different: employment will initially fall from 66.1% to 63.2% in 2040, but will rise to 69.5% by 2070. The unemployment rate in both age categories is expected to fluctuate around 5–6%, which suggests a relatively stable labour market despite the unfavourable demographic developments.

Table 11: Projections of selected labour market indicators

	2022	2025	2030	2035	2040	2045	2050	2055	2060	2065	2070	
Working-age population (aged 20–64, in thousands)	3,367.10	3,311.20	3,190.92	3,114.46	3,014.16	2,860.87	2,705.59	2,562.09	2,466.63	2,439.10	2,436.17	↓
Labour force (20–64 years, in thousands)	2,750.78	2,710.41	2,612.79	2,533.81	2,437.14	2,332.99	2,232.68	2,138.93	2,079.32	2,064.74	2,066.29	↓
Participation rate (20–64 years, %)	81.70	81.86	81.88	81.36	80.86	81.55	82.52	83.48	84.30	84.65	84.82	↑
Average labour market exit age (years)	62.39	62.62	63.20	63.37	63.82	64.31	64.83	65.20	65.59	66.00	66.43	↑
Employment rate (20-64 years, %)	76.83	77.72	77.31	76.46	75.99	76.62	77.53	78.44	79.22	79.56	79.71	↑
Employment rate (20–74 years, %)	66.13	66.39	66.07	65.60	64.59	63.47	63.39	64.30	65.61	67.58	69.45	↑
Unemployment rate (20-64 years, %)	5.96	5.05	5.59	6.02	6.02	6.04	6.05	6.04	6.02	6.02	6.02	↑
Unemployment rate (20–74 years, %)	5.89	5.0	5.52	5.94	5.92	5.91	5.89	5.85	5.83	5.83	5.84	↓

Source: IFP MF SR; processed by SAO SR.

The share of the population aged 65+ in the working-age population (20-64) is expected to increase gradually from 2022 to 2070 (Table 12). While this ratio stands at 28.5% in the base year of 2022, it is projected to reach 60% by 2070. The total dependency ratio, which reflects the ratio of children (aged 0-19) and seniors (aged 65+) to the working-age population, will rise from 63% in 2020 to approximately 103% by mid-century. After 2055, this ratio will decrease slightly but remain high, around 97%, meaning there will be almost one dependent for every worker.

Table 12: Projections of selected economic dependency indices

	2022	2025	2030	2035	2040	2045	2050	2055	2060	2065	2070	
Old-age dependency ratio	28.50	31.06	35.05	37.67	41.99	48.44	54.73	60.49	63.71	62.54	59.66	↑
Total dependency ratio	62.73	66.54	70.55	72.15	75.68	82.97	91.21	99.22	103.52	101.71	97.72	↑

Source: IFP MF SR; processed by SAO SR.

Projections of pension-related indicators

Projections indicate that gross public pension expenditure will increase from 8.50% of GDP in 2022 to a peak of approximately 12.11% of GDP around 2058-2060, and then slightly decrease to 11.32% of GDP by 2070 (Table 13). This growth is almost entirely driven by expenditures on old-age and early old-age pensions, which rise from 6.54% of GDP in 2022 to 9.49% of GDP at the peak of the projection, before declining to 8.75% of GDP. Old-age benefits therefore account for the majority of costs throughout the entire period, underscoring their dominant influence on fiscal pressure. The main drivers of this increase are demographic ageing and the worsening ratio of seniors (65+) to the working-age population, which accounts for a significant portion of the expenditure growth. While the projections consider partial compensations, such as changes in the second pension pillar or adjustments to benefits, these measures are not sufficient to fully offset the fiscal pressure according to the available scenarios[11].

Table 13: Projections of pension expenditure

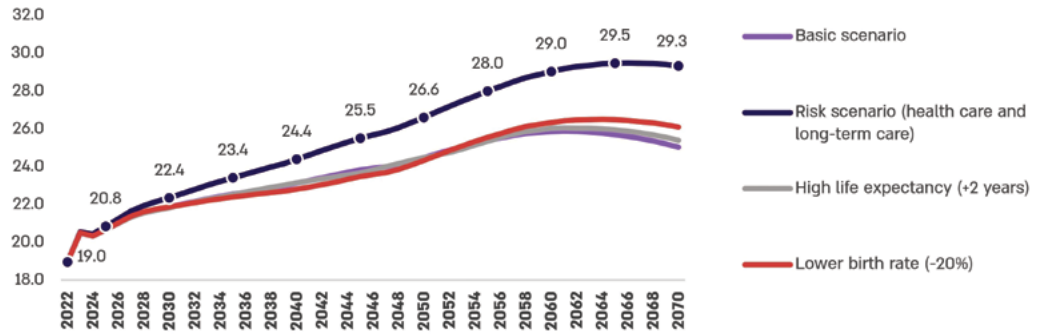
	2022	2025	2030	2035	2040	2045	2050	2055	2060	2065	2070	
Public pensions, gross expenditure	8.50	9.58	10.22	10.47	10.78	11.24	11.55	12.02	12.11	11.84	11.32	↑
Old-age and early old-age pensions, gross expenditure	6.54	7.31	7.70	7.84	8.06	8.55	8.88	9.34	9.49	9.25	8.75	↑

Source: IFP MF SR; processed by SAO SR.

11 IFP MF SR, 2023. 2024 Ageing Report Slovak Republic – Country Fiche. **[link]**.

The impact of population ageing on public finances is primarily reflected in the gradual increase in the total costs of ageing, which mainly consist of the share of pension, health, and long-term care expenditures in GDP (Figure 17). According to the baseline scenario, total ageing costs are expected to rise from 19% of GDP in 2022 to a peak of 25.9% of GDP around 2060, before slightly declining to 25% of GDP by 2070. Alternative scenarios suggest a potentially more significant increase – for example, a combination of deteriorating health and higher care costs could push this figure up to 29.5% of GDP. Conversely, a slight increase in mortality or higher fertility rates could help alleviate this trajectory.

Figure 17: Total costs associated with population ageing (percentage of GDP)



Source: IFP MF SR; processed by SAO SR.

Projections of the stability of the pension system

Projections of the stability of the Slovak pension system until 2070 indicate a gradual increase in public expenditure on pensions.[12] The calculations are based on the SLOPEM (Slovak Pension Model), which has been developed over a long period in cooperation with the Council for Budget Responsibility and IFP MF SR. The forecast was last updated in 2023, with 2022 as the base year. The model reflects the assumptions of the Ageing Working Group (AWG) at the European Commission (EC) and allows for the assessment of the impacts of demographic changes, legislative changes, and the macroeconomic environment.

SLOPEM uses data from the SIA on the structure of pensions by type, age, gender, and income categories, as well as macroeconomic assumptions approved by the AWG. The calculations are based on a cohort approach, covering the first pillar and partially the second pillar. The methodology has been verified by an expert group from the EC.

12 IFP MF SR, 2023. 2024 Ageing Report Slovak Republic – Country Fiche. **[link]**.

Gross public pension expenditure is expected to rise from 8.5% of GDP in 2022 to 12.1% of GDP in 2058, and then slightly decline to 11.3% of GDP by 2070. The main factor driving this increase is the unfavourable demographic trend: the share of the population aged 65+ relative to the 20–64 age group will rise from 28.5% in 2022 to 59.7% by 2070. This trend will be only partially offset by the expected higher participation of older age groups in the labour market, as well as the reduction in the average value of newly granted pensions relative to the average wage.

The balance of the public pension system is projected to deteriorate from -1.1% of GDP in 2022 to -5.0% of GDP by 2070. Revenues are mainly affected by the decline in the ratio of contributors to pension recipients, with only a gradual increase in the retirement age having a stabilizing effect. Greater participation of older individuals in the labour market and higher labour productivity would lead to more favourable outcomes.

In the long term, the pension system remains under pressure. Although reform measures have slowed the pace of expenditure growth, deeper systemic reforms will be required to address future public pension deficits.

Preparedness of the pension system for population ageing

Recent reforms or mechanisms to improve the sustainability of the pension system in the last 20-25 years

Since the beginning of the 21st century, the Slovak pension system has undergone several significant reforms aimed at enhancing its financial stability and preparing for the consequences of population ageing. The key reforms are listed in Table 14.

Table 14: Overview of the most significant reforms improving sustainability

Name of reform	Year of reform	Change	Impact on the sustainability of public finances
Introduction of a three-pillar pension system	2003	Pillar I – mandatory pay-as-you-go with 19.75% contributions. Pillar II – capitalisation with 9% contributions to a personal account, mandatory for those entering the labour market for the first time and voluntary for others. Pillar III – voluntary supplementary savings pillar, with the possibility of contributions from both the employee and the employer.	Diversifies pension sources and reduces exclusive dependence on the pay-as-you-go (Pillar I) system, which is most affected by demographic ageing.
Valorisation mechanism	2012	Instead of the "Swiss model" (average inflation and wage growth), pensions are increased exclusively based on inflation in pensioners' households, with fixed annual increases added during the transition period from 2013-2017 and a gradual increase in the weight of inflation from 50% to 90%.	Slows the growth of pension expenditure (pensions are adjusted based on inflation in pensioners' households rather than on wage growth).
Linking the retirement age to life expectancy	2012	Alters the method of determining the retirement age so that, from 2017, it is automatically adjusted according to the five-year moving average of life expectancy, with an annual increase of approximately 50 days.	The automatic increase in the retirement age responds to demographic changes and reduces the ratio of recipients to contributors.
Maximum assessment base	2016	Increase from 5 times to 7 times the average wage.	Increases pension system revenues from high-income individuals.

Name of reform	Year of reform	Change	Impact on the sustainability of public finances
Freezing of the minimum pension	2020	Freezes the minimum pension from January 1, 2021, at the 2020 level. The condition for counting a year of insurance (minimum contributions of at least 24.1% of the average wage) has been reintroduced.	Limits expenditure growth and increases the merit-based nature of the system.
Reform of Pillar I	2022	The retirement age is once again linked to life expectancy. Mothers can reduce their retirement age by 6 months for each child (maximum of 3 children).	Reduces the number of years during which the state pays pensions.
		Slowing down the growth of the pension point value (95% growth in average wages).	Slows the growth of expenditure.
Reform of Pillar II	2022	A default investment strategy (DIS) has been introduced. Savings are invested according to age – younger savers have a more dynamic portfolio, while older savers have a safer one.	More dynamic investing by younger savers has the potential to ease pressure on Pillar I in the long term.
		After retirement, savings are divided into two parts – 60% is gradually paid out from secure funds, and the rest is invested and later used to purchase a life annuity.	Combines gradual payouts with a life annuity, which better spreads the financial burden over time.
		Mandatory entry into Pillar II for new workers under the age of 40 from May 1, 2023, with the option to opt-out within two years.	Expands the base of savers and ensures a continuous inflow of funds into Pillar II, helping to ease the burden on Pillar I.

Source: IFP MF SR, processed by SAO SR.

Forthcoming reforms or mechanisms to improve the sustainability of the pension system

Are there automatic mechanisms in place in the pension system to ensure its actuarial sustainability?

a Linking the retirement age to life expectancy (from 2022)

The retirement age for individuals born in 1967 and later is automatically determined based on the median life expectancy over seven five-year periods. At the same time, the retirement age is set six years in advance, which enhances the predictability of the system. This mechanism ensures that the retirement age evolves in line with demographic changes, thereby contributing to the financial sustainability of the system.

b Inflation-linked indexation mechanism for pensioners (from 2018)

Pensions are increased annually based on pensioner inflation without the need for political intervention. Additionally, from 2023, an extraordinary indexation will be introduced: if pensioner inflation exceeds 5%, the indexation will automatically take place within three months.

c Reduction in the rate of growth of the pension point value (from 2023)

The value of the pension point, which is used to calculate newly granted pensions, will now increase by only 95% of the growth in the average wage, rather than 100% as before. This mechanism dampens the growth of new pensions, thereby slowing or reducing expenditure in the long term.

Are the reforms sufficient or are further actions needed?

The evaluation of pension systems in terms of sustainability, adequacy, and basic conditions is based on the Allianz Pension Index (API)[13] methodology, which reflects the assessment status of countries as of 2025. This index evaluates countries based on three main pillars – Basic Conditions, Sustainability, and Adequacy – each of which is further divided into sub-categories (Table 15).

Table 15: Structure and weighting of the Allianz Pension Index

Pillar	Categories	Types of indicators
Basic conditions (20%)	Living standards (40%)	Overall level of well-being (50%)
		Access to healthcare (30%)
		Level of societal progress (20%)
	Finance and demographics (60%)	Debt, GDP (40%)
		Demographic trends (60%)
Sustainability (40%)	Assumptions (60%)	Retirement age (80%)
		Minimum contribution period (20%)
	Finances (40%)	Financing method of the system (70%)
		Pension calculation methodology (30%)

13 [link]

Pillar	Categories	Types of indicators
Adequacy (40%)	First pillar (50%)	Level of coverage (70%)
		Benefit amount (30%)
	Other pension income (50%)	Second pillar (20%)
		Financial assets (70%)
		Income from work in retirement (10%)

Source: Allianz; processed by SAO SR.

The categories comprise a total of 40 measurable indicators. Each indicator is assessed on a scale from 1 (no need for reform) to 7 (high need for reform).

The API results indicate that Slovak Republic faces several challenges that require further reform measures or the deepening of existing reforms (Table 16). According to the overall API score, the Slovak pension system shows a moderate to medium need for further reforms. The Basic Conditions pillar indicates that external factors – the standard of living of the population and the financial and demographic situation – place relatively high demands on the system already in its initial configuration. Moreover, the Sustainability pillar highlights that, despite the existence of basic mechanisms adapting to demographic changes, the system's financial instruments need to be strengthened to respond more flexibly without frequent legislative intervention. In the Adequacy of Benefits pillar, it is clear that the state first pillar provides only a basic level of protection with limited coverage. Although additional sources of pension income provide significant support, their scope is not yet sufficient to fully compensate for the weaknesses of the public system.

Table 16: Allianz Pension Index results – Slovak Republic

API		
3.5		
Basic conditions	Living standards	Finance and demographics
4.6	4.3	4.8
Sustainability	Assumptions	Finances
3.4	2.9	4.3
Adequacy	First pillar	Other pension income
3.0	2.6	3.4

Source: Allianz; processed by SAO SR.

Israel

The Pension System in Israel - Structural Overview, Fiscal Stability, and Demographic Challenges

Description of the Pension System in Israel

Relevant Government Bodies and Their Responsibilities

Several key government bodies are involved in the management and supervision of the pension system in Israel:

The Capital Market, Insurance and Savings Authority: Charged with the supervision and regulation of occupational pensions and private savings, as well as ensuring the stability of private pension funds and safeguarding the interests of savers.

The Budget Division of the Ministry of Finance: This division is responsible for the operations of the headquarters tasked with formulating long-term fiscal policy and implementing structural reforms.

The National Insurance Institute (NII): Administers the old-age pension and survivors' pension, which constitute approximately one-third of its expenditures. The NII's remaining expenditures include disability pension, long-term care benefit, child allowance, maternity allowance, work disability pension, and income support benefit, among others.

Bank of Israel: Among its functions, the Bank of Israel supports the stability of the financial system, within which private pension funds represent a significant component. Additionally, the Bank undertakes research that addresses, inter alia, the stability and risk assessment of the financial system.

Pension Pillars

The Israeli pension system is structured upon a three-pillars framework:

First Tier (Universal Social Security): The first pillar of the pension system encompasses old-age and survivor's benefits. In accordance with the National Insurance Law, 1995[1] (the National Insurance Law), the administration of this pillar is the responsibility of the National Insurance Institute and it is financed through ongoing funding based on a Pay-As-You-Go model. Specifically, old-age and survivor's benefits are funded by insurance premiums derived from the current income of active employees and employers, rather than from pre-accumulated designated savings. This tier is designed to be progressive, with insurance premiums increasing concomitantly with income, and universal, in that all citizens are entitled irrespective of their income levels. The objective of this pillar is to ensure a basic standard of living for all citizens regardless of their employment history.

As of 2026, the basic old-age pension amounted to ILS 1,838 per month[2]. Additionally, a seniority supplement of 2% is granted for each year of insurance coverage, up to a maximum supplement of 50% (ILS 2,757)[3]. For retirees whose post-retirement monthly income falls below ILS 4,375, the NII disburses an "income supplement" pension which supplements the old-age pension up to this threshold[4], thereby guaranteeing a basic standard of living.

The Retirement Age Law, 2004, delineates the retirement age as the age at which an individual is entitled to retire from employment and to receive benefits contingent upon satisfaction of conditions prescribed by law or agreement. As of 2026, the retirement age is 67 for men, whereas for women it varies from 63 to 64 due to a legislated gradual increase, projected to reach 65 by 2032. Furthermore, the legislation defines the mandatory retirement age as the age at which an employee can be compelled to retire. This mandatory retirement age is set at 67 for both men and women as of 2026.

The National Insurance Law predicates eligibility for the senior citizen's pension upon the statutory retirement ages. From the point of retirement age, seniors are entitled to receive a pension subject to income testing; however, from age 70, recognized as the age of absolute entitlement for both women and men, pension receipt is granted without income testing and irrespective of retirement status.

The following figure provides an international comparison of public expenditure on pensions as a percentage of gross domestic product (GDP).

1 Chapter 11.
2 National Insurance, benefit amounts according to family status, 2026 **[link]**.
3 National Insurance, Supplements to Senior Citizen's Pension, 2026 **[link]**.
4 National Insurance, Senior Citizen Pension Amounts with Income Supplement, 2026 **[link]**.

Figure 1: Public Spending on Old-Age and Survivors' Pensions as a Percentage of GDP: International Comparison, by country, 2020 (In Percentages)

According to data provided by the OECD and processed by the Office of the State Comptroller.[5]

The figure indicates that public expenditure in Israel on old-age and survivors' benefits is lower than that of 33 out of 41 OECD countries. Furthermore, in 2020, this expenditure constituted approximately 5.8% of GDP; this rate of public spending in Israel on old-age and survivors' benefits is markedly lower than the average among OECD countries, which is approximately 9%.

Despite this lower level of expenditure, the National Insurance Institute faces an actuarial deficit (as detailed below), and its reserves are projected to be depleted by 2035[6] unless additional structural reforms are implemented, such as adjustments to the retirement age or insurance premium rates. This deficit arises, among other factors, from the relaxation of eligibility criteria for benefits including disability and long-term care, without the identification of appropriate funding mechanisms[7].

5 Pension spending 2020 OECD **[link]**.
6 National Insurance, Actuarial Report (2023).
7 The State Comptroller, Long-Term Care Insurance System in Israel (2026), State Comptroller, Financial Statements of the State of Israel as of December 31, 2019 – Long-Term Liabilities of the State (2021) **[link]**.

Second Pillar (Occupational Pension): Pursuant to an expansion order of a collective wage agreement[8] and the Economic Efficiency Law[9], all salaried employees and their employers (since 2008), as well as self-employed workers (since 2017)[10], are required to allocate funds for retirement purposes. This tier functions through defined contributions, indicating that the pension benefit depends on the accumulated provisions and the yield generated by the pension fund (accrual pension). In Israel, pension funds are administered by private companies competing within the capital market[11], primarily investing in bonds and equities[12]. The contribution rate for employees is 12.5% of total salary: 6% contributed by the employee and the remaining 6.5% by the employer. For self-employed individuals, the contribution rate ranges between 4.45% and 12.55%[13].

Yield and Composition of Pension Funds

As previously noted, the second pillar of the pension system comprises mandatory private savings. This pillar includes two principal types: comprehensive pension funds and general pension funds, which collectively constitute the majority of occupational pension savings.

A comprehensive pension fund encompasses two components: long-term savings and collective insurance coverage (for disability and survivors). The fund primarily invests in the capital market. Given that the comprehensive fund provides a subsidized return[14] and collective insurance coverage, it is subject to a legal cap on both the insured salary amount and the monthly deposit[15]. At the same time, a general pension fund operates concurrently. Deposits exceeding the cap in a comprehensive pension fund are automatically transferred to a general pension fund, also referred to as a supplementary pension.

The following table presents the annual returns of comprehensive and general pension funds for the years 2019 to 2024[16].

8 The Expansion Order for Comprehensive Pension Insurance in the Economy, January 1, 2008 **[link]**.
9 The Economic Efficiency Law (Legislative Amendments to Achieve Budget Goals for Budget Years 2017 and 2018), 2016-2017 **[link]**.
10 The Ministry of Finance, Mandatory Pension for the Self-Employed (2019).
11 OECD, Pensions at a Glance 2025, table 3.1.
12 OECD, Pensions at a Glance 2025, figure 9.3.
13 For the part of the income, calculated up to half of the average wage in the economy, 4.45% must be deposited. For income above half of the wage and up to the average wage in the economy, 12.55% must be deposited. For the part of the income above the average wage – there is no obligation to contribute to retirement.
14 In the past, part of savers' pension funds was invested in designated bonds issued by the state, which guaranteed a fixed and stable return (approximately 4.86% real). Since 2022, new deposits are no longer directed to designated bonds, and instead the state provides a return guarantee mechanism, which guarantees a minimum return on a portion of the savings.
15 As of 2026, the monthly deposit cap for a comprehensive pension fund is NIS 5,645. This amount is calculated as 20.5% of twice the average wage in the economy, as defined by the National Insurance Institute (NIS 13,769 × 2 × 20.5% = NIS 5,645). Deposits exceeding this cap are generally transferred to a general pension fund.
16 The Capital Market, Insurance and Savings Authority, Quantitative Data in the Field of Pension Savings (2024).

Table 1: Annual Returns of Pension Funds, by type and year, in percentages (2019-2024)

Saving Instrument	Nominal Return 2019	Nominal Return 2020	Nominal Return 2021	Nominal Return 2022	Nominal Return 2023	Nominal Return 2024	Avg. Annual Nominal Return	Avg. Annual Real Return
Comprehensive Pension Funds	▲ 11.9%	▲ 5.4%	▲ 15%	▼ -3.5%	▲ 9.9%	▲ 13.8%	▲ 8.75%	▲ 4.08%
General Pension Funds	▲ 12.9%	▲ 4.5%	▲ 13.2%	▼ -9%	▲ 9.8%	▲ 14.7%	▲ 7.7%	▲ 2.94%

Source: Capital Markets, Insurance and Savings Authority.

The data presented in the table indicate that, in Israel, with the exception of the year 2022, both real and nominal returns were positive in all years across comprehensive funds (average real return of 4.08% and average nominal return of 8.75%) and general pension funds (average real return of 2.94% and average nominal return of 7.7%).

Types of Pensions – Budgetary Pension and Accrual Pension

Budgetary Pension in Israel: This is a defined benefit pension scheme, financed directly from the state budget and primarily granted to veteran employees within the public sector, notably civil servants and members of security forces. Under this scheme, the pension amount is determined based on the number of years of service and the employee's final salary, and is disbursed to the retired employee directly by the employer. Employees covered by this pension arrangement are required to contribute 2% of their salary.

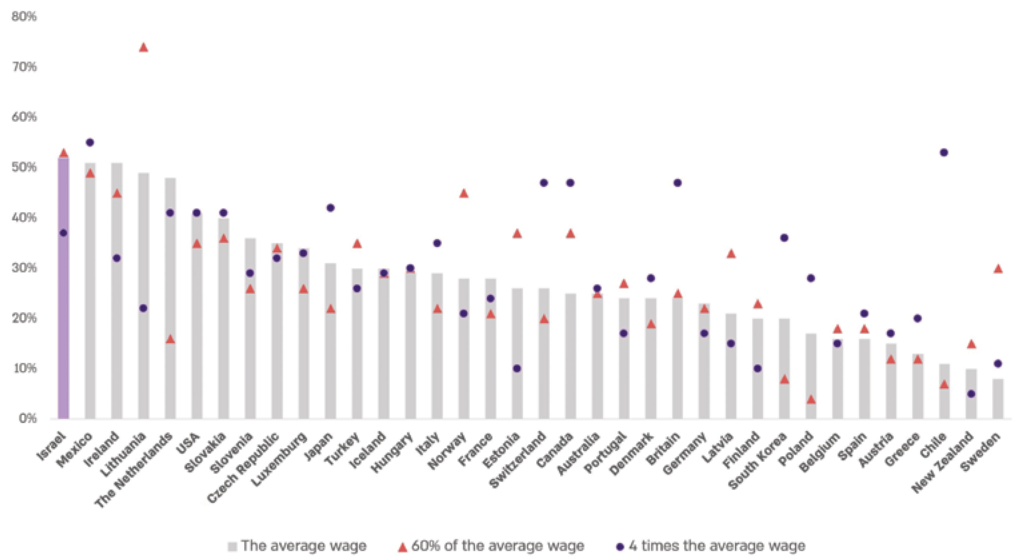
Accrual Pension: This scheme involves the employee contributing a portion of their salary to a pension fund, from which pension payments are made upon retirement.

In 1999, the Israeli government entered into a collective agreement with public sector unions which mandated a transition from a budgetary pension arrangement to an accrual pension arrangement. Employees employed in the public sector prior to the agreement continued to be covered under the budgetary pension scheme, whereas new entrants were incorporated into the accrual pension framework. This transition relieved the state budget of actuarial pension liabilities and aligned the public sector pension arrangement more closely with that of the private sector. The total financial obligations of the state budget relating to the budgetary pension are estimated to be approximately ILS 753 billion as of the end of 2024.

Tax Incentives and Benefits

Pursuant to the Income Tax Ordinance, tax benefits for pension savings in Israel are conferred in three stages across the pension lifecycle: partial exemption from income tax and national insurance contributions at the contribution stage; full exemption from capital gains tax during the accrual phase; and partial exemption from income tax alongside full exemption from national insurance contributions at the pension withdrawal stage. As of 2024, the annual scope of pension-related tax benefits is estimated at approximately ILS 34 billion. The following figure provides an international comparison of tax benefits associated with pension savings.

Figure 2: International Comparison of the Present Value of Lifetime Tax Savings from Retirement Savings by Workers at Different Earnings Levels Relative to the Present Value of Total Savings, by country, 2024 (in percentages)

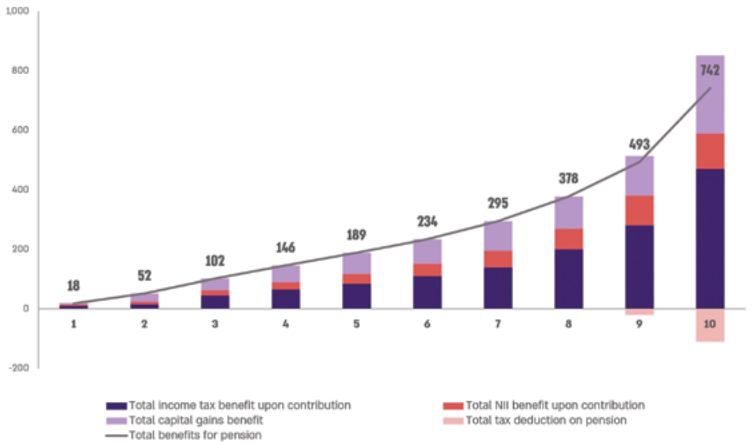


According to the Ministry of Finance data, processed by the Office of the State Comptroller.

The figure illustrates that Israel ranks first among OECD countries in terms of the value of pension tax benefits relative to provisions for average wage earners, with tax savings exceeding 50% of total provisions. For high wage earners (earning four times the average wage), Israel ranks tenth, with savings of approximately 38%, and for low wage earners (60% of the average wage), it ranks second.

The figure below depicts the distribution of tax benefits across income deciles.

Figure 3: Total Capitalized Pension Benefit Over a Lifetime (in thousand ILS, by deciles)



According to the Ministry of Finance data, Chief Economist Division[17], processed by the Office of the State Comptroller.

The data presented in the figure indicate that the distribution of all categories of tax benefits exhibits a regressive pattern relative to income. The current value of tax benefits[18] allocated to individuals within the highest income decile is approximately four times greater than those granted to individuals at the median income level and nearly forty times greater than those accorded to individuals in the lowest decile (ILS 742,000 in the top decile compared to ILS 189,000 in the fifth decile and ILS 18,000 in the first decile).

Option for Employment Concurrently with Receipt of Pension

Employment concurrent with receipt of a non-retirement old-age pension is permitted; however, pursuant to the National Insurance Law[19], if the pensioner's monthly employment income exceeds NIS 10,113, the old-age pension (first pillar) may be subject to reduction provided the pension recipient has not yet attained the full eligibility age of 70 years. Pension disbursements from the second pillar (mandatory pension savings) remain unaffected by continued employment. It is noteworthy that, based on data from the Central Bureau of Statistics (CBS), approximately 28.4% of individuals aged 67 to 74 participated in the labor market in 2025[20].

17 Ministry of Finance, Chief Economist Division, On the Tax Benefit for Pension Savings in Israel, Policy Analysis (2024).
18 The figure refers to the present value of tax benefits accumulated over the lifetime.
19 The National Insurance Law [Consolidated Version], 1995, Chapter 11, Title C, Section 245.
20 According to CBS data – Monitoring Government Employment Targets [link].

Pension Eligibility – Conditions for Receipt

The table below delineates the eligibility criteria for pension receipt in the first and second pillars.

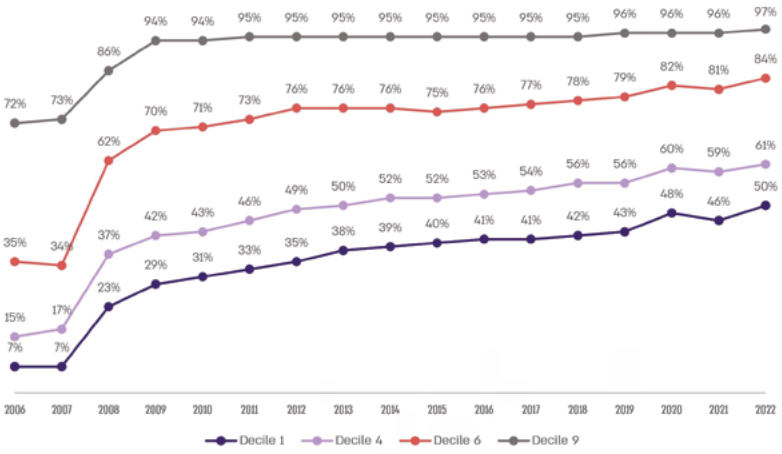
Table 2: Conditions for Receipt of Pension Benefits in the First and Second pillars

Tier	Conditions for Receiving a Pension
First Pillar	Minimum age condition: From age 67 for men and from age 62 for women (gradually increasing to 65 from 2022), individuals may receive the old-age pension subject to an income test. From age 70, pension provision is unconditional with respect to income. Minimum qualifying period: A minimum insurance period of 144 months. Or a cumulative insurance period of 60 months within the 10 years preceding the insured person's attainment of the eligible retirement age.
Second Pillar	Minimum age condition: Contingent upon employer consent and specific conditions, early retirement is possible from age 60, allowing access to some pension tax benefits.

Population Participation – Pension Coverage Rate

The figure below presents the proportion of employment positions with pension provisions corresponding to income deciles 1, 4, 6, and 9 for the period 2006–2022.

Figure 4: Percentage of Jobs with Pension Provisions, by Salary Decile, 2006-2022 (in percentages, by salary decile)



Source: Mandatory Pension in Israel: Partial Revolution and Proposals for Improvement (2025)[21]; CBS data, processed by the Office of the State Comptroller.

21 Mandatory Pension in Israel: From a Partial Revolution and Suggestions for Improvement, Spivak, Tur Sinai and Menahem Carmi (2025).

The figure demonstrates that the proportion of jobs from which pension contributions are made has increased across all salary deciles over the years. For example, in the first decile, it rose from 7% in 2006 to 50% in 2022. As of 2022, this rate ranges from approximately 50% within the lowest income decile to around 97% in the ninth decile. Additionally, the data indicate a positive correlation between salary decile and pension coverage rate[22].

Information and Data on the Pension System in Israel

Total Assets in Pension Funds

As of the end of 2024, total pension assets within the second pillar in Israel amounted to approximately ILS 1.4 trillion[23]. For comparative purposes, approximately a decade earlier, in 2015, pension fund assets amounted to only approximately ILS 0.6 trillion[24]. This represents a nominal increase of approximately 130%.

Replacement Rates

The replacement rate is defined as the rate between income after reaching retirement age and income prior to retirement – that is, what share of a person's income will remain available to them after retirement.

As noted, the retirement age in Israel is 67 for men and 62 for women. Life expectancy in Israel is 81.7 years for men and 85.7 years for women. However, according to the Capital Market Authority, there is no significant gap in pension saving duration between men and women, since women may continue contributing to pension savings even after reaching retirement age, and because women are required to begin contributing to a pension fund from age 20, whereas men are required to begin from age 21. Nevertheless, since women live longer on average, their pension savings are required to last for a longer period of time[25]. According to data from the Capital Market Authority, the most significant factor in this regard is the level of insured wages, from which women's pension contributions are derived, which remains lower for women than for men across the entire range: as of early 2025, the average male salary was approximately 54% higher than the female average – ILS 18,441 compared to ILS 11,940, respectively[26].

The figure below depicts the differences in replacement rates between men and women in Israel relative to the OECD average, across income levels categorized as low (half of average income), average, and high (double the average income)[27], in 2025.

22 One reason for this is that, by law, the obligation to contribute to a pension for an employee without prior insurance only begins after six months of seniority in the position.

23 Capital Market Authority, Quantitative Data in the Pension Sector (2024), p. 44.

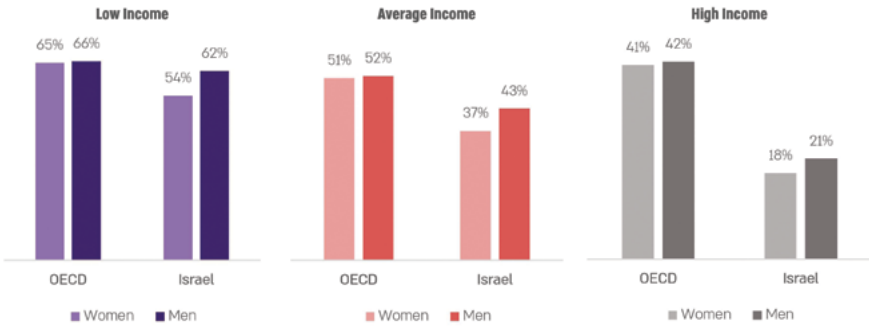
24 Capital Market Authority, Quantitative Data Capital Market, Insurance and Savings Division for 2015, p. 26

25 This is because the annuity conversion coefficient, which determines the level of pension income, is affected by the expected duration over which the pension will be paid; the longer the expected payment period, the lower the periodic payment.

26 The full National Insurance Salary Report for the First Half of 2025.

27 The replacement rate in the figure includes the pension amount resulting from the mandatory pension only (first and second tier) and does not include voluntary savings (third tier).

Figure 5: Replacement Rates in Israel and the OECD Average, by gender and income level, 2025 (in Percentages)



According to OECD data, processed by the Office of the State Comptroller[28].

The figure illustrates that replacement rates among men exceed those of women across all income levels in both Israel and, on average, OECD countries. In Israel, replacement rates are also lower than the OECD average, and gender disparities are more pronounced across all income brackets. For instance, at the average income level, the difference between men and women in Israel is six percentage points (43% for men compared to 37% for women), whereas the gap is only one percentage point in the OECD average (52% for men compared to 51% for women).

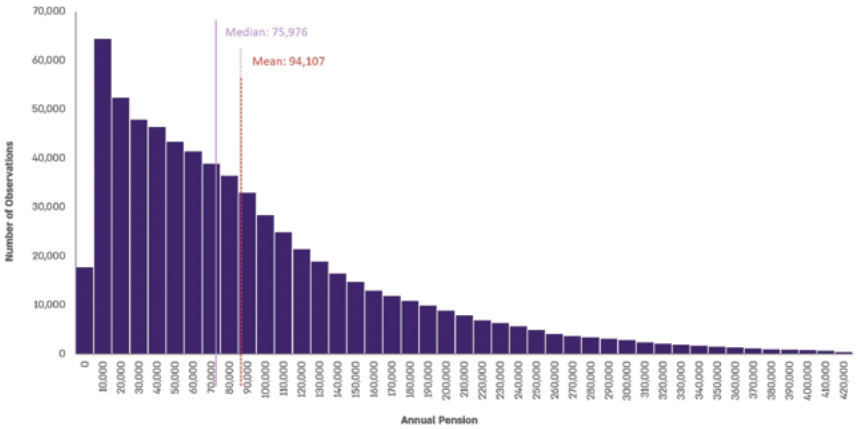
These data indicate that retirees in Israel experience a substantial reduction in post-retirement income. This reduction is more acute among women than men and is more pronounced than the income decline experienced by retirees on average in OECD countries.

Annual Pension Amount

The following figure presents the distribution of annual pension amounts among pension recipients in Israel in 2024. This distribution illustrates the dispersion of payment amounts and the concentration of pension recipients within various income brackets. The figure further displays the average and median annual pension amounts[29].

28 OECD, Pensions at a Glance 2025, table 4.1.
29 For clarity of presentation, pension amounts in the top percentile were not included in the figure.

Figure 6: Distribution of Annual Pension Amounts in Israel, 2024 (in NIS)



According to National Insurance data, processed by the Office of the State Comptroller.

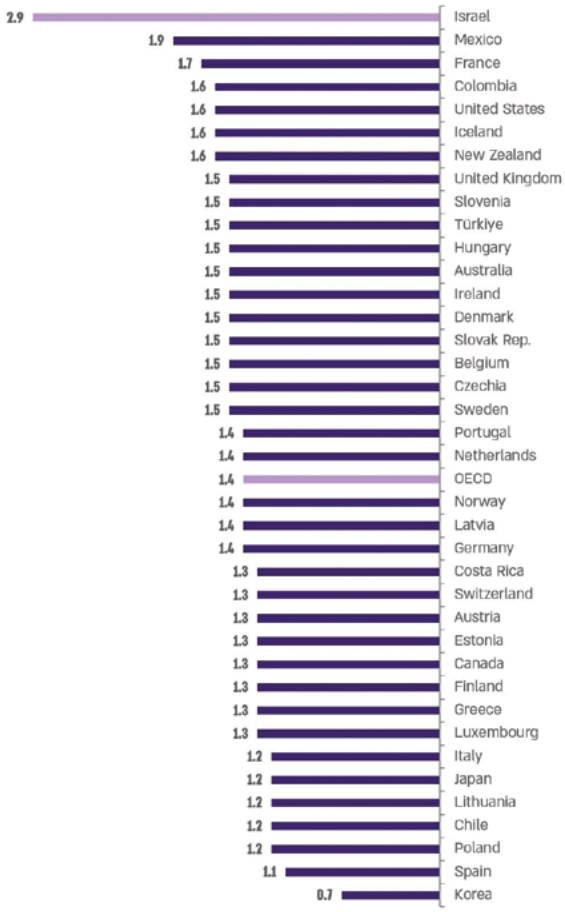
The figure shows that the most frequent pension amount range is between ILS 10,000 and ILS 20,000 annually, with approximately 65,000 pensioners receiving pensions within this range. Additionally, the average annual pension in Israel in 2024 is approximately ILS 94,000, while the median is slightly lower, at approximately ILS 76,000.

The Financial Stability of the Pension System

Indicators and Data

The fertility rate, defined as the average number of children per woman, functions as a key indicator of the stability of the pension system, particularly the first pillar, which operates under a pay-as-you-go model. A higher fertility rate corresponds to a greater number of workers contributing to the pension liabilities of each retiree, thereby enhancing the system's stability. The following figure presents the fertility rate in an international comparison.

Figure 7: Fertility Rates, International Comparison, 2023 (in percentages, by country)



According to OECD date, processed by the Office of the State Comptroller[30].

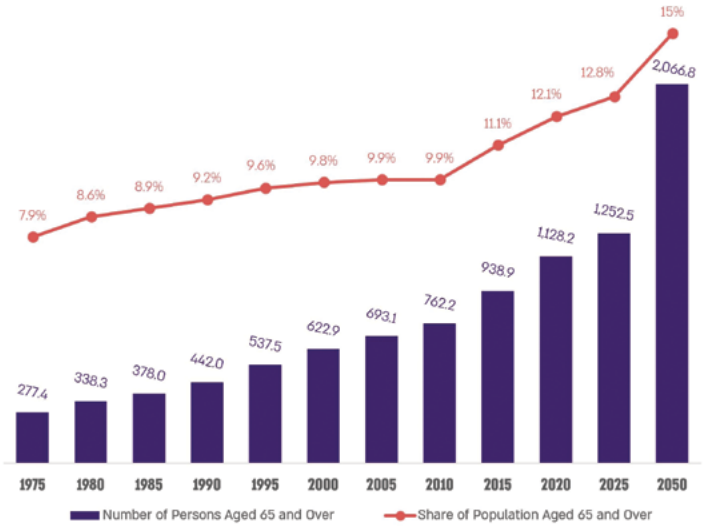
The data indicate that Israel's fertility rate is the highest among the countries compared, at 2.9, more than twice the average fertility rate of OECD countries.

Population Ageing

Despite elevated fertility rates, Israel's population is experiencing demographic ageing. Population ageing denotes an increasing proportion of individuals of retirement age within the total population, a condition that poses challenges to the stability of the first pillar. The following figure illustrates the increase both in the absolute number of elderly individuals and their relative share of the population during the period 1975-2025, alongside a projection through 2050.

30 OECD, Fertility rates, 2023.

Figure 8: Number of Elderly Persons in Israel and Their Proportion of the Population, by Year, 1975–2025, with a Forecast for 2050 (in absolute numbers and percentages)



According to Central Bureau of Statistics data, processed by the Office of the State Comptroller[31].

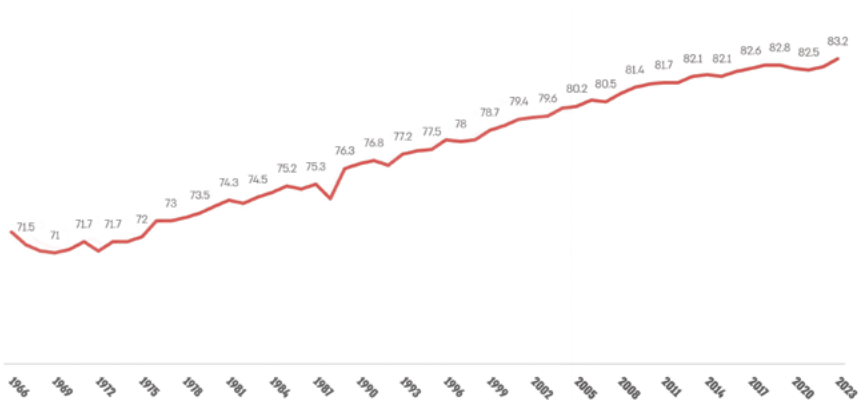
The figure indicates that as of 2025, individuals aged 65 and over constituted 12.8% of the total Israeli population. Current projections estimate this proportion will rise to approximately 15% by 2050, with the number of elderly persons expected to exceed two million.

Life Expectancy

Life expectancy in Israel has demonstrated a rising trend in recent decades. The following figure depicts changes in life expectancy from 1966 through 2023.

31 Myers Joint Brookdale, 65+ in Israel Statistical Yearbook 2024; Forecast from the Central Bureau of Statistics, National Indicators for Optimal Ageing in Israel, 2022 (November 2024).

Figure 9: Life Expectancy in Israel, by year, 1966-2023 (in years)



According to World Bank data, processed by the Office of the State Comptroller[32].

The figure indicates that in 2023, life expectancy in Israel reached 83.2 years.

This figure ranks among the highest within OECD countries, where the average life expectancy is 81.1 years[33]. This increased longevity contributes, inter alia, **to the demographic ageing phenomenon discussed above.**

Real Economic Growth

Real economic growth refers to an increase in the scale of economic activity within the economy, which is manifested through rising household incomes and thus enhanced pension accruals in the second pillar. Moreover, revenues for National Insurance are augmented, leading to an improved actuarial status. As of 2025, the Bank of Israel estimated real GDP growth at approximately 2.8%. Forecasts from the Bank of Israel anticipate[34] growth rates of approximately 3.8% in 2026 and around 5.5% in 2027[35].

32 Federal Reserve Bank, Life Expectancy at birth, Total for Israel, 2023 **[link]**.
33 OECD, Health at a Glance 2025, Life expectancy at birth **[link]**.
34 The Bank of Israel's forecast was issued against the backdrop of the effects of the war.
35 Bank of Israel, Research Division's Macroeconomic Forecast (2026).

Labor Market

The labor force participation rate represents the proportion of working-age individuals who are either employed or actively seeking employment. A higher participation rate corresponds to a larger number of wage earners, which consequently leads to an increased number of individuals making pension contributions and an improved financial status for these individuals upon retirement. As of January 2026, the labor force participation rate among individuals aged 25-64 was 81.5%, while the unemployment rate within this demographic was approximately 3%[36]. This participation rate exceeds the average rate observed in OECD countries, which stood at 69.9% in 2024[37].

Fund Stability

Pillar 1: National Insurance Stability

The stability of the first tier is fundamentally contingent upon the long-term actuarial soundness of the National Insurance system. In Israel, the National Insurance system is experiencing a significant actuarial imbalance stemming from increased expenditures, predominantly related to long-term care and disability benefits, while revenue growth has been insufficient to offset this trend. Current projections indicate that the NII's reserves are anticipated to be exhausted by 2035. Subsequent to this depletion, the state will be obligated to finance old-age pensions directly through the state budget, a requirement that poses a long-term risk to fiscal stability or, alternatively, necessitates a substantial reduction in pension amounts.

Pillar 2: Stability of Private Pension Funds

The stability of the second pillar is structured differently from that of the first pillar. This segment is actuarially stable, primarily due to its basis in defined contributions, which incorporate a conversion coefficient mechanism. The conversion coefficient determines the manner in which accumulated pension savings are transformed into monthly pension payments. This coefficient is periodically updated in accordance with changes in life expectancy and pension fund returns and is established separately for each pension fund.

36 Bank of Israel, Labor Market and Demography (2026).
37 OECD, Labour force participation rate, 2024 **[link]**.

The Pension System's Readiness for an Ageing Population

Reforms Implemented to Enhance Pension System Stability

Closing the old pension funds and transitioning to defined contribution arrangements: A government resolution[38] in 1995 mandated the closure of old pension funds to new entrants, replacing them with new pension funds featuring less favorable terms than those of the former funds. The new funds operate on a defined contribution model rather than the previously employed defined benefit system.

Nationalizing and regulating the old pension funds: In 2003, pursuant to the Israel's Economic Recovery Plan Law[39] and an amendment to the Control of Financial Services (Insurance) Law, 1981, the government nationalized deficit old pension funds, increased members' contribution rates, reduced pension entitlements of members and pensioners, and provided substantial governmental support to enable the funds to fulfill their obligations.

Implementing mandatory pension coverage for all employees: In 2008, the Expansion Order for Comprehensive Pension Insurance in the Economy[40] determined for the first time that all employees are entitled to a pension and that employers are obligated to allocate funds for their employees' pensions in accordance with contribution levels up to the economy's average wage.

Implementing mandatory pension coverage for the self-employed: In 2017, through the Economic Efficiency Law[41], pension contribution obligations were extended to include self-employed individuals.

Prospective Reforms and Mechanisms to Enhance the Pension System's Sustainability

Are there automatic mechanisms within the pension system that serve to ensure actuarial stability?

In Israel, the principal automatic mechanism that promotes actuarial stability is the conversion factor applied in second-pillar pension funds, which are based on defined contribution. This factor adjusts monthly pension payments according to changes in life expectancy, transferring longevity risk to the individual and thereby assisting in maintaining fund equilibrium over time.

The first pillar, which includes the National Insurance Institute's old-age benefits, does not include an automatic adjustment mechanism linking the retirement age to life expectancy or linking the system's revenues and expenditures. The absence of such a mechanism makes it more difficult to address the projected actuarial deficit and to prevent the depletion of the National Insurance Fund, which holds the financial reserves of the social insurance system[42].

38 Government Resolution 5156 (March 29, 1995) **[link]**.
39 Israel's Economic Recovery Plan Law (Legislative Amendments to Achieve Budget and Economic Policy Goals for Fiscal Years 2003 and 2004), 2003 **[link]**.
40 The Expansion Order for Comprehensive Pension Insurance in the Economy, January 1, 2008 **[link]**.
41 The Economic Efficiency Law (Legislative Amendments to Achieve Budget Goals for Budget Years 2017 and 2018), 2016-2017 **[link]**.
42 The State Comptroller, Report on Long-Term Care Insurance System in Israel (2026) **[link]**. See also: State Comptroller, Financial Statements of the State of Israel as of December 31, 2019 – Long-Term Liabilities of the State (2021).

Are the reforms that have passed (section 3.1) sufficient or are additional reforms needed?

Although the aggregate effect of recent reforms has substantially fortified the resilience of the Israeli pension system and expanded its coverage, these measures remain insufficient to guarantee long-term actuarial and fiscal stability. The system continues to confront significant pressure due to demographic shifts within Israel and the fiscal demands associated with the first pension pillar and the budgetary pensions. Therefore, further reforms are essential to stabilize the Israeli pension system:

Raising the retirement age for women

Over the years, numerous public committees have recommended raising the retirement age for women[43], and some of the committees that examined the issue (the Netanyahu and Nisan Committees) recommended increasing it to 67 and equalizing it with the retirement age for men[44]. Following the recommendations of these committees, the retirement age for women was gradually raised by legislation, to 65.

Automatic balancing mechanisms to uphold the financial stability of the National Insurance system

The National Insurance Law does not include automatic balancing mechanisms linking the retirement age to life expectancy, nor mechanisms requiring an increase in National Insurance contributions or a reduction in benefit expenditures whenever the institution enters an actuarial deficit. Such mechanisms were recommended by a public committee that examined this issue in 2012 (the Dominissini Committee[45]).

Summary

In recent decades, the Israeli pension system has experienced considerable structural reforms that have enhanced the extent of pension coverage and mitigated fiscal risks for the state, primarily through the adoption of a funded pension model and the extension of the deposit obligation to encompass all employees and the self-employed. Nevertheless, the system remains confronted with substantial challenges, chiefly the NII's actuarial deficit (first pillar), population ageing, increased life expectancy, and gender disparities. These challenges underscore the necessity for continued implementation of structural reforms, including the adjustment of the retirement age and the reinforcement of automatic balancing mechanisms, to ensure the long-term sustainability of the system and its capacity to provide an adequate standard of living for retirees.

43 This was stated, for example, in the conclusions of the Netanyahu Committee, the Nissan Committee, the Brodt Committee, and the Public Committee to Examine the Retirement Age.

44 State Comptroller, Pension Arrangements in the State, Special Audit Report (2016) **[link]**.

45 Conclusions of the committee examining ways to maintain the financial soundness of the National Insurance Institute in the long term **[link]**.

Summary

The stability of the pension system constitutes a fundamental tier of social security and economic stability within any contemporary society, as it is intended to ensure financial support and a dignified existence for individuals upon the conclusion of their active working lives. Presently, the instability of these systems poses significant concerns for numerous countries, attributable to accelerated population ageing and the deterioration of the ratio between the number of contributors to the system and the retirees it supports; these trends generate fiscal pressures and pose substantive risks to the long-term sustainability of the pension system.

Pension systems across various nations commonly comprise three pillars: the first pillar, designed to provide a basic social safety net for all citizens and financed through the pay-as-you-go (PAYG) method; the second pillar, based on mandatory personal occupational savings; and the third pillar, which encompasses voluntary savings.

The pay-as-you-go financing mechanism inherent in the first pillar engenders actuarial stability challenges when anticipated liabilities surpass projected tax revenues. In the second pillar, issues of stability arise when there is a mismatch between the pension provisions accumulated during the working years and the total pension disbursements throughout the retirement period.

To mitigate instability concerns within the first and second pillars, it is critical to implement automatic balancing mechanisms across all levels of the system. Examples include linking retirement age to life expectancy, as executed in Slovak Republic; updating conversion coefficients employed in the second pillar, as practiced in Israel; and adopting automatic pension adjustment mechanisms, as implemented in North Macedonia. Such strategies facilitate the dynamic adjustment of the system in response to demographic and economic fluctuations, obviating the necessity for frequent political intervention.

The table below presents a comparative analysis of the countries discussed in this chapter, with respect to a selection of key indicators:

Table 1: Comparison of Key Indicators in the Pension System Among Different Countries

	Slovak Republic	North Macedonia	Israel
Are there incentives and tax breaks for retirement savings?	Yes	No	Yes
Are there balancing mechanisms for the pension system?	Yes	Yes	Yes
Is there a stability problem in the first pension pillar?	Yes	Yes	Yes
Is there a stability problem in the second pension pillar?	No	No	No
Have significant reforms been implemented in recent years to stabilize the pension system?	Yes	Yes	Yes

The table indicates that despite the presence of balancing mechanisms[1], the pension systems within the first pillar in the three countries exhibit issues concerning stability. Additionally, it is evident that these countries have undertaken significant reforms in recent years aimed at stabilizing their pension systems. These reforms are typified by a transition to a three-pillar structure that integrates a government social component with a capital-based personal savings pillar, with objectives including the alleviation of fiscal pressure on the state budget, bringing up the retirement age and its linkage to demographic data, and the implementation of automatic balancing mechanisms.

The following table provides a synthesis of best practices relative to key risks as identified in the pension systems of Israel, North Macedonia, and Slovak Republic, as presented in each country's respective reports:

1 In some countries, balancing mechanisms exist only at the second pillar.

Table 2: Best practices and Key Risks in the Pension Systems of North Macedonia, Slovak Republic, and Israel

	Slovak Republic	North Macedonia	Israel
Best Practices	Automatic adjustment of retirement age to life expectancy Age-adjusted investment - which resulted in the exposure to stocks depending on the saver's age, in the second pillar of the pension	Establishing the Swiss adjustment model – which led to the adjustment of pensions to inflation and the increase in average wages Creating a three-pillar structure – which led to a clear separation between the various pension pillars	Establishing a conversion factor mechanism - a mechanism that led to an actuarial balance of the second pillar Imposing a pension savings obligation - led to a significant increase in the scope of savings
Key Risks	Demographic risks – a high dependency ratio projected to exceed 100% by 2060 Insufficient or minimal tax incentives to encourage retirement savings	A demographic crisis and negative migration – declining fertility rates and negative migration of young people Dependence on the state budget – a deficit in the first pillar requiring government budget transfers	An actuarial deficit resulting from rising expenditure on benefits, inter alia due to population ageing, and the depletion of National Insurance reserves. A regressive tax incentive system

The table demonstrates that the three countries are actively engaged in efforts to enhance pension coverage and fortify pension system stability. Nevertheless, fiscal and actuarial stability remain unattained in all three cases, thereby exposing the systems to potential vulnerabilities.

Long-term pension system stability is indispensable for ensuring economic security among the elderly population and for maintaining national fiscal stability; failure within pension systems can adversely affect retirees' living standards and impose substantial burdens on public finances. Given the complexity of pension systems and the significant influence of demographic and economic variables, it is crucial to derive insights from successful practices in other countries while tailoring these approaches to local conditions. Early identification of risks and challenges, including population ageing and actuarial imbalances, facilitates the implementation of preventive measures and the establishment of appropriate mechanisms.

Analyses of various national reports reveal that pension systems have undergone several major reforms over recent decades, contributing to enhanced stability and broader pension coverage. Nonetheless, full pension system stability remains an unachieved goal, leaving these systems susceptible to long-term risks associated with demographic ageing.

It is advised that pension policymakers across different countries leverage the knowledge and experience accumulated internationally to inform policy formulation. Such an approach will enable the adaptation of strategies to the specific demographic and economic contexts of each locale, thereby strengthening the pension system's capacity to address future challenges effectively and sustainably.

General Summary

General Summary

Population ageing, driven by increasing life expectancy and declining birth rates, is one of the most significant demographic transformations of the 21st century. While a longer and healthier life is a remarkable achievement, it presents profound challenges to the financial, social, and institutional sustainability of public systems worldwide. The number of people aged 65 in the world and over is projected to double in the coming decades, with the most rapid increases occurring in developing countries[1].

To address this, the Office of the State Comptroller and Ombudsman of Israel initiated an international parallel audit in November 2024, involving eight other Supreme Audit Institutions: Albania's Supreme Audit Institution, the National Audit Office of Lithuania, Malta's National Audit Office, the State Audit Office of the Republic of North Macedonia, the Controller General of the Republic of Paraguay, the Supreme Audit Office of Poland, Portugal's Court of Auditors, and the Supreme Audit Office of the Slovak Republic, to examine government preparedness for an ageing population.

The findings of this joint audit reveal a significant gap between declarative national policies and their actual, effective implementation. Comprehensive plans often lack approved action plans, measurable goals, or clear designations of responsibility, leading to fragmented implementation, duplication of efforts, and an inability to coherently address the multidimensional needs of the elderly. This implementation gap is evident in community-based health services, which are hampered by non-specific budgeting and human resource shortages among caregivers. Furthermore, despite strategic commitments, the transition from institutional to community-based care remains notably slow. In the welfare sector, there is a consistent discrepancy between acknowledging loneliness as a significant issue and the lack of proactive national mechanisms to identify and support lonely senior citizens, while post-retirement employment measures generally appear insufficient to significantly enhance participation. In the pension sector, despite ongoing reforms, long-term fiscal and actuarial stability remains unattained, leaving systems vulnerable to demographic risks like high dependency ratios and declining fertility rates.

To secure a sustainable future, the audit highlights three key recommended actions integrated into a cohesive approach. First, governments must transition from declarative policies to actionable, well-funded national strategies backed by strong coordinating bodies with the authority to enforce cooperation. Second, they need to strengthen data-driven planning and actively address workforce shortages by adapting training and employment models in community health and social care. Third, governments should implement proactive risk management and adaptive mechanisms, such as automatic balancing systems that link retirement age to life expectancy, to reduce the need for political intervention and strengthen the long-term stability of pension systems.

1 United Nations, World Population Prospects 2024 Summary of Results (2024), pp. 12, 22; World Health Organization, Ageing and Health (October 1st 2025) **[link]**

Despite these shared systemic challenges, the international parallel audit also revealed valuable good practices across the participating nations. For instance, Albania implemented digital improvements in employment processes alongside family tax breaks, while Israel established National Indicators of Optimal Ageing to measure the well-being of its senior citizens. Lithuania has adopted the Law on the Fundamentals of the Policy for Older People. whereas Malta boasts a wide array of well-developed home-based medical and clinical services. North Macedonia integrated measurable indicators and estimated costs directly into its National Development Strategy, Republic of Paraguay officially recognized family care as an essential pillar of social support, and Poland established a comprehensive national policy for seniors featuring economic incentives for post-retirement work. Additionally, Portugal prepared its active ageing action plan with direct contributions from academia, the social sector, and local municipalities, and the Slovak Republic successfully implemented an automatic adjustment of the retirement age linked to life expectancy.

Ultimately, this profound demographic transformation demands a systemic, holistic, and long-term approach to government preparedness across health, welfare, employment, and pension systems. Anticipating these future realities is vital to ensuring that longer lives are accompanied by better health, meaningful participation, and a high quality of life, safeguarding the dignity and well-being of older adults. Through their oversight, Supreme Audit Institutions can, both through local national reports and by engaging in collaborative audits such as this one, significantly support governments in developing these sustainable, evidence-based policies, ensuring that increased life expectancy translates into a positive and meaningful experience for older persons in the 21st century.

Read the full report

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