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Pensions, Health and Long-term Care

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Table of Contents

1 Executive Summary 3
2 Current Status, Reforms and the Political and Scientific Discourse during 2008 4
2.1 Pensions 4
2.1.1 Overview of the system 4
2.1.1.1 Legal framework 4
2.1.1.2 Financing 6
2.1.1.3 Retirement age (prerequisites for eligibility for old-age pension) 6
2.1.1.4 Pension formula 7
2.1.1.5 Disability pensions as a form of early retirement 7
2.1.1.6 Taxation 8
2.1.2 Overview of debates and the political discourse 9
2.1.3 Impact assessment 10
2.1.3.1 Financial sustainability of the pension system 11
2.1.3.2 Development of replacement rates 12
2.1.3.3 Labour market participation of the elderly 12
2.1.3.4 Gender impact of pension reforms 12
2.1.4 Critical assessment 13
2.2 Health 15
2.2.1 Overview of the system 15
2.2.1.1 Health care reform of the 1990s 15
2.2.1.2 Legal framework 17
2.2.1.3 Statistical data 21
2.2.2 Overview of the debates and the political discourse 21
2.2.2.1 National Strategy 21
2.2.2.2 The 2008 Reform 23
2.2.3 Impact assessment 25
2.2.4 Critical assessment of reforms 28
2.3 Long-term care 30
2.3.1 Overview of the system 30
2.3.2 Overview of the debates and the political discourse 31
2.3.3 Impact assessment 33
3 Impact of the Financial and Economic Crisis on Social Protection 34
4 Abstracts of Relevant Publications on Social Protection 37
5 List of Important Institutions 45

1 Executive Summary

National social security systems, as guarantors of citizens' social security, are a factor of social stability. The fundamental hypothesis is that Croatia as a transitional country needs to develop adequate social security models that are sustainable in market economy and that simultaneously respond to both European requirements in the process of integration and the requirements of the IMF and the World Bank, whose influence on the function and modalities of the social security systems was exercised through various means of financing of structural reforms in this area.

Internationalisation, globalisation, and an increase in mobility of capital and entrepreneurship activities and particularly in workers' mobility (in the light of European legislation) create the need for a reform of the national social security that resolves both legal issues and issues of macro-economic stability.

The impact of the global financial and economic crisis is evident from the deceleration of economic growth rates, weakened private consumption and investments downfall. GDP is expected to decrease by 3% this year.[1] The labour market has particularly negatively responded to the financial and economic turmoil. The number of unemployed persons is expected to rise by about 50,000, leading to an increase of the unemployment rate by 20% to about 14.6%.

These negative economic trends are likely to influence the progress of social security system reforms in Croatia.

Persistent concerns over financial sustainability of the pension system have lately been accentuated. Ageing population still represents a real challenge for the pension system's sustainability. The decline in the number of contributors to the pensions scheme, as a result of demographic trends, labour market participation, and unemployment rates, could only intensify the financial sustainability issues. A possible response could be in the implementation of incentives for later retirement, together with other measures of social inclusion. An increase of the percentage of contribution in the second pillar seems inevitable.

Financing of health care is still a tremendous burden. The population not contributing to the health insurance budget is twice as large as the number of employees who pay the mandatory contributions. The health care contribution payers/non-payers ratio is a clear indicator of the serious problems that the Croatian health care system is facing in the long run, especially in view of the expected further ageing of Croatian population. Expenses for the provision of health care remain persistently high. Possible solutions could include the promotion of a more efficient administration in hospitals, improved monitoring of the quality of services, auditing of financial operations of health care institutions and their results. More competition on the health care market is a necessity.

Long-term care, its accessibility, monitoring and access to information in this area need to be improved.

A general notion is that low visibility of measures, lack of coherent studies, larger public debates, and, in particular, a constant informational deficit persistently follows and shadows the progress and development of Croatia's social security system.

[1] The Institute of Economics, Zagreb, Croatian Economic Outlook Quarterly no. 38/2009 April 2009, http://www.eizg.hr/Item.aspx?Id=26&lang=1. The state budget rebalance, adopted in April 2009, is based on the Government's projections of GDP reduction of 2%.

2 Current Status, Reforms and the Political and Scientific Discourse during 2008

2.1 Pensions

The comprehensive reform of the pension system in Croatia started in 1998, with the introduction of the second and third pillar (see below) whose application was postponed until 2002. Pension insurance covers the risks of age, death and disability of the insured.

The pension insurance system is regulated by the Pension Insurance Act,[2] the Act on Compulsory and Voluntary Pension Funds,[3] and the Act on Pension Insurance Companies and Pension Payments based on the Individual Capitalised Savings.[4]

It is based on three levels:

1. Compulsory pension insurance based on generation solidarity (pillar I)
2. Compulsory pension insurance based on individual savings (pillar II)
3. Voluntary pension insurance based on individual savings (pillar III).

All three pillars of pension insurance came in force on 1 January 2002.

All employed persons are placed into 3 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) - 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, that 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).

2.1.1 Overview of the system

2.1.1.1 Legal framework

The Act on Pension Insurance regulates the general pension insurance based on generational solidarity (pillar I). The Act on Compulsory and Voluntary Pension Funds regulates the issues of compulsory pension insurance based on individual savings (pillar II) and voluntary pension insurance based on savings (pillar III). The Pension Insurance Companies and Pension Payments Based on Individual Savings Act regulates the payment of pensions when an

[2] 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 and 35/08.

[3] Official Gazette of the Republic of Croatia *Narodne novine* no. 49/99, 63/00, 103/03, 177/04, 71/07.

[4] Official Gazette of the Republic of Croatia *Narodne novine* no. 106/99, 63/00.

employee acquires the right to it. At that moment the funds from the account of a pension fund will be transferred to a pension insurance company which will make the payments of the pension to an insured person for life. The Decree on the Establishment of the Central Register of Insured Persons (REGOS)[5] regulates the establishment of REGOS, which has an important role in the functioning of the pension system. REGOS collects contributions of the members of compulsory pension funds and supervises the payment of contributions, keeps register of personal accounts of the members of compulsory pension funds, etc.

There are currently four registered compulsory pension insurance funds within the second pillar, six open voluntary pension insurance funds and 15 (12 of which are active) closed voluntary pension funds companies within the third pillar.[6]

Under the Act on Compulsory and Voluntary Pension Funds, pension funds represent separate property without legal personality, established for collecting contributions from the members of the fund and their investment on the market in order to increase their value and pay the pension benefits to the members of the fund.[7] Pension companies, established pursuant to the Pension Insurance Companies and Pension Payments Based on Individual Capitalised Savings Act, administer the pension funds.

Each member of the compulsory pension fund has a personal account, which represents his personal property and may not be used before retirement. It is not subject to forced execution and is not part of the insolvency assets of the fund. The amount on the personal account may not be pledged nor transferred to any other person but the member.

As far as the voluntary pension funds are concerned (third pillar), they may be organised as open funds, where everyone can become a member, and closed funds, designed for specific groups, i.e. employees of a certain company, members of the union or an association of self-employed persons. The state offers incentives for members of the voluntary pension funds (residents of the Republic of Croatia, or any Member State of the EU, provided that the person has compulsory pension insurance in Croatia), which amount to 25% of the assets paid in the previous calendar year, up to a maximum of HRK 5,000 (approximately EUR 675[8]). This incentive is funded from the state budget.

Strict principles for investment of the property of the pension funds are prescribed under the Act on Compulsory and Voluntary Pension Funds. Investment should be made exclusively in favour of the members of the fund, in accordance with the principles of safety, rationality and caution, loyalty etc. The same Act defines and enumerates the types of assets and securities in which the property of the pension fund may be invested, with or without the prescribed limitations. A list of prohibited investments is also prescribed. The Croatian Financial Services Supervisory Agency (HANFA) is authorised to extend the scope of admissible and prohibited investments, following the principles of safety, cost-effectiveness and marketability.

The prerequisites for realisation and the level of rights within the pension insurance have been changed in pension reform. Thus:

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5 Official Gazette of the Republic of Croatia *Narodne novine* no. 101/99.

6 The Croatian Financial Services Supervisory Agency, accessible at: http://www.hanfa.hr/index.php?LANG=HR&AKCIJA=80, last visited 15 May 2009.

7 Article 35 (1) Act on Compulsory and Voluntary Pension Funds.

8 When calculated at average an exchange rate of EUR 1.00 = HRK 7.4. Based on data obtained at InforEuro: http://ec.europa.eu/budget/inforeuro/index.cfm?fuseaction=currency_historique&currency=86&Language=en.

- The age for pension has been prolonged for five years (60 for women and 65 for men for old-age pension, early retirement: women 55, and men 60).
- The possibility of achieving an old-age pension on the basis of the years of employment regardless of the actual age has been abolished.
- Old-age pension could be realised in the transitional period depending on age which is the base for the early retirement pension, but the statutory period of employment is longer – 40 years of age for men, 35 for women.
- New method for calculation of the pension increases correlation of pensions with period and payments to pension insurance which, in turn, favours contribution payment and late retirements.
- The lowest and the highest pension are established proportionate to the length of the pension period. This encourages longer employment and later retirement.
- The definition of disability has been reduced to general and professional incapability for work, and working capability is defined according to all types of work that are appropriate for the physical and psychological capabilities of the insured person.
- Pensions of military personnel and officials employed in the police and judicial system have been lowered by gradual expansion of employment years taken in consideration in calculating the pension from one to ten most favourable years. Those were the categories privileged in the socialistic system.

2.1.1.2 Financing

Mixed financing (public and private) is evident through the pillar structure. The contribution rates are prescribed under the Act on contributions[9] and the Ordinance on contributions.[10] 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.

The share of total expenditures for pensions in GDP according to the available data for 2007 is at 11.15%. However, within that rate, 2.2% goes for payment of the so-called 'privileged pensions' to certain categories of pensioners, i.e. retired government officials and MPs being the most prominent category of pensioners, who receive significantly larger pensions than other categories of pensioners. This category also includes other pensioners who receive pension in accordance with special regulations, such as war veterans, police officers, judges etc. It is estimated that around 20% of the total number of pensioners receive privileged pensions.

2.1.1.3 Retirement age (prerequisites for eligibility for old-age pension)

A citizen is eligible for old-age pension upon the attainment of the age of 65 for men and 60 for women, provided that the person has (excluding disability and other factors) been

[9] Official Gazette of the Republic of Croatia *Narodne novine*, no. 84/2008 and 152/2008.
[10] Official Gazette of the Republic of Croatia *Narodne novine* no. 2/2009 and 9/2009.

employed for fifteen years. 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, provided that the citizen has performed 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.

2.1.1.4 Pension formula

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

Although recent legislative amendments (which entered into force in January 2008) changed one of the factors for calculation of early retirement pension benefit, resulting in more favourable terms, there is nothing to indicate that this amendment will serve as an incentive for early retirement. It rather aims at prevention of pauperisation and encompasses all beneficiaries from 1 January 1999. The statement of reasons following the Draft of the Act on Amendments to the Act on Pension Insurance[11] provides reasonable explanation of this measure. Namely, the percentage of reduction for each month of earlier retirement amounted to 0.34% pursuant to the legislative solution existing until then. This resulted in an up to 20.4% decrease of the early retirement pension benefit in comparison to the minimum old-age retirement pension benefit. Monitoring of the application of this provision showed that, given the permanent character of this decrease, this percentage was too high. Therefore, the amendments adopted in July 2007, which entered into force in January 2008, prescribed the new reduction percentage of 0.15%, resulting in up to 9% of total reduction in case the early retirement occurred five years before the fulfilment of conditions for old-age retirement.

2.1.1.5 Disability pensions as a form of early retirement

There are two different categories of coverage: disability, and accidents at work or professional diseases.

Disability coverage falls within the purview of pension insurance. Disability pension is granted in instances where a citizen's ability to work is diminished to such a degree that the statutory conditions are met, and where certain time limits as defined by the law are also met; though this latter test is not applied in instances of accidents at work or 'professional disease'.

[11] Draft Act on Amendments to the Act on Pension Insurance, accessible at official web pages of the Croatian Parliament: http://www.sabor.hr/Default.aspx?art=14829, last visited 10 November 2008.

Various forms of payment and services are envisaged for those meeting the eligibility criteria, including payment in kind in the form of treatment to facilitate rehabilitation.

Insurance coverage for accidents at work and 'professional disease' is provided under both the health insurance and pension insurance schemes, and as a corollary is administered by both the Health Insurance Institute and the Croatian Institute for Pension Insurance.

Payouts for work accidents and work-related illnesses should compensate for an inability to work. They will be guaranteed without requiring a waiting period and are based upon the degree of the reduced ability to work and are more generous than for illness and disability due to other causes.

2.1.1.6 Taxation

Personal allowance is preferential, i.e. higher than that of other categories of tax payers. Given that approximately 85% of pension benefits are below the personal allowance,[12] pensions are rarely taxed.

Table 1: Statistical data

2008 (month)	No. of contributors	No. of pensioners*	Dependency ratio**	Average pension (HRK[13])	Net replacement rate (%) ***	Estimate of necessary funds for payment of pensions (HRK)
December	1,604,848	1,148,290	1:1.40	2,126.91	n/a	n/a
November	1,616,184	1,145,438	1:1.41	2,129.17	40.46%	2,836,000,000
October	1,620,729	1,143,796	1:1.41	2,130.77	40.95%	2,929,000,000
September	1,629,857	1,141,656	1:1.43	2,121.23	40.92%	2,777,100,000
August	1,636,312	1,138,907	1:1.44	2,119.39	40.50%	2,924,000,000
July	1,639,795	1,138,137	1:1.44	2,044.84	39.57%	2,643,000,000
June	1,630,463	1,137,207	1:1.43	2,046.78	39.56%	2,673,000,000
May	1,612,892	1,137,991	1:1.42	2,042.67	40.56%	2,681,100,000
April	1,599,437	1,136,713	1:1.42	2,044.28	40.55%	2,680,000,000
March	1,587,050	1,135,526	1:1.40	2,040.79	40.87%	2,820,000,000
February	1,577,682	1,132,996	1:1.39	1,997.81	39.80%	2,860,000,000
January	1,571,522	1,128,777	1:1.39	1,997.90	40.30%	2,583,000,000

** including old-age, disability and family pensions*

*** ratio between contributors and pensioners*

**** net average pension expressed as a percentage of the net average wage*

Source: HZMO (Croatian Institute for Pension Insurance)

[12] Nestić, D., Rašić Bakarić, I., From work to retirement: Pension system incentives to continued labour market participation in Croatia, in: Vehovec, M., *New perspectives on a longer working life in Croatia and Slovenia*, The Institute of Economics, Zagreb and Friedrich-Ebert-Stiftung, 2008, p. 90.

[13] For exchange rate EUR – HRK, see supra fn. 8.

2.1.2 Overview of debates and the political discourse

Persistent concerns over financial sustainability of the pension system have lately been accentuated. This is partly due to the global financial crisis, which is influencing the Croatian economy as well. During the discussions regarding the Government's response to the financial crisis and preparation of the package of anti-recession measures at the beginning of 2009, the highest-ranking officials from the Government purportedly hinted to the idea of abolishing the second pillar, however, as these ideas met with the overwhelming public disapproval, any such statement that may have been uttered has been reinterpreted and/or recanted by the same officials and these ideas are not further pursued. Nevertheless, the Croatian financial market was temporarily disturbed as a result.

In March 2009, the Association of Companies Managing Pension Funds and Pension Insurance Companies presented their proposal for the reform of the pension system.[14] The Association believes that the main source of problems within the pension insurance systems lies with the first pillar, because it entails high contributions and expenditures which diminish the competitiveness of Croatian economy, leads to a high primary deficit of the pension system and results in a long-term fall of the ratio between average pension and average salary. The solution were the second pillar, which represents the accumulated property of the insured persons, with controlled expenses and comparatively correct contributions. They have emphasised the political neutrality of the second pillar, as it does not depend on political decisions of any of the current or future governments. However, the source of concern is the fact that, due to various factors, the first generation of insured persons which retire from the second pillar have comparatively lower pensions than the one they would normally have under the first pillar alone (this is the population which was 40-50 years old at the time when the reform was introduced and could have opted either to stay under the first pillar or transfer to the second pillar). A proposed solution to this problem is seen in the combination of the following measures:

- amendment of the formula for calculation of the basic pension;
- introduction of the pension supplement for all or some of the members of the second pillar which were 40-50 years old at the time the reform started;
- increase of the contribution rate for all or limited age groups;
- option to return to the first pillar after retirement.

Most scholars follow the same line of reasoning and advocate the reconstruction of the pension system to enable its financial sustainability and achievement of fundamental goals: decrease of pension system deficits and achieving higher pensions for insured persons in the second pillar on a long-term basis.

As a curiosity in the Croatian political arena, one can certainly mention the Croatian Pensioners' Party. Although its main area of interest lies in the improvement of the living conditions of the pensioners, its political influence is only marginal.[15]

The introduction of social pension benefits or 'state subsidies' for the elderly without any pension benefits is still not in sight. According to the UNDP Quality of Life Survey

[14] "Drugi stup mirovinskoga sustava: stvarno stanje i moguća poboljšanja" ("Second pillar of the pension system: actual status and possible improvements") accessible at: http://www.pbzco-fond.hr/news/IIStup_finalreport_Arhivanalitika.pdf, last visited 28 April 2009.

[15] The Croatian Pensioners' Party has but 1 MP in the current term of the Croatian Parliament: http://www.sabor.hr/Default.aspx?sec=2390.

conducted in Croatia in 2006, there have been roughly 86,400 persons over 64 years without any pension benefit, representing 12.4% of the population over 64 years (65+), i.e. 2% of the overall population of Croatia. Among them, 95% are women.[16] One of the implementing measures envisaged under the Programme of the Government of the Republic of Croatia 2008-2011[17] is the introduction of 'state subsidies' for elderly and other persons in need of care, who do not receive any income and are Croatian citizens above 65 years of age, have lived in Croatia for a period of 40 years without interruptions, or with interruptions for a period of 50 years. The amount of the state subsidy should be equal to the amount of permanent maintenance aid. Although the deadline prescribed for implementation of this measure was in the first half of 2008, no real attempts or discussions have been conducted as yet. Expert opinion tends to favour the model of social pensions integrated within the system of social care, which is based on the means-test and is better suited to the overall economical and fiscal conditions in Croatia.[18]

Other than those previously described, there were neither coherent attempts nor reform proposals in 2008. However, the reform of the pension system is far from completion. A more intense and substantial public debate on what seems to be an inevitable reform of the second pillar of the pension system is yet to be awaited.

2.1.3 Impact assessment

The sheer number of legislative amendments to the Act on Pension Insurance – to be precise, ten since it first entered into force in 1998 – leads to the conclusion that the pension reform is far from being over.

The impact assessment is based predominantly on the analyses of the functionality of the first pillar (PAYG scheme), since larger numbers of new pensioners with combined pensions from first and second pillars are not expected before 2010.

The most prominent short-term effects of the pension system reform are:

- increase of the retirement age of new pensioners: the average age of new pensioners has increased by three to five years in the period after 1998;
- decline in expenditures on pensions (as percentage of GDP): from 13.9% of GDP in 2001, the pension share gradually declined to 11.1% in 2007;
- improvement of the pension system dependency ratio: due to somewhat elevated economic growth in recent years (due to the current recession, this trend is likely to be overturned in the future);
- decrease in the replacement rate: a negative trend which possibly affects the decision to retire.[19]

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16 United Nations Development Programme (2007), Quality of life in Croatia: regional differences, Zagreb, 2007, accessible at: http://www.undp.hr/upload/file/171/85528/FILENAME/Regionalne_nejednakosti_hrv.pdf, last visited 10 November 2008.

17 Programme of the Government of the Republic of Croatia 2008 – 2011, accessible at: http://www.sabor.hr/fgs.axd?id=10650, last visited 28 April 2009.

18 Šućur, Z., Socijalna sigurnost i kvaliteta života starijih osoba bez mirovinskih primanja u Republici Hrvatskoj (Social security and quality of life of elderly without pension in the Republic of Croatia), *Revija za socijalnu politiku (Journal of Social Policy)*, volume 15, no. 3, Zagreb, 2008, pp. 435-453.

19 Nestić, D., Radišić Bakarić, I., op.cit., p. 86.

Studies conducted in 2002 showed that the pension system will, in the long term, be influenced by negative demographic developments. It was estimated that the number of insured persons will rise progressively until 2020, when there will be around 1.5 million insured persons. It was also predicted that the number of pensioners, after years of growth due to more lenient and favourable terms of early retirement in the 1990s, will thanks to pension system reform measures stagnate until 2010, when a large influx of new pensioners born during the 1950's baby boom is anticipated. However, in 2002, no increase in the rate of contribution in the second pillar in the long term was expected.[20] Those conclusions were based on the presumption of economic growth and increase in the number of employed persons and real increase of salaries. Another study based on the presumption of economic growth[21] predicts a decline in the number of pensioners to 1 million in 2050, when the ratio between the number of pensioners and the number of insured persons is expected to be 1:1.1, and 6.3% of the GDP would be spent on pensions.

The current worldwide economic crisis and recession will certainly influence and modify these presumptions and expectations.

2.1.3.1 Financial sustainability of the pension system

Decline in the working-age population and increase of older population and unemployed are persistent factors which over-burden the Croatian pension system. These adverse trends have been exacerbated by the negative consequences of the Homeland War and partly due to the trend implemented in the 1990s, whereby early retirement schemes were offered to older workers as a more humane alternative to lay-offs.[22] Negative democratic factors, high unemployment rates and low participation in the labour market lead to a higher dependency ratio of the pension system.[23] Even though the pension system reform improved, in general, the financial sustainability of the system, it still largely depends on activities on the labour market. The latest projections[24] show that in 2009, approximately 50,000 more workers will be laid off,[25] leading to an increase of the unemployment rate by about 20% (to 14.6%). Nevertheless, the dependency ratio of about 1:1.40 in 2008 is still seen as an improvement when compared to the lowest level of 1.36 in the period 2000 to 2002.

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20 "The Expected Trends in the Pension System of the Republic of Croatia in the Period up to 2040", edited by Puljiz, V., Zagreb, *Revija za socijalnu politiku (Journal of Social Policy)*, volume 9, no. 2 (2002): part of the larger document "*Pension and Social Care System Development Strategy*" drafted within the framework of Government project "*Croatia in the 21st Century*" (adopted by the Government of the Republic of Croatia in 2002).

21 Analiza dugoročnih fiskalnih učinaka demografskih promjena (Analyses of long-term fiscal impacts of demographic changes), Study, Institut of Economics Zagreb, 2006., accessible at: http://www.eizg.hr/AdminLite/FCKeditor/UserFiles/File/Sazetak%20-%20fiskalni%20ucinci%20starenja.pdf, last visited 10 November 2008.

22 Vehovec, M., "New perspectives on extending working life: Challenges for Croatia and Slovenia", in Vehovec, M., op.cit., p. 22.

23 Nestić, D., "Starenje stanovništva i financiranje mirovina u Hrvatskoj" ("Population ageing and pension financing in Croatia", accessible at: http://www2.hgk.hr/upolitika/prezentacije/cetvrtak/Danijel_Nestic.ppt; last visited 29 April 2009.

24 Institute of Economics, Zagreb, press clipping 38/2009 of 30 April 2009, accessible at http://www.eizg.hr/Item.aspx?Id=513&lang=1, last visited 30 April 2009.

25 Ibid.

2.1.3.2 Development of replacement rates

Low and discouraging are the best descriptors of the net replacement rate, which is calculated as the ratio of the average pension and the average wage. Peaking at 75.3% at the beginning of 1990s, it has since sunk to below 50%. In 2008, the average net replacement rate stood at around 40% (see Table 1 above). One must also take into account that the net replacement rate for women is even lower, given the lower amount of pension they receive on average (further addressed below).

2.1.3.3 Labour market participation of the elderly

Discouraging replacement rates are one (important) reason for later retirement and high participation of older workers in the labour market. Despite the fact that there are no legal obstacles to continue working (apart from some exemptions in the public sector), there exists a tradition of retiring immediately with the fulfilment of preconditions for old-age retirement (retirement age and years of employment service).

In addition, pensioners are allowed to combine pension with other income, e.g. from the one earned under service contracts, handicraft trades or secondary occupation, as long as it does not include employing other workers and the total income does not exceed a certain limit. However, work under an employment contract will immediately suspend the payment of pension.

There exist limited Government incentives for promotion of employment of elderly unemployed workers. In March 2008, the Croatian Government adopted the Annual Employment Promotion Plan for 2008, providing amongst other things incentive measures for employment of elderly unemployed persons. The target group includes women above 45 and men above 50 years of age. The measure consists of a monthly subsidy representing a percentage (in the range of 20% to 50%) of the established base amount of wages, and is aimed for co-financing of employment of the target group. The duration of the measure is 18 months. According to the data provided by CES (Croatian Employment Service)[26] out of 703 requests for co-financing received until 31 October 2008, 513 contracts have been signed, employing a total of 528 persons from this category.

2.1.3.4 Gender impact of pension reforms

Equal calculation of pension benefits is prescribed for men and women. However, since women are eligible to retire five years earlier than men, this results in lower pension benefits for women, due to (generally) fewer years of service. A female worker with life-time earnings at the level of national average earnings who retires at the minimum statutory retirement age could expect to receive around 12% lower pension than a male worker.[27] This, in turn, also affects the expected net replacement rate for women.

Among 12.4% of elderly population (65+) without any income, 95% are women.[28]

[26] http://www.hzz.hr/DocSlike/Mjere_20081031.xls, last visited 10 November 2008.
[27] Nestić, D., Rašić Bakarić, I., op.cit., p. 95.
[28] See supra fn. 12.

2.1.4 Critical assessment

The pension system reform, which was gradually introduced as from 1998, is seen generally as a necessary, if not long-overdue, transformation of the system which could no longer be supported. Nevertheless, it still carries with it some negative side-effects, among which the pauperisation of the pensioners is the most dangerous one.

During the past year, more than half out of total of 1,068,940 pension beneficiaries (old-age, disability and family pensions; data from December 2008[29]), i.e. 559,147 pensioners received pensions in the amount of less than HRK 2,000.

For example, in December 2008, the overall state average net pension amounted to HRK 2,129.17. In the same period, the minimum monthly living costs for two pensioners, according to the calculation of the Croatian Alliance of Independent Trade Unions (SSSH), was HRK 3,638.16.[30] The average pension thus could cover only approximately 58% of the minimum living costs. With pensioners representing almost a quarter of the entire Croatian population, the fact that almost half of them are living at the verge of poverty is indeed alarming.[31] According to the available data from 2007, the average at-risk-of-poverty rate in Croatia was 17.4%.[32] When compared by the prevailing activity status, apart from the economically inactive population and unemployed, pensioners were one of the most endangered population categories at risk of poverty (22.8%). The at-risk-of-poverty rate according to age and gender reveals that the most affected category includes persons above 65 years of age (31.4% of men and 25.2% of women).

Assessment of the progress made in implementing policy priorities and measures within the pension system, identified in the Joint Memorandum on Social Inclusion of the Republic of Croatia (JIM Croatia)[33] reveals the following:[34]

- *achieving long-term social security for elderly without any income and their protection in transitional period*:

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29 The total number of pensioners (which includes beneficiaries under the Pension Insurance Act, Act on Pension Insurance Right of Active Military Personnel, Police Officers and Authorised Official Persons, and the Act on the Rights of Croatian Veterans from the Homeland War and their Family Members, as well as the pension beneficiaries under the bilateral agreement with Bosnia and Herzegovina) in December 2008 amounted to 1,145,438. The number of contributors in the same period amounted to 1,616,184. The dependency ratio was at 1:1.41. Data accessible at : http://www.mirovinsko.hr/UserDocsImages/korisnici%20mirovina%202008/km12za11.pdf, last visited 30 April 2009.

30 http://www.sssh.hr/downloads/kosarica/01-2009.pdf, last visited 30 April 2009.

31 Novi list online edition, newspaper article published on 10 April 2009.

32 Priopćenje DZS: Pokazatelji siromaštva od 2005. do 2007., br. 14.1.2. od 26. rujna 2009. godine (Communication of the State Bureau of Statistics: Poverty indicators from 2005 to 2007), accessible at: http://www.dzs.hr/Hrv/Publication/2008/14-1-2_1h2008.htm, last visited 30 April 2009. The national poverty line lies at 60% of the national median income and is calculated for the population as a whole, i.e. the poverty indicators are based on a relative risk of poverty.

33 Joint Memorandum on Social Inclusion of the Republic of Croatia of 5 March 2007, accessible at: http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2007/JIM-croatia_en.pdf. "*In line with the Accession Partnership, the Government of the Republic of Croatia, Ministry of Health and Social Welfare has drawn up a Joint Inclusion Memorandum, together with the European Commission, Directorate General for Employment, Social Affairs and Equal Opportunities, which is designed to assist Croatia to combat poverty and social exclusion and to modernise its systems of social protection as well as to prepare the country for full participation in the open method of coordination on social protection and social inclusion upon accession.*."

34 The data are taken from the Implementation Report of the JIM Follow-up Process on Social Inclusion of the Republic of Croatia, between the Government of Croatia and the European Commission for the Period March 2007 – June 2008, Republic of Croatia, Ministry of Health and Social Welfare, Zagreb, July 2008.

The Government plan to introduce social pension in its mandate from 2008-2011 (see *supra*), set for the second half of 2008, was not developed.

- *review the role of the minimum pension*:

The methods of sustainable financing of the minimum pension are still in the process of development. The current mode of financing burdens the contributors, rather than all tax payers, and negatively affects labour costs. However, a simulation of a different model of the minimum pension financing has not been prepared yet.[35]

- *establish preconditions for involvement of pensioners in remunerated jobs:*

Pensioners are allowed to earn additional income, which is exempt from payment of contributions for mandatory insurance under the Act on Contributions.[36]

- *monitor the impact of the transition to individual capital savings to the pension gender inequalities, as well as the impact of the pension adjustment mix (in line with wages and the consumer price index) to the older pensioners*:

As previously explained (under the title: *Impact assessment: Gender impact of the pension reform*), inequalities persist due to stated reasons.

Pension adjustment in accordance with the so-called "Swiss formula" (see supra under the title: *Overview of the system: Pension formula*) takes place twice a year. The amount of real pension growth rate is thus half the amount of real wage growth rate.

Ageing of the population still represents a real challenge for the pension system's sustainability. The number of population of older age (65+) as opposed to the number of inhabitants of working age (demographic dependency ratio) is expected to rise in the future. Although reforms contributed to the overall sustainability of the pension system, the above factors should be addressed more appropriately in the future. Incentives for later retirement need to be implemented, together with measures of social inclusion. Later retirement should represent a real option for workers, and not just a more tolerable alternative to retirement with low replacement rates and a significant immediate decline of the standard of living.

Otherwise, a declining number of contributors paying pension contributions, as a result of demographic trends, labour market participation and unemployment rates, could only intensify the financial sustainability issues.

The suggestion to increase the percentage of contribution in the second pillar is quite disturbing, especially since no open public debate on the issue has started yet. The experts warn that an increase of the percentage of contribution in the second pillar should be accompanied by an increase of the basic pension benefit paid under the first pillar, as this could be the only way to solve the issue of lower pensions due to the 'second-pillar' contributors (i.e. employees under 40 at the time of implementation of the pension reform) under the first pillar, which is expected to arise in the future.[37]

Continued efforts for finding the mode and framework for payment of minimum social pension is required, given the outmost importance of this type of benefit for assuring the dignity and quality of life of pensioners.

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35 Ibid., p.76.

36 Official Gazette of the Republic of Croatia *Narodne novine*, no. 84/08 and 152/08.

37 See further: Marušić, Lj.; Škember, A., Socijalni i gospodarski aspekti uvođenja obveznog mirovinskog osiguranja na temelju individualizirane kapitalizirane štednje (Social and economic aspects of mandatory pension insurance based on individual capital saving), *Revija za socijalnu politiku (Journal of Social Policy)*, volume 15, no. 3, Zagreb, 2008, pp. 343 – 363.

In the context of economic recession, positive effects of the pension reform are likely to be minimal, while negative effects will be more pronounced.

2.2 Health

2.2.1 Overview of the system

2.2.1.1 Health care reform of the 1990s

It is impossible to provide an overview of the current system without a historical reference to the health care reform. The transition from collective/state economy to private/market oriented economy has had a profound influence on the health care system as well. On the other hand, the evaluation of legal and organisational changes introduced in 1993 cannot be separated form the description of the system functioning until the end of the last decade of the 20th century.

The prevailing opinion is that Croatia entered the 1990 with a dysfunctional, inefficiently organised and expensive health care system, which had to be completely restructured.[38]

The goals of transition in the economic and political aspect were clear (market and democracy) – although the paths to it were not – but this may not be said for the transformation in the field of social policies.[39] The need to adjust the health care system to the new social and economic circumstances was entirely undisputable, but the first reforms taught us that if taken "lightly" (many advantages of the reform were explained merely through a detachment from the old system), such an approach may lead to many unwanted consequences. After 1993, the health care system has started to show first signs of a permanent crisis. However, the World Bank spoke highly of the results of the reforms, or rather its financial impact, calling them impressive, but nevertheless predicted skyrocketing expenses in the future.[40]

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[38] European Observatory on Health Care Systems, Health care systems in transition. Croatia, 1999, accessible at: http://euro.who.int/document/e68394.pdf.

[39] Zrinščak, S., Zdravstvena politika Hrvatske. U vrtlogu reformi i suvremenih društvenih izazova (Croatian Health Care Policy. In the Whirl of Reforms and Contemporary Challenges in the Society), *Revija za socijalnu politiku, (Journal of Social Policy)*, volume 14, no. 2, 2007, pp. 193-200, p. 199.

[40] Svjetska banka (1997) (World Bank, 1997), Financiranje javnog sektora, reforma zdravstva i mirovinska reforma u Hrvatskoj (Financing of public sector, health care and pension system reform in Croatia), *Revija za socijalnu politiku, (Journal of Social Policy)* volume 4, no. 3, pp. 265-285; World Bank, 1999, Croatia. Health Policy Note, Document no.19505-HR. This evaluation is based on a centralised control of the courses of financing, the mechanisms introduced to control the expenses, and the set foundations of the privatisation of health care. In 1993 and 1994, the total costs of the health care system were diminished and the deficit in HZZO was reduced from 2.8 GDP in 1992 to 0.2 in 1994. But this was not accomplished by a significant reorganisation of the health care system, but rather through financial measures which lost their effectiveness very soon, such as the increase of the contribution rates and the introduction of the system of limited expenses. The diminution of expenses in health care was also affected by a decision in 1994 to no longer report the amortisation expenses in accounting records which led, in the long run, to a very negative consequence for the investment maintenance and the renewal of capital equipment. That is the reason why the World Bank evaluated this reform as impressive and at the same time pointed out to skyrocketing expenses in the second half of the 1990s and a series of other problems of the system's functioning. For example, the explicit goal of the 1993 reform was the strengthening of the role of primary medical care and solving issues on the primary level, without the often unnecessary reference to specialists and hospitals. But in 1995, primary medical care used only 14.6% of the total health care expenditure and in the same period the hospital expenses rose by 3%.

The framework for reforms was also shaped by the factors of economic and social consequences of system transformation and the war, which imposed the maintenance of a basic health care security and the issue of health care expenses as a priority. In the case of Croatia, this is visible in the strong, long-term and direct impact of global agencies and the World Bank, in particular in the Croatian health care system reforms.[41]

The main characteristics of the health care reform in 1993 were centralisation and privatisation. Being the first extensive health care reform, the 1993 reform was implemented in the subsequent few years and it tried to solve the problems of the past system (too much expenses and an inherited debt, inefficient decentralisation), new social problems (the health care crisis caused by economic difficulties and the war), and new social circumstances (the freedom of patients to decide, the right to private practice).[42]

The basic division was preserved, and it included primary (medical centres, institutions for emergency medical assistance, and institutions for secondary care at home, pharmacies), secondary (policlinics, hospitals, and sanatoriums), and tertiary medical care (state medical institutes, clinical institutions). It was prescribed that everyone is obliged to take care of his/her own health and to freely choose the doctor, which certainly represented a legal novelty, even though, at that time, there was no Act on the Protection of Patients Rights and given the very low level of awareness, it was more of a declaratory, rather than a realistic possibility.

The process of privatisation was the issue which caused most concern from the outset.[43] Namely, the law differentiated ownership between the central state and the counties:

- the state owned clinics as independent institutions, clinical hospitals, clinical hospital centres and state medical institutes,

[41] The impact of the World Bank to the Croatian health care system, as well as the social system in general, is evident throughout the entire process of reforms. The policy approach is shaped in accordance with the World Bank surveys and proposals. For example, the first project agreed between the World Bank and the Government of the Republic of Croatia, which started in 1995 and ended in 1999, amounted to USD 54 million. It was created to support the 1993 reform through the introduction of an information system and the supply of medical equipment. The next project, which came into force in March 2000, marked a new period in the ambitious health care reform. Its aim was fostering privatisation of the primary level health care; unfortunately, the results of the pilot project initiated under this project, according to Zrinšćak, were never systematically evaluated nor used as a basis for development of further strategies. The Ministry of Health and Social Welfare adopted in June 2000 the document entitled "Strategy and Plan of the Reform of the Health Care and Health Insurance in the Republic of Croatia". The Document then served as a basis for preparation of the strategy of the development of health care, which was part of a larger Government project at that time under the title "Croatia in the 21st century" (Office for Strategy, 2002). The overall reform of the health care system included a series of changes in the health care system management, the effectiveness and quality improvement and the strengthening of the preventive and primary medical care. Among others, it was planned to define the basic package of medical services, improve the payment system in order to use services more rationally, define a network of medical capacities, introduce more rational medical procedures by defining clinical guidelines, rationalise drug consumption, and similar. A list of World Bank funded projects in Croatia is available at: http://www.worldbank.hr/external/default/main?menuPK=301276&pagePK=141155&piPK=141124&theSitePK=301245; last visited 28 May 2009.

[42] Zrinšćak, S., op. cit., p. 199.

[43] "The World Health Organisation advised the legislator not to rush with the privatisation, because of negative experiences of countries which attempted to do so (Hungary) and also because of the significant factor that people were not used to private ownership in the health care segment." See: Hebrang, A., Njavro, Đ., Mrkonjić, I., Komentar Zakona o zdravstvenoj zaštiti i Zakona o zdravstvenom osiguranju (Commentary of the Health Protection Act and the Health Insurance Act), Zagreb, Privredni biro, 1993, pp. 17, 18. It must be also said that the level of centralisation was lesser than in the, for instance, educational or social care system, at that time.

- the counties and the City of Zagreb owned medical centres, home care medical institutions, policlinics, general hospitals, special hospitals, pharmacies, sanatoriums, emergency medical assistance institutions and institutes for public health and transfusion medicine.

It was prescribed that all medical institutions, owned by counties, may be in private or mixed ownership, except for medical centres, emergency medical assistance institutions and institutes for public health and transfusion medicine. A new form of ownership over medical institutions was best reflected in the managing bodies, i.e. managing boards where the majority was held by the owner (either the state or the county).

The regulation of financing the health care system followed a similar logic, but it showed a lot more centralisation. As the system was still basically founded on the obligatory medical care insurance and the payment of contributions (along with additional income from the state budget and participation of the insured), the basic institution became the newly established Croatian Institute for Medical Insurance - HZZO).

Based on insurance, the insured are entitled to medical care (primary, specialist – consulting and clinical) and to the following financial compensations:

- remuneration during sick leave,
- compensation for travel expenses in relation to using medical care,
- aid for buying equipment for a new born child,
- compensation for funeral expenses.

The specific aspect of privatisation consisted of the introduction of participation for certain services and the possibility for some doctors, to provide privately, in the premises of state medical institutions, certain medical services, after their mandatory working hours.

In this way, the general and medical care accessible to all in principle, was explicitly connected to the possibilities of direct payment, and the possibility of private work in public institutions inaugurated a (non)regulated public-private mix which did not prove to be a good solution anywhere and which makes possible for a series of abuses of the right to equal access to medical care and causes real difficulties in the access to medical care (more on this issue can be found further below).[44] It is interesting that the World Health Organisation did not recommend this solution and it was the pressure of medical workers that lead to it.[45]

2.2.1.2 Legal framework

Generally speaking, the Croatian social security system is based on the principles of universality, continuity and accessibility.[46]

The operation of the principle of universality ensures that social insurance protection is in principle provided for the entire population of the Republic of Croatia (Art. 58 of the Constitution). The principle of continuity is reflected by the fact that, for example, medical insurance is provided to citizens of all ages throughout their lives, without any interruptions.

[44] Zrinšćak, S., op. cit., p. 201.

[45] "The recommended frames of this World Organisation imposed a rule of non-mixing private and state ownership in the same institution, which the legislator observed in the first version of the Act, but later partly gave in under the pressure of medical workers." Hebrang, A., Njavro, Đ., Mrkonjić, I., op. cit., p. 18.

[46] Bodiroga-Vukobrat, N., in: Tomandl, T., Mazal, W. (Hrsg.): *Soziale Sicherheit in Mitteleuropa*, Wien, Orac, 2000, p. 41-42.

The principle of accessibility ensures that there is an attempt to provide all Croatian citizens with medical care, regardless of the remoteness of the location and the costs involved in providing such care.[47]

On 1 January 2009, the new Health Protection Act entered into force[48]. It replaced the previous Health Protection Act and its changes and amendments.[49]

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 on three basic levels:

- primary,
- secondary,
- tertiary, and
- on 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 exist a number of doctors in the medical centres who, due to the aforementioned 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.

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47 Bodiroga-Vukobrat, N., 'Social security system' in: WILIAMS, S., *Modern Legal Systems Cyclopaedia*, Hein, 2005, p. 149-159.

48 Official Gazette of the Republic of Croatia, *Narodne novine* no. 150/08.

49 Official Gazette of the Republic of Croatia, *Narodne novine* no. 121/2003, 48/2005, 85/2006, 117/08.

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 new Obligatory Medical Insurance Act entered into force on 1 January 2009,[50] replacing the previous act[51] under the same title from 2006. Medical insurance is defined as obligatory on the one part, carried out by the Croatian Medical Insurance Institute, 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 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,
- 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 apparatuses,
- 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 comprise 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 following categories of population are exonerated from co-payments for medical care:

- children up to 18 years of age,

[50] Official Gazette of the Republic of Croatia, *Narodne novine* no. 150/08.

[51] Official Gazette of the Republic of Croatia, *Narodne novine* no. 85/06, 105/06, 118/06, 77/07, 111/07 and 35/08.

- disabled persons and other persons who have been entitled to be assisted by another person in performing most or all vital functions according to special regulations,
- persons with at least 80% physical disability pursuant to pension insurance regulations and the Act on Rights of Croatian Veterans from the Homeland War and Members of their Families, or other special regulations, as well as physically disabled persons,
- voluntary blood donors with over 35 donations (men), and 25 donation (women),
- persons whose income per family member in one calendar year does not exceed a certain amount (or if the total monthly amount per family member does not exceed 45.59% of the state budget base, for single pensioners 58.31%).

When the Obligatory Medical Insurance Act was in the process of adoption, the last category was the one to raise most public attention because the issue was how much of a negative impact the provisions on co-financing will have on the accessibility of medical care for the poorer. It is important to mention here that we talk about total income, even though it remains unclear in which way these total incomes are established.

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,
- compensation of transport costs in relation to using medical care from obligatory medical insurance.

The Voluntary Medical Insurance Act[52] defines voluntary medical insurance as:

- supplementary,
- additional,
- private.

Supplementary medical insurance covers part of the expenses up to the full price of medical care from obligatory medical insurance. Additional 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.

In this context it is necessary also to mention the Patients' Rights Protection Act[53] which regulates, for the first time, the rights of patients. It is an important step in the Croatian health care system in spite of much criticism about the declarative nature or inapplicability of the said Act – the way from legal formulations to actual fulfilment and enforcement of the rights in real life will certainly be a long one.

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

[53] Official Gazette of the Republic of Croatia, *Narodne novine* no. 196/04 and 37/08 (Decision of the Constitutional Court of the Republic of Croatia).

2.2.1.3 Statistical data

Generally speaking, the statistical follow-up of health care indicators is only sporadic. The following charts are adapted and taken over from various sources and, due to a lack of available data, are not updated to reflect the current condition (latest data in the charts are from 2007, and 2005 respectively).

Table 2: Health expenditure and outcomes (comparative chart)*

	Total expenditure on health (% of GDP)	Public expenditure on health (% of GDP)	Healthy life expectancy (years)
Croatia	7.9	6.6	66.6
Slovenia	8.9	6.8	69.5
Bulgaria	7.7	6.6	64.6
Hungary	7.9	5.6	64.9
OECD average	8.7	6.3	70.7

* Adapted from Jafarov & Gunnarsson, *Efficiency of Government Social Spending in Croatia* (see fn. 86)

Table 3: Difficulties regarding access to health care services **

Obstacle	Persons declaring that a certain problem significantly hindered their access to services (in %)
Distance from the place of treatment	12
Appointment waiting time	22
Waiting at the doctor's office	17
Costs associated with treatment (i.e. travelling costs etc.)	19

** Adapted from Zrinšćak, *Health Care Policy* (see fn. 55)

2.2.2 Overview of the debates and the political discourse

2.2.2.1 National Strategy

The key document is the National Strategy of the Development of Health 2006- 2011[54] adopted by the Croatian Parliament in June 2006 (National Strategy 2006-2011).

It starts from the statement that according to the classification of the WHO, and based on the indicators on mortality of children and adults, Croatia is placed in the prestigious Group A of countries with a very low mortality of children and adults. On the other hand, a lot of

[54] Official Gazette of the Republic of Croatia, *Narodne novine* no. 72/2006.

problems of the system are recognised, such as territorial imbalance of the capacities of secondary medical care, concentration of specialist services within institutions of primary medical care, which are moreover excessively concentrated in the capital city, the lack of a categorisation of hospitals, a further reduction of the role of primary medical care and the further reduction of preventive check-ups and similar.[55]

The National Strategy 2006-2011 inadequately addresses the relatedness between health risks and health outcomes; hence it seems as if the Croatian population is by and large healthy.[56]

Furthermore, the adopted National Strategy does not sufficiently focus on macroeconomic policies related to health care financing or neutralising difficulties in health care financing on a microeconomic level, other than those in the primary care. The announcement that was made concerning the savings by reducing the list of pharmaceuticals available without participation has encountered strong resistance of the public opinion. Hence, it is unlikely that the most recent reform will manage to achieve anything else than to prevent an increase in health care expenses in the short term.[57]

On the basis of this analysis of the state of health care and the Government policy and reforms in Croatia, Mihaljek concludes that one of the essential actions that should be taken is "to change the HZZO financing mix in favour of general tax revenues transferred from the central and local budgets." This measure is highly recommendable because Croatia is not at all aligned with the standards of either the old or the new EU Member States, not in terms of an excessively high share of state health insurance financing, an unusually low share of government budget, and a nearly inexistent share of private health insurance in the overall health care financial scheme.[58]

Mihaljek further recommends that the future reform should be oriented towards re-examination "of the social benefits and costs of the current system of sick leave and maternity leave allowances."[59] This recommendation, aimed at modification of the HZZO finances, was partially adopted in the new Health Protection Act.

Some authors are of the opinion that the issue of inadequate disability and veterans' allowances could be resolved by introducing the so-called "zero pillar" of pension insurance.[60]

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55 Zrinščak, S., Zdravstvena politika (Health Care Policy), in Puljiz V., *et. al.*: *Socijalna politika Hrvatske (Croatian Social Policy)*, Zagreb, 2008, pp. 119-162, p. 136, 137.

56 Mihaljek, D., Zdravstvena politika i reforma u Hrvatskoj: kako vidjeti šumu od drveća? (Health Care Policy and Reform in Croatia: How to see the Forest for the Trees?) in Ott, K. (ed.), *Pridruživanje Hrvatske Europskoj uniji. Izazovi sudjelovanja*, Zagreb: Institut za javne financije, Zaklada Friedrich Ebert, 2006, p. 289; accessible at: http://www.fes.hr/E-books/pdf/Pridruzivanje%20hrvatske%20EU_4_svezak/Overview.htm. Dr. Dubravko Mihaljek is a Senior Economist at the Bank for International Settlements, Basel, Switzerland; renown in professional circles in Croatia for his extensive and insightful analyses of health care system.

57 Mihaljek, D., op. cit., p. 301.

58 Mihaljek, D., op. cit., p. 303.

59 Mihaljek, D., op. cit., p. 304.

60 Mihaljek, D., op. cit., p. 305. The idea of introducing a zero pillar is often brought up in discussions on how to regulate pensions for persons of low or no income, based on principles of social assistance. The aim of this pillar would be the prevention of poverty among those categories of population with insufficient means to secure a minimum socially acceptable standard of living. It would be financed through taxes.

2.2.2.2 The 2008 Reform

On 11 December 2008, the Government of the Republic of Croatia announced on its web pages[61] that the Proposition for Reform of the Health System was accepted.[62] The Proposition for Reform of the Health System is accessible at the web pages of the Ministry of Health and Social Welfare as a Powerpoint presentation of the Minister.[63]

After the presentation of the reform and all the reactions which followed the proposal, a public debate was initiated during which the Minister changed the proposal. Namely, he receded from what was, considered by many, the most disputable part of the reform, the introduction of a parallel private basic medical insurance which would cause the spill-over of social means into private insurance companies. Even though he did not speak of a deficiency of doctors in the first public presentation, in the later discussions he announced the creation of a fund to solve this problem. In this report, we present the basis of the reform proposal as it was first presented in the public.

The Minister pointed out that reform is necessary for a couple of reasons. Health care is financed solely from one source, which consists of the one and a half million employees contributing with 15% of their gross wages, thus financing the medical care for the entire population of Croatia of 4.5 million. Health care generates, moreover, a debt of HRK 2 billion a year. Further problems are the existence of the perception of corruption and the decline in the popularity of the profession, which lead to a deficiency of doctors. The accessibility of medical care, primary, secondary, etc. is also questionable.

The goal of the reform, as pointed out by the Minister, is placing the insured/patient in the centre of attention, the improvement of health care, health indicators, and the promotion of the medical care system. Also, the goals are to establish a fixed rate of contributions from the state budget for health care over the next three years, allow equal accessibility of medical care, find new sources of financing, separate the health care fund from the state treasury, preserve the social sensibility and solidarity, continue decentralisation, fight against corruption etc. Another goal of the reform is to allow the best hospitals and doctors in the primary medical care to increase their income through providing medical services and establishing the quality of medical care through the activity of the Agency for Health Care Quality and Accreditation.

Rationalisation in health care will be accomplished by introducing new mechanisms of payment of primary medical care, hospitals and intensive treatment, a new way of payment of primary medical care, reform of the emergency medical assistance, categorisation and accreditation of medical institutions, computerisation of the primary medical care, reference price of drugs, decrease of the sick leave rate and other.

The goals purport the introduction of more ways of payment which would, as pointed out by Minister Milinović, motivate the physicians in primary medical care to improve their work, the quality and increase the amount of services and thus enable a more successful activity of

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61 http://www.vlada.hr/hr/aktualne_teme_i_projekti/aktualne_teme/reforma_zdravstva.

62 A quick research on web browser programs for the phrase "zdravstvena reforma" (health reform) generates more than 24,000 results. Furthermore, research of Government sessions, decisions, public announcements, etc. always leads back to the original text of the National Strategy for Health from 2006 and not to the official Powerpoint document presentation of the Proposition for Reform of the Health System as published by the Minister on the web pages of the Ministry of Health and Social Welfare and the Croatian Chamber of Physicians: http://www.mzss.hr/hr/novosti/priopcenja/prezentacija_prvih_rezultata_reforme_zdravstva_pred_strukom; http://www.hlk.hr/default.asp?ru=133&gl=200812180000025&sid=&jezik=1, last visited 01 March 2009.

63 http://www.mzss.hr/hr/novosti/priopcenja/prezentacija_prvih_rezultata_reforme_zdravstva_pred_strukom.

teams. The teams in primary medical care would receive, instead of 100% of capitations, only 60% and the rest would depend on the services rendered.

The payment for services and drugs can be summarised as follows:

- Since 1 January 2009, the PPTP (payment per therapeutic procedure) and Blue Book no longer apply and all hospitals must calculate their services according to diagnostic therapeutic groups (DTS).
- The application of calculation of payment according to DTS aims at encouraging and rewarding the effective work of hospitals, assure equality of all hospitals, and patients and improve the equality in determining the hospitals' limits.
- The reform struggles with sick leaves because Croatia is on the very top in Europe when it comes to the sick leave rate (3.57%). On average, 58,000 employees are on sick leave per day, which costs HRK 2.350 billion per year. Most of them are ill for up to one year (184,893), followed by illness from one to five years (16,135), and then five to fifteen years (300). Sick leave is paid by the employers for 42 days and after that the HZZO pays, without limitations. Last year HZZO paid out HRK 1.350 billion for sick leave.
- Drug consumption on receipt will be limited to the so-called pay back, which means that HZZP will sign contracts with drug producers to buy exact amounts of drugs and all expenses for drugs sold above the contracted and paid amount shall be paid by the pharmaceutical industry. By signing contracts, the pharmaceutical industry will be motivated to diminish the unnecessary enlargement of indicators for a certain group of drugs.
- A new reference list of drugs will be introduced, which should save HRK 200 million in 2009. The state will take care of patients who need extremely expensive drugs and will waive the margin, with the aim of saving HRK 40 million.

The plan is to introduce a unique rate of co-payments of 20%, with a minimal amount of payment. Co-payments from HRK 15 to 3,000 per medical service shall be paid by all persons except for children under 18 years of age, pregnant women and those categories which will have the supplementary medical insurance policy paid from the state budget. In this way the payment of the supplementary medical insurance becomes a rational solution because it covers co-payment. Co-payment will not be paid for domiciliary medical care, medical care in home visits, sanitary transport, emergency medical help and haemodialysis. In primary medical care, co-payments in the amount of HRK 15 will be paid for medical examination and drug prescription, and in secondary medical care it shall amount to 20% of the price. In this way, the primary medical care and hospitals make it possible to increase income from co-payments.

The conditions of supplementary medical insurance are changed only for 415,633 of the working population whose wage is above HRK 5,200. Their insurance policy is now HRK 80, and it shall increase by HRK 10 to 90. For 986,128 of the working population whose wages are lower than the average, the conditions do not change and the supplementary medical insurance policy will still cost HRK 80. For 115,148 of the working population, who are now exonerated from co-payments, the policy will be paid form the state budget, also in the amount of HRK 80.

For 691,141 pensioners, whose pension is less than HRK 5,200, the price of the supplementary medical insurance policy will remain the same, and will amount to HRK 50. The amount of HRK 50 will be paid from the state budget for policies of 355,323 pensioners

who are now exonerated from co-payments. New conditions will apply for 20,095 pensioners with a pension above HRK 5,200: their supplementary medical insurance policy which is now HRK 50 will also cost more. For 610 persons with privileged pensions, Parliament representatives, Government and HAZU members, the conditions will be the same as those for working people.

For disabled persons due to the Homeland War, 30,576 of them are now exonerated from co-payments, the supplementary medical insurance policy will be paid form the state budget. In addition, 836,195 children are exonerated from making any payment at all and do not need to pay the supplementary medical insurance policy.

Overall, for 4,001,122 persons the conditions will remain the same as they are now, and for 436,338 they will change. The new revenues from the supplementary medical insurance will be more than HRK 1,551 billion.

A million and a half of the population of Croatia which contribute to medical care use only 25% of the total funds, and 75% are spent for those who do not contribute to medical care. The present condition is not sustainable, and "we shall either go into a deficit of the state budget or find new sources of financing," says Minister Milinović.

An interesting proposal for tackling efficiency problems in health care comes from Jafarov and Gunnarsson.[64] They offer a "menu" of reform measures, some of which could be considered quite unpopular (to say the least) in the context of social solidarity, which include:

- increase of co-payments while minimising exemptions;
- further reduction of subsidisation of pharmaceuticals;
- acceleration of the introduction of the Diagnoses Related Groups (DRG) payment method;
- restriction of the basic benefits package covered by HZZO;
- shift of resources to more affordable outpatient care;
- increase of the role of the private sector in the provision of health care services;
- strengthening of incentives for general practitioners to reduce referrals;
- rationalisation of the hospital network.

These suggestions take into account only financial aspects, without recognising all macroeconomic and microeconomic factors. Such considerations presently cause significant discussions and will probably continue in the future.

2.2.3 Impact assessment

Croatia has positioned itself in-between the old and the new EU Member States regarding the percentage of GDP which is devoted to the functioning of the health care system. This leads Mihaljek to the conclusion that it is not the shortage of resources, but the problems in the health care financing system as such that give rise to negative tendencies in health care. These problems exist at both levels, microeconomic and macroeconomic. It is thus regrettable that due to the described circumstances considerable funds are used inefficiently.[65]

[64] Jafarov, E.; Gunnarsson, V., op. cit., p. 314.
[65] Mihaljek, D., op. cit., p. 294.

According to Mihaljek's calculation on the basis of WHO data and data from the regional offices, Croatia spends approximately 8% of its GDP annually on health care. Interestingly, this figure, although somewhat lower than the average in the EU-15, is still higher than the average of the new Member States. From the total amount of health care spending, 84% are covered by public and 16% by private sources. The public health care funds are principally collected through payroll contributions imposed on every employer on the basis of the amount of the employees' wages, while the remaining part of public sources comes from the general-purpose tax revenues. Owing to the relatively insignificant function that private health insurance plays in the health care system, private resources for health care basically consist of patients' own expenditures. The largest spender within the public sector is the Croatian Health Insurance Institute (HZZO),[66] with a share of 96% of the General Government sources allocated for this purpose. In conjunction with the Ministry of Health and Social Welfare, the HZZO also has the authority to define standards and negotiate prices for provision of health care services with providers.[67]

According to the available information, Croatia's ratios of hospital beds and doctors per 1,000 population and the density of health workers index (6.2 and 8 respectively) are at or lower than the averages of the EU-15 countries (6.3 and 13, respectively), and are lower than the

[66] The Croatian Institute for Health Insurance (*Hrvatski zavod za zdravstveno osiguranje – HZZO*) was established for the purpose of implementing a basic health insurance, and for other activities according to the previously applicable Health Insurance Act from 2001, and the Health Protection Act from 1993, and the new acts in force (see fn. 10; 12).
On 22 March 2006 the Government of the Republic of Croatia commenced a legislative procedure in the Croatian Parliament by preparing a Draft Health Insurance and Health Protection at Work Act. The Croatian Parliament adopted the Act on 13 July 2006, and it entered into force on 3 August 2006 (Official Gazette of the Republic of Croatia *Narodne novine* no. 85/06). The Act regulates the following: system of compulsory health insurance for protection of health at work; stipulation of compulsory health insurance against injuries at work and professional diseases, rights included in health protection and other rights of insured persons, conditions and manner of their realisation in case of injury at work or professional diseases including rights and obligations of contracting parties/providers of health protection in case of injuries at work and professional diseases. "Health insurance for health protection at work guarantees to beneficiaries rights under the Act in accordance with the principle of reciprocity and solidarity." (Art. 1. para. 2. Health Insurance of Health Protection at Work Act).
The rights and obligations, and responsibilities of the HZZO are established by the Health Insurance Act and HZZO Statute. The Ministry of Health and Social Welfare controls the legality of the work of the HZZO. According to the Health Insurance Act the audit of the HZZO is effected by the State Audit Office. The HZZO is included in the State Treasury system. The contributions for health insurance are paid on the single account of the State Treasury and as such are a part of the State Budget revenues. The funds for the work performed for medical services are paid to hospitals from the State Budget based on agreements concluded with the HZZO, whereas all the other funds for health protection are paid to from the State Budget to the HZZO which than makes payments.
The HZZO provides also additional health insurance according to the provisions of the Health Insurance Act.
The activity of the Institute in the implementation of the basic health insurance is the following:
- implementation of policies to develop and improve health insurance in relation to basic health insurance,
- activities in relation to the achievement of rights of insured, taking care of the legality of achieving these rights, and giving all the necessary assistance in the achievement of these rights and the protection of their interests,
- planning and collecting financial means of basic health insurance and paying services to health authorities and private medical workers,
- involvement in proposing the basic medical net of activities according to a special law,
- participation in proposing to the minister in charge of health care the measures of health protection,
- counselling to the minister in charge of health care on the establishment of health authorities and the beginning of private practices of medical workers with the purpose of their involvement in the basic net of medical activity.

[67] Mihaljek, D., op. cit., p. 278.

averages of EU-10 (7.3 and 10 respectively) and OECD countries (6.3 and 13 respectively).[68] Suburban and rural areas are reported to have underutilised capacities. Jafarov and Gunnarsson correctly observed some weaknesses of the system prior to the ongoing reform:

- payments to hospitals are capacity-based and input-based and stimulate hospitals to maintain beds full and extend the length of patients' stay.[69] This system does not motivate hospital managers to reduce costs, which is likely to have contributed to the long average length of stay in (all) hospitals (ALOS) in Croatia: about 10.3 days, which was one of the longest in Europe in 2005.
- a great share of the primary level care is provided by expensive specialists. This is mainly due to the fact that primary care physicians, who should be the gatekeepers of the health system, are paid on a capitation basis (meaning physicians are paid flat fees per patient per year). This stimulated physicians to sign up for as many patients as possible and then refer them to specialists instead of treating them.

A particularly difficult problem in the Croatian health care system relates to the disproportion between primary care on the one hand, and secondary and tertiary care on the other. In contrast to the situation in the majority of European countries where 75% of all cases are treated in the primary care facilities, such facilities in Croatia manage to solve less than 50%. This is the result of the one-third increase in the portion of cases treated within the secondary and tertiary facilities in the period of five years at the beginning of this decade.[70] Such development generated large costs due to augmented and often unnecessary laboratory and diagnostic tests and specialised and sophisticated types of treatments. Another trend that has been noticed in the past several years is the decrease in provision of preventative health services at the cost of the growing use of pharmaceuticals.[71]

The health care costs in Croatia are secured through contributions from wages up to some 80%, while the remainder is furnished in the form of revenues collected by central and local government budgets, supplementary and private health insurance, borrowing by the HZZO and certain other sources. The basic rate for calculating the mandatory health insurance contribution is 15% from the wage. The payment of the payroll contribution is the employers' duty, in contrast to the earlier system before 2003 when employers had to pay 7% and employees 9% of employees' wages. Besides the fact that such a regulatory scheme affects the financing of health care, it also has an important bearing on the Croatian labour market because in fact four-fifths of the total national health care insurance costs are paid directly by employers regardless whether these are covering health care services provided to employees or to other non-active categories of the population. It is therefore surprising that none of the national participants in the health care reforms or the international organisations which supported these reforms made an effort to effect changes in this respect.[72]

As already stated, 16% of health care spending in Croatia is private expenditure and these resources, equal to approximately 1.3% of GDP, are mostly paid by the patients themselves. The reason lies in the fact that the private health insurance has not developed to have any impact on the practical level. In effect, the amount Croatian citizens themselves have to pay for the health care insurance is nearly the same as the amount that EU citizens have to bear.

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68 Jafarov, E.; Gunnarsson, V., op. cit., p. 292. EU-10 countries are new EU members (Cyprus and Malta excluded) and EU-15 countries comprise other Member States.

69 Ibid., p. 295.

70 Draft proposal of the National Strategy for the Development of Health Care, Ministry of Health and Social Welfare, Zagreb, 2006.

71 Croatian Office for the Strategy of Development, Croatia in the 21st Century.

72 Mihaljek, D., op. cit., p. 297.

For that reason, the future health care reform should set as one of its objectives the readdressing of a portion of health insurance funds from the HZZO to private insurance companies without the need for a large increase in the average payment by the citizens.[73]

Capital investments in the health care sector are for the most part financed from the budget of the Ministry of Health and Social Welfare, the budgets of the local governments, and foreign donations. On top of that, it seems that depreciation of buildings and equipment is not considered as an operational expense. As a result, the potential for future investments in the Croatian health care system is truly uncertain.[74]

When it comes to the quality of health care, the quality assessment is based on the Health Care Quality Act.[75] Actually, this Act is the first example of how a benchmarking method is applied as a legislative instrument within the health care system. It determines the principles and system of measures for implementation and fostering of the comprehensive quality in health care. The Agency for Quality and Accreditation in Health Care, established under this Act, performs various activities in the field of health care quality assurance, sets and proposes standards for evaluation of quality, issues, renews and revokes accreditations to providers of health care services etc. The Health Care Quality Act further prescribes the accreditation procedure for medial institutions, companies performing medical activity and private medical practitioners.

In order to ensure effective, efficient, equally accessible and an equally high quality level of health care across the health care activities and on the entire territory of Croatia, the Minister for Health and Social Welfare, upon the proposal of the Agency for Quality and Accreditation in Health Care and after obtaining opinions of the relevant professional chambers, is authorised to issue a plan and programme of the measures for assurance, promotion, improvement and monitoring of the quality of health care. The said plan and programme should include priorities aimed at improvement of the health care standards and measures for implementation of a unique system of quality standards and clinical indicators of quality.

The Health Care Quality Act defines the health care quality standards as precise quantified descriptions of criteria in relation to performance of medical procedures, medical workers, equipment, materials and environment in which medical procedures are performed and which secure medical care quality. Health care quality promotion includes procedures which enable the increase of the patients' influence in decision making within the health care system, which contributes to the promotion of their health.

2.2.4 Critical assessment of reforms

The public health system with the existing public institutions is facing a fundamental reform. Acceptance of the Republic of Croatia into EU and fulfilment of requirements in this area that primarily consist of cost reduction in health services, creates the need for transformation of the HZZO and all other institutions and agencies within the public health system and creation of new institutions (institution building) that will be able to function efficiently in the new environment.

Instruments and methods of social and legal comparison, issues of acceptability and applicability of foreign models, and European convergence policy gain in importance. The rules of social stability and principles of universality and solidarity gave rise, on one hand, to

[73] Mihaljek, D., op. cit., p. 298.
[74] Mihaljek, D., op. cit., p. 299.
[75] Official Gazette of the Republic of Croatia, *Narodne novine* no. 107/2007.

social rights traditionally guaranteed by the state. On the other hand, rules of market competition (European law, Croatian law, case-law of the ECJ) undeniably penetrate in this field and reduce social rights. Numerous, disorganised and inconsistent regulations of social security rights in Croatia in reality significantly impair, and often prevent, the actual realisation of social rights (including access to health care).[76]

Significant differences have been recorded among different regions (counties) in Croatia regarding access to health care services. Access to health services is measured based on four indicators: distance to physician/hospital, waiting time for appointment, waiting time at the doctor's office, and costs associated with treatment (i.e. travelling costs). The problem of distance to the physician/hospital is mostly affecting the citizens in Bjelovar-Bilogora County and Lika-Senj County (more than one quarter of all persons tested).[77] Waiting for an appointment as an obstacle to access to health care services mostly affects (one third or more persons tested) the inhabitants of the counties of Sisak-Moslavina, Virovitica-Podravina, Karlovac and Zadar. Waiting at the doctor's office is an obstacle for citizens of Sisak-Moslavina, Virovitica-Podravina and Karlovac County, while costs associated with treatment are a common problem in Sisak-Moslavina, Vukovar-Srijem, Karlovac and Šibenik-Knin County.

The common conclusion is that the citizens in Sisak-Moslavina, Virovitica-Podravina and Karlovac County (all situated in central part of Croatia) are mostly facing the obstacles regarding the access to health care services. On the other hand, the least affected are those who live in Istria, City of Zagreb, Split-Dalmatia, and Zagreb County. It is not uncommon that the access to health services is influenced by the level of urbanisation. Inhabitants of rural areas face the most of obstacles. Almost one half of all tested inhabitants of rural areas highlight the costs of travelling to see a physician as an obstacle, compared to one third of the urban population nominating the same complaint.

From the demographic perspective, it is important to emphasise that the population not contributing to the health insurance budget is twice as large as the number of employees who pay the mandatory contributions, meaning that each contribution paid has to be sufficient to cover the costs for health care services provided to the payer as well as to two additional non-payers. It is precisely this large non-paying population that accounts for the majority of health care costs because it consists mainly of retired persons, unemployed people, family members of insured persons, such as children, and other population categories. The health care contribution payers/non-payers ratio is a clear indicator of the serious problems that the Croatian health care system is facing in the long run, especially in view of the expected further ageing of the Croatian population.[78]

In the forthcoming period, Croatia would also need to resolve the problem of the lack of the persons possessing suitable management skills to administer the Croatian hospitals. The situation at present is such that the physicians with little or no training in management, finances or other fields are running the whole secondary and tertiary health care sectors.

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[76] See further on these issues: Bodiroga-Vukobrat, N. (ed.), Socijana sigurnost i tržišno natjecanje – europski zahtjevi i nacionalna rješenja (Social Security and Competition – European Requirements and Croatian solutions), Pravni fakultet Sveučilišta u Rijeci, Hanns-Seidel-Stiftung, Rijeka, 2008.

[77] This study has been conducted within the UNDP study of regional differences conducted in Croatia in 2006, published in: Quality of Life Report – Regional Differences, Zagreb, 2007, accessible at: http://www.undp.hr/upload/file/171/85528/FILENAME/Regionalne_nejednakosti_hrv.pdf, last visited 20 May 2009.

[78] Mihaljek, D., op. cit., pp. 290-291.

Likewise, monitoring and auditing financial aspects of administering the health care institutions, the hospitals and specialised health care localities, need to be improved because one has to fight the imbalance between the quality of services provided to the patients and the funds the state provides.[79]

Another issue that should be addressed in the health care reform concerns the introduction of more competition into health care markets. This result may be achieved through different methods, such as that a hospital may be allowed to retain the financial gains and invest them in the quality of its services.[80]

One of the reasons for the small proportion of the private health care sector in Croatia is in the lack of a regulatory scheme which would clearly define the involvement of private actors in the health care services. Indeed, some improvements have been made by leasing the publicly-owned facilities for use by physicians in their private capacities. Also the proposal to lease unutilised hospital capacities to private health insurance companies would be a good step forward, but still would not generate such effects that would be perceived by the patients. Rather the measures taken so far have benefited individual physicians only.[81]

The situation is practically the same in terms of development of private health insurance which covers only 0.6% of total health care spending in Croatia, while in the old EU Member States the average is 7% and in the new Member States the average is half of that figure. The reason for that is a lack of clear and precise institutional, regulatory and market structures, or stimuli for their expansion. The latter is well illustrated by the fact that the HZZO covers some of the costs of pharmaceuticals not included in the free-from-co-payment drugs list. Obviously, the private health insurance sees no economic interest in offering supplementary insurance for the same costs. On a more general level, some doubts have been expressed concerning the operation of the health insurance companies in Croatia in the best interests of potential patients, because their functioning has not been adequately regulated.[82]

So far, there has been no public and transparent discussion about the level of medical care which is possible to offer to the Croatian citizens and in which way these possibilities may be equally shared.

2.3 Long-term care

2.3.1 Overview of the system

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 includes the Social Welfare Act,[83] Foster Families Act[84] and the Ordinance on children/elderly homes and their activities, space and equipment conditions and on professional and other workers engaged.[85] Two basic categories of recipients of social assistance and welfare are those, on the one hand, who do not receive any income or their income is below the prescribed census, and on the other hand, persons

79 Mihaljek, D., op. cit., p. 306.
80 Mihaljek, D., op. cit., p. 306.
81 Mihaljek, D., op. cit., p. 307.
82 Mihaljek, D., op. cit., p. 307.
83 Official Gazette of the Republic of Croatia, *Narodne novine* no. 73/97, 27/01, 59/01, 82/01, 103/03, 44/06, 79/07.
84 Official Gazette of the Republic of Croatia, *Narodne novine* no. 79/07.
85 Official Gazette of the Republic of Croatia, *Narodne novine* no. 101/99, 120/02, 74/04.

who receive assistance in order to satisfy their personal specific needs, resulting mostly from disability, old-age, psychological condition, addiction etc. (including children and young persons without parental care, children and young persons with behavioural disorders and victims of family violence).[86]

Long-term care is organised on the principle of social assistance and financed through state and local budgets. It is directed towards persons who are dependent on help with basic activities of daily living, caused by chronic conditions of 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 another 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.

An allowance for assistance and care, for example, is granted as a cash benefit to the 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).[87] According to the data from December 2008, a total of 76,797 persons received this allowance, out of which 51,634 received the full amount, and 25,163 received 70% of the full amount of allowance.[88] 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.[89] This amount represents an increase by HRK 100 in comparison to the previous amount of HRK 400 (which was applicable from 2001 to 2008) and has applied as from November 2008. This increase is based on the Strategy for Reform of Social Benefits for 2007 and 2008 proposed by the Government.

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.[90]

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.

2.3.2 Overview of the debates and the political discourse

Initial reform activities of the overall social welfare system date back to the year 2000. These activities were aimed at establishing the basis for three components of the reform, namely, improvement of the provision of social services, development of strong information technology within the system, and extension of the existing infrastructure. The means for the reform of social welfare are estimated at EUR 45.6 million, and almost two thirds are

86 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, p. 64.

87 Social Welfare Act, Article 43(1).

88 Monthly Statistical Report, December 2008, Ministry of Health and Social Welfare, accessible at: http://www.mzss.hr:80/hr/zdravstvo_i_socijalna_skrb/socijalna_skrb/statisticka_izvjesca/mjesecna_izvjesca_2008, last visited 29 April 2009.

89 Official Gazette of the Republic of Croatia, *Narodne novine* no. 30/2008.

90 Social Welfare Act, Article 50(1)

intended for construction works for the improvement of the existing infrastructure.[91] The funding is predominantly secured from the loan facility granted by the World Bank.

In 2007, the Government spent about 4.5% GDP on social assistance and social benefits, out of which only 0.6% were used for poverty-related social assistance programmes.[92] Common objections related to the system of social protection in general are its complexity, fragmentation of administration of social benefits, and insufficient coordination between different service providers, as well as a lack of a common frame database of recipients.[93]

Jafarov and Gunnarsson propose a variety of reforms aiming to improve the efficiency of social protection spending in general,[94] such as:

- Expanding the use of means test in providing benefits would improve their targeting.
- Consolidation of supervisory responsibility under a single agency and unification of the administration of benefits to a single office at local level would improve efficiency.
- reducing the share of categorical benefits and increasing the share of well-targeted programmes;
- implementation of better work incentives as a means to re-connect unemployed to the labour market.

In its strategic programme for the term 2008 to 2011, the Government of the Republic of Croatia has assumed the commitment to continuously promote the development of non-institutional care for the elderly, establishment of centres for home assistance and care by various humanitarian and non-profit organisations.[95] Social protection and inclusion of the elderly seems to be the main point of concern. Other categories of persons in need of long-term care, for reasons unknown, are clearly left out in this strategy.

The development of the non-institutional forms of care for elderly is in progress, but still far from being comprehensive. The main objection is that the system is not equally accessible in all parts and regions of Croatia. There remains a problem of even distribution and accessibility of the network of services throughout Croatia.

Local authorities play a significant role in the development of the network of services, providing all types of support.

For example, in Rijeka (third largest city in Croatia, last recorded number of population in 2001 was 144,043 inhabitants), the share of pensioners is 25.7%, or a quarter of the city's population. In 2008, as much as 8.57% among them received a monthly pension in the amount lesser than HRK 1,500. The city administers various programmes, ranging from telephone assistance and counselling centres, to financial aid to the category of pensioners receiving pensions of less than HRK 1,100 per month (a rather symbolic amount of HRK 100 is contributed by the city), organisation of home care and assistance and preparation of meals to free public transportation for the 65+ population. Social programmes are usually linked

[91] See further: Žganec, N., Socijalna skrb u Hrvatskoj – smjerovi razvoja i reformi (Social care in Croatia – directions of development and reforms), *Revija za socijalnu politku (Journal of Social Polic*y), Volume 15, no. 3, pp. 365 – 378.

[92] Jafarov, E.; Gunnarsson, V., Efficiency of Government Social Spending in Croatia*, Financial Theory and Practice* 32 (3), 2008, pp. 289 – 320, p. 299.

[93] Loc. cit.

[94] Ibid., p. 313.

[95] See supra at fn. 11.

with the condition that the beneficiaries are also recipients of state social services, or that their income is extremely low.

In Zagreb, Croatia's capital, the share of pensioners in the total population is 14.89%.[96] The eligible pensioner may benefit from a number of programmes, including financial aid, home care and assistance, preparation and delivery of meals, free public transportation, counselling, etc.

Both Rijeka and Zagreb have a developed system of care for the senior population, mainly owing to the fact that those communities are able to financially cover and provide for it. For example, the records show that 2005 GDP per capita in Zagreb was almost twice as high as the Croatian average.[97] However, because of existing regional differences, not all local authorities in different parts of Croatia are able to organise and finance a variety of social services.

2.3.3 Impact assessment

Long-term care is predominantly implemented within the social welfare system. The system is funded from the state budget, but local contribution is also very important. However, regional demographic and economic differences carry a risk of unequal distribution, low accessibility and different standards of quality of long-term care.

There is still both scope and the need for improvements. This particularly concerns the low visibility of the measures available for the population in need of long-term care. Improved monitoring and conduct of comprehensive surveys regarding the long-term care application and its beneficiaries, as well as the sustainability of system is necessary. That would hopefully enhance debates and enable constructive strategy proposals.

Emphasis should be given to evaluation of eligibility criteria and thresholds for access to long-term benefits. Also, a true reform and evaluation of the functioning of the system, its efficiency and ability to timely address the needs of the affected persons should be high on the agenda.

There is a substantial information deficit in this area. Access to information and (gathering and publishing of) statistical data is also one of the prerequisites for a functional and efficient organisation of the system. Deinstitutionalisation and decentralisation are welcomed, but should be part of a coherent and comprehensive strategy.

Deinstitutionalisation and promotion of alternative forms of care in the community, as a measure intended to provide assistance for the most vulnerable groups, people with disabilities, is a policy priority in tackling social exclusion in Croatia.[98]

A practical example of decentralisation and deinstitutionalisation in the field of long-term care is the Programme of intergenerational solidarity entitled "Home Assistance and Care for the Elderly", implemented by the Ministry of Family, War Veterans and Intergenerational Solidarity as well as by the local and regional self-government entities. The stated purpose of the programme lies in a wider coverage of elderly in non-institutional forms of care through organising and providing necessary services in households. The available data show that there were 4,975 beneficiaries of the In-Home Assistance programme, which employed 306 persons

[96] Last recorded number of population in 2001 was 779,145, of which 115,980 were pensioners.

[97] http://www.zagreb.hr/UserDocsImages/statistika/BDP%202005.doc, last visited November 30, 2008.

[98] Joint Memorandum on Social Inclusion of the Republic of Croatia (see Fn. 33) at p. 26; Implementation Report of the JIM Follow-up Process on Social Inclusion of the Republic of Croatia (see Fn. 34) at p. 57.

providing home services to elderly. The goal is an annual increase of the share of beneficiaries by 12%.

3 Impact of the Financial and Economic Crisis on Social Protection

Croatian economy is in recession. The fall of the GDP in the past three months of 2008 is 0.4 compared to the previous three months, when a decrease of 0.7 was registered. According to the projections of the Institute of Economics,[99] GDP will fall by 3% in 2009. A mild increase of 0.9% is expected only in 2010. The World Bank predicts a drop of GDP from 2.7% to 3.5%, which is largely dependent on the tourism revenues.[100] The financial and economic turmoil has particularly negatively affected the labour market. The number of unemployed persons is expected to rise by about 50,000, leading to an increase of the unemployment rate by 20%, to about 14.6%.

Table 4: The prognoses of the Institute of Economics can be summarised as follows:

	2008 (accomplished)	2009	2010
Real GDP growth (in %)	2.4	-3.0	0.9
Current account payment balance (as % of GDP)	-9.4	-4.7	-4.7
Consumer prices inflation (in %)	6.1	2.5	2.5

Source: The Institute of Economics, Zagreb

The latest unemployment figures reveal that the total registered unemployment rate in April 2009 was 14.8%.[101] The year 2008 saw the lowest unemployment in the past decade (on average 27.705 less unemployed persons as compared to year 2007). However, this positive trend is in the process of reversing at a troublesome speed (there have been 25,494 more unemployed persons in the first quarter of 2009, as compared to the 2008 average). The unemployment has been rising steadily as from the last quarter of 2008 (from 222,217 registered unemployed persons in September 2008 to 263,785 in April 2009[102]). The negative trend is expected to fall back in the forthcoming period, due to seasonal employment in tourism. Young (20-25) and elderly (50+) unemployed persons count as the most vulnerable categories, the share of unemployed women being at an average of 50%-70% throughout different age groups (the share of unemployed women in the population 55+ falls below 50%,

99 The Institute of Economics, Zagreb, Croatian Economic Outlook Quarterly no. 38/2009, April 2009, retrieved from: http://www.eizg.hr/Item.aspx?Id=26&lang=1.

100 The World Bank, EU-10 Regular Economic Report, Croatia Supplement, May 2009, accessible at: http://siteresources.worldbank.org/INTECA/Resources/257896-1242920964286/RER_CRO_May.doc, last visited 26 May 2009.

101 At the time of revision of this report, on 21 May 2009 the Government has adopted the National Plan for Promotion of Employment in 2009 and 2010, which is aimed at increasing the supply of labour force and investment in human resources as well as flexibilisation of employees and companies. The measures will be implemented by different state authorities. HRK 520 million will be invested for employment, out of which HRK 130 million will be placed through the Croatian Employment Service for education and self employment. Additional HRK 20 million are to be provided from an IPA programme for the development of human resources.

102 Croatian Employment Service, http://www.hzz.hr/docslike/statistike/tablica%204.xls, last visited 20 May 2009.

probably due to the earlier retirement age for women). Typical regional differences regarding the unemployment rate persist, with the Split-Dalmatian County in the lead, closely followed by the City of Zagreb and Osijek-Baranja County.

Prices of goods and services for personal consumption measured by consumer price indices in April 2009 increased by 0.8% on average, as compared to March 2009 and by 3.9% compared to April 2008.

The negative impact of the recession on the stock market has affected the structure of investments and the yield of the compulsory and voluntary pension funds. According to the available data for the last quarter of 2008, compulsory pension funds had an average yield of -4.83%.[103] This is a continuance of the negative trend from the preceding quarter, when the average yield amounted to -2.96%. The total net assets of all compulsory pension funds were slightly increased in the last quarter of 2008, amounting to HRK 22.59 billion, an increase of 0.47% compared to the previous quarter. As regards the open voluntary pension funds, their total net value has increased by 7.72% as compared to the previous period, to HRK 799.6 million. Four out of six open voluntary pension funds had negative results, and the total amount of yield was between -9.06% up to 5.04%.

The funding of pensions from the second pillar will face a test in 2010, when a larger number of combined pensioners, who receive pension from the first and the second pillars are expected.

The World Bank has recently issued its warnings and recommendations to the Croatian Government for tackling the effects of the financial crisis on public finances. According to the World Bank, Croatia's expenditures for the pension system are too high and burdensome. As part of the general effort to reduce public expenditures by 7% (despite the economic crisis), several measures are recommended in the field of pension insurance. Among them are the proposals to increase the contribution rate in the second pillar of the pension insurance from 5% to 10%, prolongation of the pension age for women to 65 years,[104] reconsideration of the privileged pensions and their amount. Health expenditures should be decreased by 2% of the GDP, by reducing fixed payments to hospitals and expenditures for drugs, as well as expanding co-payments for medical care. The main criticism in the field of social welfare is that only 0.6% of GDP (out of a total 4% intended for social welfare) goes to payments to the impoverished persons. The total social expenditures should be reduced by 1.5% of the GDP.

One of the Government's first responses to the recession is an attempt to cut back public expenditures, by reducing wages of civil servants and persons employed in the sector of public services. Whether the Government Package, containing 10 anti-recession measures, adopted during the 71st Government Session of 26 February 2009, will be able to effectively deal with the crisis, remains to be seen. The three ministries charged with the implementation of the measures aiming to ensure the preservation of the standard of living of the most vulnerable are the Ministry of Family, War Veterans and Generational Solidarity, the Ministry of Health and Social Welfare, and the Ministry of Economy, Labour and Entrepreneurship. The goal is to ensure an appropriate level of means to preserve the living standard of the categories of population that are most at risk. No precise definition of the 'most vulnerable/at risk categories of population' is provided. There are no specific measures yet, so it is impossible to provide further comments.

[103] The Croatian Financial Services Supervisory Agency, Quarterly Bulletin IV/2008 (in Croatian language), accessible at: http://www.hanfa.hr/index.php?ID=0&AKCIJA=63&LANG=HR, last visited 20 May 2009.

[104] Gradual equalisation of the age of retirement for women and men by 2019 is Croatia's obligation, since the Constitutional Court of the Republic of Croatia passed a decision in 2007, establishing that the current different age of retirement for men and women is contrary to the constitutional guarantee of gender equality.

The first budget rebalance of April 2009 is based on the Government's projection of the fall in GDP of 2% in this year. The Ministry of Finances does not exclude the possibility of another rebalance taking place this year, bearing in mind that other independent sources (e.g. the Institute of Economics) predict a decrease of 3%.

The Mission of the International Monetary Fund has also expressed its doubts that the reduction of GDP of 2% in 2009 is realistic, although it is not entirely impossible if the recovery of the economy starts in the second half of 2009.[105] The IMF Mission emphasised that the realisation of the budget is a key priority and "welcomed the recent health sector reforms to improve cost recovery and the adoption of tax identification numbers that would allow better tax compliance and better targeting of social benefits".[106]

At this point, it is impossible to predict whether other proposed anti-recession measures by the Government (which include strengthening of macroeconomic stability (budget rebalance), relief of economy from non-fiscal payments, ensuring liquidity of public enterprises (and thus private sector as well), harmonising domestic aids with those of the EU, strengthening of the financial position of CBRD, strengthening of tourism, incentives for direct investments and technology transfers, support to the real estate market, monitoring of import) will actually work towards stabilisation of the financial and economic position of the country and contribute to overcome the crisis. Since social protection generally depends on the economy, should the global financial crises persist and the domestic economy fails to adapt, it could have a severe negative impact on all aspects of social security. Repayment of foreign debts and results expected from the forthcoming tourist season are factors which will significantly influence the predicted economic trends.[107]

[105] International Monetary Fund, Croatia – 2009 Article IV Consultations, Concluding Statement, accessible at http://www.imf.org/external/np/ms/2009/040609.htm, last visited 20 May 2009.

[106] Ibid.

[107] Ibid.

4 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.

[R1; H1; L] BABIĆ, Zdenko, «Redistribucijski učinci socijalnih transfera u Republici Hrvatskoj», Revija za socijalnu politiku, god. 15, br. 2, 151-170, Zagreb, 2008.
"Redistributive Effects of Social Transfers in the Republic of Croatia"

Description: Original scientific paper, published in the Journal of Social Policy, Vol. 15, no. 2. The paper analytically investigates the system of social transfers in Croatia and evaluates their impact on reducing poverty and economic inequality in Croatia. In the theoretical part of the paper, recent results from economic research studies about the new role of social expenditure and social transfers in the new environment are presented. The conclusion is that there is space for improvement regarding the efficiency of the social transfer system.

[R2; H1; H3 - H5; L] BODIROGA-VUKOBRAT, Nada «Socijalna sigurnost i tržišno natjecanje – europski zahtjevi i nacionalna rješenja / Soziale Sicherung und Wettbewerb – europäische Vorgaben und nationale Regelungen», Pravni fakultet Sveučilišta u Rijeci, Hanns-Seidel-Stiftung, 2008.
"Social Security and Competition – European Requirements and National Solutions"

This book is a collection of papers presented at the international scientific conference "Social Security and Competition – European requirements and National Solutions" hosted by the University of Rijeka, Faculty of Law in 2005. Eminent European scholars and experts in the field of social security, notably Prof. Dr. Ulrich Becker, Prof. Dr. Beatrix Karl, Prof. Dr. Bernd von Maydell, Dr. Markus Sichert, Prof. Dr. Edita Čulinović-Herc, Doc. Dr. Dionis Jurić, Prof. Dr. Andreas Hänlein, Doc. Dr. Hana Horak, Prof. Dr. Marija Kaštelan-Mrak and Prof. Dr. Nada Bodiroga-Vukobrat have all contributed with their valuable insight and research in various fields of social security, with special emphasis on competition, operation of market principles and development of various forms of cooperation of different actors who provide services in the field of social security. The book is written in Croatian and German language.

[R2; H1; L] BODIROGA-VUKOBRAT, Nada «Socijalno odgovorno gospodarenje», Timmpress, 2008.
"Corporate Social Responsibility"

This book is a collection of papers presented at the international scientific conference "Corporate Social Responsibility" hosted by the University of Rijeka, Faculty of Law in 2007. The collection includes 12 papers dedicated to the issues of corporate social responsibility from a European and the Croatian perspective.

[R2; H1; L] DOBROTIĆ, Ivana, «Sustav skrbi za branitelje iz Domovinskog rata», Revija za socijalnu politiku, god. 15, br. 1, 57-83, Zagreb, 2008.
"Social Care System for Defenders from the Homeland War"

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[R2; H1; H2; L] GOVERNMENT OF THE REPUBLIC OF CROATIA: «Program Vlade Republike Hrvatske za mandat 2008.-2011».
"Programme of the Government of the Republic of Croatia for the mandate 2008 -2011"
Government programme on commitments during the mandate from 2008-2011.

[R1; H1; L] JAFAROV, Etibar, & GUNNARSSON, Victoria «Efficiency of Government Social Spending in Croatia».

This paper analyses the relative efficiency of social spending and service delivery in Croatia by comparing social spending and key social (outcome) indicators in Croatia to those of comparator countries. The analysis finds evidence of significant inefficiencies in Croatia's social spending, mainly related to inadequate cost recovery for health and education services, weaknesses in the financing mechanisms and institutional arrangements, weak competition in the provision of social services, and weaknesses in targeting benefits. The paper also identifies areas for cost recovery and reform.

[R1 - R5] MARUŠIĆ, Ljiljana, & ŠKEMBER, Ante, «Socijalni i gospodarski aspekti uvođenja obveznog mirovinskog osiguranja na temelju individualne kapitalizirane štednje» Revija za socijalnu politiku, god. 15, br. 3, 343-363, Zagreb, 2008.
"Social and Economic Aspects of the Introduction of Mandatory Pension Insurance Based on Individual Capitalised Saving."

Original scientific paper, published in the Journal of Social Policy, vol. 15, no. 3. The paper analyses social and economic aspects of the pension reform, focusing on the pensions realised through the compulsory pension insurance on the basis of intergenerational solidarity or the first pillar and the mandatory pension insurance based on individual capitalised savings or the second pillar, and the projection of future trends. The authors recommend measures required for correction of certain parameters on which the level of pensions and costs in the reformed pension system are calculated.

[R1; R2; R5] POTOČNJAK, Željko, & VUKOREPA, Ivana «Upravljanje rizikom prinosa u obveznim kapitalno financiranim mirovinskim fondovima», Revija za socijalnu politiku, god. 15, br. 3, 323-342, Zagreb, 2008.
"Risk Management of Returns in Mandatory Funded Pension Systems"

Original scientific paper, published in the Journal of Social Policy, vol. 15, no. 3. The authors address the issue of introduction of pension systems of individual savings and the extensive debate surrounding it, regarding the protection of insured persons from different risks associated with the capital market. These issues aggravated lately because of a large drop in the value of assets that are traded on the Zagreb market,

and in which the Croatian pension funds have been investing, due to negative trends on the world capital markets. The authors pay special attention to the risk of returns, a most important risk on which the level of pensions of insured persons from the compulsory funded part of the pension system largely depends.

[R1; R2; H1 - H5; L] PULJIZ, Vlado, et. al. «Socijalna politika Hrvatske», Pravni fakultet Sveučilišta u Zagrebu, 2008.
"Croatian Social Policy"

The book represents a systematic approach to all fields of social policy. The authors deal with the issues of social policy and its development in Croatia, with special emphasis on the 'Europeanisation' of social policy in the light of the preparations for Croatia's accession to the EU. The pension system, health care policy and the need for its reform, unemployment issues and measures for promotion of employment, overview and development of social welfare, family policy, housing etc. are some of the main topics elaborated in the book. Studies and research conducted in relevant fields is included.

[R1; H2] STUBBS, Paul, «Reflections on International Actors and the Making of Social Policy in Croatia», Revija za socijalnu politiku, god. 15, br. 3, 365-378, Zagreb, 2008 review, published in the Journal of Social Policy, Vol. 15, no. 3.

Addressing the role of international actors in three pivotal moments in the development of social policy in post-independence Croatia, the article sees welfare reforms as complex interactive processes in which legacies and contexts matter. The mistrust created by and implicit social policy in the context of a new humanitarianism during the wars, compounded by the problems of externally driven reform projects, continue to limit changes in Croatia's social welfare policies and practices. However, a delayed yet emergent Europeanisation, expressed in the Joint Memorandum on Social Inclusion, opens up four dialogic zones and potential alignments between EU thinking and Croatian realities: statistical, participatory, governance, and policy commitments and practice.

[R1 - R5] ŠUĆUR, Zoran «Socijalna sigurnost i kvaliteta života starijih osoba bez mirovinskih primanja u Republici Hrvatskoj», Revija za socijalnu politiku, god. 15, br. 3, 435-454, Zagreb, 2008.
"Social Security and Quality of Life of Elderly Persons without Pensions in the Republic of Croatia"

Original scientific paper, published in the Journal of Social Policy, vol. 15, no. 3. The paper aims to estimate the number of elderly persons who do not receive pensions, analyse their social, demographic and family characteristics, analyse and compare some indicators of the quality of life of elderly persons without pensions to the indicators of quality of life of elderly retired persons, analyse the structure of income and the role of the social welfare transfers in the households in which elderly persons who do not receive pensions live, and discuss the models of social protection for elderly persons without pensions. The author analyses advantages and disadvantages of social pensions and social assistance as an alternative in social protection of elderly population without pension.

[R1 - R5] VEHOVEC, Maja, «New perspectives on a longer working life in Croatia and Slovenia», The Institute of Economics, Zagreb and Friedrich-Ebert-Stiftung, 2008.

A team of experts has analysed the basic demographic forces shaping future labour market developments in Croatia and Slovenia, identified those elements of the pension system influencing retirement decisions in the two countries and scrutinised the employers' willingness to retain older workers.

[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

[R1; H1; L] BABIĆ, Zdenko, «Redistribucijski učinci socijalnih transfera u Republici Hrvatskoj», Revija za socijalnu politiku, god. 15, br. 2, 151-170, Zagreb, 2008.
"Redistributive Effects of Social Transfers in the Republic of Croatia"
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[R2; H1; H3 - H5; L] BODIROGA-VUKOBRAT, Nada «Socijalna sigurnost i tržišno natjecanje – europski zahtjevi i nacionalna rješenja / Soziale Sicherung und Wettbewerb – europäische Vorgaben und nationale Regelungen», Pravni fakultet Sveučilišta u Rijeci, Hanns-Seidel-Stiftung, 2008.
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[R2; H1; H2; L] GOVERNMENT OF THE REPUBLIC OF CROATIA, «Program Vlade Republike Hrvatske za mandat 2008-2011».
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[H1; H4] NOVAKOVIĆ, Nataša, «Hrvatski zavod za zdravstveno osiguranje zaštite zdravlja na radu», Radno pravo br. 5/08, 36-42.
"Croatian Institute for Protection of Health at Work Insurance"

Review of novelties in the Compulsory Health Insurance Act, article published in the Labour law journal no. 4/08.

[H1; H4] PAP, Jasenka, & MIRKOVIĆ, Nevenka, «Novine uvedene Zakonom o izmjenama i dopuni Zakona o obveznom zdravstvenom osiguranju», Radno pravo br. 4/08, 27-30.
"Novelties in the Compulsory Health Insurance Act"

Review of novelties in the Compulsory Health Insurance Act, article published in journal Labour law, no. 4/08

[R1; R2; H1 - H5; L] PULJIZ, Vlado, et. al. «Socijalna politika Hrvatske», Pravni fakultet Sveučilišta u Zagrebu, 2008.
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[L] Long-term care

[R1; H1; L] BABIĆ, Zdenko, «Redistribucijski učinci socijalnih transfera u Republici Hrvatskoj», Revija za socijalnu politiku, god. 15, br. 2, 151-170, Zagreb, 2008.
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[L] BABIĆ, Zdenko, «Uloga socijalne pomoći u politici prema siromaštvu u Hrvatskoj», Privredna kretanja i ekonomska politika 116/2008, Ekonomski institut, Zagreb, 2008.
"The Role of Social Assistance in the Policy against Poverty in Croatia"

Professional paper, published in the journal "Privredna kretanja i ekonomska politika", Vol. 116, 2008. The paper analyses the effects of policies and instruments used in the struggle against poverty in Croatia. Special emphasis is given to the evaluation of the instruments of social care. After transition and defence war in Croatia, social issues have significantly arisen. Social programmes have been directed towards the protection of the standards of refugees and war victims. Only recently, in the last couple of years, has the poverty been subjected to more intensive research, and the first comprehensive programme for the fight against poverty has been adopted by the Croatian Government in 2002. However, the programme only demonstrated declarative will of the Government to tackle poverty issues, while the implementation of the adopted measures has lagged behind. Every research shows that the social care, i.e. the maintenance care is the best directed transfer to the impoverished persons. However, the base amount of the social care has not been elevated since 2001, which, together with the lack of systematic policy and coordinated measures for fight against poverty, is the main reason that in the decade of intensive development the number of impoverished people in Croatia was not reduced.

[R2; H1; H3 - H5; L] BODIROGA-VUKOBRAT, Nada «Socijalna sigurnost i tržišno natjecanje – europski zahtjevi i nacionalna rješenja / Soziale Sicherung und Wettbewerb – europäische Vorgaben und nationale Regelungen», Pravni fakultet Sveučilišta u Rijeci, Hanns-Seidel-Stiftung, 2008.

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"Programme of the Government of the Republic of Croatia for the mandate 2008 -2011"

Government programme on commitments during the mandate from 2008-2011

[R1; H1; L] JAFAROV, Etibar, & GUNNARSSON, Victoria «Efficiency of Government Social Spending in Croatia»

This paper analyses the relative efficiency of social spending and service delivery in Croatia by comparing social spending and key social (outcome) indicators in Croatia to those of comparator countries. The analysis finds evidence of significant inefficiencies in Croatia's social spending, mainly related to inadequate cost recovery for health and education services, weaknesses in the financing mechanisms and institutional arrangements, weak competition in the provision of social services, and

weaknesses in targeting benefits. The paper also identifies areas for cost recovery and reform.

[R1; R2; H1 - H5; L] PULJIZ, Vlado, et. al. «Socijalna politika Hrvatske», Pravni fakultet Sveučilišta u Zagrebu, 2008.
"Croatian Social Policy"

The book represents a systematic approach to all fields of social policy. The authors deal with the issues of social policy and its development in Croatia, with special emphasis on the 'Europeanisation' of social policy in the light of the preparations for Croatia's accession to the EU. Pension system, health care policy and the need for its reform, unemployment issues and measures for promotion of employment, an overview and development of social welfare, family policy, housing etc. are some of the main topics elaborated in the book. Studies and research conducted in relevant fields are included.

[L] ŽGANEC, Nino, «Socijalna skrb u Hrvatskoj – smjerovi razvoja i reformi», Revija za socijalnu politiku, god. 15, br. 3, 379-393, Zagreb, 2008.
"Social Welfare in Croatia – Trends of the Development and Reforms"

Review, published in the Journal of Social Policy, Vol. 15, no. 3. Following the war conditions, the Republic of Croatia launched significant welfare reforms, among which is the social welfare reform embarked on at the beginning of 2000s. After the completion of the professional background, a political decision was made to restructure the reform and slow it down considerably, which led to stagnation in the development of the entire social welfare system.

5 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 our mixed financing – approx. 60% of our 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*

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

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 – Ministy of Health and Social Care

Address: Ksaver 200a, 10 000 Zagreb, Croatia
Webpage: http://www.vlada.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 next international conference is scheduled in October 2009, under the title "Open Methods of Coordination". 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.

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(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/employment_social/progress/index_en.html