Croatia

Health Care & Long-Term Care Systems

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Croatia

Health care systems

1.4. CROATIA

General context: Expenditure, fiscal sustainability and demographic trends

General statistics: GDP, GDP per capita; population

Croatia, independent country since 1991 and member of the European Union since 2013, has a population of 4.3 million, roughly 0.8% of the EU population. After a long spell of contraction, growth picked up over the course of 2015, marking it the first year of positive growth (1.8%) since 2008. Overall, real GDP is expected to grow by 2.1% in 2016 and 2017. ([60]) In current prices the GDP of Croatia has been increasing fast from 2003 to 2008, from EUR 31 to EUR 48 billion. Since 2008 it decreased to EUR 43 billion. GDP per capita was in 2013 with 15,200 PPS well below the EU average of 27,900 PPS.

The population in 2013 is 4.3 million and, according to Eurostat 2013 projections, total population in Croatia is projected to decrease in 50 years with some 13.1% to 3.7 million in 2060.

Total and public expenditure on health as % of GDP

Total health expenditure was at 7.3% of GDP in 2013, lower than the EU average of 10.1%. Public expenditure on health as a percentage of GDP (5.8%) remains under the EU average (7.8%), but is still higher than neighbouring Hungary. At the same time, the share of health in public expenditure is very large with 20.1%, recorded in 2012, of total government expenditure, where the EU average is 14.9%. With some 80% the share of public expenditure in total expenditure on health was in 2013 higher than the EU average of 77.4%.

When expressed in per capita terms, total spending on health at 1,100 PPS in 2011 was significantly under the EU average in the same year (2,904 PPS) and it is below the latest figure (2,988 in 2013). So is public spending on health: 880 PPS in 2013 vs. an average of 2,208 PPS in the EU in 2013.

([60]) European Commission (2016), European Economic Forecast Winter 2016.

Expenditure projections and fiscal sustainability

As a consequence of population ageing, health care expenditure is projected to increase by 1.7 pps of GDP, at the average growth level expected for the EU of 0.9 pps of GDP, according to the "AWG reference scenario". ([61]) When taking into account the impact of non-demographic drivers on future spending growth ("AWG risk scenario"), health care expenditure is expected to increase by 2.7 pps of GDP from now until 2060 (EU: 1.6). Overall, the country faces high medium-terms risks from a debt sustainability analysis perspective due to the high debt-to-GDP ratio and the unfavourable initial budgetary position ([62]).

Health status

Life expectancy at birth for both women and men is respectively 81 years and 74.5 years and is, although having increased during the decade; below the EU average (83.3 and 77.8 years respectively). Similarly healthy life years at birth for both sexes are with 60.4 years (women) and 57.6 years (men) slightly lower than the EU-average (61.5 and 61.4 respectively), the biggest gaps in both indicators being recorded for males. Infant mortality has gradually declined to 4.1 per 1000 live births in 2013, but is still higher than the EU average of 3.9.

System characteristics

Overall description of the system

Since 1990, Croatian health care went through a series of reforms that have helped to transform the once fragmented and highly decentralised health system, inherited from former Yugoslavia and battered by five years of war, into a health care system that maintains the principles of universality and solidarity.

The system of health care in Croatia is based on mixed financing (with predominant public financing, nearly 85%) and provision by public and private health services providers. Health care is financed from mandatory contributions

([61]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

([62]) Fiscal Sustainability Report 2015: http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf.

(approximately 91%) as well as from taxes and co-payments and private insurance. Also a share of compulsory car insurance premiums is part of the healthcare budget.

Health care is contracted by the Croatian Health Insurance Fund (HZZO), counties (20) and the City of Zagreb and beneficiaries. Rates of contributions for the mandatory health insurance were in May 2012 reduced from 15% to 13% of gross salary (measure implemented with the aim of increasing competitiveness of the economy)., but the government has decided that this measure will be revoked in 2014. ([63]) 0.5% contribution is paid as a special contribution to cover costs of occupational injuries.

Two basic rights arising from the compulsory basic health insurance include in-kind benefits (right to health protection) and cash benefits (e.g. compensation for sick leave, travel expenses ([64]), etc).

Coverage

The average number of insured persons in 2015 was 4,325,852, which is 0.45 % less than in 2014, when an average of 4,345,435 insured persons was recorded.

The average number of active insured persons (paying the full premium of 15% of the gross salary) was, in 2014, 1,466,654, which is 1.24%, higher, with 17,917 additional individuals recorded, than in 2014 (in which the number was 1,448,737). ([65])

It is estimated that only 1/3 of the population is liable to pay health care contributions, while the remaining population includes pensioners (who pay a reduced healthcare premium), insured persons' family members, unemployed (health contribution 5% of the prescribed base amount, paid from the state budget) and other inactive persons.

46.77% (685,988) of active insured persons are women and 53.23% or 780,666 persons are men. Furthermore, 1,061,553 pensioners were registered in 2015, which is slightly higher than in 2014 (1,058,751 recorded pensioners). The number of farmers has decreased by 13.08% over the period, with an average of 21,845 as opposed to 25,131 farmers recorded last year during the same period. ([66]) Other categories of insured (which comprises the unemployed, insured abroad - pensioners, students and high school students, persons incapable of independent life and work, etc.) increased by 29.44% in 2015. ([67])

Administrative organisation and revenue collection mechanism

Contributions are paid on the monthly contribution base, which represents the salary or other income from employment paid by employer and subject to income tax or income from self-employment, which is calculated as the product of monthly contribution base and a coefficient depending on the nature of self-employment. Health contribution on pensions above average net wage is paid in the amount of 3%.

In 2008 the efficiency of the sector was increased through the introduction of public procurement of medication, centralised procurement of medical equipment, better supervision of transfers to households, reorganisation of emergency medical services, use of eHealth tools in primary health care and introduction of national waiting lists. Diagnoses related groups (DRGs) replaced the unpopular PPTPs in 2009 and allowed for more refined case-groupings.

([63]) Act on Amendments of the Contributions Act, OG, No. 41/14).

([64]) Insured persons are entitled to claim reimbursement of travel expenses if they used health services at a contracted health facility or physician which is more than 50 km distant from their residence, provided they are not able to obtain the same treatment in the place of their residence. However, complicated rules of reimbursement do not allow for a full reimbursement of costs in all cases.

([65]) Source: Croatian Health Insurance Fund Annual Report for 2015, http://cdn.hzzo.hr/wp-content/uploads/2016/04/Izvjesce_o_poslovanju_hzzo_za_2015_godinu.pdf.

([66]) Source: Croatian Health Insurance Fund Annual Report for 2015,http://cdn.hzzo.hr/wp-content/uploads/2016/04/Izvjesce_o_poslovanju_hzzo_za_2015_godinu.pdf.

([67]) Source: Croatian Health Insurance Fund Annual Report for 2015, http://cdn.hzzo.hr/wp-content/uploads/2016/04/Izvjesce_o_poslovanju_hzzo_za_2015_godinu.pdf.

Role of private insurance and out of pocket co-payments

Patients have to pay co-payments for medicines which are on a complementary list of medicines, even if they have complementary insurance. Complementary insurance is a part of voluntary insurance. Patients without complementary health insurance have to pay additional fixed amount of HRK 10 (EUR 1.50) per prescription and HRK 10 (EUR 1.5) for GP check-up.

They also have to pay 20% of hospital expenditures with the maximum amount of approximately EUR 260 per invoice (for treatments, medical tests, hospital bed).

With the Healthcare Reform of 2008, the share of the population excluded from paying co-payments was reduced. At the same time, the HZZO offered a complementary health insurance (CHI), which would cover these co-payments. (Voncina, 2012).

The total number of insured persons in supplementary health insurance was in 2015 2,597,831. 1,623,799 of insured persons pay supplementary policy by themselves. The costs of supplementary health insurance policy for 974,032 insured persons are covered from the state budget (these categories include persons with 100% disability, organ donors, blood donors, pupils and students under 26 years, as well as persons below the minimum income threshold). ([68])

HZZO provides the supplementary health insurance at a yearly loss (EUR 23 million in 2012). Nevertheless, the HZZO reduced the price of supplementary policy to HRK 70 (EUR 9) for all insured persons in September 2013. With this measure, HZZO hoped to retain the majority of 2,370,000 insured persons and beat the competitors in the market. The largest private insurer in Croatia, Osiguranje, offered their supplementary policies at a price of HRK 75, and with the opening of the market after Croatia joined the EU; additional private insurance companies have announced their interest in this segment. HZZO is currently holding around 98% of the market in supplementary insurance (Bodiroga-Vukobrat, 2013).

Private voluntary insurance is still a luxury for Croatian citizens, since only about 1.19% of citizens have a private health insurance policy. The 1993 Law allowed opting-out of the public insurance system and acquiring substitutive insurance with private insurers. This was abolished in 2002.

Types of providers, referral systems and patient choice

The number of practising physicians per 100,000 inhabitants (303 in 2013) is slightly below the EU average (344 in 2013), showing an increase since 2003 (244). The number of GPs per 100,000 inhabitants (54 in 2013) is below the EU average (78.3 the same year), and has remained roughly stable since 2009. The number of practising nurses per 100,000 inhabitants (621 in 2013) is well below the EU average (837) despite having increased throughout the decade, from a level of 470 in 2003. ([69])

Teaching hospitals, clinical hospital centres and state institutes of public health are state owned. Health centres, polyclinics, general and special hospitals, pharmacies, institutions for emergency medical aid, home care institutions and county institutes of public health are county-owned. During 2002, health centres began the process of merging through which their number was reduced from 120 in 2001 down to 49 in 2014. Out of 73 hospital institutions and sanatoriums, ten special hospitals and five sanatoriums were privately owned. By the end of 2014, there were 5,399 private practice units (doctors' offices, laboratories, private pharmacies, private physical therapy practices and home care services) registered. ([70]) The majority of primary health care general practitioner (GP) offices located in health centres were since 1991 privatised, and the remaining ones were left under county ownership (Bodiroga-Vukobrat, 2013).

([68]) Source: Croatian Health Insurance Fund Annual Report for 2015, http://cdn.hzzo.hr/wp-content/uploads/2016/04/Izvjesce_o_poslovanju_hzzo_za_2015_godinu.pdf.

([69]) Data for density of health personnel is taken from the OECD database. As this figure includes only nurses employed in hospitals, the actual number may be underestimated.

([70]) Croatian Institute of Public Health, Croatian Health Service Yearbook 2014, http://www.hzjz.hr/wp-content/uploads/2015/05/ljetopis_2014.pdf.

Treatment options, covered health services

As the main purchaser of health services, the HZZO also plays a key role in the definition of basic health services covered under statutory insurance, the establishment of performance standards and price setting for services covered by the HZZO (Vončina et al., 2006).

With 1.8 hospitals and 549 hospital beds per 100,000 inhabitants, Croatia is in line with older EU Member States and does not have excess hospital facilities like many other countries in Central and Eastern Europe. However, the Croatian hospitals have inadequate medical technology and equipment. Comparing the number of MRI scans, mammograms and CT scans per 100,000 inhabitants reveals that Croatia is in the lower ranking within the EU. In addition, regional coverage varies and regional differences persevere, since many capacities are unequally distributed and concentrated in metropolitan areas. Roughly half of the healthcare budget is being spent in hospitals (Bodiroga-Vukobrat, 2013).

Price of healthcare services, purchasing, contracting and remuneration mechanisms

Hospitals were financed directly from the state budget (based on the contract concluded with the HZZO), while all other payments are effectuated through the HZZO. Clinical medical institutions received during the year the maximum amounts to perform clinical and specialist medical care and at the end of the year the work performed and the allocated means are harmonised. Since 2015, HZZO is out of state budget. This means that all hospitals and primary care providers are financed from HZZO budget. The treatment of acute patients is paid to clinical medical institutions according to diagnostic-therapeutic groups (DTS), or according to day of clinical (hospital) treatment (DBL) for chronic diseases. Additional coverage is provided for particularly expensive medicines and certain complicated procedures. In the year 2015, 24,069 beds have been contacted, of which 12,617 are for acute care, 1,324 for long-term care, 6,357 beds for chronic diseases and 3,771 day care beds, with an increase in the number of the latter from the previous year (15,940 acute, 3,033 day care and 5,898 beds for chronic diseases and physical therapy). The average monthly hospital limit in 2015 was HRK 664,907,700, increased from 576,573 million in 2014 ([71]). Depending on the structure, the majority of hospital expenses cover employees' wages (56.67% in 2010, 57.38% in 2011).

In 2015, the average number of waiting days for all diagnostic procedures was 147 with 178,344 orders waiting (decreased from 166 with 189,540 orders in 2014); the average number of days for therapeutic procedures was 253 with 42,791 orders (down from 267 with 44,822 in 2014), and the average number of days for first examination was 102 with 128,847 orders (lower than 111 with 125,236 orders recorded the previous year).

In 2014 there were 77 hospital institutions and treatment centres in Croatia: 5 clinical hospital centres, 7 clinical hospitals and clinics, 20 general hospitals, 33 special hospitals and treatment centres, 1 hospice, 10 general wards and 1 out-of-hospital maternity ward.

In 2014, Croatian hospitals treated 742,452 people (744,188 in 2013). The care included hospital stays for childbirth, abortion, and hospital rehabilitation. According to individual reports on treated patients (excluding childbirth, abortions and rehabilitation), the number of patients treated in Croatian hospitals in 2014 was 578,569 (577,565 in 2013).

The number of beds (expressed per 1,000 population) in all hospital-type institutions in 2014 was 5.89 (in 2013 it was 5.86). By bed structure per 1,000 inhabitants in 2014, there were 4.07 acute beds (1.80 in general hospitals and 2.31 in teaching hospitals). For chronic and subacute patients, 1.82 beds per 1,000 inhabitants were available.

In Croatian hospitals, in 2014 there were 6,536,737 days of hospital treatment. In other words, the average length of treatment per stay was 8.80 days (against the 1990 average length of treatment of 15.37 days). Average length of treatment in general hospitals has been reduced from 12.3 days in 1990 to 6.80 days in 2014. The average length of stay in teaching hospital centres, teaching hospitals and clinics was reduced from 12.05 to

([71]) Network of Public Health Services (Official Gazette, No 101/12, 31/13, 113/15).

7.34 days and in special hospitals from 34.83 to 23.36 days. ([72])

It is recognised that a reduction of existing inefficiencies in hospital management is required in the short run in order to decrease the debt and arrears of the hospitals. Reconsidering the model of financing of hospitals seems inevitable in the long run. To this end, the Hospital Master Plan, which is the National plan of development of clinical hospital centres, clinical hospitals and general hospitals in Republic of Croatia for 2015.-2016, has come into force since March 2015. ([73]) The World Bank supports the preparation of the plan, and provided funds to hire French consultancy firm *Conseil Santé* to assist with the writing of the plan.

The market for pharmaceutical products

Out of the total expenditure by HZZO, pharmaceuticals accounted for a share of 14.1% in 2002 (Vončina, 2006). In 2011, there were 16 licensed pharmaceutical manufacturers in Croatia. Domestic manufacturers held 20% of the market share by value produced and 33% by volume produced (Ministry of Health and Social Welfare, 2011). The major domestic pharmaceutical companies are Pliva, Belupo and Jadran Galenski Laboratorij.

The HZZO is a purchasing monopoly. It controls drug prices and it has enforced price reductions in the market. The access of new drugs to the market used to take two to three years. However, the 2003 Drugs Law introduced a new Agency for Drugs and Medical Products and set out a shorter, more ambitious time frame for registration (210 days for ready-prepared drugs).

The Drug Reference Price System was introduced in 1999 in an attempt to contain pharmaceutical expenditure. To further rationalise costs for drugs, the HZZO has introduced risk-sharing, pay-back and cross-product agreements with pharmaceutical companies. In addition, according to the new model, whenever both an off-patent and a generic are available, generics are preferred, unless there are specific medical indications to the contrary (Vončina, 2006).

To curb the volume of prescriptions, the HZZO has imposed annual caps on the number of prescriptions per beneficiary and limited the number of drugs per prescription, which, however were not successful as the number of prescriptions actually increased over time. The HZZO reviews prescribing practices but does not include them as part of performance indicators for payments. Overspending by individual GPs is, however, subject to financial punishment of up to 10% of monthly capitation. The punishments are enforced (Vončina, 2006).

Pharmaceuticals covered by the HZZO are classified into two lists: the positive list entirely covered within the MHI scheme, and the supplementary list with medicines covered in part by the MHI scheme and in part by OOP payments. Medicines are free of charge if they are on the positive list, regardless of the patient's situation (age, financial status, inpatient or outpatient setting, etc.). There is a prescription fee for all reimbursable medicines of HRK 10 (approximately EUR 1.5) per prescription. Private health insurance schemes do not cover medicines.

Use of Health Technology Assessments and cost-benefit analysis

In accordance to the Act on Quality of Health Care and Social Welfare (Official gazette, no 107/07, 124/11), the Agency for Quality and Accreditation in Health Care and Social Welfare is in charge for health technology assessment (HTA). However this is optional and not mandatory. Regrettably, HTA in Croatia is rather "underused" and "underdeveloped". The HZZO is playing a big role in HTA decisions and, through its "Drugs Committee" and "Medical Devices Committee", it is responsible for the appraisal and gives a recommendation to the Board of the HZZO, which then makes the pricing and reimbursement decision. The HZZO can make a request to the Agency for Quality and Accreditation in Healthcare and Social Welfare – HTA Department to conduct an assessment. The Ministry of Health is involved in the HTA process, when it comes to legislation. As a member state, Croatia is also taking part in EUnetHTA and is represented in some of the work groups of the network.

([72]) Source: Croatian Institute of Public Health, Croatian Health Service Yearbook 2014, http://www.hzjz.hr/wp-content/uploads/2015/05/ljetopis_2014.pdf.

([73]) http://narodne-novine.nn.hr/clanci/sluzbeni/2015_03_26_544.html.

The World Bank identifies HTA and use of protocols as a field for improvement (Bodiroga-Vukobrat, 2013).

eHealth, Electronic Health Record

Information and eHealth strengthening is the first priority identified in the 2012 National Health Care Strategy. The aim would be the integration and standardisation of health information and equalisation of the level of informatisation in the health care system as a whole, the further establishment of Electronic Health Records, to improve the use of statistical information to support decision making and establishing a reporting and warning system. It is the aim of the Government of Croatia to improve, modernise and maintain the existing information systems in health care.

Health promotion and disease prevention policies

The Government of Croatia confirms in the National Health Care Strategy that it needs to increase its focus on the prevention of disease, for which it needs to gradually increase the share of preventive programmes and activities in the health care budget. The primary focus in prevention must be on the biggest health problems of the Croatian population – chronic non-infectious diseases, malignant tumours, injuries, mental disorders and risk behaviours, including smoking, misuse of alcohol and drugs, physical inactivity and poor nutritional habits. The broad ambitions of the government would need to be translated in to concrete actions.

Recently legislated and/or planned policy reforms

The focus of reforms that were implemented between 2006 and 2013 was the financial stabilisation of the health care system. The key reform, implemented between 2008 and 2011, contained a number of measures: diversification of public revenue collection mechanisms through the introduction of new mandatory and complementary health insurance contributions; increases in co-payments; and measures to resolve accumulated arrears. Other important reforms included changes in the payment mechanisms for primary and hospital care; pharmaceutical pricing and reimbursement reform; and changes to health care provision (e.g. emergency care reform).

The launch of many of these reforms was not difficult, as for many of them policy options were not publicly discussed and no comprehensive implementation plans were developed. However, as a result, many of them soon faced serious implementation problems and some were only partially implemented.

Planned reform activities for 2014–2016 will mainly be directed at achieving cost–effectiveness in the hospital sector. ([74])

([74]) Republic of Croatia has regulated healthcare by Health Care Protection Act ("Official Gazette", 150/08., 155/09., 71/10., 139/10., 22.11., 84/11., 154 / 11., 12.12., 70/12., 144/12., 82/13., 159/13., 22/14.), Compulsory Health Insurance Act ("Official Gazette" No. 80/13 ., 137/13.) and Voluntary Health Insurance Act ("Official Gazette", 85/06., 150/08., 71/10.).
Health Protection Act: regulates principles and procedures of health care, rights and obligations of persons in the use of health care services, social welfare holders for population health, content and organisational forms of health activities and supervision of the performance of health care activities.
Compulsory Health Insurance Act: regulates compulsory health insurance in the Republic of Croatia, the scope of the right to health care and other rights and obligations of the insured persons, acquiring and financing terms and manners of, as well as rights and obligations of compulsory health insurance, including the rights and obligations of the contracting entities for the implementation of health care from the compulsory health insurance. Under this Act the Directive 2011/24 / EC of the European Parliament and of the Council of 9 March 2011 is transposed into national legal system and the application of patients' rights in cross-border healthcare (OJ L 88, 4 4th, 2011).
Voluntary Health Insurance Act : regulates types, conditions and manners of implementation of voluntary health insurance (voluntary, supplementary and private health insurance).
National Strategy for the Development of Health (2012-2014) which sets the direction of development of the Croatian Health Care ("Official Gazette" No. 116/12.), and laws governing the conduct of certain medical procedures. All those laws include provisions of the acts of the European Union, such as Transplantation of Human Organs for the Purpose of Medical Treatment Act ("Official Gazette" No. 144/12), Medically Assisted Reproduction ("Official Gazette" No. 86/12), Application of Human Tissues and Cells Act ("Official Gazette" No. 144/12).
The organisation itself, as well as conditions for carrying out certain health activities are regulated by following laws:Medical Practice Act ("Official Gazette", no. 121/03 and 117/08.), Medical- Biochemical Activities Act ("Official Gazette" No. 121/03 and 117/08.), Dentistry Act ("Official Gazette", 121/03. 117/08., and 120/09), Pharmacy Act ("Official Gazette", 121/03. 142/06., 35/08., and 117/08), Nursing Act ("Official Gazette", 121/03.

Based on the National Reforms Program for 2016 adopted by Croatian Government in April 2016, spending control, rationalisation and optimisation of costs should ensure a high level of health protection. This should be achieved through changes of the health insurance system, through a reform of emergency medicine, the reorganisation of the hospital network, the rationalisation and reorganisation of hospital non-medical services, a reform of primary health care, further development and implementation of the joint public procurement procedure, and through the stricter control of drug prescriptions and the informatisation of the health system. ([75])

Joint hospital procurement

While initially the health care sector was largely unaffected by the austerity measures implemented in response to the financial crisis, since 2012 (after the new centre-left government took office), it has faced more pressure to rationalise health care costs. One of the measures that were meant to achieve significant savings was the implementation of a joint hospital procurement programme for public hospitals.

Public hospitals, which previously procured all medical products and other goods individually, were directed to form joint purchasing bodies for items that account for the largest share of expenditure, such as medicines, medical devices and energy. A decentralised approach was adopted, whereby a number of hospitals were assigned to procure categories of goods for all participating hospitals. Hospitals that had previously achieved best value for money for certain procurement categories were selected to be the central purchasers. Central procurement was launched for 15 groups of goods and services in October 2012.

Despite substantial opposition from manufacturers and retailers, a number of joint procurement tenders have been successfully concluded. So far, the reform is proving to be successful in reducing prices and achieving savings, and in standardising the quality of procured goods.

Sanation of public hospitals

The problem of poor hospital finances has persisted over many years and in the last 15 years; there were more than 10 cases where hospitals had to be financially reorganised in the short term (Bodiroga-Vukobrat, 2013). In 2012, the Act on Sanation([76]) of Public Institutions was adopted, mainly with the aim of improving the finances of heavily indebted county-owned hospitals. It enabled temporary centralisation of the hospital management, and it was conceived as one of the measures aimed at reducing the overall public debt and improving the efficiency of the public sector (measures were also undertaken in other sectors).

In April 2013, the government adopted decisions on the financial reorganisation of nine State-owned clinical hospitals at a cost of HRK 1.9 billion (EUR 0.25 billion) and an additional 25 health care facilities (mostly county-owned hospitals) at a cost of HRK 1.13 billion (EUR 0.15 billion) (Bodiroga-Vukobrat, 2013). The measure is to be applied to all hospitals whose expenditures exceeded revenues at the end of 2013. However, both the hospitals and the HZZO continue to generate new debts (and at the same time both the State budget for health care and co-payments have been reduced). Problems with poor hospital management also persist due to the political designation of hospital directors and managers.

During 2013 and 2014 total amount of sanation was HRK 3.5 billion (EUR 0.461 billion). ([77])

Other reforms

Some of reforms that were introduced between 2006 and 31 December 2013 were encouraged by previous experiences (for example, the introduction of a prospective case-adjusted hospital payment system, based on DRGs, was encouraged by evidence on efficiency gains

117/08., 57/11.). Health care in the Republic of Croatia is also regulated by other regulations which are adopted under the basis of the specified laws.

([75]) Source: National Reforms Program for 2016, https://vlada.gov.hr/UserDocsImages//Sjednice/2016/17%20sjednica%20Vlade//17%20-%201a.pdf.

([76]) The word "sanation" refers to the act of healing. In the context of the Croatian health care system it means restoring the financial position and improving management.

([77]) https://vlada.gov.hr/UserDocsImages/Sjednice/2016/272%20sjednica%20Vlade/272%20-%201.pdf.

reported since the implementation of the payment per therapeutic procedure (PPTP) schedule in 2005) (Bodiroga-Vukobrat, 2012), most measures had not been tested before.

The Government Programme for the 2011–2015 Mandate recognised that citizens have over the years become increasingly burdened with health care financing and the focus has been shifted to patient-oriented health policy, maintaining solidarity between the healthy and the ill, the rich and the poor, and the young and the elderly. This is to be achieved through a number of measures, such as the reorganisation of emergency medical care, primary health care and hospitals; education of human resources; more emphasis on preventive measures; and the shortening of waiting lists.

The large number of changes that have been introduced and the speed of their implementation have resulted in insufficient preparation of some measures, delays and problems with implementation. Nevertheless, several reforms (the pharmaceutical pricing and reimbursement reform; the 2013 payment mechanisms reform; and also the EMS reform) seem to have been successfully implemented.

According to the Hospital Master Plan, in 2015 reorganisation of hospitals was initiated. In the last quarter of 2015, the Network of Public Health Services was changed which implied a reclassification of hospitals beds from acute beds to palliative, chronic, prolonged and day-care beds. The full implementation of the Master Plan, including the reshaping of the hospital network, will start by the end of 2016. ([78])

Challenges

A range of reforms have been implemented in recent years – or are still in the state of gradual implementation. They imply substantial structural changes, with a focus on controlling the growth of health expenditure and improving efficiency and quality. The main challenges for the Croatian health care system are as follows:

- To continue increasing the efficiency of health care spending in order to adequately respond to the increasing health care expenditure over the coming decades. To this end, to strengthen the existing public procurement system.

- To improve the basis for more sustainable and efficient financing of health care (e.g. considering additional sources of general budget funds), aiming at a better balance between resources and spending, and diminishing the reliance on retroactive government transfers to cover deficits by health care providers and of regressive financing;

- To increase efficiency in hospital productivity by adjusting the way providers are remunerated, including staff wages, thereby containing the issue of deficits and arrears, the elimination of which is lagging behind. To this end, to further the efforts in the introduction of activity-based systems as a driver of cost-efficiency.

- To explore how current financing schemes could be adjusted to a mix of capitation-based reimbursement and of activity/quality linked incentives, to increase efficiency and quality in the delivery of services at all levels of care (primary and specialist care) and notably to encourage more health promotion and disease prevention activities (e.g. vaccination).

- To optimise the configuration of the hospital system (including capacity, staff and service mix) to tackle existing regional differences and obstacles to access to services. To design and implement a policy of human resources management based on improved training and on achieving a skill mix consistent with a primary-care based system.

- To improve data collection, especially in some crucial areas such as resources and care utilisation; to improve the patient information system promoting the development and utilisation of eHealth tools as envisaged by the 2012 National Health Care Strategy, which can help ensuring effective referral systems from primary to specialist care and improving care coordination between types of care.

([78]) Source: Convergence Program of Republic of Croatia for 2016-2019, https://vlada.gov.hr/UserDocsImages//Sjednice/2016/17%20sjednica%20Vlade//17%20-%201b.pdf.

- To consider additional measures to improve the rational prescribing and usage of medicines, such as information and education campaigns, the monitoring of prescription of medicines and a more explicit policy on incentivising the uptake of generics. The policies could help improving population health, reducing the high level of out-of-pocket payments and improving access to cost-effective new medicines by generating savings to the public payer.

- To gradually increase the use of cost-effectiveness information in determining the basket of goods and the extent of cost-sharing, increasing the use of HTA currently underused and underdeveloped, possibly making it a compulsory step and strengthening the role of the Agency for Quality and Accreditation in Health Care and Social Welfare.

- To further enhance health promotion and disease prevention activities, promoting healthy life styles and disease screening given the most recent pattern of risk factors (such as, for instance alcohol consumption).

- Implementing the Health Care Strategy (2012-2020), with a view of increasing ownership of the strategy by all stakeholders of the health system.

Table 1.4.1: **Statistical Annex – Croatia**

General context												**EU- latest national data**		
GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
GDP, in billion Euro, current prices	31	33	37	40	44	48	45	45	45	44	43	9289	9800	9934
GDP per capita PPS (thousands)	15.1	15.6	15.9	16.3	17.3	17.0	15.1	14.9	15.3	15.4	15.2	26.8	28.0	27.9
Real GDP growth (% year-on-year) per capita	5.4	4.1	4.2	4.9	5.1	2.1	-6.8	-2.0	0.1	-1.9	-0.5	-4.8	1.4	-0.1
Real total health expenditure growth (% year-on-year) per capita	:	7.5	9.5	5.5	12.7	5.6	-1.7	-0.5	-12.8	-2.6	0.5	3.2	-0.2	-0.4

Expenditure on health*												**2009**	**2011**	**2013**
Total as % of GDP	6.4	6.7	7.0	7.0	7.5	7.8	8.2	8.4	7.3	7.2	7.3	10.4	10.1	10.1
Total current as % of GDP	:	:	:	:	:	:	:	:	7.1	7.0	7.3	9.8	9.6	9.7
Total capital investment as % of GDP	:	:	:	:	:	:	:	:	0.2	0.2	0.0	0.6	0.5	0.5
Total per capita PPS	678	755	854	936	1098	1226	1232	1242	1100	:	:	2828	2911	2995
Public as % of GDP	5.3	5.4	6.0	6.0	6.5	6.6	7.0	7.2	5.7	5.8	5.8	8.1	7.8	7.8
Public current as % of GDP	:	:	:	:	:	:	:	:	5.5	5.6	5.8	7.9	7.7	7.7
Public per capita PPS	558	613	733	799	947	1037	1048	1070	865	872	880	2079	2218	2208
Public capital investment as % of GDP	:	:	:	:	:	:	:	:	0.2	0.2	0.0	0.2	0.2	0.1
Public as % total expenditure on health	82.3	81.2	85.8	85.3	86.2	84.6	85.1	86.1	78.6	80.1	80.0	77.6	77.2	77.4
Public expenditure on health in % of total government expenditure	:	:	:	:	:	:	:	:	:	20.1	:	14.8	14.9	:
Proportion of the population covered by public or primary private health insurance	:	:	:	:	:	:	:	:	100.0	100.0	:	99.7	99.7	98.7
Out-of-pocket expenditure on health as % of total expenditure on health	16.7	18.2	13.4	13.4	12.5	14.5	13.7	13.8	13.4	12.8	12.5	14.1	14.4	14.1

Note: *Including also expenditure on medical long-term care component, as reported in standard internation databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

Population and health status												**2009**	**2011**	**2013**
Population, current (millions)	4.3	4.3	4.3	4.3	4.3	4.3	4.3	4.3	4.3	4.3	4.3	502.1	504.5	506.6
Life expectancy at birth for females	78.1	78.8	78.8	79.3	79.2	79.7	79.7	79.9	80.4	80.6	81.0	82.6	83.1	83.3
Life expectancy at birth for males	71.0	71.8	71.7	72.4	72.2	72.3	72.8	73.4	73.8	73.9	74.5	76.6	77.3	77.8
Healthy life years at birth females	0.0	:	:	:	:	:	:	60.4	61.7	64.2	60.4	:	62.1	61.5
Healthy life years at birth males	:	:	:	:	:	:	:	57.4	59.8	61.9	57.6	:	61.7	61.4
Amenable mortality rates per 100 000 inhabitants*	157	145	149	142	144	136	132	125	268	249	:	64.4	128.4	:
Infant mortality rate per 1 000 life births	6.3	6.1	5.7	5.2	5.6	4.5	5.3	4.4	4.7	3.6	4.1	4.2	3.9	3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics												**EU- latest national data**		
Composition of total current expenditure as % of GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Inpatient curative and rehabilitative care	:	:	:	:	:	:	:	:	1.96	1.87	1.56	3.13	2.99	3.01
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	0.19	0.19	0.24	0.18	0.18	0.19
Out-patient curative and rehabilitative care	:	:	:	:	:	:	:	:	1.72	1.71	1.70	2.29	2.25	2.24
Pharmaceuticals and other medical non-durables	:	:	:	:	:	:	:	:	2.04	2.04	2.38	1.60	1.55	1.44
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	0.16	0.15	0.14	0.31	0.31	0.32
Prevention and public health services	:	:	:	:	:	:	:	:	0.14	0.16	:	0.25	0.25	0.24
Health administration and health insurance	:	:	:	:	:	:	:	:	0.18	0.20	:	0.42	0.41	0.47
Composition of public current expenditure as % of GDP														
Inpatient curative and rehabilitative care	:	:	:	:	:	:	:	:	1.78	1.72	1.44	2.73	2.61	2.62
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	0.18	0.18	0.23	0.16	0.16	0.18
Out-patient curative and rehabilitative care	:	:	:	:	:	:	:	:	1.33	1.35	1.37	1.74	1.71	1.80
Pharmaceuticals and other medical non-durables	:	:	:	:	:	:	:	:	1.25	1.28	1.60	0.79	1.07	0.96
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	0.07	0.07	0.07	0.13	0.12	0.13
Prevention and public health services	:	:	:	:	:	:	:	:	0.13	0.15	:	0.25	0.20	0.19
Health administration and health insurance	:	:	:	:	:	:	:	:	0.16	0.18	:	0.11	0.27	0.27

Sources: EUROSTAT, OECD and WHO

Table 1.4.2: **Statistical Annex - continued – Croatia**

Composition of total as % of total current health expenditure	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU- latest national data 2009	2011	2013
Inpatient curative and rehabilitative care	:	:	:	:	:	:	:	:	27.7%	26.6%	21.4%	31.8%	31.3%	31.1%
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	2.7%	2.7%	3.3%	1.8%	1.9%	1.9%
Out-patient curative and rehabilitative care	:	:	:	:	:	:	:	:	24.3%	24.3%	23.4%	23.3%	23.5%	23.2%
Pharmaceuticals and other medical non-durables	:	:	:	:	:	:	:	:	28.8%	29.0%	32.7%	16.3%	16.2%	14.9%
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	2.3%	2.1%	1.9%	3.2%	3.3%	3.3%
Prevention and public health services	:	:	:	:	:	:	:	:	2.0%	2.3%	:	2.6%	2.6%	2.5%
Health administration and health insurance	:	:	:	:	:	:	:	:	2.5%	2.8%	:	4.2%	4.3%	4.9%
Composition of public as % of public current health expenditure														
Inpatient curative and rehabilitative care	:	:	:	:	:	:	:	:	32.2%	30.7%	24.7%	34.6%	34.1%	34.0%
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	3.3%	3.2%	3.9%	2.0%	2.1%	2.3%
Out-patient curative and rehabilitative care	:	:	:	:	:	:	:	:	24.1%	24.1%	23.5%	22.0%	22.3%	23.4%
Pharmaceuticals and other medical non-durables	:	:	:	:	:	:	:	:	22.6%	22.9%	27.4%	10.0%	13.9%	12.5%
Therapeutic appliances and other medical durables	:	:	:	:	:	:	:	:	1.3%	1.3%	1.2%	1.6%	1.6%	1.6%
Prevention and public health services	:	:	:	:	:	:	:	:	2.4%	2.7%	:	3.2%	2.7%	2.5%
Health administration and health insurance	:	:	:	:	:	:	:	:	2.9%	3.1%	:	1.4%	3.5%	3.5%

Expenditure drivers (technology, life style)	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU- latest national data 2009	2011	2013
MRI units per 100 000 inhabitants	:	:	:	:	:	0.70	:	0.72	:	0.98	1.06	1.0	1.1	1.0
Angiography units per 100 000 inhabitants	:	:	:	:	:	0.5	:	0.6	:	0.6	0.7	0.9	0.9	0.8
CTS per 100 000 inhabitants	:	:	:	:	:	1.4	:	1.6	:	1.6	1.6	1.8	1.7	1.6
PET scanners per 100 000 inhabitants	0.0	:	:	:	:	0.0	:	0.1	:	0.1	0.1	0.1	0.1	0.1
Proportion of the population that is obese	:	:	:	:	:	:	:	:	:	:	:	14.9	15.4	15.5
Proportion of the population that is a regular smoker	27.4	:	:	:	:	:	:	:	:	:	:	23.2	22.4	22.0
Alcohol consumption litres per capita	12.3	11.7	10.5	10.6	11.4	10.9	11.0	10.7	10.6	:	:	10.3	10.0	9.8

Providers	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
Practising physicians per 100 000 inhabitants	244	250	250	253	266	266	267	278	284	299	303	329	335	344
Practising nurses per 100 000 inhabitants	470	479	483	492	503	522	511	531	542	568	621	840	812	837
General practitioners per 100 000 inhabitants	:	:	:	:	:	:	55	50	51	53	54	:	78	78.3
Acute hospital beds per 100 000 inhabitants	338	342	338	339	340	341	336	352	350	357	357	373	360	356

Outputs	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
Doctors consultations per capita	:	7.6	6.9	6.4	6.4	6.0	6.4	6.1	6.0	6.9	6.1	6.3	6.2	6.2
Hospital inpatient discharges per 100 inhabitants	14.5	14.8	15.1	15.9	16.0	15.9	15.7	14.8	15.3	14.9	15.1	16.6	16.4	16.5
Day cases discharges per 100 000 inhabitants	309	315	298	332	319	1,863	3,076	4,538	5,487	6,704	7,949	6368	6530	7031
Acute care bed occupancy rates	91.0	90.0	88.0	87.0	86.0	84.9	83.1	75.2	76.7	77.3	73.7	72.0	73.1	70.2
Hospital curative average length of stay	8.4	8.2	7.8	7.6	7.5	7.3	7.4	7.2	7.2	6.9	6.9	6.5	6.3	6.3
Day cases as % of all hospital discharges	2.1	2.1	1.9	2.0	1.9	10.5	16.4	23.5	26.4	31.0	34.5	27.8	28.7	30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP*	2013	2020	2030	2040	2050	2060	Change 2013 - 2060	EU Change 2013 - 2060
AWG reference scenario	5.7	6.8	7.1	7.3	7.4	7.5	1.7	0.9
AWG risk scenario	5.7	7.0	7.6	8.1	8.4	8.4	2.7	1.6

Note: *Excluding expenditure on medical long-term care component.

Population projections	2013	2020	2030	2040	2050	2060	Change 2013 - 2060, in %	EU - Change 2013 - 2060, in %
Population projections until 2060 (millions)	4.3	4.2	4.1	4.0	3.8	3.7	-13.1	3.1

Sources: EUROSTAT, OECD and WHO

Croatia

Long-term care systems

2.4. CROATIA

General context: expenditure, fiscal sustainability and demographic trends

Croatia, member of the European Union since the summer of 2013, has a population of almost 4.3 million inhabitants, which is roughly 0.8% of the EU population. In the absence of any sizeable immigration and a decline in fertility, the population of Croatia is steadily decreasing. In the period from 2013 to 2060 a decrease of 13 percent can be expected, based on the population forecast of Eurostat, leading to a population in 2060 of 3.7 million.

In current prices the GDP of Croatia has been increasing fast from 2003 to 2008, from EUR 31 to EUR 48 bn. Since 2008 it decreased to EUR 43 bn. GDP per capita decreased from 2008 to 2009, and has remained roughly stable at a lower level since then, currently reaching 15,200 PPS, well below the EU average of 27,900 PPS.

Public expenditure on LTC was with 0.1% of GDP in 2012 low compared to the overall EU average of 1.0% of GDP.

Health status

Life expectancy at birth was, in 2013, 81 years for women and 74.5 years for men and is, although having increased during the past decade, below the EU average (83.3 and 77.8 years for women and men respectively in 2013). Similarly, the healthy life years at birth for both sexes are with 60.4 years (women) and 57.6 years (men) lower than the EU-average (61.5 and 61.4 respectively). On the other hand, the percentage of the Croatian population having a long-standing illness or health problem is slightly lower than in the Union as a whole (31% and 32.5% respectively). The percentage of the population indicating a self-perceived severe limitation in its daily activities decreased from, 2010 to 2013, from 11.4% to 8%, which is slightly lower than the EU-average (8.7%).

Dependency trends

The number of people depending on others to carry out activities of daily living is projected to increase over the coming 50 years. From 270 thousand residents living with strong limitations due to health problems in 2013, an increase of 19% is envisaged until 2060 to around 330 thousand. That is less steep an increase than in the EU as a whole (40%). Also as a share of the population, the dependents are becoming a bigger group, from 6.4% to 8.8%. However, this is roughly in line with EU average, at a projected 37% (EU: 36%).

Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is likely increasing. In the AWG reference scenario, public long-term expenditure is driven by the combination of changes in the population structure and a moderately positive evolution of the health (non-disability) status. The joint impact of those factors is a small projected increase in spending of about 0.1 pps of GDP (15%) by 2060, well below the EU average of 40%. ([355]) The "AWG risk scenario", which in comparison to the "AWG reference scenario" captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, projects an increase in spending of 1.2 pps (268%) of GDP by 2060, markedly higher than the EU average of 149%. Overall, projected long-term care expenditure increase is expected to add to budgetary pressure. However, no sustainability risks appear over the long run due to the projected decrease in age-related spending driven by pensions.([356])

System Characteristics

Long-term care is organised on the principle of social assistance and financed mainly from the state budget (96%), while the remainder comes from beneficiaries' participation in payment of costs of care outside one's own family. Local and regional self-governing units participate in the financing of the system and organisation of social welfare services within the scope of their competences.

The acting Social Welfare Act (Official Gazette of the Republic of Croatia, 157/13, 152/14, 99/15) is the result of a comprehensive social welfare reform, which includes the reform of cash benefits,

([355]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

([356]) Fiscal Sustainability Report 2015: http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf.

the system of social services, the mode of their financing and the system of public social welfare centres. The primary objective was to simplify the system and provide better and more efficient access to services and benefits, establish clearer division between cash benefits and social services and rationalise the network of social services centres. Previous 15 cash benefits with different criteria and conditions for obtaining were reduced to 10 better targeted and defined ones([357]).

There is no specific data available on long-term care expenses in Croatia. In 2009 expenses for financing of the social welfare system amounted to 0.89% of GDP (Bodiroga-Vukobrat, 2012). The share of beneficiaries of permanent social assistance in total population in 2010 stood at 2.3%, which is an increase of 0.2% as opposed to 2009 (2.1%).

The Ministry of Social Policy and Youth is in the lead as far as social welfare (including long-term care) is concerned. Social services are carried out by public institutions: Social Welfare Centres established by the State, institutions for elderly and disabled and people who suffer from severe illnesses, institutions for those with a physical, mental or sensory impairment, care homes for people suffer from mental illness and homes for children and youth with disabilities and behavioural disorders. Social Welfare Centres also decide upon monetary social assistance (European Commission 2013).

Types of care

Social welfare beneficiaries are entitled to (choose freely between) cash benefits, benefits in kind and social services, as established by law.

There are currently ten cash benefits according to the Social Welfare Act (Article 25): the guaranteed minimum benefit, the compensation for the cost of housing, the right on firewood costs, the allowance for the personal needs of users of accommodation, the one-off cash allowances, the fees related to education, the personal disability allowance, the allowance for assistance and care, the parent caregiver or caregiver allowance and the unemployment allowance. The personal disability allowance is granted to persons with grave disability or other severe and permanent changes in health status, for the purpose of satisfying necessities of life for involvement in the daily life of the community.

Large cities and cities which are the seats of counties are obliged to provide other types of material support and assistance, including the stimulation of volunteering and work of civil society organisation. Elderly people mostly rely on the guaranteed minimum benefit, the compensation for the cost of housing, the right on firewood costs, the allowance for the personal needs of users of accommodation, the one-off cash allowances, the personal disability allowance, the allowance for assistance and care and the in-home assistance. The in-home assistance is awarded to persons with secured housing and other living conditions, but who are, due to old age, disability or other grave health conditions unable to take care of their personal needs alone or with help from their families. The condition for receiving this means-tested social service is that the assistance cannot be obtained from parents, spouse or children, nor based on life maintenance and support agreements or other regulations.

There are nine categories of social services, which are basically social benefits in kind. In-home assistance is an example of a social service. It implies the provision of different practical forms of help, prescribed in bylaws (typically includes delivery of meals, housework, assistance with personal hygiene and satisfying other everyday needs).

The LTC users are most often elderly and people with disabilities. Long-term care is carried out both through institutional and non-institutional forms of care. Long-term accommodation is granted to users who need over a long period of time necessity intensive care and other life needs. There

([357]) Among ten cash benefits with different criteria and conditions for obtaining, which are better targeted and defined than previous ones, the most innovative is the guaranteed minimum benefit (GMB). GMB consolidates 4 previous supplementary cash benefits, ensuring that persons have enough funds to satisfy their basic monthly personal needs, while also stimulates the activation of those capable of working. Introduction of the GMB through a new web application in Social Welfare Centres represents the beginning of the unification of cash benefits at the state level (as it is stipulated that establishing a unique cash center - “One stop shop”). Deinstitutionalisation and the role of private providers of social services are emphasised.

also exists a range of institutionalised forms of care, e.g. permanent or temporary accommodation or even daily or shorter stays in care centres.

In 2014, there were 258 institutional LTC providers, governmental and non-governmental LTC homes and other legal providers (persons) for stay in and accommodation of adults and the elderly (159 for the elderly and infirm/ seriously sick people, 68 for disabled children and adults with physical, intellectual or sensory impairments, 31 homes for mentally ill adults). ([358])

Eligibility criteria and user choices: dependency, care needs, income

Reliance on long-term care is certified by the social welfare centres, established through special regulations. Degree of physical and mental impairment, duration of reliance on care, degree of (full or partial) incapacity for independent living, urgency and scope of assistance and care, screening of income and assets are among the indicators being assessed.

As a rule, the Social Welfare Centre has to verify occasionally or at least once a year, if the conditions for social assistance are still met. It is also a duty of the recipient to report all relevant changes within eight days. ([359])

There is an exception when means test does not apply, such as serious mental or physical impairment, blindness and/or deafness (if blind/deaf persons have trained to care for themselves, when determining if persons have the right to receive the allowance for assistance and care in full amount, as well as blindness and/or deafness (if blind/deaf persons have trained to care for themselves), or the fact that a person is totally deprived of legal capacity, when determining if persons have the right to receive the allowance for assistance and care in reduced amount.

Means-testing is applied, meaning that a person is only eligible for this kind of assistance if his/her average 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) (Article 57 (2) Social Welfare Act). (the base amount is defined by Social Welfare Act, Article 27, paragraph 2, and in 2015 it was 500 HRK (about EUR 66)).

In 2010, the total of HRK 58.1 million (about EUR 7.5 mln) was utilised for the implementation of social services of generational solidarity (day care services and in-home assistance), as well as the improvement of work quality. 75% was financed from the State budget of the Republic of Croatia, while the rest of the financing (25%) was born by the local and regional self-government units.

Role of private sector, private insurance and out of pocket co-payments

In Croatia, more than two thirds of institutional homes for the elderly are privately owned (see footnote 4).

Long-term care is financed from the state budget and partly from the budgets of regional communities (also the city of Zagreb) and local communities. Social services might be co-financed by the beneficiaries and their family members. (European Commission, 2013).

Prevention and rehabilitation measures

National and county Centres for gerontology operate at the county institutes of public health. Apart from Centres of Gerontology, there are Gerontology Centres as multifunctional centres of immediate and integral multidisciplinary care for elderly people in the local community. A total of 79 Gerontology Centres for community care of elderly people operate in Croatia, 12 thereof in

([358]) Governmental and non-governmental LTC homes, county LTC homes and other legal providers (persons) of LTC - total (1.+ 2.+ 3.) includes 258 provides and serves 31.392 users, of which 21.782 are LTC users. These can be broken down into the following categories
1. Governmental LTC homes: 46 providers and serves 8310 users, of which 3884 are LTC users.
2. Non- governmental LTC homes: 151 providers and serves 21.038 users, of which 17.154 are LTC users.
3. Other legal providers (persons) of LTC: 61 providers and serves 2.044 users, of which 744 are LTC users.

Source: Data from governmental and non-governmental LTC homes, county LTC homes and other legal providers (persons) of LTC; Ministry of Social Politics and Youth.

([359]) Previous supplementary cash benefits, ensuring that persons have enough funds to satisfy their basic monthly personal needs, while also stimulates the activation of those capable of working. Introduction of the GMB through a new web application in Social Welfare Centres represents the beginning of the unification of cash benefits at the state level (as it is stipulated that establishing a unique cash center - "One stop shop"). Deinstitutionalisation and the role of private providers of social services are emphasised.

Zagreb, where most elderly people live (Ministry of Health)

Formal/informal caregiving

The aim of the Foster Families Act (Official Gazette, 90/11, 78/12) is deinstitutionalisation and increase of the number of foster families, their professionalisation and specialisation for taking care of certain categories of beneficiaries. Foster care is defined as a non-institutional type of care for children and adults out of their families. Types of foster care are defined according to beneficiaries (traditional, specialised, urgent and temporary) as well as the status of foster care (kinship, professional). Foster families for adults, are taking care mainly for elderly and frail persons, persons with disability and mentally ill adults. Foster care is provided only upon referral from the competent Social Welfare Centre.

The scale of family care in Croatia is above the EU27 average. Around 17% of the respondents aged 35-49 report having to care for elderly relatives at least several times a week. The age cohort 50-64 apparently bears the greatest load when it comes to taking care of elderly: 24% female respondents and 13% male respondents of that age group are involved in those activities, which places Croatia among the top three countries in Europe (after Italy and Estonia). (Bodiroga-Vukobrat, 2012).

In addition to religious communities and non-governmental organisations, the role of the civil sector's associations in the long-term care arrangements is important in Croatia. There are various pensioners' associations organised at national, regional and local levels. For example, one of the oldest civil society organisations in Croatia is the National Pensioners' Convention of Croatia (*Cro. Matica umirovljenika Hrvatske*) with around 270,000 members, 300 associations and 800 branches and clubs at the local level. The association and its members, organise the purchase of winter foodstuffs, meat, fruits and vegetables, as well as heating fuel at preferential prices with payment by installments, while its volunteers visit the sick and infirm, and socialise in clubs, branches and associations.

Recently legislated and/or planned policy reforms

During 2013 a new Act on Social Welfare was created and it was put into force on January 1 2014. This Act established prerequisites for enhancing efficiency, transparency, IT and expertise base in the system of social welfare and as well raises the community awareness of social rights. It contains new criteria for social benefits and services in order to promote the integration of those who suffer social exclusion. Setting standards for quality in social services lays foundations for deinstitutionalisation and developing new extra-institutional services, it offers wider choice and services improvement within the process of social integration; it enables creation of comprehensive social beneficiaries base. As for the cash benefits, they are better defined in the context of persons at great risk of poverty and social exclusion. The new Act introduced **guaranteed minimum benefit** which is a new type of cash benefit merged from four previous social cash benefits which were under jurisdiction of three different Ministries. The state decides on the height of this allowance on an annual basis.

The new Act on Social Welfare enabled transparent and fair system of "social services contracting" which means that all service providers within the network will form the service **price on basis of a single calculation methodology** and this procedure will be prescribed in a separate bylaw. Final service price will also depend on the service provider's harmonisation with directives for service providing within the network, taking into account his/her professional resources, location and harmonisation with minimum quality standards.

Introducing guaranteed minimum benefit into social welfare system represents the beginning of merging various benefits and services and is a step forward to establishing a centre in charge of all cash benefits, a kind of „one stop shop". This centre would consequently take charge of all existing cash benefits which are currently under jurisdiction of various state institutes and offices. Further informatisation of the social welfare system and establishing network with other systems with the scope of data exchange will result

with lowering administration costs as well as simplifying the whole process.

Law on Unique Expertise Body (Official Gazette, 85/14, 95/15) presumes founding of the single expertise body meaning that expertise would be done in one place which would shorten the existing administrative procedures. According to the past regulations every service claimer has to be examined every single time when he/she is claiming for benefits in various systems. Besides generating unnecessary expenses this procedure is quite tiring for the benefit claimer.

According to the new Law on Unique Expertise Body, an individual benefit claimer can obtain his/her rights in various systems based on one document and the expertise given from the single expertise body (pension insurance, professional rehabilitation and employment of persons with disability, various types of maternity and parental allowances, allowances for civil and military war victims). This body should function as an independent working unit within the Institute for expertise, professional rehabilitation and employment of persons with disability, with branch offices all around the country (local and regional). The expertise procedure would be based on a single methodology for determining the disability level/residual functional and working capacity. Since January 1, 2015 for this is responsible respective Institute for expert evaluation, professional rehabilitation and employment of disabled people.

Besides the above mentioned laws, this is partly regulated by the Family Law (Official Gazette,103/15) according to which parents have obligation to maintain an adult child who has severe and permanent illness and disability and is not able to live independently/work, children have obligation to maintain their disabled and without living resources parents, and grandchildren have obligation to maintain their disabled and without living resources grandparents (if grandparents maintained grandchildren).

The social welfare system provides assistance to individuals at risk of poverty or social exclusion as well as those living in non-adequate personal or family environment. It includes prevention, promoting changes, assisting individuals, families or groups in their everyday needs as well as enhancing their social inclusion. The concept for fulfilling these conditions is defined by the Ministry of Social Policy and Youth Strategic plan 2015-2017 which sets three goals to be achieved in the upcoming period:

Goal 1. Develop comprehensive approach to various user groups by improving the legislative frame and upgrading service providers efficiency:

- provide equal access to the social services network for all users and providers alike, and effective access to cash benefits for disabled people;
- improve and develop of strategic and legislative framework focussed on elderly, people with addiction problems, asylum seekers, victims of trafficking and homeless
- increase the efficiency of the social welfare centers;
- improve of legal regulations and implement regulations to ensure more effective protection of the individual rights of citizens;
- implement and monitor the process of transformation and de-institutionalisation of social welfare homes founded by the Republic of Croatia;
- increase service quality by improving the infrastructure of homes founded by the Republic of Croatia;
- as stated above, the goal is to improve the system through more efficient legislative frame and developing various social programs which will, consequently, guarantee system improvements especially in the context of groups at social risk.

Goal 2. Enhance the process of social inclusion for various user groups:

- develop volunteerism and systems of measurement and evaluate of volunteer contributions;

- increase availability and quality of social services with the regional uniformity;
- improve quality of professional work providers;
- increase level of social inclusion of people with disabilities;
- develop services that contribute to the inclusion of the elderly, people with addiction problems;, asylum seekers, victims of trafficking and the homeless in the community life.

The idea of volunteering development is present in several national documents such as: Croatian Government programme for the period 2011-2015, Law on Youth, Law on Youth Advisory Boards, Law on Agency for Mobility and EU Programmes, National Youth Programme 2014-2017 and Strategy of Social Care for Older People 2014-2016. Volunteering is presented as an activity to be enhanced and promoted with the goal of improving life quality both for service users and volunteers and enhancing social inclusion of marginalised social groups. Promoting more active engagement of local and regional self-government in social care system by enhancing the work of NGO's and humanitarian aid organisations and assuring them financial assistance contributes to extra institutional service development. This type of service development is planned as well in the Transformation and deinstitutionalisation plan of social care homes and other legal entities who practice social welfare activities in Republic of Croatia 2011-2016 (2018).

Goal 3 Improve care for vulnerable groups by setting more efficient coordination in enforcement of national and international strategic documents:

- ensure conditions for the implementation of EU policies, VE and other international initiatives in accordance with the competence;
- ensure conditions for use of EU funds;
- strengthen workforce and capacity of the respective Croatian social welfare authorities;
- improve care of disabled people by establishing more effective coordination, monitoring and evaluation of the implementation of the National Strategy for Equalisation of Opportunities for Disabled People 2007 to 2015 and the Convention on the Rights of Disabled People.

The Ministry of Social Policy and Youth conducts expert activities related to EU, Council of Europe and UN membership obligations as well as other international and regional initiatives in the field of social policy and social inclusion and it is obliged to submit reports to these organisations. Ministry also informs various user groups on the possibilities offered in EU funds. Furthermore, it develops bilateral and multilateral cooperation with organisations/institutions acting in the field of social welfare by organising and participating in international and regional events

Challenges

Croatia has a relatively fragmented system of LTC, a feature that often leads to inefficiencies. At present, Croatia has not developed a comprehensive strategy and long-term care is spread across health and social-welfare systems.

The main challenges of the system appear to be:

- **Improving the governance framework and administrative efficiency**: to establish a coherent and integrated legal and governance framework for a clear delineation of responsibilities of state authorities concerning the provision of long-term care services; to strategically integrate medical and social services via such a legal framework; to use care planning processes, based on individualised need assessments, involving health and care providers and linking need assessment to resource allocation; **Improving financing arrangements:** to determine the extent of user cost-sharing on LTC benefits; to include assets in the means-test used to determine individual cost-sharing (or entitlement to public support) for B&L costs better reflects the distribution of economic welfare among individuals.
- **Providing adequate levels of care to those in need of care:** to adapt and improve LTC

coverage schemes, setting the need-level triggering entitlement to coverage; the depth of coverage, that is, setting the extent of user cost-sharing on LTC benefits.

- **Encouraging home care:** to develop alternatives to institutional care by e.g. developing new legislative frameworks encouraging home care and regulation controlling admissions to institutional care or the establishment of additional payments, cash benefits or financial incentives to encourage home care; to monitor and evaluate alternative services, including incentives for use of alternative settings.

- **Ensuring availability of formal carers:** to determine current and future needs for qualified human resources and facilities for long-term care;

- **Supporting family carers:** to establish policies for supporting informal carers, such as through flexible working conditions, respite care, carer's allowances replacing lost wages or covering expenses incurred due to caring, cash benefits paid to the care recipients, while ensuring that incentives for employment of carers are not diminished and women are not encouraged to withdraw from the labour market for caring reasons.

- **To facilitate appropriate utilisation across health and long-term care:** to arrange for adequate supply of services and support outside hospitals, changing payment systems and financial incentives to discourage acute care use for LTC; to steer LTC users towards appropriate settings.

- **Improving value for money:** to invest in ICT as an important source of information, care management and coordination**.**

- **Prevention:** to promote healthy ageing and preventing physical and mental deterioration of people with chronic care; to employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.

Table 2.4.1: **Statistical Annex – Croatia**

GENERAL CONTEXT

GDP and Population	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
GDP, in billion euro, current prices	31	33	37	40	44	48	45	45	45	44	43	9,289	9,545	9,800	9,835	9,934
GDP per capita, PPS	15.1	15.6	15.9	16.3	17.3	17.0	15.1	14.9	15.3	15.4	15.2	26.8	27.6	28.0	28.1	27.9
Population, in millions	4.3	4.3	4.3	4.3	4.3	4.3	4.3	4.3	4.3	4.3	4.3	502	503	504	506	507
Public expenditure on long-term care																
As % of GDP	:	:	:	:	:	:	:	:	0.0	0.1	:	1.0	1.0	1.0	1.0	:
Per capita PPS	:	:	:	:	:	:	:	:	6.6	7.4	:	297.1	316.7	328.5	317.8	:
As % of total government expenditure	:	:	:	:	:	:	:	:	:	0.1	:	2.1	2.2	2.2	2.1	:
Note: Based on OECD, Eurostat - System of Health Accounts																
Health status																
Life expectancy at birth for females	78.1	78.8	78.8	79.3	79.2	79.7	79.7	79.9	80.4	80.6	81.0	82.6	82.8	83.1	83.1	83.3
Life expectancy at birth for males	71.0	71.8	71.7	72.4	72.2	72.3	72.8	73.4	73.8	73.9	74.5	76.6	76.9	77.3	77.4	77.8
Healthy life years at birth for females	:	:	:	:	:	:	:	60.4	61.7	64.2	60.4	:	62.6	62.1	62.1	61.5
Healthy life years at birth for males	:	:	:	:	:	:	:	57.4	59.8	61.9	57.6	:	61.8	61.7	61.5	61.4
People having a long-standing illness or health problem, in % of pop.	:	:	:	:	:	:	:	36.5	36.8	29.2	31.0	:	31.4	31.8	31.5	32.5
People having self-perceived severe limitations in daily activities (% of pop.)	:	:	:	:	:	:	:	11.4	7.7	5.3	8.0	:	8.1	8.3	8.6	8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
Number of people receiving care in an institution, in thousands	:	:	:	:	:	:	:	:	:	:	16	3,433	3,771	3,851	3,931	4,183
Number of people receiving care at home, in thousands	:	:	:	:	:	:	:	:	:	:	17	6,442	7,296	7,444	7,569	6,700
% of pop. receiving formal LTC in-kind	:	:	:	:	:	:	:	:	:	:	0.8	2.0	2.2	2.2	2.3	2.1
Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients																
Providers																
Number of informal carers, in thousands	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
Number of formal carers, in thousands	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:

Source: EUROSTAT, OECD and WHO

Table 2.4.2: **Statistical Annex - continued – Croatia**

PROJECTIONS

Population	2013	2020	2030	2040	2050	2060	MS Change 2013-2060	EU Change 2013-2060
Population projection in millions	4.3	4.2	4.1	4.0	3.8	3.7	-13%	3%
Dependency								
Number of dependents in millions	0.27	0.29	0.31	0.32	0.33	0.33	19%	40%
Share of dependents, in %	6.4	7.0	7.5	8.2	8.5	8.8	37%	36%
Projected public expenditure on LTC as % of GDP								
AWG reference scenario	0.4	0.4	0.5	0.5	0.5	0.5	15%	40%
AWG risk scenario	0.4	0.5	0.6	0.8	1.1	1.6	268%	149%
Coverage								
Number of people receiving care in an institution	15,574	16,210	16,658	17,075	16,872	16,533	6%	79%
Number of people receiving care at home	17,001	17,696	18,185	18,640	18,418	18,048	6%	78%
Number of people receiving cash benefits	107,516	111,912	115,005	117,883	116,483	114,140	6%	68%
% of pop. receiving formal LTC in-kind and/or cash benefits	3.3	3.5	3.7	3.9	4.0	4.0	22%	68%
% of dependents receiving formal LTC in-kind and/or cash benefits	51.1	49.9	48.7	47.6	46.6	45.7	-11%	23%
Composition of public expenditure and unit costs								
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	89.0	88.8	88.5	88.0	87.9	88.0	-1%	1%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	11.0	11.2	11.5	12.0	12.1	12.0	9%	-5%
Public spending on institutional care (% of tot. publ. spending LTC)	61.5	61.3	60.8	60.3	59.9	59.6	-3%	1%
Public spending on home care (% of tot. publ. spending LTC in-kind)	38.5	38.7	39.2	39.7	40.1	40.4	5%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	63.9	62.5	60.7	57.5	57.2	57.5	-10%	-2%
Unit costs of home care per recipient, as % of GDP per capita	36.6	36.1	35.8	34.7	35.1	35.6	-3%	-3%
Unit costs of cash benefits per recipient, as % of GDP per capita	1.9	1.9	1.9	1.9	1.9	1.9	2%	-2%

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060).