Annual National Report 2011

Pensions, Health Care and Long-term Care

Croatia

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1 Executive Summary

Croatia's economy was severely affected by the economic and financial crisis, whose outburst was mainly due to domestic economic structural weaknesses, rather than a consequence of global economic downturn. However, indicators in the third quarter 2010 suggest that recession has come to an end, with a modest GDP growth of 1.3 – 1.5% expected in 2011.

Key vulnerability of the Croatian economy is high external indebtedness. Much of the foreign debt is aimed at servicing already existing obligations, as well as covering current expenditures. Ongoing reforms in the field of pensions, health and long-term care are targeted at achieving long-term sustainability of the systems of social protection. Nevertheless, some of the implemented changes seem belated, and some necessary reforms are delayed even further.

Economic growth is a prerequisite for the functional, affordable and sustainable social protection schemes. The Government's response to the crisis was the adoption of the Economic Recovery Programme in April 2010, containing a set of measures which should be implemented in short, medium and long-term to revive the economy and labour market. One year into its applications, it is clear that the achievement of these goals is still not in sight. Negative effects of the crisis were mostly pronounced in the highly rigid labour market, with the average registered unemployment reaching 17.6% in 2010 and expected to deteriorate even further in 2011.

A number of legislative amendments in the pension system took place in 2010. Gradual equalisation of retirement age for men and women will take place by 2030; stricter financial sanctions are prescribed for early retirement, while later retirement is rewarded. However, prolongation of retirement age, solutions for keeping elderly workers at work, modalities for obtaining and financing of minimum and disability pensions, pension inequalities resulting from the differences between first and second pillars, as well as collection of contributions are just some of the issues which are still not appropriately addressed.

Health care reforms continue, followed by controversies and scandals. Public-private partnerships come under particular public scrutiny. The impact of on-going categorisation and accreditation of hospitals, as well as re-organisation of emergency health care is yet to be tested in practice. Recent legislative amendments open up the market for voluntary additional medical insurance to the Croatian Medical Insurance Institute (HZZO). Due to difficulties and delays encountered in the process of granting concessions in primary health care, the deadline for the completion of the process is pushed to the end of 2011. The amount of co-payments for services in primary health care is reduced.

Currently, LTC schemes boil down to two programmes: In-home assistance for the elderly and day care and in-home assistance for the elderly. As can be concluded from the draft Social Welfare Act, this will basically continue in the future. So far, this service has been provided without charges for the beneficiaries. The draft act leaves open the possibility of a certain type of participation in payment of such services, which will be performed by private providers. The state and the local communities have a share in the financing of the programmes. Long-term care rests mainly on public funding and organisation of the provision of services, while there are no incentives from the state for private insurance schemes, apart from limited incentives for saving within the voluntary pension insurance schemes. The traditional role of the family is accentuated. Although further promotion of non-institutional forms of care is more than welcomed, due consideration is yet to be given to the development and expansion of institutional capacities for those who really need them.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2010 until May 2011)

2.1 Overarching developments

The implication of the economic and financial crisis on pensions, health care and long-term care, as well as social protection policies in general, appears limited on the savings part, rather than effective rethinking of the policies as such. The prevailing opinion of the political leaders (the government, opposition, as well the President of the Republic) is that cutbacks of pensions and salaries, including other social expenses, could undermine the political stability of the state. Therefore, at least momentarily, there are no such attempts and cutbacks aimed at reducing budgetary expenses touch upon social expenses only to a limited extent. This means that only selected rights or payments within the various systems of social protection have been either temporarily suspended or abolished.

Croatia's economy was severely affected by the economic and financial crisis, whose outburst was mainly due to domestic economic structural weaknesses, rather than a consequence of global economic downturn. However, indicators in the third quarter 2010 suggest that recession has come to an end and GDP grew according to seasonally adjusted figures for the first time after more than two years.[1] A modest GDP growth of 1.3 – 1.5% is expected in 2011. Economic analysts identify growing unemployment and fiscal imbalance as major risks to economic recovery. In 2010, the fiscal deficit amounted to 4.7% of GDP, while external debt reached EUR 46 billion. External indebtedness is a key vulnerability of the economy.[2] Nevertheless, the government renounces any idea of IMF involvement at the moment.[3] Negative effects of the crisis were mostly pronounced in the highly rigid labour market. Average registered unemployment rate in 2010 was 17.6% and is expected to deteriorate even further in 2011 (to average 18.2% or 340 – 350,000 unemployed), with mild recovery starting only in 2012.[4]

Economic growth is a prerequisite for the functional, affordable and sustainable social protection schemes. Analysts agree that the approaching EU membership could boost the economy. EU accession negotiations have reached the final phase this year, 6 years after their commencement. The remaining five negotiations chapters (out of 35) are hoped to be closed by June (optimistic prognosis).

The Croatia 2010 Progress Report[5] notes a good level of alignment with the acquis in the field of social inclusion and social protection. Some progress in these fields is reported, however, it is highlighted that more efforts are needed to improve employment of older workers and protection of elderly without income. A low support ratio and the deficit of the public PAYG scheme are accurately identified as the areas of particular concern, especially given the economic crisis and slow recovery process. In the area of health care, a comprehensive reform

[1] Institute of Economics, Zagreb: Croatian Economic Outlook Quarterly (No. 45/January 2011), Summary, retrieved on 21 April 2011 from: http://www.eizg.hr/oporavak-ce-biti-spor-hr-HR/639.aspx.
[2] As noted also in the Communication from the Commission to the European Parliament and the Council, Enlargement Strategy and Main Challenges 2010-2011, Brussels, 9 November 2010 (COM(2010) 660).
[3] Newspaper article published in Novi list, 18 April 2011.
[4] The Institute of Economics, Zagreb: Croatian Economic Outlook Quarterly (No. 45/January 2011), Summary, op. cit.
[5] Croatia 2010 PROGRESS REPORT, SEC(2010) 1326, Brussels, 09 November 2010; Commission staff working document accompanying the Communication from the Commission to the European Parliament and the Council, Enlargement Strategy and Main Challenges 2010-2011(COM(2010) 660).

needs to continue, while the social benefits reform to improve targeting of social spending is yet to take place, with the adoption of the Social Welfare Act (unduly) delayed in 2010 (actually, the parliamentary proceedings for the adoption of the Social Welfare Act started only in the beginning of April, the draft act was adopted at the first reading in parliament and is expected to be forwarded to the second reading after adjustments[6]). Limited progress in the field of administrative and fiscal decentralisation of social services and a slow pace of the transition from institutional to community-based care were also detected.

While both national and international analysts and experts warn of the need for urgent remodelling towards achieving sustainable social protection schemes, especially in the field of pensions, the government refrained from applying severe austerity measures in the reported period. This is due to the fact that parliamentary elections are supposed to take place at the end of this year or at the beginning of 2012. The political parties of the opposition are also reluctant to express their position on further development of the social protection, leaving the debate to other actors, such as trade unions and scholars. It is quite clear that the weak economy will not be able to support the current package of rights within the social protection system and budgetary transfers committed for this purpose.

2.2 Pensions

2.2.1 The system's characteristics and reforms

The comprehensive reform of the pension system in Croatia started in 1998, with the introduction of the second and third pillar, whose application was postponed until 2002. Pension insurance covers the risks of old age, death and disability of the insured. The pension insurance system is regulated by the Pension Insurance Act,[7] the Act on Compulsory and Voluntary Pension Funds,[8] and the Act on Pension Insurance Companies and Pension Payments based on the Individual Capitalised Savings.[9]

It includes three insurance pillars:

1. Compulsory pension insurance based on generational solidarity – "PAYG" (pillar I)

2. Compulsory pension insurance based on individual savings (pillar II)

3. Voluntary pension insurance based on individual savings (pillar III).

As of 1 January 2002, all employed persons are placed into three categories within the new pension system:

a) Employees under the age of 40 have to be insured on two levels: within the system of compulsory pension insurance based on generational solidarity (pillar I), and within the system of compulsory pension insurance based on individual capitalised savings (pillar II).

b) Employees in the age group between 40 and 50 can choose to be insured only within the system of generational solidarity (pillar I), or they can choose to be insured on both pillar I and II (in that case they would have the same status as the category described under point a) -

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6 The Croatian Parliament, Draft Act 746 – Social Welfare Act, retrieved on 21 April 2011 from: http://www.sabor.hr/Default.aspx?art=38514.

7 Official Gazette of the Republic of Croatia, *Narodne novine* no.102/98, 127/00, 59/01, 109/01, 147/02, 30/04, 117/04, 92/05, 79/07, 35/08 and 121/10.

8 Official Gazette of the Republic of Croatia, *Narodne novine* no. 49/99, 63/00, 103/03, 177/04, 71/07 and 124/10.

9 Official Gazette of the Republic of Croatia, *Narodne novine* no. 106/99, 63/00, 107/07.

employees under the age of 40). The choice of the system is permanent and cannot be changed.

c) Employees above the age of 50 can be insured only within the system of pillar I, which is within the compulsory pension insurance system based on generational solidarity, and cannot be insured within the system of compulsory individual savings (pillar II).

All employees, regardless of their age, can be included in the voluntary pension insurance system based on individual savings (pillar III).

Apart from the beneficiaries who are entitled to pension under general provisions, there are 13 categories of so-called 'privileged pensioners', who stand to receive pension under privileged conditions based on their status.[10] The largest category are the war veterans from the Homeland War, but the one receiving the most public disapproval includes retired parliamentary representatives, due to their high pension amounts and relatively short service time.

Mixed *financing* (public and private) is evident through the pillar structure. The contribution rates are prescribed under the Act on Contributions[11] and the Ordinance on Contributions.[12] The rate of contribution for the insured persons within the first pillar (based on generational solidarity) is 20%. The rate of contribution for the insured persons both within the first and the second pillar is split: 15% in the first pillar and 5% in the second pillar. The basis for calculation is the wage or other earnings (in case of employed persons) or income (in case of self-employed or other categories of insured persons). The contribution is paid up from the basis for calculation.

Until the entry into force of the Act on Amendments to the Pension Insurance Act[13] (on 1 November 2010), the *retirement age* for old-age pension was 65 years for men and 60 years for women, provided that the person has been employed for 15 years (excluding disability and other factors). The full age pension may be paid regardless of a person's age where a citizen is able to demonstrate a period of employment totalling 45 years for men and 40 years for women. An early pension may be attained by men upon reaching 60 years of age and by women upon reaching 55 years, provided that the citizen has completed 35 years of employment. It should be noted that the 15 years of employment requirement is satisfied when, during the preceding 24 months, unemployment benefits were requested for at least twelve months during that period. The amendments provide for gradual equalisation of the retirement age between men and women by 2030.

The pension formula is the product of personal points (PP), pension factor (PF) and the actual pension value (APV): pension = PP x PF x APV. The pension factor is determined in accordance with the type of pension (1.00 in case of old-age, early retirement and disability pensions). The actual pension value is the determined amount of pension for one personal point. It is updated every six months at the rate which represents 50% of the rate of fluctuation of the average consumer price index and 50% of the rate of fluctuation of the average gross salary of all employees in the Republic of Croatia in the preceding half-year period compared to the six months before that (so-called "Swiss formula", i.e. 50% of the price increase and 50% of the wage increase). Personal points are calculated in accordance

[10] There was a total of 177,205 privileged pensioners in December 2010, which is approximately 15% of the overall number of pensioners (1,023,181), with HRK 7.2 billion or 20% of all pension expenditures in 2010 designated (in the state budget) for their payment.

[11] Official Gazette of the Republic of Croatia, *Narodne novine* no. 84/08, 152/08 and 94/09.

[12] Official Gazette of the Republic of Croatia, *Narodne novine* no. 2/09, 9/09 and 97/09.

[13] Official Gazette of the Republic of Croatia, *Narodne novine* no. 121/10.

with the prescribed formula and basically represent the worker's contribution to pension fund with his/her benefit.

Personal allowance is preferential, i.e. higher than that of other categories of tax payers (currently HRK 3,200[14]). Taxation follows the pillar structure. One fifth of the pensioners are liable to pay income tax.[15]

In 2010, several changes in the pension system can be reported:

- amendments to the Pension Insurance Act,

- amendments to the Act on Compulsory and Voluntary Pension Funds,

- temporary moratorium on the pension adjustment and

- decrease of pensions paid for certain categories of 'privileged' pensioners.

The most important amendments to the Pension Insurance Act include gradual equalisation of retirement age for men and women and more stringent financial sanctions for early retirement (from 0.15% to 0.34% decrease per month of early retirement), as well as providing incentives/rewarding later retirement. The retirement age for women is to be gradually increased, by 3 months each year, to reach 65 years for old-age pension and 60 years for early pension by the year 2030. Equalisation of the retirement age was mandated under the Decision of the Constitutional Court of the Republic of Croatia from 2007,[16] which abolished the previous provisions as contrary to the constitutional prohibition of discrimination based on sex. However, under the said decision, the transition period should have been completed by 2019. A longer transition period is certainly a grave risk to the financial sustainability of the system, but the legislator apparently opted for it to minimise public tension and resistance towards this measure. As from 1 November 2010, percentile of decrease for early retirement will fluctuate in accordance with the accrued pension service, from 0.15% to 0.34% per month of early retirement. This is a compromise solution, which in the short term triggered the upsurge of early retirement[17] (until the amendment entered into force). For the first time, the amended Pension Insurance Act provides incentives for extending the working life, in the amount of 0.15% per month of later retirement, up to a maximum of five years, i.e. maximum of 9% increase.

The Act on Compulsory and Voluntary Pension Funds[18] was amended to align with the Directive 2003/41/EC of the European Parliament and of the Council of 3 June 2003 on the activities and supervision of the institutions for the occupational retirement provision (these amendments are to enter into force on the day of Croatia's accession to the EU). Another

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14 All currency conversions in this report are based on an average exchange rate of EUR 1.00 = HRK 7.3 valid in April 2011, in accordance with the monthly accounting rate of the euro obtained at InforEuro website: http://ec.europa.eu/budget/inforeuro/index.cfm?fuseaction=currency_historique¤cy=86&Language=en On 1 April, HRK 1 was equal to EUR 0.135547, while EUR 1 was equal to HRK 7.377500.

15 On the inequalities in the taxation of pensions see M. Zuber, Kontroverze važećeg sustava oporezivanja mirovina, retrieved on 24 April 2011 from: http://www.bankamagazine.hr/Projekti/Analizamirovinskogsustava.aspx.

16 Decision of the Constitutional Court of the Republic of Croatia U-I-1152/200, U-I-1814/2001, U-I-1478/2004, U-I-3137/2004, U-I-3760/2005 of 18 April 2007.

17 Some estimates show an increase of 76% in early retirement in the first half of 2010, compared to the same period of the previous year. See Bađun, Marijana (2010) Hrvatski mirovinski sustav i gospodarska kriza (Croatian pension system and economic crisis), Institute of Public Finance, retrieved on 24 April 2011 from http://www.ijf.hr/osvrti/21.pdf.

18 Act on Amendments to the Act on Compulsory and Voluntary Pension Funds, Official Gazette of the Republic of Croatia *Narodne novine* no. 124/10.

important amendment is the decrease of state incentives for saving with the voluntary pension funds, from 25% to 15% of paid contribution of a fund member. The decrease applies also to contributions paid in 2010, which will reduce expenditures allocated for this purpose in the state budget (by HRK 20.8 million in 2011 compared to 2010[19]). At the same time, amendments to taxation enabled the recognition of the employer's expenses for the voluntary pension insurance premiums as tax deductions up to the amount of HRK 500 per month or HRK 6,000 annually.

Pursuant to the act on delay of pension adjustment in the period from 1 January to 31 December 2011,[20] a temporary moratorium on pension adjustment in accordance with the so-called Swiss formula (reflecting the consumer price index and average gross salary increase), will continue throughout 2011.[21] Although the government justifies the moratorium as necessary to prevent a decrease of pensions due to negative trends of the adjustment factors, it is basically an austerity measure to ease the pressure on public expenditure.

Pursuant to the act on decrease of pensions determined or realised under special provisions on pension insurance,[22] starting from 1 July 2010, the amount of pension for certain categories of privileged pensioners is decreased by 10%.[23]

2.2.2 Debates and political discourse

The main government strategy papers which set the goals and framework of economic policy in the period 2011 -2013 include the Strategy of the Government Programmes 2011 – 2013, Economic and Fiscal Policy Guidelines 2011 – 2013, Pre-accession Economic Programme 2011 – 2013 as well as the Economic Recovery Programme from April 2010.[24]

The strengthening of the social justness is a general strategic goal according to the Strategy of the Government Programmes in the period from 2011 to 2013.[25] One of the special targets within that goal is achieving financial sustainability of the pension system, especially given the rapid population ageing and unfavourable dependency and replacement ratios. The goal is to increase the share of beneficiaries based on individualised capitalised savings in the total number of beneficiaries and decrease the share of pension expenditures for the system of generational solidarity in GDP.[26] According to the Strategy, the analysis of the present state in the systems of generational solidarity and pensions acquired under special conditions should be conducted and reform proposals drafted. Proposed changes in the system of intergenerational solidarity should relate to equalisation of retirement age for men and women by 2020, disincentives (financial penalties) for early retirement, modalities of financing of minimum pensions, as well as conditions for entitlement to minimum pension with the

[19] Pre-accession Economic Programme 2011-2013, retrieved on 21 April 2011 from http://www.mfin.hr/adminmax/docs/PEP_2011.-2013..pdf.
[20] Official Gazette of the Republic of Croatia, *Narodne novine* no. 139/2010.
[21] The first moratorium was prescribed in 2010 based on the Act on Special Tax on Salaries, Pensions and Other Income, which suspended the adjustment of the pensions with effect from 1 July 2009 until the end of 2010.
[22] Official Gazette of the Republic of Croatia, *Narodne novine* no. 77/2010.
[23] Parliamentary representatives, ex-members of the government, Constitutional Court judges, General State Auditor, President of the Republic, war veterans from the Homeland War, political prisoners, soldiers from WWII, ex-Yugoslav Army officers, military personnel, police officers and other officials, members of the HVO, members of the Croatian Academy of Arts and Sciences.
[24] For a detailed elaboration of the Economic Recovery Programme see Croatia ANR 2010.
[25] The Strategy of the Government Programmes 2011 – 2013, retrieved on 23 April 2011 from www.vlada.hr/hr/content/download/143103/2077156/file/80-02.pdf.
[26] Ibid, p. 165

introduction of income or asset-based tests. The pension formula for the calculation of basic pensions for insurees insured within both the first and second pillar and service-time calculation in certain cases will also be reconsidered. The strategy also provides for a gradual transfer of certain categories of persons entitled to pension under special conditions to the general system. Another means for achieving the strategic special target is the enhancement and simplification of the system of generational solidarity and technical support for the capitalised savings system, which should bring about gradual increase of the contribution rate in the second pillar, revision of the investment policy and decrease of management fees. Exchange of electronic data with other institutions in the system of social protection, as well as international coordination (especially post-accession) should also be improved and appropriate administrative capacities developed. The Pre-accession Economic Programme 2011 – 2013[27] provides a detailed elaboration of macroeconomic developments and projections and necessary structural reforms in the same period, with a view to the measures and timeline set in the Economic Recovery Programme.[28] The Pre-accession Economic Programme acknowledges that the desired impacts of the pension reform initiated 12 years ago were delayed and significantly diminished, meaning that further developments of the pension system should be directed towards achieving both financial and social sustainability, as well as preserving the balance between pensions from the first and second pillar. Some of the changes envisaged under the Strategy of the Government Programmes 2011-2013 have already been implemented (equalisation of retirement age, financial disincentives for early retirement). The Pre-accession Economic Programme sets the timeline for the revision of minimum pensions, which should occur by the end of 2012, while the decision on gradual increase of the contribution rate in the second pillar is expected by the end of 2011. It is interesting that neither the Strategy nor the Pre-accession Economic Programme offer any solution for the lack of interest for savings within the third pillar, i.e. voluntary pension insurance based on capitalised savings. The Pre-accession Economic Programme merely reports the number of insurees[29] and concludes that the weak interest is due to unfavourable global and local economic conditions.

A much welcomed public debate on the pension system was initiated through the project titled *The Analysis of the Pension System*, managed by the Institute of Public Finances and the business journal Banka. The goal of the project is to analyse options and methods for establishing a sustainable pension system, while stimulating a public debate towards reaching a common understanding on reform solutions. Regular discussions and meetings (first round table was held in January 2011) are held on various topics and the proceeds disseminated through the website of the project.[30] The discussions include academics, analysts, representatives of the government, trade unions, pension funds, civil society organisations, etc. The topics range from general issues of the pension system to specific problems, such as labour market participation of the elderly and extension of working life, reconsideration of the role and model of minimum and disability pensions. All of these areas are identified as structural weaknesses of the system by themselves and their effect has only been aggravated by the financial and economic crisis.

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[27] Pre-accession Economic Programme, retrieved on 23 April 2001 from http://www.mfin.hr/adminmax/docs/PEP_2011.-2013..pdf.

[28] The Economic Recovery Programme is often criticised for not having achieved the proclaimed goals, i.e. the revival of the economy and activation of labour market.

[29] The open voluntary pension funds had 174,440 members, while the closed voluntary pension funds had 17,664 members.

[30] Web site of the project: http://www.bankamagazine.hr/Projekti/Analizamirovinskogsustava.aspx.

With the approaching of the national parliamentary elections (end of 2011/beginning of 2012), the political rhetoric intensifies. Political programmes regarding social protection schemes are rather mostly general, vague and populist in nature,[31] if at all available. For example, increasing the retirement age is hardly a matter of political debate, even if it is obviously an issue which deserves closer consideration. Political points are pursued mainly by criticising other solutions, rather than opening new perspectives. The head of the leading opposition party SDP (Social Democrats) asserts that equalisation of retirement age is not fair for women, since they generally lead a more challenging life and should be allowed to choose to retire earlier, even if this means changing the constitution.[32]

2.2.3 Impact of EU social policies on the national level

In 2007, as part of the Accession Partnership, the Croatian Ministry of Health and Social Welfare prepared a *Joint Memorandum on Social Inclusion* (JIM) with the European Commission, designed "to assist Croatia to combat poverty and social exclusion and modernise its systems of social protection as well as prepare the country for full participation in the open methods of coordination on social protection and social exclusion upon accession."[33] The memorandum identified the main challenges and presented policy measures aimed at translating the EU's common objectives to national policies. Progress is monitored and tracked regularly in the JIM follow-up process. At the last (4th) JIM conference held on 11 February 2010 in Zagreb, the conclusion was that Croatia has to focus on four key priorities: 1) to decrease the disproportion of the labour force skills on the labour market, 2) to enhance social inclusion of the vulnerable groups, 3) to adopt anti-recession measures, measures for lifelong-learning processes, and measures in other key areas, 4) to provide/ensure financial resources (in the budget) for planning measures (despite the crisis). One of the recommendations of the European Commission in the latest available report and evaluation[34] was that the Europe 2020 Strategy should be taken into consideration and associated with the JIM process. The National Implementation Plan for Social Inclusion 2011 – 2012[35] (NPPSU) was drafted and based on the Europe 2020 Strategy. Key priorities identified in the plan are aimed at finding a way out of the economic and financial crisis towards sustainable, smart and inclusive growth. The priorities which should revive the economy include increasing employability of groups mostly affected by long-term unemployment through active labour market measures, tracking the participation of social assistance beneficiaries in these programmes (i.e., under the new draft Social Welfare Act, a person loses social benefits if he/she turns down a job offer), as well as finding long-term and sustainable solutions for poverty issues among elderly and protect them in the transition

[31] See, for example, web pages of the currently governing party HDZ at http://www.hdz.hr/default.aspx?id=166 and the largest opposition party SDP at http://www.sdp.hr/politike/mirovinska-politika; retrieved on 21 April 2011.

[32] Newspaper article, Večernji list 27 November 2010, retrieved on 21 April 2011 from http://www.vecernji.hr/vijesti/milanovic-zenama-omoguciti-raniji-odlazak-mirovinu-clanak-221019.

[33] Joint Memorandum on Social Inclusion, retrieved on 21 April 2011 from http://www.mzss.hr/hr/medunarodna_suradnja/socijalna_skrb/jim_zajednicki_memorandum_o_socijalnom_ukljucivanju_rh/joint_memorandum_on_social_inclusion_of_the_republic_of_croatia/(offset)/10.

[34] European Commission, JIM Evaluation 2009, retrieved on 21 April 2011 from: http://www.mzss.hr/hr/medunarodna_suradnja/socijalna_skrb/jim_zajednicki_memorandum_o_socijalnom_ukljucivanju_rh/zajednicki_memorandum_o_socijalnom_ukljucivanju_hr. The government is obliged to submit the report on the implementation of JIM and NPPSU to the European Commission in the first half of 2011.

[35] National Implementation Plan for Social Inclusion (NPPSU), retrieved on 21 April 2011 from http://www.mzss.hr/hr/medunarodna_suradnja/socijalna_skrb/jim_zajednicki_memorandum_o_socijalnom_ukljucivanju_rh/zajednicki_memorandum_o_socijalnom_ukljucivanju_hr.

period through well targeted social assistance programmes. Active labour market measures targeting unemployed persons over 50, older employees and employees at risk of job losses in the form of co-financing for training and employment should be devised.

In the field of pensions, the proposed activities in NPPSU during 2011 include the revision of the mode of financing of minimum pensions and entitlement to it, with possible introduction of income or asset-based test. The issue of low pensions acquired from both pillars will be addressed by preparing the actuarial model for the projection of long-term movements in the pension system. Another envisaged activity is to analyse the possibility of working based on employment agreement while receiving pensions.

2.2.4 Impact assessment

The pension system is one of the main sources of the state budget deficit, as pension contributions cover only 3/5 of the pension expenditures. It is estimated that the deficit in this year could amount to HRK 16.6 billion, which is approximately HRK 1 billion more than the previous year.[36] In 2009, the share of pension expenditures in GDP increased to 10.5% of GDP, as opposed to 9.8% in 2008. In February 2011, the dependency ratio amounted to 1:1.21 (number of insurees: 1,463,133, number of pensioners: 1,206,138), while the replacement rate went down to 40.45%.[37] Negative demographic trends continue, as the effects of the economic and financial crisis are still holding on. With the slow recovery of the GDP and the expected continued high unemployment rate, sustainability of the system is at risk.

Table 1: Number of insurees and beneficiaries in the pension system in the period from 1980 to 2010 (in thousand)

Year	**1980**	**1985**	**1990**	**1995**	**2000**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
Insurees	1,816	1,931	1,968	1,568	1,381	1,460	1,507	1,538	1,579	1,605	1,530	1,431
Beneficiaries	419	524	656	865	1,019	1,066	1,078	1,100	1,122	1,148	1,174	1,197
Ratio	4.04	3.68	3	1.81	1.36	1.37	1.4	1.4	1.4	1.49	1.3	1.25

Source: HZMO (Croatian Institute for Pension Insurance); adapted from Bejaković, Predrag: Mirovinski sustavi u RH, Problemi i perspektiva, Presentation prepared for round table of the magazine Bank and the Institute of Public Finances, Zagreb, 19 January 2011, http://www.bankamagazine.hr/Projekti/Analizamirovinskogsustava.aspx.

[36] Newspaper article, Novi list, 2 February 2011.
[37] The Croatian Institute for Pension Insurance, statistical data, retrieved on 20 April 2011 from http://www.mirovinsko.hr/.

Table 2: Share of average pension in average wage in the period from 1995 to 2009

Year	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Replacement ratio	45.88	45.85	47.01	46.32	38.37	37.62	41.4	40.83	40	42.13	41.8	40.45	39.95	39.77	40.61

Source: HZMO (Croatian Institute for Pension Insurance); adapted from Bejaković, Predrag: Mirovinski sustavi u RH, Problemi i perspektiva, Presentation prepared for round table of the magazine Bank and the Institute of Public Finances, Zagreb, 19 January 2011,
http://www.bankamagazine.hr/Projekti/Analizamirovinskogsustava.aspx

Table 3**:** Pension expenditures as share of GDP in the period from 1995-2010

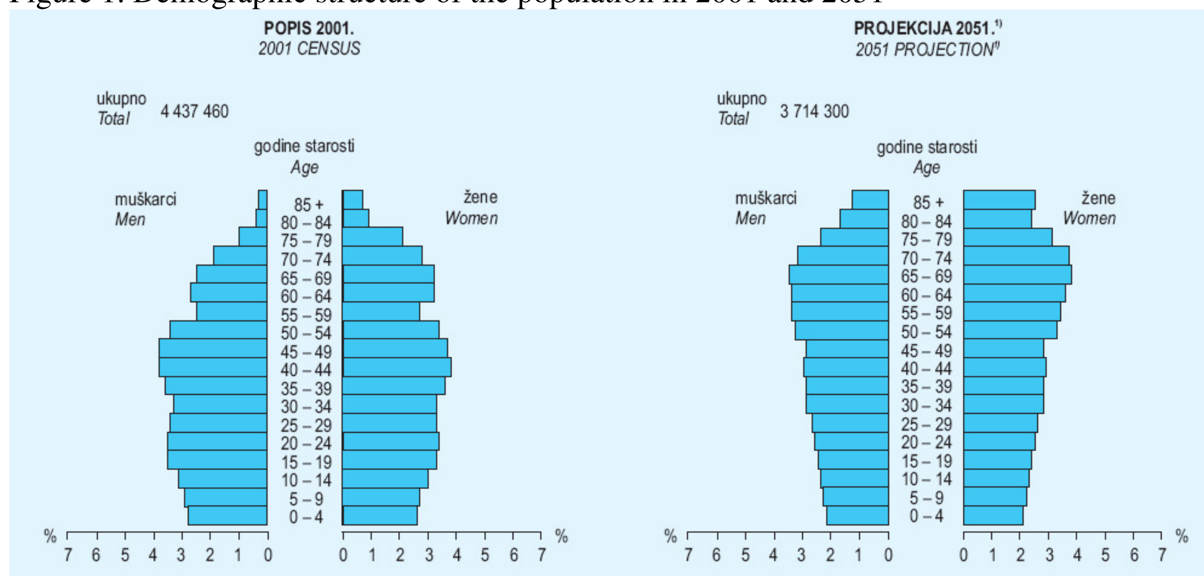
Year	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
% of GDP	9.22	9.71	10.62	10.3	11.61	11.45	12.04	11.39	10.88	10.59	10.33	10.1	9.71	9.8	10.53

Source: HZMO (Croatian Institute for Pension Insurance); adapted from Bejaković, Predrag: Mirovinski sustavi u RH, Problemi i perspektiva, Presentation prepared for round table of the magazine Bank and the Institute of Public Finances, Zagreb, 19 January 2011,
http://www.bankamagazine.hr/Projekti/Analizamirovinskogsustava.aspx

The best and most comprehensive analysis of the pension system and the outstanding issues is currently a product of the above mentioned project „The Analysis of the Pension System". Demographic ageing is a world-wide issue, but the Croatian particularities are also early exit from the labour market, i.e. significant number of 'young' pensioners and a low activity rate. Experts warn that the effective retirement age is lower than the prescribed minimum (59.9 on average in 2008, compared to 61.4 in EU-27),[38] which, coupled with a relatively short required period of service, produces a weak connection between the contributions paid and the retirement income, which in turn leads to ever growing state budget transfers and deficit.

[38] Bejaković, Predrag (2011) Mirovinski sustavi u RH, Problemi i perspektiva, Presentation prepared for the round table of the magazine Banka and the Institute of Public Finances, Zagreb, 19 January 2011, retrieved on 27 April 2011 from http://www.bankamagazine.hr/Projekti/Analizamirovinskogsustava.aspx.

Figure 1: Demographic structure of the population in 2001 and 2051



Source: DZS (Croatian Bureau of Statistics); adapted from Bejaković, Predrag: Mirovinski sustavi u RH, Problemi i perspektiva, Presentation prepared for round table of the magazine Bank and the Institute of Public Finances, Zagreb, 19 January 2011,
http://www.bankamagazine.hr/Projekti/Analizamirovinskogsustava.aspx

The Labour Force Survey[39] shows that labour market participation sharply declines between 55 and 65 years of age, with 75% of the population working at 50 years of age and only 10% share of active population of 65 years.[40] However, even the prolongation of working life might not be enough to cover pension insurance expenditures, as recent OECD analysis shows.[41] Other measures, primarily the activation of the elderly in the labour market, are needed. Practice shows that it is harder to activate a person who is already retired, than to keep a person working longer. The programme of gradual retirement, whereby older workers are encouraged to postpone retirement and continue working part-time, with decreased wage and a certain incentive is an attempt to address this issue. It was drafted by a team of independent experts, but it did not receive appropriate consideration from agenda setters and the legislator.[42]

Instead, the latest amendment of the Pension Insurance Act aims to encourage the extension of the working life through financial compensations. This option will be viable if accompanied by other incentives for the employers. However, there are potential obstacles, such as the provision of the Compulsory Health Insurance Act, whereby employers who have reached the required age and period of service for retirement are not entitled to compensation of salary from compulsory health insurance during sick leave (their employer is liable to pay

[39] Labour Force Survey, retrieved on 27 April 2011 from http://www.dzs.hr/Eng/Publication/2009/SI-1393.pdf.
[40] Project "Analysis of the pension system", retrieved on 27 April 2011 from http://www.bankamagazine.hr/Naslovnica/Hrvatska/tabid/102/View/Details/ItemID/67899/Default.aspx?ttl=Ako-stariji-ne-rade-tko-ce%3f.
[41] OECD(2011), Pensions at a Glance 2011: Retirement-Income Systems in OECD and G20 Countries, retrieved on 28 April 2011 from www.oecd.org/els/social/pensions/PAG.
[42] Project "Analysis of the pension system", retrieved on 27 April 2011 from http://www.bankamagazine.hr/Naslovnica/Hrvatska/tabid/102/View/Details/ItemID/68248/ttl/Pola-u-mirovini-pola-na-poslu/Default.aspx.

salary compensation during sick leave, which puts them at a disadvantage compared to younger workers).[43]

Another Croatian particularity is that early labour market exits are not always voluntary, and early retirement is used as a mean to curb the negative effects of job losses. Nevertheless, it has partly contributed to the low replacement rate. Average pension amounted to HRK 2,160.86 in February 2011. According to the available statistical data,[44] the at-risk-of-poverty threshold at the annual level amounted to HRK 26,703 in 2009 for a one-person household (or HRK 2,225.25 per month), which is above the average pension. The at-risk-of-poverty rate in 2009 was the highest for persons aged 65 years and over.

Improvement of employment of older workers and the protection of elderly without income are highlighted in the Croatia 2010 Progress Report as the areas in which progress is slow. Special income support for the elderly (popularly called 'social pension') was discussed by the working group which prepared the draft Social Welfare Act and it was agreed that the amount of the support should exceed the amount of the standard permanent social assistance currently received by the elderly without pensions in the social welfare system. However, this concept needs further developing and planning, given that the difference between the amount of social assistance for older persons and the amount of the lowest pensions for the minimal pension service years of 15 years is very slim (approximately HRK 100). Eventually, instead of introducing a special income support for the elderly, which was postponed, the amount of social assistance for older single persons was increased by 20% or HRK 100.

The sustainability of the system in the medium and long term will depend on the ability to revive the labour market and economy, which is a prerequisite for the functioning pension system. Even though the increase of contributions to the second pillar (which some suggest should be from the current 5% to 10% over the period of seven years[45]) is inevitable, it might also prove to be an additional burden for the weak economy. However, analysts warn that the share of pension expenditures in GDP should not exceed 9% for the system to be sustainable.[46]

2.2.5 Critical assessment of reforms, discussions and research carried out

As the available records show, the dependency ratio and replacement rate in 2010 aggravated, which makes the objective of adequate retirement incomes for all and access to pensions even less achievable in the mid term. The replacement rate for persons who have opted only for the second pillar of insurance is of particular concern, since their choice is permanent and they are not allowed to switch back to the first pillar. Apart from that, the role and modality of payment of minimum pensions, as an instrument of generational solidarity, need to be scrutinised. The number of such beneficiaries is expected to rise in the next 15 years[47] (currently approximately 160,000 beneficiaries). The minimum pension is calculated from a basis which represents 45% of the average monthly net wage of all employees in the year preceding the year when the entitlement is realised. In 2010, the average minimum pension

[43] Vukorepa, Ivana (2011) Novele Zakona o mirovinskom osiguranju, Revija za socijalnu politiku vol. 18, no. 1, p. 93 – 97.

[44] Croatian Bureau of Statistics, First Release, Poverty indicators 2009, 12 October 2010, http://www.dzs.hr/.

[45] Project "Analysis of the pension system", retrieved on 27 April 2011 from http://www.bankamagazine.hr/Naslovnica/Hrvatska/tabid/102/View/Details/ItemID/66243/ttl/Mirovinska-prava-nadilaze-razinu-uplacenih-doprinosa/Default.aspx.

[46] Ibid.

[47] Marušić, Ljiljana (2011) Najniža i najviša mirovina, Presentation prepared for the round table of the magazine Bank and the Institute of Public Finances, Zagreb, 16 February 2011, retrieved on 27 April 2011 at http://www.bankamagazine.hr/Projekti/Analizamirovinskogsustava.aspx.

amounted to HRK 1,336.00, or HRK 800 less than the average pension. Around 25% of the beneficiaries retired after 1 January 1999 receive a minimum pension.[48] The issue of social pensions, as a form of unified social assistance to the elderly without sufficient means, is still kept under the table. The draft act is supposedly in preparatory stage and the expected amount could reach around HRK 700 (meaning that HRK 400-500 million should be earmarked for this purpose in the state budget). Estimates show that approximately 55,000 elderly might become eligible (as they already receive some type of social assistance).[49] The amount of the social pension should be carefully assessed, so that it would not discourage payment of pension insurance contributions.

Recent legislative amendments directed towards more stringent financial disincentives for early retirement and financial incentives for later retirement are a welcomed step towards reaching the objective of *more people at work and working longer*. However, a comprehensive analysis and revision of other provisions which might reverse the positive impact of these amendments is needed. Also, more effort should be made to prevent the legislative changes to be by-passed in practice. A useful starting point would be to conduct a national survey on working conditions of older workers to determine whether there exists discrimination or stigmatisation of older workers at their workplace, whether older workers are provided with equal training and promotion opportunities, etc. The current economic climate is not favourable for the creation of new jobs. One year into the application of the Government's Economic Recovery Programme (adopted in April 2010), it is quite obvious that it has failed to fulfil its primary purpose: revive the economy and labour market.

Balancing contributions and benefits in an appropriate and socially fair manner is a challenging task. For example, there are inequalities relative to the basis of insurance (employment, self-employment, and other special provisions); whereby pension service time is recognised to employees even if the employer has not paid the contributions, while non-payment of contributions by self-employed results in non-recognition of that pension service time.[50] Collection of contributions is unsatisfactory and requires more reaction from the state, as one out of five individual pension insurance accounts is inactive, i.e. contributions are not being paid in.[51]

There are unresolved information gaps in practice regarding the status of payment of contributions for employees. Namely, contributions are collected from employers by tax administration, which keeps the records of payments only at the level of contribution payer, i.e. employer, and not the insured person. This means that an insuree cannot verify whether his employer actually paid in pension contributions to his pension account either from the Tax Administration or the Croatian Pension Insurance Institute or REGOS (The Registry of Insured Persons). Employers are only obliged to deliver the data on service times and salary for employees to the Croatian Pension Insurance Institute by themselves on an annual basis. However, many employers fail to respond and even that information is only obtained at the request of the institute when the employee files a request for retirement.

[48] Project "Analysis of the pension system", retrieved on 27 April 2011 at http://www.bankamagazine.hr/Naslovnica/Hrvatska/tabid/102/View/Details/ItemID/67160/ttl/Prosjecna-najniza-mirovina-je-1336-kuna-a-ima-i-nizih/Default.aspx.

[49] Newspaper article, Večernji list, 19 November 2010, retrieved on 27 April 2011 at http://www.vecernji.hr/vijesti/predizborne-penzije-onima-koji-nisu-radili-700-kuna-mirovine-clanak-204789.

[50] Zuber, Marija (2011), Kontroverze važećeg sustava oporezivanja mirovina, Presentation prepared for the round table of the magazine Bank and the Institute of Public Finances, Zagreb, 17 March 2011, retrieved on 27 April 2011 at http://www.bankamagazine.hr/Projekti/Analizamirovinskogsustava.aspx.

[51] Ibid, based on data from 2007.

Within the objective of *promoting the affordability and the security of funded and private schemes*, better targeted incentives for saving within voluntary pension insurance pillars are required, but not adequately addressed. With the decrease of state subsidies for members of voluntary pension funds (from 25% to 15% of the paid contribution, i.e. from HRK 1,250 annually to HRK 750), the only remaining incentive is directed at employers (i.e. acknowledging paid contributions to a certain amount as a tax relief). Even though the number of members of open voluntary pension funds steadily rises, it is at a rather slow pace and should be further promoted. Mandatory and voluntary pension funds play a significant role in the Croatian capital market. The average rate of return since their inception is roughly 5% for mandatory pension funds, while it varies from 2 to 9% for open voluntary pension funds.[52] This is a moderate, but acceptable rate of return, given their legally constrained conservative investment policies.

Table 4: Pension funds membership

Type of fund	2002	2003	2004	2005	2006	12/ 2007	12/2008	12/2009	12/2010	03/2011
Compulsory pension funds	983,310	1,070,932	1,170,092	1,248,931	1,322,010	1,395,693	1,475,729	1,522,149	1,561,154	1,572,162
Open voluntary pension funds	1,345	8,773	30,022	51,121	75,161	103,923	127,738	146,410	169,841	174,440
Closed voluntary pension funds			1,112	5,336	10,633	11,943	17,285	17,733	17,613	17,666

Source: HANFA - The Croatian Financial Services Supervisory Agency

Table 5: Number of new CPF members by method of joining in 2010

Month 2010.	New members		Of whom	
	number	index 2010/2009	Applied in person	Allocated by REGOS
1	2 (4+5)	3	4	5
Jan	4,167	78.76	184	3,983
Feb	4,237	84.72	238	3,999
Mar	3,715	81.77	254	3,461
Apr	2,811	82.05	205	2,606
May	4,154	112.00	259	3,895
Jun	3,901	117.08	214	3,687
Jul	3,466	109.79	230	3,236
Aug	3,732	107.40	245	3,487
Sept	3,836	70.19	202	3,634
Oct	4,528	77.85	348	4,180
Nov	5,787	93.44	315	5,472
Dec	3,354	114.04	317	3,037
TOTAL	**47,688**	**91.10**	**3,011**	**44,677**

Source: REGOS, http://www.regos.hr/default.aspx?id=861

[52] Croatian Financial Services Supervisory Agency (HANFA) Reports - Hanfa Ripe, retrieved on 27 April 2011 from: http://www.ripe.hanfa.hr/hr/publiciranje/izvjesca/.

2.3 Health Care

2.3.1 The system's characteristics and reforms

The system of health care in Croatia is based on mixed financing and the combination of public and private health services. Health protection is financed from mandatory contributions (approximately 80%) as well as from taxes. Health protection is financed by the Croatian Institute for Health Insurance, counties and the City of Zagreb and beneficiaries. Rates of contributions paid by employers for employees are 15% for the basic health insurance and 0.5% for special contribution in case of occupational injuries. Contributions are paid on the monthly contribution base, which represents the salary or other income from employment paid by employer and subject to income tax or income from self-employment, which is calculated as the product of monthly contribution base and a coefficient depending on the nature of self-employment. It is estimated that only 1/3 of the population is liable to pay health care contributions, while the remaining population includes pensioners, insured person's family members, unemployed and other inactive persons. The Croatian Institute for Health Insurance (HZZO) and health care providers and institutions conclude agreements stipulating mutual rights and obligations in health care provision and the maximum annual amount of payment which will be transferred to them by the Croatian Institute of Health Insurance (HZZO). HZZO monitors regular performance of obligations based on monthly invoices received from the providers. Hospitals are financed directly from the state budget (based on the contract concluded with the HZZO), while all other payments are effectuated through the HZZO. The amount of co-payment for services in primary health care and for prescription medicines is currently HRK 10.

Facilities involved in health care activities are either state- or county-owned, or private. Teaching hospitals, clinical hospital centres and state institutes of public health are state-owned. Health centres, polyclinics, general and special hospitals, pharmacies, institutions for emergency medical aid, home care institutions and county institutes of public health are county-owned. The number of health centres has steadily decreased from 120 in 2002 (when the process of merging began) to 49 in 2009. Out of 77 hospital institutions and sanatariums, seven special hospitals and sanatoriums were privately owned. By the end of 2009, there were 6,379 private practice units (doctors' surgeries, laboratories, private pharmacies, private physical therapy practices and home care services) registered.[53] By the end of 2009, Croatia's health care had a permanent work force of 70,592 (52,956 health professionals and associates, 5,081 administrative and 12,555 technical staff). Additional 9,238 health professionals and associates were temporarily employed in the same period.[54]

Table 6: Structure of social expenditures in the Republic of Croatia for health care according to ESSPROS methodology (% of GDP)

Year	2003	2004	2005	2006	2007
% of GDP	5.9	6.0	5.7	5.6	5.4

Source: Croatian Bureau of Statistics

[53] Croatian Health Service Yearbook 2009, The Croatian National Institute of Public Health (2010) Zagreb, retrieved on 21 April 2011 from http://www.hzjz.hr/publikacije/hzs_ljetopis/index.htm.
[54] Ibid.

The *Health Protection Act* entered into force on 1 January 2009.[55] It prescribes principles and measures of health protection, rights and obligations of beneficiaries, health care providers and supervision over the performance of health care activities.

Health care is defined as a system of social, group and individual measures, services and activities aimed at preserving and improving health, prevention of disease, early discovery of illness and timely treatment and medical care and rehabilitation. It is organised at three basic levels: primary, secondary, tertiary and at the level of medical institutes.

The payment of medical care in the primary medical care is performed through so-called '*glavarina*' (payment per capita or capitation), and in 2004 a payment mechanism was introduced according to service, firstly for preventive programmes and then also for curative care. Since 2005, a payment mechanism according to therapeutic procedure (or the so-called diagnostic groups system) has been in place. Clinical medical institutions are financed through monthly budgets – limits which the institutions justify by the invoices made for the activities performed. Here, the clinical medical care is also, along with defining the total budget, paid by the payment mechanisms according to service and payments according to therapeutic procedures. Capital investments are financed by the means of the HZZO, ministries, and decentralised means of the regional and local self-government and through donations.

The primary level of health care includes: observing the health condition of the population and the suggestion of measures to protect and improve the health of the population, the prevention and discovery of illness as well as rehabilitation of patients, the specific preventive protection of children and juveniles, the medical protection of women, the preventive medical protection of groups at risk, according to programmes of preventive health protection, counselling, medical education and promotion of health in order to preserve and improve it, hygiene-epidemiologic protection, prevention, discovery and treatment of teeth and mouth illnesses with rehabilitation, health rehabilitation of children and juveniles with disorders in physical and mental development, home visits, medical care and home treatment, labour medicine, emergency medical care, palliative care and protection of mental health. Institutions on the primary level are medical centres, institutions for emergency medical care, institutions for medical care, pharmaceutical institutions and institutions for palliative care. All these institutions are owned by the counties, although there exists a number of doctors in the medical centres who, due to the process of privatisation, have their practices in lease. The secondary level health care system comprises specialist and hospital activity. The institutions at this level include policlinics, hospitals and sanatoriums, again owned by the counties. The institutions on the tertiary level (clinical institutions) are owned by the state and provide the most sophisticated form of medical care in specialist and hospital activity as well as perform scientific research and education.

The activity of medical institutes is part of the health care activity which is performed in the primary, secondary and tertiary level of medical activity. On the level of state medical institutes, it comprises public health activities, labour medicine activities, the activity of transfusion medicine and activities of mental health care, and on the level of medical institutes of regional self-administration units, it comprises the public health activities.

The *Health Protection Act* of 2009 introduced the system of concessions for public health care services at primary level of health protection. Concession is granted by the county prefect or the mayor, at the proposal from the head of the health administrative authority, with the

[55] Official Gazette of the Republic of Croatia, *Narodne novine* no. 150/08, 155/09, 71/10, 139/10, 22/11.

consent of the Minister of Health and Social Welfare. However, this procedure, which should have been completed by 31 December 2010, proved to be extremely complicated, demanding and long.[56] This was the reason for another legislative intervention in the form of the latest amendments to the Health Protection Act,[57] which pushes the deadline for granting of concessions to the end of 2011.

The *Obligatory Medical Insurance Act* entered into force on 1 January 2009 and was followed by 5 subsequent legislative amendments.[58] Medical insurance is defined as obligatory on the one part, carried out by the Croatian Institute for Health Insurance HZZO), and voluntary on the other part, which is defined by particular regulations. The act defines single categories of persons who are covered by the medical insurance, e.g. employed persons, or other persons such as members of their families, people undergoing education, people registered with the employment institutes, and so on.

Actually, almost the entire population is covered by obligatory medical insurance, which is visible form the data that about 97% of the population are insured, where non-insurance is mostly a consequence of disregarding deadlines for registration with the Croatian Institute for Health Insurance (HZZO), often applying to persons working temporarily abroad who have not regulated their status in Croatia. The rights from medical insurance cover the right to medical care and the right to financial compensation. The rights to medical care include primary medical care, hospital medical care, the right to obtain drugs as established in the basic and additional list of drugs of the institute, the right to dental-prosthetic care and dental-prosthetic implants, the right to orthopaedic and other apparatus, the right to medical care abroad.

The *Obligatory Medical Insurance Act* defines which parts of medical care are fully covered for the insured, and which are partly covered, by 85%, 75%, 70% and 50% of the price. The latter comprises, for example, dental medical care regarding mobile and fixed prosthetics of adults. The obligatory insurance fully covers the cost of drugs on the basic list, while the additional list includes the amount to be contributed for single drugs.

The right to financial compensation covers: remuneration for temporary impediment or inability to work due to use of medical care (sick leave) or financial compensation due to impossibility to perform activities which generate other income and compensation of transport costs in relation to using medical care from obligatory medical insurance.
The latest amendments were instigated by the necessity to align certain provisions with the EU *acquis* (regarding the administrative procedure for realisation and protection of rights from obligatory health insurance).[59] Also, the amount of co-payment of services in primary health care and for prescription medicines is reduced to 0.30% of the budget base (previously 0.45%), i.e. from HRK 15 to 10.

The *Voluntary Medical Insurance Act*[60] defines voluntary medical insurance as supplementary, additional and private. Supplementary medical insurance covers part of the expenses up to the full price of medical care from obligatory medical insurance. Additional

[56] Only eight counties succeeded in meeting the prescribed deadline. The procedure for granting 2,300 concessions in seven counties was suspended due to lodging of appeals against decisions accepting the best bidders to the State Authority for Supervision of Public Procurement. See Draft Act 698 - Health Protection Act, Croatian Parliament.

[57] Official Gazette of the Republic of Croatia Narodne novine no. 22/11.

[58] Official Gazette of the Republic of Croatia, *Narodne novine* no. 150/08, 94/09, 153/09, 71/10, 139/10 and 49/11.

[59] Official Gazette of the Republic of Croatia, *Narodne novine* no. 49/11.

[60] Official Gazette of the Republic of Croatia, *Narodne novine* no. 85/2006, 150/2008, 71/10.

medical insurance covers a higher standard of medical care in relation to the standard foreseen by the obligatory medical insurance and a larger scale of rights when compared to obligatory medical insurance. The private medical insurance covers medical care for persons in Croatia who do not have obligatory medical insurance according to the Obligatory Medical Insurance Act, and foreigners. Additional medical insurance is provided by the insurance companies, licensed by the supervisory authority in accordance with the Insurance Act and authorised by the Minister of Health and Social Welfare. As a measure for economic recovery and expansion of market activities of the HZZO, the latest amendments to the Voluntary Medical Insurance Act[61] authorise the Institute to provide additional health insurance as well. The same amendments expand the circle of beneficiaries whose additional health insurance is covered from the state budget.[62]

2.3.2 Debates and political discourse

Reforms initiated in 2010 will continue throughout 2011, reinforced by the latest legislative amendments. During the period covered by this ANR, the categorisation system for hospitals and reorganisation of emergency health care have stirred the most debates.

Regarding the categorisation of hospitals, the Minister of Health Darko Milinović handed out to managers of the Croatian hospitals decisions on categorisation of their hospitals. Hospitals are classified in four categories: category I comprises of seven national hospitals – four in Zagreb, one in Split, Rijeka and Osijek; category II of five county hospitals of regional importance; category III of 13 county hospitals and category IV of five local hospitals. Each has been awarded certain points and the Minister motivated competition among them in fulfilling the 11 criteria set, promising a better status to 'good pupils'.

This is only the path to accreditation of all Croatian hospitals and once this process is over, the patient will know exactly which quality he/she will get in each hospital and according to it he/she will be able to choose the hospital in which he/she wishes to be treated. If this ambitious project succeeds, each patient treated in Croatian hospitals will know beforehand which hospital will provide quality service, what service will he/she get exactly, how will he/she be treated, which are the unwanted treatment results, discuss with the doctor treatment details, such as treatment and convalescence ahead of him/her, which teams of doctors are at his/her disposal, how much they know and how successful they are. Moreover, the patient should be better informed: receive all medical documentation, know when he/she is scheduled for release, how big the risk of getting an infection is, and what the chances for a full recovery are. The Minister of Health and Social Welfare stated that the categorisation provides for evaluation of quantity and classification of the hospitals. It enables the setting of directions for the development of each hospital. It also revealed which hospitals are in need of better equipment. The next step is the evaluation of quality. Categorisation does not mean that a hospital of lower category is bad, since quality evaluation and accreditation are the only appropriate procedures for determining the quality of service - an operation in a category III hospital could be performed just as well as in a category I hospital.

The possibility to shift into another category exists, but only under extreme conditions. The goal is to rationalise the system, to put the finances under control and at the same time to develop quality and maximum security for the patients. The accreditation will begin in a few

[61] The Act on Amendments to the Voluntary Medical Insurance Act entered into force on 18 June 2010. Official Gazette of the Republic of Croatia, *Narodne novine* no. 71/10.

[62] Beneficiaries are persons with certain degree and nature of disability, blood donors (above a certain number of donations), pupils and students, as well as persons eligible based on the criteria of income.

months. The Accreditation Regulation is practically finished and awaits only the consent of the Medical Chamber.[63] The accreditation for each hospital will take from six months to one year. The expenses will be HRK 500,000.00 per hospital. The Ministry will finance the accreditation for about ten hospitals through tenders. The accreditation procedure will begin after the regulation is adopted. The tender will be prepared by the Agency for Quality and Accreditation in Health. Hospitals which have already fulfilled a lot of preconditions in the field of improvement of medical care quality and process regulation, following the patterns of other countries, will surely be able to apply. The managers who, along with their assistants for quality, have recognised that the hospital needs to develop in terms of security and quality surely have a significant advantage. The financing for this first tender will not be from the hospital budget, in order to stimulate and award those who have worked more on quality improvement. All other institutions may apply for the accreditation process and, as the Medical Care Quality Act says, the accredited hospitals will be granted a limit increase exactly for being accredited. The clinical medical institution can be 'organised' according to the standards, but does not have to apply for accreditation, because it is a voluntary procedure. Nevertheless, it must submit quality indicators. In the accreditation procedure the first task of the hospitals is to organise according to the standards, and to conduct a self-evaluation. Then, the appraisers from the Agency for Quality and Accreditation in Health are called and they verify the congruence with the standards and render the accreditation decisions. The agency was established in 2007, but became operative only in 2009. Its task is to follow the quality and security of medical care, conduct procedures of voluntary accreditation, and appraise medical technologies. The agency has currently seven employees.

The target of the emergency health care reform is to have better educated teams, more sophisticated equipment and improved response time.[64] By 2013, there will be at least one medical emergency team every 50 km which will be able to provide emergency medical care within 10 to 20 minutes from the patient's call, depending on the location. The project of reorganisation of the emergency medical care, which the Ministry of Health and Social Welfare started in 2009, is worth EUR 90 million. The specialisation for emergency medicine for doctors, as well as the specialist training for medical nurses and technicians is introduced for the first time. Moreover, national directions for the emergency medical care service are introduced and for the first time the emergency medicine network is introduced. The project of reorganisation started with the establishment of the state institute for emergency medicine, and the plan is to establish institutes in all the counties as well.

Croatia will, thus, have 21 specialised institutes for performing non-clinical medical care services, whereas a centralised emergency clinical reception will be organised in all acute hospitals. In practice this means less 'wandering around' and waiting for patients which will no longer visit certain departments, but will all go to a centralised clinical reception where they will be immediately helped or will be referred elsewhere after being examined. In the future, this job will be performed only by emergency medicine specialists and not by general practice physicians, as it was done so far.

By introducing the emergency medicine network, for the first time the number, composition and type of emergency medicine teams which will operate on specific areas is prescribed. This network will cover the entire country, with at least one emergency medicine team in the

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[63] Newspaper article, Jutarnji list, 13 February 2011.

[64] The Ministry of Health and Social Welfare presented the reform of the emergency medical care in the form of a PowerPoint presentation, available at the homepage of the Ministry, retrieved on 29 April 2011 at http://www.mzss.hr/hr/novosti/novosti_iz_zdravstva/mreza_i_pregled_provedbe_projekta_reforme_hitne_medicinske_pomoci.

radius of 25 km. To achieve this, it is necessary to secure the education of doctors, medical nurses and technicians. Mentors will be recruited among the physicians with more than 15 years of experience in the emergency medicine, and which are, according to the opinion of the chamber, professionally competent. The specialisation will take five years. The goal is to have 200 physicians - specialists in emergency medicine. Because of the lack of doctors in Croatia, teams T2 will be introduced in certain locations, along with the already existing emergency medicine teams T1 which are composed of one doctor, one nurse and a driver. These teams will not have a doctor, but there will be two medical technicians and one of them will have to undergo specialist training. After the exam has been passed, this technician will receive a license of the Croatian Chamber of Medical Nurses and Technicians to go on interventions without a doctor. They will have an excellently equipped vehicle and will be able to provide the patient with quality emergency medical care. The Minister of Health and Social Welfare stated that the targeted average response time should reduce to ten minutes in urban areas and 20 minutes in rural areas in 80% of cases.

One of the goals is also to achieve that the time from the call to the arrival of the patient in the unified clinical emergency reception to the beginning of the intervention is less than one hour. This is the so called 'golden hour' in which the patient has more chances for a positive outcome. If all is done within one hour the patient has 30-50% more chances for survival. At present, the average time from the call to the intervention is two hours. Also, there is a plan to divide medical transport from emergency transport in the way that medical transport will stay with the medical centres and perform the so called 'cold' transport of patients, whereas the emergency transport will be transferred to the institutes for emergency medicine. Each county institute for emergency medicine will have a dispatch unit. There will be one emergency number, for example 112, to which trained medical technicians or nurses will answer. They will have in front of them a book on the procedure protocol. When someone calls, the technician will evaluate the case immediately and send the closest team to the spot. He/she will talk to the patient and simultaneously relay the most important information to the team. Everything will be computerised, there will be satellite navigation so that the technician can feed in the information, see immediately the position of the vehicle and send the closest vehicle to the intervention. At the same time, the information will be given to the team, so that it can work more efficiently.

The reform plans for the emergency medical care received mixed responses, especially in professional circles, i.e. those who will be directly implementing them in practice. Although many acknowledge that the reform is well-structured and needed,[65] many doubt its impact in practice.[66] The criticisms are coming primarily from less populated areas, where it is feared that the reform will keep the current (unsatisfactory) conditions or mean even less resources and longer response time.[67]

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[65] See, for example, comment by the Assistant Head of Health Centre in Zadar, retrieved on 21 April 2011 from http://www.057info.hr/vijesti/2011-02-17/neostvariva-reforma-hitne.

[66] Head of Emergency Medical Care in Zagreb claims that the reform could leave Zagreb with five emergency teams less, retrieved on 21 April 2011 from http://dalje.com/hr-zagreb/reforma-hitne-posvadjala-slobodanku-keleuvu-i-ministarstvo-zdravstva/341803.

[67] See, for example, the situation in Imotski (Dalmatinska Zagora region), where average response time is 40 minutes and the reform does not propose the introduction of any new teams; retrieved on 21 April 2011 from http://www.radioimotski.hr/index.php?option=com_content&task=view&id=1008.

2.3.3 Impact of EU social policies on the national level

The Strategic plan for the development of public health in the period from 2011 to 2015 was drafted by the Ministry of Health and Social Welfare,[68] which takes into account the demographic ageing of the Croatian society, development of illnesses, as well as cross-border environmental issues. In the light of the Croatian accession to the EU, the public health system requires continuous evaluation with a view of building and reinforcing capacities, improvement of organisation, prevention of illnesses and better quality of life. The Strategic Plan implements the principles of equality and fairness, evidence-based decision-making and horizontal inclusion of public health issues in various sectoral plans and policies. The Strategic Plan is based on the Strategic Approach to Health for the EU (2008 – 2013).

2.3.4 Impact assessment

The data from the National Waiting List for February 2011[69] reports the longest average waiting time in KBC (Clinical Hospital Centre) in Osijek (150 days), followed by KBC "Sestre Milosrdnice" in Zagreb (100 days). Average waiting time for individual treatments varies, depending on the region and the hospital. For example, for a complete knee prosthesis a patient has to wait for 792 days in the General Hospital in Koprivnica, but only 14 days in the General Hospital in Slavonski Brod, while three hospitals do not even have waiting lists for this type of operation. Waiting time for a CT diagnosis is 150 days in KBC Osijek, 100 days in KBC "Sestre Milosrdnice", and 60 days in KBC Rijeka. Almost a year, or 330 days will pass before a patient is given an ultrasound of the heart in KBC Rijeka and the waiting time for the same procedure is above 100 days in most of the larger clinical centres in the country. Average waiting time for breast ultrasound is 256 days in KBC Split, 180 days in KBC Rijeka, 170 in KBC Osijek and 30 in KBC Zagreb. On the other hand, waiting time for a MR procedure is 232 days in KBC Zagreb (the national longest) or at least 60 days in the General Hospital Gospić (the national shortest).[70]

Fluctuations of waiting times are not unusual, with some improvements in certain areas. For example, the data from September 2010 shows: waiting time for a complete knee prostheses is 536 days, for a hip endoprosthesis 388, for a CT in Rijeka 173 days, in KBC Osijek 120 days, in KBC Sestre Milosrdnice in Zagreb 100 days and in Nova Gradiška these procedures have not been performed in the month of September – the device is broken. The waiting time for a MR diagnosis is in Rijeka 216 days, in Zadar 180, for an ultrasound of the heart in Čakovec 350 days, in Rijeka 330, in Bjelovar 306 days, for a breast ultrasound on average in KBC Zagreb is 319 days, for a colonoscopy in Sisak 330 days, in KB Dubrava 181 days, for a gastroscopy in Zabok 140 days, in KBC Zagreb 126 days. However, in general, waiting times have even aggravated since the end of 2008.[71] Regional inequalities are strongly pronounced. Even when waiting times are shorter in certain hospitals, not all patients can benefit from it, because of the distance of such hospitals from their residence and the fact many of them are not in a position either to cover travel expenses by themselves or to travel at all (due to illness).

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[68] The Strategic plan for the development of public health in the period from 2011 to 2015, retrieved on 28 April 2011 from http://www.mzss.hr/hr/zdravstvo_i_socijalna_skrb/zdravstvo/strateski_plan_razvoja_javnog_zdravstva_za_razdoblje_2011_2015.

[69] Retrieved on 20 April 2011 from http://www.mzss.hr/hr/zdravstvo_i_socijalna_skrb/nacionalna_lista_cekanja.

[70] This is indicative for the lack of territorial dimension when planning the acquisition of expensive medical equipment.

[71] Newspaper article, Novi list, 5 November 2010.

Table 7: Ten leading causes of death in 2007 and 2009

DIAGNOSIS	RC (2007)	DIAGNOSIS	RC (2009)
Ischemic heart disease	18.48	Ischemic heart disease	20.11
Cerebrovascular diseases	15.89	Cerebrovascular diseases	15.12
Heart failure	5.83	Malignant neoplasms of trachea and lung	5.34
Malignant neoplasms of trachea and lung	5.26	Heart failure	4.58
Malignant neoplasms of the colon	3.32	Malignant neoplasms of the colon	3.56
Bronchitis, emphysema and asthma	2.66	Bronchitis, emphysema and asthma	3.02
Diabetes mellitus	2.53	Hypertension	2.61
Chronic liver diseases and cirrhosis	2.49	Diabetes mellitus	2.60
Hypertension	2.43	Atherosclerosis	2.46
Pneumonia	1.96	Chronic liver diseases and cirrhosis	2.42

Source: *The Croatian Institute for Public Health*

The Croatian Association of Patients warns that hospitals are dividing the rich from the poor, breeching the constitutional right to equally accessible and quality medical care for everyone. The President of the Association, Mario Drlje, says that the patients complain mostly about the inaccessibility to the right of medical treatment, long waiting lists, a weakening communication with the doctor. The patient has to pay more and more to be treated with quality and in a timely manner. Everyone has an appointment at the same time, waits for several hours, the capacities in the second shift are not used and it is harder and harder to get an experienced doctor without pulling any strings.

The categorisation of hospitals has brought dissatisfaction in some hospitals whose managers are convinced that political influence has also played a role, at the expense of hospitals situated in regions other than the capital city.[72]

The Croatian Medical Chamber warned that the emergency medical institutions are more often managed by persons who are not medical professionals, which could be detrimental, both for the medical profession and for the patients. Many health professionals believe that for the reorganisation of emergency medical services to be efficient, more professionals have to be employed. At a recent round table devoted to the topic, it was highlighted that the reform should focus on training and employing more professionals for the provision of emergency health care, more funds should be devoted to these services and professional managers employed.[73] In certain regions, e.g. in Krapinsko-Zagorska County, doctors play a triple role, since, in addition to their position as family physicians in primary health care, they cover also

[72] Comment by the head of General Hospital in Pula, retrieved on 20 April 2011 from http://dnevnik.hr/vijesti/hrvatska/koja-je-razlika-kad-dobijete-infarkt-u-zagrebu-i-u-puli.html.

[73] Round table "Family Medicine and Emergency Health Care", 2. Congress of the Coordination of Family Medicine Doctors (KoHOm), Zagreb, 25-26 March 2011. See also report in Liječničke novine 98, April 2011, retrieved on 29 April 2011 from http://www.hlk.hr/Default.aspx?sec=175.

emergency health care services (which means that they sometimes need to leave their practice to respond to an emergency call) and act as coroners as well.[74]

2.3.5 Critical assessment of reforms, discussions and research carried out

Health care reform continues to be riddled with scandals and controversies, which endanger the accessibility and sustainability of the system and bring into question the efficiency of the reforms in the first place. One example includes the recently revealed dubious functioning of the public-private partnership between the Croatian Medical Insurance Institute (HZZO) and the private company Medikol. The operation of the partnership was very simple: the PET/CT instruments were purchased by Medikol, patients for costly examinations are secured by the hospitals, and money for the examinations is given by the HZZO. Under the terms of this contract, Medikol was given a dominant position on the market: there is no competition in Croatia in this kind of almost obligatory diagnostic and therapeutic examination in oncological illnesses, because they are the only ones to provide it. The complete profit goes to Medikol, whereas the hospitals collect a miserable HRK 500 per month for renting the premises. Out of five PET/CT instruments which were agreed, three were acquired. The first one arrived in the Hospital in Vinogradska, and in the following two years the instruments were received by the KBC Split and Rijeka. HZZO paid Medikol HRK 9,000 for each examination with the expensive PET/CT instrument, which is more than the cost in the countries in the region, including Austria, Slovenia and Hungary. In November and December 2007, Medikol was paid the first HRK 3 million by HZZO. In 2008, Medikol was paid HRK 42 million. In 2009, when Croatia was hit by recession at full speed and citizens had to pay a crisis tax, the crisis did not exist for Medikol because HZZO paid them in that year HRK 76 million. In the recession year 2010, Medikol's earning from HZZO grew to HRK 110 million. The director of Medikol, Ivan Rajković, explained to the journalist of Večernji list that his company had large expenses, and said that each PET/CT instrument, along with the premises in Croatian hospitals, costs about EUR 5 million, which is HRK 37 million. Given the fact that HZZO paid Medikol in 3 years the total amount of HRK 231 million, the expense for all 3 instruments bought is covered and leaves a profit of HRK 100 million. The Croatian Radiologists' Association posed the question why the most modern diagnostic and therapeutic method in medicine is pulled out from public health and left completely to a private entity.[75]

Reform of the emergency medical care leaves some open issues regarding the accessibility of health care. The situation in less populated areas will probably not improve and some predict

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[74] Ibid.

[75] In February this year, six of the most prominent doctors and radiologists sent a letter to a few relevant addresses, where they warn about the euthanasia of our public health and academic radiology. When the first PET/CT instrument arrived in the Vinogradska, the Radiologists' Association was thrilled, believing that the instrument was the property of the hospital. Only after it was installed they found out it was owned by the company Medikol. Professor Ranka Štern Padovan, Head of the Department for Radiology of the Medical Faculty in Zagreb and Head of the Radiology on KBC Rebro, stated that the problem is not that private entity owns PET/CT instruments, but that there is no such instrument owned by a public hospital, meaning that this medical branch was completely pulled out from the public system, which is not the practice in any western European country. Professor Štern Padovan, one of the leading authorities in the radiology field in Croatia warned that a random privatisation of health care is carried out, without laws and without a coherent concept. The consequence will be endangering the health of people, because in the long run this service will be available only for the rich. Štern Padovan says that the experts, who were invited by the ministry in the Committee for Radiology, pointed out the harmful practice already after the first PET/CT instrument was installed in Vinogradska, in two meetings held in the ministry in March and June 2008. They also warned the HZZO that they are paying Medikol one of the most expensive prices in Europe. There were no reactions from the competent authorities to their warnings.

that it might even deteriorate. Particular concern should be devoted to the provision of emergency health care on islands, especially during summer time when the population multiplies by several times. Phyisicians from the islands warn that emergency transport of patients is completely neglected, especially since the project for the acquisition of ER-boats has been abandoned.[76]

Policies and strategies regarding the acquisition of medical equipment and staff should reflect regional differences and take into account various indicators, including population health surveys and existing capacities, as well as waiting lists on certain procedures, so as to enable better and even access to health care in different regions and avoid complete centralisation and concentration on services provided in the City of Zagreb.

Sustainability of health care will also depend on the future developments and trends in medical specialist and polyclinic activities, i.e. the proportion of specialist and polyclinic medical examinations in the total number of examinations in primary health care. This number has steadily grown from 37% in 2000 to 46% in 2009.[77] It is suggested that the filtering of referrals to specialist examinations and therapies by primary health care providers could keep the same quality of treatment, while bringing the needed rationalisation of health consumption. Primary health care providers are more than equipped to handle some of the necessary diagnostic procedures themselves, which could take some burden of the providers of specialist care and enable them to concentrate on their fields of expertise.[78]
Opening up the market for selling additional insurance to the Croatian Health Insurance Institute could cause imbalances in the equality of access. Some estimates show that those paying less money to this public fund might even receive better service.[79]

2.4 Long-term Care

2.4.1 The system's characteristics and reforms

Long-term care in Croatia is organised within the system of social welfare, at the national as well as the regional level. The legal framework for social benefits includes the Social Welfare Act,[80] Foster Families Act[81] and numerous by-laws. Two basic categories of recipients of social assistance and welfare are those, on the one hand, who do not receive any income or whose income is below the prescribed census, and on the other hand, persons who receive assistance in order to satisfy their personal specific needs, resulting mostly from disability, old age, psychological conditions, addiction, etc. (including children and young persons without

[76] For example, the transport of an injured person from the island of Mljet to the nearest hospital in Dubrovnik takes more than three hours in perfect conditions. Newspaper article, Novi list, 8 February 2011.
[77] Croatian Health Service Yearbook 2009, The Croatian National Institute of Public Health (2010) Zagreb, retrieved on 21 April 2011 from http://www.hzjz.hr/publikacije/hzs_ljetopis/index.htm.
[78] Ibid.
[79] Calculations show that the amount annually collected from citizens with average wage who pay mandatory health care contributions and supplementary insurance is HRK 15,612; the amount collected from those receiving a wage of HRK 10,000 and who pay supplementary insurance is HRK 30,360, and both of these groups recive the same basic insurance package. However, citizens who do not receive a wage (i.e. do not pay mandatory health care contributions) or those who are using loopholes in the system and report minimum wage (i.e. pay comparatively less mandatory health contributions), but pay additional insurance in the same fund, receive better and more quality services; even if the amount collected from them on an annual basis is comparatively smaller. These estimates are published in the newspaper Novi list, 17 January 2011.
[80] Official Gazette of the Republic of Croatia, *Narodne novine* no. 73/97, 27/01, 59/01, 82/01, 103/03, 44/06, 79/07.
[81] Official Gazette of the Republic of Croatia, *Narodne novine* no. 79/07.

parental care, children and young persons with behavioural disorders and victims of family violence).[82]

Long-term care is organised on the principle of social assistance and financed mainly from the state budget (96%), while the remainder comes from beneficiaries' participation in payment of costs of care outside one's own family. Local and regional self-governing units participate in the financing of the system as well. In 2009, expenses for financing of the social welfare system amounted to 0.89% of GDP.

Assistance is directed towards persons who are dependent on help with basic activities of daily living, caused by chronic conditions or physical or mental disability. Pursuant to Article 10(2) and (3) of the Social Welfare Act, the beneficiary receiving social welfare is defined, amongst others, as a single person or a family member or the entire family, who is an adult with physical or mental disabilities, or frail elderly, person incapable of looking after himself/herself or any other person who is not able to fulfil his/her vital needs due to permanent or temporary changes in health conditions.

The benefits include benefits in kind and cash benefits.

Cash benefits include an allowance for assistance and care, for example, and are granted to persons unable to care for themselves, on a permanent or temporary basis. Means-testing is applied, meaning that a person is eligible for this kind of assistance if his/her income in the three months preceding the application does not exceed 200% of the base amount (per family member) or 250% of the base amount (single persons).[83]

Currently, the basis for the realisation of social welfare rights amounts to HRK 500 and it is determined under the decision on the basis for the implementation of the social welfare rights.[84]

In-home assistance (including delivery of meals, housework, and assistance with personal hygiene) to persons having no other assistance from their family members is an example of the administered benefits in kind.[85] There also exists a range of institutionalised forms of care, e.g. permanent or temporary accommodation or even daily or shorter stays in care centres. Elderly people mostly rely on permanent assistance, supplement for assistance and care at home and personal disability allowance.

Out of 519,033 persons with disability in the Register of Persons with Disability, there were 203,098 persons over 65 years of age, representing a share of 39.1% in the total number of disabled persons.[86] Disabled persons in general represent 11.7% of the total population of the Republic of Croatia, while the frequency of disability in the age cohort of 65+ is 29.3%. Approximately equal share of men and women is specific for this age cohort, given that the proportion of men is generally higher in the total number of persons with disability (the ratio is 59.7% of men as opposed to 40.3% of women). In the age cohort 65+, there are 36% (73,794) of disabled persons who are beneficiaries within the system of social welfare. The largest number of disabled persons in this group (50,922 or 69.7%) lives with their family, while 27.8% or 20,288 live alone. 2% or 1,461 disabled persons over 65 reside in an

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[82] Babić, Z. Uloga socijalne pomoći u politici prema siromaštvu u Hrvatskoj (The Role of Social Welfare in the Policy against Poverty in Croatia), *Privredna kretanja i ekonomska politika* 116/2008, Ekonomski institut, Zagreb, 2008, pp. 53 – 81, 64

[83] Social Welfare Act, Article 43(1).

[84] Official Gazette of the Republic of Croatia, *Narodne novine* no. 30/08.

[85] Social Welfare Act, Article 50(1).

[86] Benjak, Tomislav, Osobe s invaliditetom u dobi 65 i više godine (Persons with disability in the age cohort 65+), Hrvatski zavod za javno zdravstvo (2010).

institution. Approximately 20% of persons have inappropriate living conditions, while 67% of them are entitled to cash benefits – allowance for assistance and care.

On 6 April 2011, the draft of the new Social Welfare Act entered the ordinary parliamentary procedure in the Croatian Parliament. It was adopted in the first reading, and is currently subjected to amendments and the preparation of the final draft. The draft act is the result of a comprehensive social welfare reform, which includes the reform of cash benefits, the system of social services, the mode of their financing and the system of public social welfare centres. The amendments are aimed at simplifying the system and providing better and more efficient access to services and benefits. Among the proposed changes, which have caused lively public debate even before the draft act entered into parliamentary procedures, are the reduction of the existing 15 cash benefits with different criteria and conditions for obtaining them to eight, better targeted and defined ones, clearer division between cash benefits and the provision of social services and rationalisation of the network of social services centres.[87] One of the core reform targets is deinstitutionalisation, i.e. the provision of non-institutionalised forms of social services, with the introduction of nine basic social services.
The new draft act will include the provisions regarding generational solidarity and residence, whose purpose is to "improve the quality of life of elderly".[88] Under the act, elderly persons are defined as persons belonging to the age cohort 65+, however, even persons under this age threshold are eligible for this type of services if they are indispensable due to temporary severe health aggravation, and are provided for the duration of such condition. The proposed services, as defined in the draft act, include "different types of services to persons with secured housing and other living conditions, who, due to old age, exclusion, diminished functional capacities or other severe changes of their health conditions, are unable to take care of their basic personal needs alone or with the help of their family member, and are in need of assistance" (Article 120(1) of the Draft Act). The services are generally stated to include assistance with household and other activities, assistance with social integration and other assistance indispensable for the beneficiary (Article 120(3) of the Draft Act). The ministry responsible for generational solidarity organises various activities and services for proactive spending of free time, with the aim of promoting social integration and inclusion and participation of volunteers from all age cohorts (Article 121 of the Draft Act). The services will be provided by legal and natural persons, who have signed a contract with the ministry (Article 123(1) of the Draft Act). Another novelty is the legally prescribed obligation to provide such services in accordance with the minimum quality standards, which will be laid down by the competent minister, as well as all other criteria for the provision and participation in payment of such services (article 122 of the Draft Act).

Currently, LTC schemes boil down to two programmes: 'In-home assistance for the elderly' and 'Daycare and in-home assistance for the elderly'. As can be concluded from the draft Social Welfare Act, this will basically continue in the future. So far, this service was provided without charges for the beneficiaries. The draft act leaves open the possibility of a certain type of participation in payment of such services. The state and the local communities have a share in financing of the programmes. Long-term care rests mainly on public funding and organisation of the provision of services, while there are no incentives from the state for private insurance schemes, apart from limited incentives for saving within the voluntary pension insurance schemes (see chapter 2.2.5).

[87] The Croatian Parliament, Draft Act 746 – Social Welfare Act, retrieved on 21 April 2011 from: http://www.sabor.hr/Default.aspx?art=38514.
[88] The Croatian Parliament, Explanation accompanying the Draft Act 746 – Social Welfare Act, retrieved on 21 April 2011 from: http://www.sabor.hr/Default.aspx?art=38514.

Private providers will be the primary service providers if the new draft act is adopted in its current text. Provision of services will be based on a contract, concluded with the ministry competent for generational solidarity.

With the new draft act, the traditional role of family care and solidarity in informal care will be given even more weight. Under the draft act, a person is eligible for assistance only if he/she cannot take care of his/her needs by him/herself or with the help of a family member. Although not explicitly stated here, it follows that the general definition of family from the act applies, whereby a family includes only specified relatives who live together. This condition should be defined with more precision. It is clear that the intention of the act is to put family-based care first, even though the status of a caregiving family member for the frail elderly is not recognised. However, finding an appropriate mode for fostering this type of family solidarity, through tax incentives, a system of cash and in-kind benefits, adjustments in employment relations (caretakers are usually children of the elderly person in need of care, who are still employed), etc. is not the focal point of discussions at the moment. Facilitated home care could reduce the demand for institutional services, which surpasses supply by dozens of times, as well as non-institutional forms of care. The provision of home and community/residence care should be expanded and fostered together with the implementation of quality insurance mechanisms, for example through obligatory care consultancy, in-home visits by supervisors, free care courses, etc.

So far, austerity programmes have not produced a negative impact on financing of current long-term care programmes. However, the introduction of the social pension is once again delayed. Since it is basically a form of social assistance to elderly without income, it was supposed to be part of the new Social Welfare Act, but this solution was abandoned by the government. Instead, there are indications that a new, separate act on social pension is in preparation. Members of the opposition have already criticised this announcement, claiming that the state budget with the growing deficit and foreign indebtedness cannot support payment of social pensions, and that the next government will be left with an impossible mission to secure the means for payment of such obligation, if the act were to be adopted prior to the elections.[89]

2.4.2 Debates and political discourse

The programme for the development of services for elderly persons based on intergenerational solidarity in the period from 2008 to 2011[90] was adopted in 2007 and is still in force. Priority and goal of the programme is the provision of non-institutional long-term care through involvement of various actors at state and local level (state and local authorities, representatives of the civil society, religious organisations as well as elderly and members of their family), which should produce long-term results, more humane treatment and participation, respecting the right of the elderly to choose how to live their lives. According to the data provided by the Ministry of Family, War Veterans from the Homeland War and Generational Solidarity,[91] it appears that the goals of the programme are mainly achieved – there are 84 operational programmes ("In-home assistance for the elderly" and "day care and in-home assistance for the elderly") (the programme sets a minimum of 64 running programmes at the end of the 2011) covering 15,200 elderly persons in 20 counties. There

[89] Newspaper article, Večernji list 19 October 2010, retrieved on 23 April 2011 from http://www.vecernji.hr/vijesti/predizborne-penzije-onima-koji-nisu-radili-700-kuna-mirovine-clanak-204789.

[90] Official Gazette of the Republic of Croatia *Narodne novine* no. 90/07

[91] Data retrieved on 27 April 2011 from http://www.mobms.hr/ministarstvo/uprava-za-medugeneracijsku-solidarnost/izvaninstitucionalna-skrb-o-starijima/programi-medugeneracijske-solidarnosti.aspx.

were no cutbacks of the financial envelope of HRK 40,000,000 (approximately EUR 4.5 million) for the final year of the programme (2011) earmarked in the state budget.

Public awareness of the importance of long-term care is slowly rising, with the rapid demographic ageing and the traditional role of the family as a fall-back mechanism of care for the elderly diminishing due to changed lifestyles. However, this issue is still not brought to forefront. The Strategic Plan of the Ministry of Family, War Veterans from the Homeland War and Generational Solidarity 2011-2013[92] does provide for a public promotion of positive attitudes towards the elderly, through media, round tables, conferences, commercials and billboards, but its effects remain to be seen.

Table 8: Croatia's population by age groups by population censuses from 1953 to 2001

Census (year)	No. of population	0-14 (%)	15-64 (%)	65 and above + unknown
1953	3,936,022	27	66	7.0
1961	4,159,696	27.2	65.3	7.5
1971	4,426,221	22.6	67.2	10.2
1981	4,601,469	20.9	66.9	12.2
1991	4,784,265	19.4	67.5	13.1
2001	4,437,460	17.1	67.2	15.7

Source: *Croatian Health Service Yearbook 2009, The Croatian National Institute of Public Health (2010)*

One of the general targets of the mentioned strategic plan is the improvement of the quality of life of sensitive groups, including dependent elderly, through promotion of active ageing, improved relations and solidarity between generations and especially volunteering. This target should be accomplished with the expansion of the network of non-institutional forms of care for the elderly, primarily in isolated areas and areas with a high percentage of dependent elderly persons. The following period will not bring about substantial changes, since the only actual measure is the expansion of the already existing (and functioning) model. Apart from that, local communities are mainly left to themselves to organise and administer other programmes for their dependent elderly population, which will depend on the size, available resources, needs etc.

2.4.3 Impact of EU social policies on the national level

As in the field of pensions and health care, the JIM follow-up process and the National Implementation Plan for Social Inclusion (NPPSU) 2011 – 2012 integrate the Europe 2020 Strategy. One of the key priorities is to expand the network of social services for children, elderly and disabled persons, draft the action plan on deinstitutionalisation of services and shift the provision of necessary services to the community. Deinstitutionalisation and decentralisation is described in the NPPSU as the absolute priority, however, they slowed down in 2009 and 2010 due to economic and fiscal difficulties. The plan provides for the expansion of services of in-home assistance and daycare from 75 to 83 programmes of generational solidarity, expansion of such services to other local communities and beneficiaries, application of minimum standards for service and drafting of the legislative basis for those types of services. Planned budgetary funds for this purpose in 2011 and 2012 are equal and amount to HRK 8,081,500.

[92] Strategic plan of the Ministry of Family, War Veterans from the Homeland War and Generational Solidarity 2011-2013, retrieved on 26 April 2011 from http://www.mobms.hr/media/307/strateski_plan_2011-2013-dodavanje_tablica.doc.

The Europe 2020 Strategy is integrated in the new draft Social Welfare Act, according to the explanation of the rationale and targets. It served as a basis and a guideline for the creation of the new act, but there are no further references to it in the text or the comments of the draft act.[93]

2.4.4 Impact assessment

According to the Strategic Plan of the Ministry of Family, War Veterans from the Homeland War and Generational Solidarity 2011 – 2013, the expansion of the network of non-institutional services in the upcoming two-year period should include additional 5,000 elderly persons, i.e. approximately 20,000 persons would benefit from the programme by the end of that period. This type of service is advocated because, as stated in the programme for the development of services for elderly persons based on intergenerational solidarity in the period from 2008 to 2011, it achieves long-term results at relatively lower costs and activates the role of the family and beneficiaries themselves.

According to the strategic plan, a comprehensive independent evaluation of services provided to the elderly population was conducted in 2009. One of the main findings concerned the need to develop minimum quality standards in order to improve and balance the quality of the programmes and their accessibility and sustainability. This task should be conducted in the forthcoming period and the standards should apply to local self-governing units, service providers and should define the role of the Ministry as well. Under the draft Social Welfare Act, minimum standards for service providers and quality of services of generational solidarity will be prescribed by the minister of generational solidarity.

Due to economic crisis, all public expenditure, including the costs for social protection system, has been temporarily frozen in an effort to contain high budgetary deficits. Nevertheless, no significant cutbacks and austerity measures have been taken within this segment of social protection.

2.4.5 Critical assessment of reforms, discussions and research carried out

The inclusion of provisions on services based on generational solidarity in the new draft Social Welfare Act is more than welcomed, but the rules should be more clearly defined, so as to eliminate any possibility of dubious interpretations. The explanation accompanying the draft act is very concise at best and will not provide any assistance in case of ambiguities. One of the most important tasks after adoption of the act will be to devise and implement quality assurance standards which will guarantee that services are planned and performed at satisfactory levels.

However, further development of institutional forms of care is still required, given the alarming number of elderly people who currently need it, but are entirely left to the care of their families. This is true for hospices and institutions of palliative care, as well as homes for the elderly. Available records show that almost 30% of persons with a disability over 65 years of age live alone and 20% do not have appropriate living conditions (see Section 1.4.1.) A notable exception is the organisation of three mobile teams for palliative care which operate within the local health centre in the City of Rijeka and are co-funded by the Croatian Health Insurance Institute, City of Rijeka, Primorsko-goranska County and several other municipalities. These teams are organised within the system of primary health care and the

[93] The Croatian Parliament, Draft Act 746 – Social Welfare Act, retrieved on 26 April 2011 from http://www.sabor.hr/Default.aspx?art=38514.

funds for their operation are about HRK 1.5 million annually.[94] One team, comprising of a medical doctor and a nurse, can visit up to seven patients a day. Three existing teams are still insufficient to cover the needs of the county, given that it is estimated that most of the patients using such care are those with malignant diseases and that around 1,000 people with malignant diseases die each year in the county. However, this model could serve as an example for organisation and improved accessibility of long-term care services at local levels, even without a coherent policy at state level.

There are currently 47 homes for the elderly established and owned by the counties, as well as 20 homes for mentally ill elderly persons established and owned by the state.[95] Institutional capacities of the counties are insufficient to cover the demand. For example, in the Primorsko-goranska county, there are approximately 1,200 beds in homes for the elderly (both county and private), while demand surpasses the offer by more than 100%. Waiting time was almost one and a half years, and there were 1,765 persons on the waiting list for county homes in Primorsko-goranska County.[96] Thus, more efforts are needed to reach the OMC objective of improved access to long-term care.

Quality indicators for long-term care need to be devised, especially when it comes to private providers.

A necessary precondition for the implementation of the new draft Social Welfare Act and a prerequisite for fairer and more just social transfers within the system of social welfare is the full application of PIN and cross-comparability of different records and registers, as well as cooperation between different authorities at central, regional and local level. Namely, given that social benefits are based on income and assets test, verification of assets owned by an individual seeking assistance is essential for avoidance of duplication of benefits, and ensuring that they are received by those who really need them. This measure is envisaged under the Government Economic Recovery Programme – exchange of data on assets ownership between the tax administration and various other records, which is based on personal identity number of the citizen (PIN). It has not completely come to life yet and the overall reluctance of the government to take more substantial steps, which could mean abolishment of certain rights and/or redirection of payments to other segments, is noticeable.

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94 Newspaper article, Novi list, 3 January 2011.

95 According to the catalogue published by the Ministry of Health and Social Welfare, retrieved on 29 April 2011 from http://www.mzss.hr/hr/adresar_ustanova/ustanove_socijalne_skrbi/domovi_za_psihicki_bolesne_odrasle_osobe_domovi_ciji_je_osnivac_republika_hrvatska and http://www.mzss.hr/hr/adresar_ustanova/ustanove_socijalne_skrbi/domovi_za_starije_i_nemocne_osobe_domovi_ciji_je_osnivac_zupanija.

96 According to data from May 2010, Novi list, 21 May 2010.

References

BABIĆ, Z. (2008) Uloga socijalne pomoći u politici prema siromaštvu u Hrvatskoj (The Role of Social Welfare in the Policy against Poverty in Croatia), *Privredna kretanja i ekonomska politika* 116/2008, Ekonomski institut, Zagreb, 2008, pp. 53 – 81.

BEJAKOVIĆ, Predrag (2011) Mirovinski sustavi u RH, Problemi i perspektiva, Presentation prepared for the round table of the magazine Banka and the Institute of Public Finances, Zagreb, 19 January 2011, retrieved on 27 April 2011 from http://www.bankamagazine.hr/Projekti/Analizamirovinskogsustava.aspx.

BENJAK, Tomislav (2010) Osobe s invaliditetom u dobi 65 i više godine (Persons with disability in the age cohort 65+), Hrvatski zavod za javno zdravstvo, Zagreb.

MARUŠIĆ, Ljiljana (2011) Najniža i najviša mirovina, Presentation prepared for the round table of the magazine Banka and the Institute of Public Finances, Zagreb, 16 February 2011, retrieved on 27 April 2011 from http://www.bankamagazine.hr/Projekti/Analizamirovinskogsustava.aspx

VUKOREPA, Ivana (2011) Novele Zakona o mirovinskom osiguranju, Revija za socijalnu politiku vol. 18, no. 1, p. 93 – 97.

ZUBER, Marija (2011), Kontroverze važećeg sustava oporezivanja mirovina, Presentation prepared for the round table of the magazine Banka and the Institute of Public Finances, Zagreb, 17 March 2011, retrieved on 27 April 2011 from http://www.bankamagazine.hr/Projekti/Analizamirovinskogsustava.aspx.

3 Abstracts of Relevant Publications on Social Protection

[R] Pensions
- [R1] General trends: demographic and financial forecasts
- [R2] General organisation: pillars, financing, calculation methods or pension formula
- [R3] Retirement age: legal age, early retirement, etc.
- [R4] Older workers activity: active measures on labour market, unemployment benefit policies, etc.
- [R5] Income and income conditions for senior workers and retired people: level of pensions, accumulation of pensions with earnings from work, etc.

[H] Health
- [H1] Health expenditures: financing, macroeconomic impact, forecasting, etc.
- [H2] Public health policies, anti-addiction measures, prevention, etc.
- [H3] Health inequalities and access to health care: public insurance coverage, spatial inequalities, etc.
- [H4] Governance of the health system: institutional reforms, transfer to local authorities, etc.
- [H5] Management of the health system: HMO, payments system (capitation, reimbursement, etc.)
- [H6] Regulation of the pharmaceutical market
- [H7] Handicap

[L] Long-term care

[R] Pensions

[R1] BABIĆ, Zdenko, Dokumentacija: Izdaci za socijalnu zaštitu u Hrvatskoj – usporedba sa zemljama Europske Unije, in: Revija za socijalnu politiku 17/3 (2010), Zagreb 2010, p. 427-431.

"Document Analysis: Social Protection Expenditures in Croatia – Cross-comparison with the EU Member States (document analysis)"

Scientific and professional publications sometimes state different, even contradictory data on the level of expenditures for social protection in the Republic of Croatia. Consequently, they often reach a conclusion that social expenditures in Croatia are too high. The purpose of this contribution is to show the level and development of social protection expenditures in Croatia in the last couple of years, in accordance with the standardised international methodology. This enables the accurate cross-comparison with the EU Member States.

[R2] BAGARIĆ, Nevenka, Ostvarivanje prava iz mirovinskog osiguranja branitelja iz domovinskog rata – izmjene propisa, in: Hrvatska pravna revija 2 (2010), Zagreb 2010, p. 59-61.

"Realisation of the Rights from Pension Insurance of the Veterans of the Croatian Homeland War – Change of Regulations"

The criteria and the mode of assessment of pensions of the veterans of the Croatian Homeland War were modified in the amendments to the Law on the Rights of the Veterans of the Croatian Homeland War and the Members of their Families. The paper analyses the amendments which will contribute to decrease or even complete stop to the recognition of status of new beneficiaries of disability and family pensions to those categories.

[R3] BALOKOVIĆ, Snježana, Prijevremeno umirovljenje u Republici Hrvatskoj, in: Revija za socijalnu politiku 18/1(2011), Zagreb 2011, p. 61-76.

"Early Retirement in the Republic of Croatia"

The subject of paper is the review of early retirement system in the Republic of Croatia before pension reform, which began at the beginning of 1999, and a comparison with the system

after the introduction of reforms. Early retirement system is a part of pension insurance system in almost every European country, and was particularly popular in South- Eastern European countries, due to rather generous schemes. These systems are different, regarding conditions for entitlements to the early retirement, as well as regarding the amount of pensions. South-Eastern European countries have prescribed rather generous conditions for early retirement before the commencement of pension reforms, and at the same time the amounts of the early retirement pensions were relatively high. Those amounts were only slightly below the amount of old-age pension, although the right to an anticipatory pension could be acquired in average up to five years before the old-age pension. Therefore, the early retirement was very interesting for a large number of potential beneficiaries, so this kind of pension was not treated as an exemption, but as a rule for retirement as soon as people were entitled to it. Economic crisis is a kind of trigger for obtaining the right to early retirement, because sometimes it is the only way out of a new situation where job seeking could be rather unsuccessful due to bad conditions caused by the economic crisis. However, after the introduction of reforms, the rules for early retirement are more or less similar in all European countries.

[R] BEJAKOVIĆ, Predrag, Croatia: Social impact of the crisis and strengthening immunity, in: Društvena istraživanja 20/1 (2011), Zagreb 2010, p. 271-274.

This contribution is a presentation of the Report of the World Bank Group: Social Impact of the Crisis and Building Resilience by the author.

[R] BUSELIC, Marija, Family Structure and Demographic Picture in the Republic of Croatia, in: Ekonomska istraživanja 23/2 (2010), Zagreb 2010, p. 112-26.

The analyses of population movements in the Republic of Croatia are characterised by depopulation features, which have been especially prominent since 1991. Natural and mechanical population movements contribute to total depopulation. Natural depopulation is mostly caused by diminution in the number of marriages, divorce increment as well as marriages without children. An empirical research on students' population has been applied in our work in order to identify their attitudes towards marriage, family and children.

The results point to students' positive attitudes and the fact that these attitudes reflect their family structure and their provenience (urban, rural). They associate their positive attitudes with the later entry into marriage as a consequence of social and economic factors.

[R1; R2] GUARDIANCHICH, Igor, Pensions and Social Inclusion in Three Ex-Yugoslav Countries: Slovenia, Croatia and Serbia, in: Acta Oeconomica, 60/2 (2010), pp.161-95.

Building upon the research by Meyer et al. (2007), this study employs risk biographies to evaluate how three ex-Yugoslav pension systems cope with the social exclusion of the elderly. The article simulates pension entitlements in Slovenia, Croatia and Serbia and comes to two broad conclusions. First, the three pension systems that originated from a common legislative base, albeit in countries with marked differences in economic development, now diverge in almost every aspect. Hence, further research should analyse the entire retirement microcosm of the former Yugoslavia and delve deeper into the mechanisms of pension system evolution. Second, the study expounds the pros and cons of the three schemes and argues that none can avoid further reforms. Slovenian public pensions are excessively generous and

consequently require fiscal cuts, the Croatian funded tier is too small to complement lower public benefits, and the Serbian arrangements should be a temporary sacrifice to cope with fiscal austerity. The paper complements a traditional overview of the three systems by analysing the problems of each risk biography. It concludes by giving a number of prescriptive recommendations for the future well-being of the elderly in the region.

[R1] LAKOŠ, Ivan, Dokumentacija: O socijalnim učincima ekonomske krize u Hrvatskoj: utjecaj, odgovori i preporuke (analiza dokumenata Svjetske banke i UNDP-a), in: Revija za socijalnu politiku 17/3(2010), Zagreb 2010, p. 433-440.

"On Social Consequences of Economic Crisis in Croatia: Impact, Solutions and Recommendations (analysis of the World Bank and UNDP documents)"

The impact of the global crisis on the Croatian economy was severe, which produced profound social consequences. This paper presents the social dimension of the impact of the economic crisis in Croatian society by analysing recent documents (reports) of the World Bank and UNDP concerning Croatia. The paper scrutinises each document and provides a cross-comparison and puts them in relation with the Government's Economic Programme. The purpose is to show main findings and recommendations resulting from the analised documents.

[R3] RADIĆ, Mijat, Izjednačavanje dobi muškaraca i žena kao uvjet za mirovinu te prijevremeno umirovljenje – stanje u europskim zemljama, in: Radno pravo 9(2010), Zagreb 2010, p. 68-79.

"Equalisation of Retirement Age for Men and Women and Early Retirement – A Cross-comparison with European States"

The author compares different solutions regarding the equalisation of the retirement age for men and women and the conditions for early retirement existing in certain European states and in Croatia.

[R3] RISMONDO, Mihovil, Neke napomene o radu umirovljenika i primanju mirovine, in: Radno pravo 4(2010), Zagreb 2010, p. 49-52.

"Some Remarks on the Work of Pensioners"

The paper analyses the possibility of entering into an employment relationship while receiving pension and possible scenarios. The conditions for recalculation of pension are also considered.

[R3] RISMONDO, Mihovil, Odluka Ustavnog suda RH o izjednačavanju dobi muškaraca i žena za stjecanje prava na mirovinu i njezina primjena u mirovinskom osiguranju, in: Radno pravo 5(2010), Zagreb 2010, p. 52-71.

"Decision of the Constitutional Court of the Republic of Croatia Regarding the Equalisation of Retirement Age for Men and Women and its Application in the Pension System"

The paper provides an overview of the Decision of the Constitutional Court of the Republic of Croatia of 18 April 2007, whereby certain provisions of the Pension Insurance Act were annulled as contrary to the Constitution.

[R1; R2] RISMONDO, Mihovil, Hrvatski sustav mirovinskog osiguranja i europski socijalni model, in: Revija za socijalnu politiku 17/1 (2010), Zagreb 2010, p. 89-112.

"The Croatian Pension Insurance System and the European Social Model"

In the paper, the author compares the legislation that regulates the Croatian pension insurance system with the obligations from acquis communitaire in the context of the harmonisation of the legislation in the process of the accession of the Republic of Croatia to the European Union (EU). The author is not merely limited to the formal adjustment of the Croatian legislation with acquis communitaire, but also questions the adjustment of the Croatian pension system with the European social model which is applied in the pension system area, and which derives from acquis communitaire, as well as the practice in Western European countries. In the concluding part, the author determined the adjustment of the legislation that regulates the Croatian pension system with acquis communitaire, but also points out that a part of this system is not adjusted to the European social model.

[R2] ŠENHORST, Nevenka, Ustavnost mirovinskog sustava Republike Hrvatske, in: Pravo i porezi 5(2010), Zagreb 2010, p. 36-46.

"On the Constitutionality of the Pension System in the Republic of Croatia"

The author analyses the Decision of the Constitutional Court of the Republic of Croatia of 17 March 2010 regarding the constitutionality of certain provisions of the Pension Insurance Act.

[R2] SPETIĆ, Neven, Određivanje mirovine, in: Radno pravo 9-10 (2010), Zagreb 2010, p. 64-67.

"Calculation of Pension"

Subject matter of this paper is the calculation of pension, based on the Pension Insurance Act. Various practical examples for the calculation method are presented, with author's comments. Particular attention is given to the effect of service time on the amount of pension.

[R2] VUKŠIĆ, Zdravko, Mirovina iz prvog i drugog mirovinskog stupa, in: Hrvatska pravna revija 9 (2010), Zagreb 2010, p. 40-49.

"Pensions from the First and Second Pillar"

Pensions have lately become a never-ending topic for the electronic media. We are exposed to different comparisons of, for example, pension amounts in other countries (both the EU member countries and those which are not), how many retirees there are per person employed, i.e. how much of the state budget do countries allocate to pensions, etc. Different pension systems around the world are constantly being criticised by the public. As of 1 January 1999, the Pension Insurance Act is in force in Croatia (Official Gazette 102/98, 127/00, 59/01, 109/01, 147/02, 117/03, 30/04, 177/04, 92/05, 79/07 and 35/08). There were ten more or less

significant amendments to it which shows a need for further improvement and adjustment of the pension insurance system to the economic and social changes in the country.

The Croatian pension system ensures a right to: old-age pension, early retirement old-age pension, disability pension, family pension, minimum pension, basic pension, occupational rehabilitation, compensation for physical injury, compensation of travel expenses with regard to the realisation of insured rights (Article 4 of the Pension Insurance Act). Due to the economic crisis a significant number of employees were forced to go into the early retirement old-age pension. Early retirement old-age pension is a form of old-age pension that gives the user the right to pension in a given period of time before he reaches the age required for pension (as a rule, up to five years), and one which is followed by a certain decrease of the pension amount, depending on the insured person's age at the time the right to pension is being realised.

The purpose of this article is to demonstrate the implementation of the provisions of the Pension Insurance Act, the Compulsory and Voluntary Pension Funds Act (Official Gazette 49/99 to 71/07) and the Pension Insurance Companies and Payment of Pension Annuities Based on Individual Capitalised Savings Act (Official Gazette 109/99 to 107/07) on an insured person that is receiving pension from the first (compulsory pension insurance based on generational solidarity) and second pension pillar (compulsory pension insurance based on individual capitalised savings).

[H] Health

[H1] BABIĆ, Zdenko, Dokumentacija: Izdaci za socijalnu zaštitu u Hrvatskoj – usporedba sa zemljama Europske Unije, in: Revija za socijalnu politiku 17/3 (2010), Zagreb 2010, p. 427-431.

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[H4] BAGAT, Mario, DRAKULIĆ, Velibor, Utjecaj ekonomske recesije na tržište rata sustava zdravstva u Hrvatskoj, in: Liječnički vjesnik 132/3-4 (2010), Zagreb 2010, p. 76-80.

"The Influence of the Economic Recession on Health Care Labour Market in Croatia"

Trends in the labour market, as a result of global economic recession, are characterised by reduction of manpower activity, decreased number of employed and increased number of unemployed persons. As the result of economic recession more then million workplaces are expected to be lost in the European Union. The aim of this study was to analyse the influence of economic recession on labour market in general and health care labour market in Croatia. In Q1/2009, the number of employed persons in the European Union declined by –1.2% compared to the same quarter of 2008, while in Croatia the number of employed persons declined by –0.4%. The comparison of quarterly employment rate in Croatia and the European Union in the period from Q2/2008 to Q1/2009 was not significantly different (p=0.169, df=6, t=1.564, Student t test). Average unemployment rate in Q1/2009 in the

European Union was 8.1%±0.3 and it was increased by 9.4% compared to Q4/2008, while in Croatia the average unemployment rate in Q1/2009 was 8.4%±0.1 and it was increased by 3.3% compared to Q4/2008. Monthly changes of unemployment rates compared between the European Union and Croatia in the six month period (Q4/2008 and Q1/2009) was significantly different (p=0.001, df=10, t=4.425, Student t test). In the Croatian health care system in Q1/2009 the number of employed person increased by 0.7% compared to Q1/2008, while the number of unemployed persons in the same period was reduced by –1.0%. Trends in the labour market in Croatia follow the global trends in the labour market in times of economic recession, although the increase in unemployment in Croatia was slower than in the countries of the European Union. As a result of Croatian health care system organisation, system of financing, supply and demand on health care labour market, health care workforce in Croatia was less affected by recession than the workforce in Croatia in general.

[H] BEJAKOVIĆ, Predrag, Croatia: Social impact of the crisis and strengthening immunity, in: Društvena istraživanja 20/1 (2011), Zagreb 2010, p. 271-274.

This contribution is a presentation of the Report of the World Bank Group: Social Impact of the Crisis and Building Resilience by the author.

[H5] BOROVEČKI, Ana et al., Developing a Model of Healthcare Ethics Support in Croatia, in: Cambridge Quarterly of Healthcare Ethics, 19/3 (2010), Cambridge 2010, p. 395-401.

Croatia is a transitional society in that it is a country emerging from a socialist command economy toward a market-based economy with ensuing structural changes of a social and political nature—some extending into the health care system. A legacy from our past is that, until now, Croatian health care institutions have had no real experience with clinical ethics support services. When clinical cases arise presenting complex ethical dilemmas in treatment options, the challenges presented to the medical team are substantial. The case described below recently occurred on a ward in a university hospital in Croatia. An unexpected request from the patient's parents created a number of issues that needed to be addressed by the medical team, which was made more difficult by the lack of clinical ethics support services. Such cases press the question currently being debated as to what type of ethics support services would be suitable for Croatia and why.

[H] BUSELIC, Marija, Family Structure and Demographic Picture in the Republic of Croatia, in: Ekonomska istraživanja 23/2 (2010), Zagreb 2010, p. 112-26.

The analyses of population movements in the Republic of Croatia are characterised by depopulation features, which have been especially prominent since 1991. Natural and mechanical population movements contribute to total depopulation. Natural depopulation is mostly caused by diminution in the number of marriages, divorce increment as well as marriages without children. An empirical research on students' population has been applied in our work in order to identify their attitudes towards marriage, family and children.

The results point to students' positive attitudes and the fact that these attitudes reflect their family structure and their provenience (urban, rural). They associate their positive attitudes with the later entry into marriage as a consequence of social and economic factors.

[H3] GORJANSKI, Dražen / GAJSKI, Lidija / ŠKARIČIĆ, Nataša / SLADOLJEV, Srećko / MARUŠIĆ, Matko, Korupcija u hrvatskom zdravstvu, Osijek 2010.

"Corruption in Croatian Health Care"

The aim of this book is to clarify fundamental concepts related to corruption in health systems. It clarifies sources of corruption, conditions for it, manners of its achievement and suggests measures of its prevention. No specific cases of corruption are analysed, the book rather contains wider and systematic thoughts of corruption.

[H1] LAKOŠ, Ivan, Dokumentacija: O socijalnim učincima ekonomske krize u Hrvatskoj: utjecaj, odgovori i preporuke (analiza dokumenata Svjetske banke i UNDP-a), in: Revija za socijalnu politiku 17/3(2010), Zagreb 2010, p. 433-440.

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[H4] MRDULJAŠ-DUJIĆ, Nataša, KUZMANIĆ, Marion, KARDUM, Goran, RUMBOLDT, Mirjana, Job Satisfaction among Medical Doctors in one of the Countries in Transition: Experience from Croatia, in: Collegium Antropologicum 34/3 (2010), Zagreb 2010, p. 813-818.

The aim was to explore and compare the job satisfaction between family physicians and hospital specialists in Split, Croatia. The survey was carried out in 2005 and 2006. A validated questionnaire was composed of two parts: 92 statements and questions about job satisfaction in the form of a Lickert scale (range 1–5) and eight questions concerning demographic issues. The questionnaire was completed and returned by 165 hospital specialists from the University Hospital and by 131 family physicians from the Split County. Response rate for family physicians was 39.81% and 41.46% for hospital specialists. Hospital doctors were divided in two groups: internal and surgical. There were no significant differences between family physicians and hospital specialists in total job satisfaction ($F=1.02$; $p=0.41$). Family physicians were more satisfied with their workplace conditions than internal medicine specialists (19.37 ± 4.23 vs. 17.37 ± 4.59; $F=5.93$; $p=0.003$), and less satisfied with the possibilities for postgraduate training than surgeons (5.27 ± 1.90 vs. 6.59 ± 2.07; $F=9.26$; $p<0.001$). Global job satisfaction was rather low but does not differ between the three medical groups. Disparities were observed in some segments (opportunity for further training and academic advancement, vacation, and salary). The reason for the family physician's relative satisfaction may be due to stable working conditions, independence in organising work schedules and personal responsibility.

[H1; H4; H5] OZRETIĆ DOŠEN, Đurđana / ŠKARE, Vatroslav / ŠKARE, Tatjana, Mjerenje kvalitete usluge primarne zdravstvene zaštite SERVQUAL instrumentom, in: Revija za socijalnu politiku 17 (1), Zagreb 2010, p. 27-44.

"Measuring Health Care Service Quality by Using SERVQUAL"

The paper deals with the reflections on the problems involved in the measurement of the quality of health care services. It presents theoretical contributions to a study of specific characteristics of services marketing in health care, including a review of the results of a previous research which measured customer satisfaction with health care services.

Special attention is devoted to a presentation of the most frequently used model of service quality measurement or SERVQUAL, which is also widely used for measuring the service quality within health care. The paper presents the results of a research of the quality of health care services provided by primary health care institutions in the City of Zagreb and the Zagreb County (with a special emphasis on public sector health care institutions) by using the SERVQUAL scale. The research focuses on the extent to which the Croatian customers use the services of the public sector vs. those of private sector primary health care institutions. It attempts to determine the importance paid to individual dimensions of service quality and to find out whether there are any significant gaps between the perceptions by customers and their expectations of the quality of services provided by primary health care institutions. The results revealed a significant gap between the perceptions and expectations by health care service users, while showing that the gap varies according to different dimensions of service quality. The management of public sector primary health care institutions ought to improve their service according to all dimensions of service quality. At the same time, they should pay particular attention to the dimensions where this gap was found to be the largest, i.e. »responsiveness«, »assurance« and »reliability«. No connection was established between the size of the measured gap as far as any individual service quality dimension is concerned, and the significance of that particular dimension for service users as compared to other dimensions. The paper may prompt the management and employees of health care institutions to conduct further measuring of their service quality in the future so as to identify the elements which must be improved in order to enhance customer satisfaction.

[H1; H4; H5] RABAR, Danijela, Ocjenjivanje efikasnosti poslovanja hrvatskih bolnica metodom analize omeđivanja podataka, in: Ekonomski pregled 61 (9-10), Zagreb 2010, p. 511-533.

"Efficiency Assessment of Croatian Hospitals Using Data Envelopment Analysis"

Data Envelopment Analysis (DEA) is a non-parametric linear programming-based technique used for evaluating the relative efficiency of homogenous operating entities on the basis of empirical data on their inputs and outputs. It is suitable in cases where other approaches do not provide satisfactory results. The aim of this paper is its application in measuring the efficiency of 63 hospitals in the Croatian health care system on the basis of two inputs and two outputs. Comparison of the results of basic models having constant and variable returns to scale has shown the relevance of BCC model, and input-oriented model has been chosen. DEA identified efficient hospitals as benchmark members and those inefficient to be analysed as candidates for reorganisation. Sources and amounts of relative inefficiency, which were identified in each input and output, establish guidelines for needed improvements. As an extension of the basic model, we introduced categorical one that takes into account different levels of services provided by hospitals and isolate the impact of their unequal position in

efficiency results. Analysis showed no significant differences between results which leads to conclusion that the level of services has no great impact on hospital performance if it is evaluated through here selected inputs and outputs.

[H1] STAMENIĆ, Valerija, STRNAD, Marija, Urban-rural Differences in a Population-based Breast Cancer Screening Program in Croatia, in: Croatian Medical Journal 52/1 (2011), Zagreb 2010, p. 76-86.

Aim: To investigate urban-rural differences in the distribution of risk factors for breast cancer. Methods: The authors analysed the data from the first round of the "Mamma" population based-screening programme conducted in Croatia between 2007 and 2009 and self-reported questionnaire results for 924 patients with histologically verified breast cancer. Reproductive and anthropometric characteristics, family history of breast cancer, history of breast disease, and prior breast screening history were compared between participants from the city of Zagreb (n = 270) and participants from 13 counties with more than 50% of rural inhabitants (n = 654). Results: The screen-detected breast cancer rate was 4.5 per 1,000 mammographies in rural counties and 4.6 in the city of Zagreb, while the participation rate was 61% in rural counties and 59% in Zagreb. Women from Zagreb had significantly more characteristics associated with an increased risk of breast cancer ($P < 0.001$ in all cases): no pregnancies (15% vs 7%), late age of first pregnancy (≥30 years) (10% vs 4%), and the most recent mammogram conducted 2-3 years ago (32% vs 14%). Women from rural counties were more often obese (41% vs 28%) and had early age of first live birth (<20 years) (20% vs 7%, $P < 0.001$ for both). Conclusion: Identification of rural-urban differences in mammography use and their causes at the population level can be useful in designing and implementing interventions targeted at the reduction of inequalities and modifiable risk factors.

[H6] TOMIĆ et al., Regulating Medicines in Croatia: Five-year Experience of Agency for Medicinal Products and Medical Devices, in: Croatian Medical Journal 51/2 (2010), Zagreb 2010, p. 104-112.

Aim: To present the activities of the Agency for Medicinal Products and Medical Devices in the first 5 years of its existence and to define its future challenges. Methods: Main activities within the scope of the agency as a regulatory authority were retrospectively analysed for the period from 2004-2008. Data were collected from the agency's database and analysed by descriptive statistics. Results: The number of issued medicine authorisations rose from 240 in 2004 to 580 in 2008. The greatest number of new chemical and biological entities was approved in 2005. The greatest number of regular quality controls (n = 5833) and special quality controls was performed in 2008 (n = 589), while the greatest number of off-shelf quality controls (n = 132) was performed in 2007. The greatest number of medicine labelling irregularities was found in 2007 (n = 19) and of quality irregularities in 2004 (n = 9). The greatest number of adverse reactions was reported in 2008 (n = 1393). The number of registered medical devices rose from 213 in 2004 to 565 in 2008. Conclusion: Over its 5 years of existence, the agency has successfully coped with the constant increase in workload. In the future, as Croatia enters the European Union, the agency will have to face the challenge of joining the integrated European regulatory framework.

[H6] VOGLER, Sabine et al., Comparing Pharmaceutical Pricing and Reimbursement Policies in Croatia to the European Union Member States, in: Croatian Medical Journal 52/2 (2011), Zagreb 2011, p. 183-97.

Aim: To perform a comparative analysis of the pharmaceutical pricing and reimbursement systems in Croatia and the 27 European Union (EU) Member States. Methods: Knowledge about the pharmaceutical systems in Croatia and the 27 EU Member States was acquired by literature review and primary research with stakeholders. Results: Pharmaceutical prices are controlled at all levels in Croatia, which is also the case in 21 EU Member States. Like many EU countries, Croatia also applies external price referencing, i.e. compares prices with other countries. While the wholesale remuneration by a statutorily regulated linear mark-up is applied in Croatia and in several EU countries, the pharmacy compensation for dispensing reimbursable medicines in the form of a flat rate service fee in Croatia is rare among EU countries, which usually apply a linear or regressive pharmacy mark-up scheme. Like in most EU countries, the Croatian Social Insurance reimburses specific medicines at 100%, whereas patients are charged co-payments for other reimbursable medicines. Criteria for reimbursement include the medicine's importance from the public health perspective, its therapeutic value, and relative effectiveness. In Croatia and in many EU Member States, reimbursement is based on a reference price system. Conclusion: The Croatian pharmaceutical system is similar to those in the EU Member States. Key policies, like external price referencing and reference price systems, which have increasingly been introduced in EU countries are also applied in Croatia and serve the same purpose: to ensure access to medicines while containing public pharmaceutical expenditure.

[H1] VONČINA, Luka et al, Health Insurance in Croatia: Dynamics and Politics of Balancing Revenues and Expenditures, in: European Journal of Health Economics, 11 (2), Dordrecht 2010, p. 227 – 233.

Since 2002, the Croatian social health insurance system has undergone substantial reforms, initiated for the most part with the aim of addressing the perpetual financial deficits of the state health insurance fund. While the reforms focussed heavily on increasing the inflow of private funds into the health care system, underlying inefficiencies contributing significantly to poor financial performance have been largely ignored. Furthermore, contrary to demographic trends and developments in social health insurance schemes in other countries, funding health care became even more dependent on its main collection mechanism -payroll tax- and consequently on the employment ratio and wage level. Little effort has been made to diversify the revenue base or to increase the efficiency of revenue collection. Like other countries, Croatia is facing difficulties in adjusting its 'Bismarck' system to its changing demographic and socio-economic context. Instead of targeting a comprehensive effort at improving revenue collection and limitating unnecessary expenditure and system inefficiencies, simplified approaches to balance the budget have been implemented at a high price to users and with limited effect. As a result, the Croatian health insurance system now offers a lower level of financial protection, while still facing the problem of spending more than can be collected through the current mix of revenue collection mechanisms. The authors suggest that, in order to meet the sustainability requirement of the health financing system, measures affecting both revenue and expenditure should be considered and implemented. On the revenue collection side, the Croatian government must make further efforts to improve collection from the informally employed to broaden the base of contributing members; equally important is the diversification of revenue sources by increasing transfers from general taxation revenues. On the expenditure side, exploring inefficiencies of the delivery

system can be delayed no longer, and the introduction of effective cost-control mechanisms and financial discipline would seem to be unavoidable.

[L] Long-term care

[L] BABIĆ, Zdenko, Dokumentacija: Izdaci za socijalnu zaštitu u Hrvatskoj – usporedba sa zemljama Europske Unije, in: Revija za socijalnu politiku 17/3 (2010), Zagreb 2010, p. 427-431.

"Document Analysis: Social Protection Expenditures in Croatia – Cross-comparison with the EU Member States (document analysis)"

Scientific and professional publications sometimes state different, even contradictory data on the level of expenditures for social protection in the Republic of Croatia. Consequently, they often reach a conclusion that social expenditures in Croatia are too high. The purpose of this contribution is to show the level and development of social protection expenditures in Croatia in the last couple of years, in accordance with the standardised international methodology. This enables the accurate cross-comparison with the EU Member States.

[L] BEJAKOVIĆ, Predrag, Croatia: Social impact of the crisis and strengthening immunity, in: Društvena istraživanja 20/1 (2011), Zagreb 2010, p. 271-274.

This contribution is a presentation of the Report of the World Bank Group: Social Impact of the Crisis and Building Resilience by the author.

[L] BUSELIC, Marija, Family Structure and Demographic Picture in the Republic of Croatia, in: Ekonomska istraživanja 23/2 (2010), Zagreb 2010, p. 112-26.

The analyses of population movements in the Republic of Croatia are characterised by depopulation features, which have been especially prominent since 1991. Natural and mechanical population movements contribute to total depopulation. Natural depopulation is mostly caused by diminution in the number of marriages, divorce increment as well as marriages without children. An empirical research on students' population has been applied in our work in order to identify their attitudes towards marriage, family and children.

The results point to students' positive attitudes and the fact that these attitudes reflect their family structure and their provenience (urban, rural). They associate their positive attitudes with the later entry into marriage as a consequence of social and economic factors.

[L] LAKOŠ, Ivan, Dokumentacija: O socijalnim učincima ekonomske krize u Hrvatskoj: utjecaj, odgovori i preporuke (analiza dokumenata Svjetske banke i UNDP-a), in: Revija za socijalnu politiku 17/3(2010), Zagreb 2010, p. 433-440.

"On Social Consequences of Economic Crisis in Croatia: Impact, Solutions and Recommendations (analysis of the World Bank and UNDP documents)"

The impact of the global crisis on the Croatian economy was severe, which produced profound social consequences. This paper presents the social dimension of the impact of the economic crisis in Croatian society by analysing recent documents (reports) of the World Bank and UNDP concerning Croatia. The paper scrutinises each document and provides a cross-comparison and puts them in relation with the Government's Economic Programme.

The purpose is to show main findings and recommendations resulting from the analised documents.

[L] TOMEK-ROKSANDIĆ, Spomenka et al., Functional Ability of the Elderly in Institutional and Non-institutional Care in Croatia, in: Collegium Antropologicum 34/3 (2010), Zagreb 2010, p. 841-846.

Gerontology-public health indicators of functional ability of the elderly in institutional and non-institutional health care in Croatia were determined by use of expert methodology developed at Department of Gerontology, Dr. Andrija Štampar Institute of Public Health in Zagreb, with the aim to upgrade the Programme of Health Care Measures and Procedures in Health Care of the Elderly. Comparison of functional ability between the users of selected old people's homes (institutional care; N=5030) and gerontology centres (non-institutional care; N=2112) yielded highest between-group difference in the proportion of »fully movable« and »fully independent« categories in favor of the latter, thus steering the programme of health care for the elderly accordingly. In addition, study results showed greater difference in the proportion of categories describing mental status of institutional and non-institutional care users as compared with the categories describing their physical status, suggesting that mental status plays amore important role than physical status in the geriatric user's stay in non-institutional care versus institutional care. This issue requires additional studies. The results obtained by this indicator analysis pointed to the preventive and geroprophylactic measures to ensure efficient health care for the elderly and to develop the programme of mental health promotion and preservation. According to 2007 estimate, there were 759,318 (16.9%) persons aged 65 in Croatia. Data collected at gerontology database kept at Department of Gerontology, Dr. Andrija Štampar Institute of Public Health (September 2008) showed 2% of the elderly (N=14807) to be accommodated at old people's homes, which is below the European average of 4%.

4 List of Important Institutions

Ekonomski institut Zagreb – The Institute of Economics, Zagreb

Contact person: Maja Vehovec
Address: Trg J. F. Kennedyja 7, P.O. box 149, 10000 Zagreb, Croatia,
Webpage: http://www.eizg.hr/

The Institute of Economics, Zagreb is a public scientific institute that conducts scientific and development research in the field of economics. It is particularly dedicated to conducting empirical research in order to improve the understanding of Croatia's economy and identify policy measures that could spur its growth and development.
The Institute was founded in 1939, and owes its longevity to perseverance in the objectivity and quality of scientific research. Since then, the Institute has encouraged freedom of thought and expression. It is independent of any political structure or interest group, and unburdened by ruling ideologies. The impartiality in the scientific work is also derived from the institute's mixed financing – approx. 60% of the institute's income is paid from the state budget, while the rest is earned on the market and comes from donations.
Serial Publications:

- *EIZ Working Papers*
- *Economic trends and economic policy*
- *Croatian Economic Survey*
- *Croatian Economic Outlook Quarterly*

Hrvatski zavod za javno zdravstvo – The Croatian National Institute for Public Health

Contact person: Prim. mr. sc. Željko Baklaić, Head of the Institute
Address: Rockefellerova 7, 10000 Zagreb, Croatia
Webpage: http://www.hzjz.hr/index.htm

The Croatian National Institute for Public Health, established in 1923, is a central institution of public health in Croatia. Its task is to monitor and evaluate all factors influencing the health of the Croatian population, including contagious diseases, non-contagious massive chronic and acute illnesses, safe and healthy nutrition, public water supply and waste disposal, as well as information regarding laboratory diagnostics and analytics and various data regarding the organisation and operation of the health care system in its entirety. It publishes various reports and the Croatian Health Service Yearbook.

Institut za javne financije - The Institute of Public Finance

Contact person: Dr Katarina Ott, Head of the Institute
Address: Smičiklasova 21, 10000 Zagreb, Croatia
Webpage: http://www.ijf.hr

The Institute of Public Finance, founded in 1970, is a public institution dealing with research into primarily economic topics important for economic growth and development, transition to the market economy and meeting the requirements for European integration.
Under the general aegis of public sector economics, topics such as transparency, accountability and participation, the tax system, costs of taxation, progressiveness of taxation, fiscal federalism, the pensions system and the welfare system, public debt, the unofficial economy, state aid, foreign direct investment, the financing of science and higher education, and the relations between the executive branch and the legislature in the budgetary process are subjected to ongoing investigation.

Ministarstvo Gospodarstva, Rada i Poduzetništva – Ministry of Economy, Labour and Entrepreneurship

Contact person: Đuro Popijač
Address: Ulica grada Vukovara 78, 10 000 Zagreb, Croatia
Webpage: http://www.mingorp.hr

The Ministry of Economy, Labour and Entrepreneurship conducts active policy of employment and administrative and other work concerning industry as well as the involvement in European economic integration; coordination of activities concerning Croatia's membership in the World Trade Organisation and participation in multilateral trade negotiations within the framework of this organisation. The Ministry conducts administrative and other work concerning: work relations; labour market and employment; relationships with unions and employers' associations; labour law status of Croatian citizens employed in foreign countries and work concerning their return and employment in the county; labour law status of aliens employed in the Republic of Croatia; occupational safety; international cooperation in labour and employment sector and pension and disability insurance system and policy.

Ministarstvo zdravstva i socijalne skrbi Republike Hrvatske – Ministry of Health and Social Care

Contact person: Darko Milinović
Address: Ksaver 200a, 10 000 Zagreb, Croatia
Webpage: http://www.mzss.hr/

The Ministry of Health and Social Care does administrative and other tasks related to: protecting the population from infectious and non-infectious diseases, ionising and non-ionising radiation; health validity of foods and objects in an everyday use; use of health care potentials; construction and investments in health care; setting up of health care institutions and private practice; organisation of state and professional exams for health care personnel and their specialist training; recognition of primarius title; naming of health care institutions: referral centre, clinic, hospital clinic and hospital clinic centre; administrative supervision of functioning of Croatian Health Insurance Institute, Croatian Red Cross and chambers; health care inspection of functioning of health care institutions, health care employees and private practice; drugs registrations, pharmaceutical inspection of manufacturing and traffic of drugs and health products; sanitary inspection of manufacturing, traffic, use and disposition of poisons; manufacturing, traffic and use of narcotics ;sanitary inspection of persons and activities, buildings, offices, spaces, facilities and equipment which can have any harmful effects on human health; sanitary inspection of international traffic at the state borders.

Pravni fakultet Sveučilišta u Zagrebu, Studijski centar socijalnog rada – Faculty of Law, University of Zagreb, Social Work Study Centre

Contact person: Prof. Dr. sc. Siniša Zrinšćak
Address: Nazorova 51, 10000 Zagreb, Croatia
Webpage: http://www.pravo.hr

The Social Work Study Centre is a place of dissemination of knowledge and research activities in the fields of social policy. The departments organised within the Centre include the Social Policy Department, Department of Special Fields of Social Labour, Department of Social Gerontology, Department of Theory and Methodology.
Publishing activities within the Centre include the following publications:

- *The Journal of Social Policy – includes a variety of social policy issues, papers on pension, health, family, housing, educational policies, work related issues,*

unemployment, poverty, social assistance and other social issues and current processes in the society. Along with original papers, the journal also includes translated papers, various documents, statistical data and reviews.

- *Yearbook of Social Work Study Centre deals with various subjects, including theoretical and methodological findings and education in the field of social work. Papers from all applied fields of social work and associated fields are also published.*

Pravni fakultet Sveučilišta u Rijeci – Faculty of Law, University of Rijeka
Contact person: Prof. Dr. sc. Nada Bodiroga – Vukobrat
Address: Hahlić 6, 51000 Rijeka, Croatia
Webpage: http://www.pravri.hr/

International conferences in the field of social protection and insurance are organised each year under the auspices of the Faculty of Law Rijeka. The Organisation Committee is chaired by Professor Nada Bodiroga-Vukobrat. The last international conference was held in October 2010, under the title "Regulatory Agencies". In October 2009, the international conference "Open Methods of Coordination" was held, in 2008, the international conference "Social Rights as Fundamental Rights" took place, and in 2007 "Corporate Social Responsibility". In 2006, the topic was cross-border and regional cooperation, while in 2005 the international conference was entitled "Social Security and Competition – European Requirements and National Solutions".
The works of eminent scholars and participants in the conferences are published in the collection of papers which follows each conference.

This publication is financed by the European Community Programme for Employment and Social Solidarity (2007-2013). This programme was established to support the implementation of the objectives of the European Union in the employment and social affairs area, as set out in the Social Agenda, and thereby contribute to the achievement of the Lisbon Strategy goals in these fields. The seven-year Programme targets all stakeholders who can help shape the development of appropriate and effective employment and social legislation and policies, across the EU-27, EFTA and EU candidate and pre-candidate countries. The Programme has six general objectives. These are:

(1) to improve the knowledge and understanding of the situation prevailing in the Member States (and in other participating countries) through analysis, evaluation and close monitoring of policies;
(2) to support the development of statistical tools and methods and common indicators, where appropriate broken down by gender and age group, in the areas covered by the programme;
(3) to support and monitor the implementation of Community law, where applicable, and policy objectives in the Member States, and assess their effectiveness and impact;
(4) to promote networking, mutual learning, identification and dissemination of good practice and innovative approaches at EU level;
(5) to enhance the awareness of the stakeholders and the general public about the EU policies and objectives pursued under each of the policy sections;
(6) to boost the capacity of key EU networks to promote, support and further develop EU policies and objectives, where applicable.

For more information see:
http://ec.europa.eu/social/main.jsp?catId=327&langId=en