Social Protection and Social Inclusion in Croatia

Final Report

for

The European Commission

Employment, Social Affairs and Equal Opportunities DG

Dubravka Jurlina-Alibegović
Miroslav Mastilica
Danijel Nestić
Paul Stubbs
with
Zdenko Babić
Luka Vončina

May 2006

Contract reference number: VC/2005/0345

Table of Contents

ACRONYMS CITED IN TEXT

bn.	Billions
CARDS	Community Assistance for Reconstruction, Development and Stabilisation
CBS	Croatian Bureau of Statistics
CES	Croatian Employment Services
CSO	Civil Society Organisation
CSW	Centre for Social Welfare
DRG	Diagnostic Related Groups
ESSPROS	European System of Integrated Social Protection Statistics
FFS	Fee for Service
GDP	Gross Domestic Product
GFS	Government Finance Statistics
€/EUR	Euros
EU	European Union
FDI	Foreign Direct Investment
GP	General Practitioner
HAGENA	Croatian Agency for Supervision of Pension Funds and Insurance
HANFA	Croatian Agency for the Supervision of Financial Services
HBS	Household Budget Survey
HIV	Human Immune Deficiency Virus
HZJZ	Croatian National Institute of Public Health
HZMO	Croatian Institute for Pension Insurance
HZZO	Croatian Health Insurance Institute
IBRD	International Bank for Reconstruction and Development
ICTU	Independent Croatian Trade Unions
ILO	International Labour Organisation
IMF	International Monetary Fund
ISCED	International Standard Classification of Education
JAP	Joint Assessment of Employment Policy Priorities
JIM	Joint Inclusion Memorandum
kn./HRK	Croatian Kuna (€1 = 7.27 HRK)
LFS	Labour Force Survey
m.	Millions
MELE	Ministry of the Economy, Labour and Entrepreneurship
MFVS	Ministry of the Family, Veterans and Inter-Generational Solidarity
MHSW	Ministry of Health and Social Welfare

MLSW	(former) Ministry of Labour and Social Welfare
MOS-20	Medical Outcomes Study: 20-item short survey
MSTTD	Ministry of the Sea, Tourism, Transport and Development
NACE	Statistical Classification of Economic Activities in the European Union
NAP/Incl	National Action Plan, Social Inclusion
NGO	Non-Governmental Organisation
NN	*Narodni novine* (Official Gazette)
NUTS	Nomenclature of Territorial Units of Statistics
OECD	Organisation for Economic Co-operation and Development
OSI	Open Society Institute
pa	Per Annum
PAL	(World Bank) Programme Adjustment Loan
PDDA	Programme for the Development of Disadvantaged Areas
PEP	Pre-Accession Economic Programme
PISA	Programme for International Student Assessment
PPP	Purchasing Power Parity
PPS	Purchasing Power Standard
PPTP	Payment per Thearapeutic Approach
PYGO	Pay-as-you go Pension System
QUOTE	Quality of Care Through the Patients' Eyes
REGOS	Central Register of Insured Persons
SIDA	Swedish International Development Assistance
SME	Small and Medium Entreprises
SWDP	Social Welfare Development Project
TB	Tuberculosis
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USD	United States Dollars
VAT	Value-Added Tax
WHO	World Health Organisation
y/y	Year On Year

Summary

Social Protection and Social Inclusion in Croatia

The study

1. This study presents a broad picture of the current state of social inclusion and social protection in Croatia as it prepares to complete its Joint Inclusion Memorandum (JIM) on the road to accession to the European Union. It provides up-to-date information on the extent and pattern of poverty and social exclusion set in historical perspective, and also looks at the broad strategic emphasis of government policy and the role of diverse stakeholders. The report provides an overview of the structure, challenges and current and proposed reforms of the social protection/social welfare, pensions and health care systems. It identifies key future challenges for the modernisation of these systems to improve their effectiveness in combating social exclusion. Finally, in the context of current JIM processes, it outlines broad recommendations for reforms in the medium-term. This summary provides a brief overview of the report, in English and Croatian languages.

The Republic of Croatia: economic, financial and demographic background

2. In a unique position amongst EU member states and candidate countries, Croatia has undergone a 'triple transition' from war to peace, from a command to a free market economy, and from a single party system to a pluralist democracy, in the space of 15 years. In the context of war, the early years of transition were marked by hyperinflation, rising unemployment, and negative economic growth, with GDP having fallen by 1993 to 60% of its 1989 level. Following a stabilisation programme in late 1993, there has been solid economic growth ever since, with the exception of 1999. Growth since 2000 has annually reached at least 4%. Currently, per capita GDP at PPS is around €10,000, which represents about 47% of the average of the EU 25. There appear to be substantial regional differences in economic development with GDP per capita in the city of Zagreb being three times that in some of the poorest, war affected, counties.

3. Croatia faces high levels of unemployment, with a rate of 13.6% in 2004 using the ILO methodology, the highest amongst EU member states and candidate countries with the exception of Poland and Slovakia. This is accompanied by low participation rates, particularly amongst women. There are high rates of unemployment for young people (15-24) and older people (55-64), and amongst

women. In addition, nearly half of those unemployed have been so for one year or more. The general trend in unemployment is downwards but only very slowly.

4. The Croatian economy has high external debt, with a debt to GDP ratio of around 83% and a current account deficit of 6% of GDP in 2005. The average wage at the end of 2005 was 6,409 HRK or the equivalent of €870, inclusive of tax and contributions. Public debt reached a level of around 45% of GDP at the end of 2005.

5. Croatia's population is approximately 4.4 million, and is declining. The total fertility rate is low, at around 1.35, so that there is a rather dramatic ageing of the population. In part as a result of war events and their aftermath, Croatia's population declined between the census of 1991 and that of 2001. In addition, the proportion of those of Serbian ethnicity has fallen from 12.2% in 1991 to 4.5% in 2001. Demographic projections indicate that Croatia's population could fall by almost 1/5 by 2050 to some 3.7 million. The working age population (15-64 years of age) is projected to fall by almost 30% in the period 2005-2050 and its share in the total population to decline from 67% in 2005 to 57% in 2050. The number of elderly persons (aged 65 years or over) will rise by some 20%, so that the old age dependency ratio, the ratio of older people compared to the working age population is expected to rise from some 26% in 2005 to 50% in 2050. All of these trends are typical of current EU member states.

6. The at-risk-of-poverty rate, expressed as the proportion living below 60% of the median income, was 16.7% in 2004, above the EU average of 15%. Social transfers reduce the poverty rate from 33.7%, one of the strongest reduction rates in comparison to the EU or other candidate countries. Croatia has inequality, measured by the Gini coefficient, of 0.29, slightly above the EU 25 average.

7. Total government expenditures on social protection have been slowly declining since 2002. According to the GFS 2001 accounting rules, these expenditures account for around 18.5% of GDP in 2005, whereas in 2002 they were at the level of 20% of GDP. Unfortunately, official figures on the matter are often confusing. Data on expenditures on social protection according to the ESSPROS methodology are not yet available. Figures from government statistics are scarce and affected by the change in the accounting standard. However, it seems that the major factor behind the recent drop in overall social expenditures is a lowering of the GDP share of expenditures on public pensions which were 12.7% in 2004 compared to 14.1% in 2001. Public expenditures on health, albeit using a different accounting procedure, are estimated at 6.8% of GDP in 2004.

Social Inclusion and Social Protection – historical perspectives, decentralisation, and strategic directions

8. Contemporary Croatia still bears the marks of the legacy of Bismarckian social insurance and health care systems dating back to the late 19th and early 20th centuries. Whilst some of this was eroded, particularly in the early years of the socialist system established after 1945, a period marked by rapid urbanisation and a dual social structure between the new industrial workers and small farmers, other elements were built on, particularly in terms of universal health care coverage, universal public education, and mass literacy programmes. In the era of 'self management socialism', unlike in those communist countries within the Soviet bloc, there was a recognition of the need for professional social work and social assistance programmes to tackle social problems, accompanied by a large degree of decentralisation and a tolerance of some non-Governmental charitable activity. A series of economic and, later, political, crises throughout the 1980s placed great strains on the social protection system, with crisis management programmes seeking to guarantee a social minimum and with social assistance extended to those fit to work.

9. In the context of independence and war, a new emergency Social programme was introduced in 1993, with social cards identifying social assistance beneficiaries, also used to access humanitarian aid, held by 5.4% of the population. The crisis of refugees and displaced persons placed immense strains on public Centres for Social Work in this period. Legislation in 1997 began the modernisation of the social welfare system, seeking to promote decentralisation, to an extent, diversification to include non-state providers, and greater emphasis on individual effort and responsibility.

10. In part as a result of the necessities of war but, also in part, as a conscious political choice, Croatia became a very centralised political system in the early part of the 1990s. Indeed, this process was encouraged by Laws which allowed for a rapid growth of small, unviable, municipalities, and a highly complex division of responsibilities between the national, regional (county) and local levels of governance. By 2003, following limited decentralisation initiatives, local and regional governments accounted for some 15.2% of all government expenditures, still very low by EU standards. Social welfare accounted for 4.6% of total regional and local government expenditures.

11. In the last decade, there have been many strategic documents produced, but with uncertain follow-up and little co-ordination between them. A new Strategic Development Framework for 2006-2013 is just beginning a consultative process. This includes 'social cohesion and social justice' as one of ten key areas for development. In addition, a draft National Strategy for Regional Development, recently completed with the support of CARDS funding, recommends the

establishment of a Programme for the Development of Disadvantaged Areas in order to reduce gaps in income and living standards across the country. A number of other documents have implications for the fight against social exclusion, although they exhibit little overall coherence or, even, cross-referencing with each other. A number of problems can also be noted in terms of the establishment of multi-stakeholder dialogue to combat social exclusion which has, thus far, seen little direct input by excluded groups and their organisations, by groups representing young people and older people, by those from rural areas, by the private sector, and by professional associations.

Poverty and Social Exclusion: profile and indicators

12. Croatia does not have an official poverty line, and there was little academic research on the topic until the late 1990s. In addition, the concept of 'social exclusion' is only just beginning to receive academic, policy-maker, and public attention. The first, and most influential, poverty study was prepared by the World Bank in 2000, based on 1998 household consumption data, which found that some 10% of the population could not satisfy basic food and non-food needs. Another often quoted figure is that for 'subjective poverty' which is high, around 80%, although the proportion reporting 'great difficulties' in meeting needs is closer to the 10% figure. There are a number of 'quasi-poverty lines' such as Trade Union baskets regarding minimum monthly expenditure, usually compared with the average wage; the value of personal tax allowance (currently 1,600 HRK per month) or the social assistance benefit which is currently 400 HRK per month.

13. Calculations based on EUROSTAT methodology only began to appear recently and, still, some of the EU Laeken indicators cannot be calculated. As noted above, the headline figure of at-risk-of-poverty rate was 16.7% in 2004, when in-kind income is included. At risk groups, with higher rates include: older people, especially women; single-person households; the unemployed (especially the long-term unemployed and those with few years of education). Other studies also suggest that farmers; Roma; those in rural areas; and those in war-affected areas, are also at risk.

14. Among the knowledge gaps on poverty and social exclusion it is important, in particular to note the lack of time series data through panel surveys so that there is no information on careers into and/or out of poverty. In addition, a number of vulnerable groups are either not sufficiently covered by research, notably those with disabilities, national minorities, those in rural areas, and those affected by war, or else are too small or hidden from large-scale surveys such as institutionalised populations, the homeless, and so on.

The Social Protection System

15. At the state level, responsibilities for social protection and social welfare are divided between three Ministries, although the main responsibility falls on the Ministry of Health and Social Welfare. There are 80 deconcentrated Centres for Social Work employing some 1,892 people. Following reforms in 2003, there has been some decentralisation with counties now the owners of public old people's homes. In addition, many cities have their own social welfare programmes.

16. Unemployment benefit of between 797 HRK and 1000 HRK per month is paid for up to 390 days, depending on years of employment. Maternity benefit, based on salary, of between 1,600 HRK and 4,250 HRK per month is paid from 28 days before the due date until the child is 6 months old. A further 6 months of benefit can be claimed of 1,600 HRK per month. Child benefits are now means tested and are paid at a rate of 166.30 HRK per month. The social assistance benefit is 400 HRK for an individual and additionally for other household members based on an equivalence scale of 80%.

17. The report highlights a number of current problems in the system, notably confusing and overlapping responsibilities both horizontally and vertically, with those local authorities with the most resources introducing additional, parallel, welfare benefits. Overall, the cash benefits system is somewhat confusing with a wide range of benefits, unclear costs, opportunities for 'double-dipping', and, in some cases, low poverty alleviation effects. In addition, the social services system is still too reliant on institutional care which, whilst the numbers are not in themselves alarming, is often remote from centres of population and hard to exit. There is little integration of cash and care services and, still, too few, and geographically, very patchy, community-based services, especially run by NGOs. NGOs tend to receive little funding, or short-term project funding with very little opportunity for longer-term contracting of services. The system remains rather bureaucratic with reporting done according to disciplinary boundaries, rather than incorporating an holistic approach to need.

18. A number of current and proposed reforms have sought to tackle these problems, although many have been framed in terms of the need to reduce high social expenditures. This is the case with the current World Bank Programme Adjustment Loan (PAL) through which the Government pledges to reduce total spending on social benefits from 4.1% of GDP to 3.5% of GDP whilst increasing the share of the best-targeted social assistance allowance. An IBRD loan, a SIDA grant and a Government contribution currently fund an ambitious Social Welfare Development project to improve social services delivery, promote innovation and

deinstitutionalisation, and upgrade existing social service facilities. The project is beginning a piloting phase in three counties so that the results remain uncertain.

The Pensions System

19. Croatia now has a three-pillar pensions system. The first pillar is a mandatory defined reformed pay-as-you-go system, the second pillar is mandatory defined contribution, and the third pillar is a voluntarily defined contribution. The retirement age has been gradually increased, and now stands at 60 for women and 65 for men. A large number of institutions are involved in administering the pensions system although, in late November 2005, the supervisory agency HAGENA was replaced by HANFA which is tasked with supervision of a wide range of financial services.

20. In the context of demographic and economic problems, there was a need for pension reform, to reduce dependence on the state budget and to ensure sustainable pensions beyond the current generation. The pensions crisis was compounded by an increase in early retirement in the early 1990s. The main legislative underpinning of the reform was the Pension Insurance Act of 1999.

21. One of the main problems still facing the pension system is the low level of pension benefits. Average pensions increased significantly between 2000 and 2001 but have increased only slowly since. In 2004, the average old age retirement benefit was 1,946.74 HRK and the average pension (including disability and sickness pensions) was 1,758.12 HRK. At the end of 2004, of the 1,022,282 retirement pension beneficiaries almost 44% received 1,500 HRK or less, with some 17% receiving 1,000 HRK or less. Using HZMO data for the end of 2005, shows that there were 643,821 persons aged 65 or over in Croatia receiving pensions, out of a total estimated population aged 65 or over of 746,500. This suggests, therefore, that some 103,000 persons aged 65 or over, or 13.8% of the total, were not receiving pensions In addition, having increased from 2000 to 2001 the replacement ratio, the proportion of the average pension compared to average monthly wages has now fallen to 42.1%. In addition, there is a considerable difference in the value of pensions for 'new' retirees compared to those who retired earlier. Other problems, such as the continued high dependence on the state budget and the low level of contributions because of the grey economy or employees declaring only minimum salaries for contributions purposes, have not been solved by the reforms. Poverty in rural areas is also influenced by the fact that whilst those farmers who do receive a pension are now noticeably better off than under the old system, large numbers of subsistence farmers have not paid sufficient levels of contributions to qualify for a pension.

22. Whilst the main, fundamental reform, is now in place, a number of other reforms have been made or are planned. There have been attempts to try to raise the level of pension benefits. There is also concern regarding so-called 'privileged pensions' based on the inheritance of special rights. A large number of small adjustments have been made to the pension system, making projections difficult.

The Health Care System

23. In Croatia universal access to primary and secondary health care within a long-standing, comprehensive, solidarity-based structure is at the heart of the system. At the national level the main institutional stakeholders are the Ministry of Health and Social Welfare, the Ministry of Finance and the Croatian Health Insurance Institute. In addition, there is a National Institute of Public Health. Primary health care is provided by 47 health centres, 2657 family medicine teams, 252 gynaecological teams and 145 nursing care institutions. In 2004, Croatia has 2 clinical hospital centres, 5 clinical hospitals, 7 clinics, 22 general hospitals, 29 special hospitals, 7 health resorts, 4 emergency care stations and 278 polyclinics. A WHO estimate in 2002 was that Croatia spent some €560 per capita on health care. Approximately 80% of the system is financed through social health insurance.

24. As with many health care systems in developed countries and in countries in transition, the system suffers from a problem of lack of resources. In addition, some 146,000 people, or some 3.2% of the population, did not have health insurance in 2003, partly as a result of deadlines for registration. There are also significant variations in access to health care and in number of health facilities by county, with the number of acute hospital beds per 1,000 inhabitants ranging from 2.01 in Ličko-Senjska county to 4.45 in Primorsko-Goransko county and 6.47 in the City of Zagreb.

25. Significant inequalities on the basis of socio-economic status exist in Croatia with studies showing that low income groups use significantly less specialist services than higher income groups when health status is held constant. Equity issues are also raised by the growth in out of pocket payments which are disproportionately paid by lower income groups. Health care remains over centralised and, to an extent, over politicised. In addition, privatisation of some services has introduced a two tier system. Main groups at risk in terms of low access to quality health services are: those on a low income, the unemployed, large families, the elderly and people living in remote areas (including coastal areas and islands).

26. The health system has been subject to a number of reforms, some of which have been financed, in part at least, by World Bank loans, seeking to promote

efficiencies and secure adequate health protection for all whilst securing sustainable financing. Cost containment measures have only been partly successful, however, and have shifted a proportion of costs on to users. The current PAL strategy has, as an expected result, a reduction in total public health expenditure to 6% of GDP in 2008, through revision of the basic health benefit package, reduction of co-payment exemptions and, eventually, a new Health Insurance Act.

Conclusions and Recommendations

27. The study ends with a series of broad recommendations for future work on combating poverty and social exclusion in Croatia. These include:

i The need for a strong political commitment to tackling social exclusion through the designation of a body, either existing or newly created, to play a leadership role.

ii. Improving the knowledge base on social exclusion through planned or needed reforms to statistical systems and through the commissioning of long-term research.

iii. Strengthening and modernising the social protection system through:

a) improved horizontal and vertical co-ordination, a rationalization of benefits, and a greater emphasis on those benefits with a demonstrable poverty alleviation function, and adjusting these payments in line with increases in the cost of living and inflation
b) greater emphasis on innovation, mixed provision and local social planning and contracting within a system of national quality standards
c) urgent action on deinstitutionalisation particularly for young children and persons with learning difficulties based on clear, realisable targets and a switch in funding towards community-based care services
d) an integrated strategy to combat social exclusion combining activation programmes, combating of regional disadvantage and specific positive action programmes.

iv. Ensuring a socially inclusive pension and old age protection system through:

a) greater efficiency, transparency and enforcement of pension contribution collection
b) a clear strategy to reduce inequalities in pensions caused by inherited special rights
c) exploring the possibility of increasing contributions to the second pillar
d) encouraging full compliance regarding contributions to the pension insurance fund

e) a feasibility study on the costs and benefits of introducing a social old-age minimum benefit for those old people not in receipt of a pension

v. Improving the quality of, and ensuring equality of access to, public health services through:

a) a transparent public debate leading to a clear national strategy on health care
b) the introduction of more decentralization of health care services, combining autonomy for health care providers with the possibility of subsidies to disadvantaged areas
c) the elaboration of positive health care action programmes, and health care action zones, to promote the health needs of disadvantaged groups and regions
d) the introduction of a fairer payment structure reflecting the ability to pay.

vi. Expanding active labour market measures to promote integration into meaningful work through:

a) facilitating more flexible forms of employment
b) introducing locally based activation measures of benefit to the local community
c) promoting closer collaboration between Centres for Social Work and Bureaux for Employment, through a first stop shop system for those out of work
d) introducing special counselling and re-training programmes for vulnerable groups
e) optimising coverage of pre-school and school-based child care facilities during working hours

vii. Promoting quality education for all, life-long learning, and an integrated approach to the education of children with special needs.

viii. Strengthening the role of non-state actors in preventing and alleviating poverty and social exclusion.

Sažetak

Socijalna zaštita i socijalna uključenost u Hrvatskoj

Studija

1. Ova studija predstavlja prikaz trenutnog stanja na području socijalne uključenosti i socijalne zaštite u Hrvatskoj u vremenu kada se završava priprema Zajedničkog memoranduma o uključivanju (JIM) u okviru puta prema punopravnom članstvu u Europskoj uniji. Studija pruža najnovije podatke o siromaštvu i socijalnoj isključenosti, stavlja ih u povijesni kontekst, te promatra strateške ciljeve vladine politike kao i uloge različitih interesnih skupina. Ona daje pregled strukture, poteškoća te postojećih i predloženih reformi sustava socijalne zaštite/socijalne skrbi, mirovinskog sustava te sustava zdravstvene zaštite. Prepoznaje glavne teškoće u budućem procesu modernizacije ovih sustava s ciljem poboljšanja njihove djelotvornosti u borbi protiv socijalne isključenosti. Naposljetku iznosi, u kontekstu tekućih procesa povezanih s izradom Zajedničkog memoranduma o uključivanju, okvirne preporuke za provedbu reformi u srednjoročnom razdoblju. Ovaj sažetak daje kratki pregled studije, na engleskom i hrvatskom jeziku.

Republika Hrvatska: ekonomski, financijski i demografski okvir

2. U svom jedinstvenom položaju među zemljama kandidatkinjama i državama članicama Europske unije, Hrvatska je u razdoblju od 15 godina prošla 'trostruku tranziciju'; iz rata u mir, iz planske ekonomije u slobodnu tržišnu ekonomiju i iz jednostranačkog sustava u pluralističku demokraciju. U vrijeme rata, rano razdoblje tranzicije obilježila je hiperinflacija, porast nezaposlenosti i negativan gospodarski rast koji je rezultirao smanjenjem BDP-a u 1993. na 60% vrijednosti iz 1989. Nakon uvođenja stabilizacijskog programa krajem 1993. uslijedio je solidan gospodarski rast koji je izostao samo 1999., a od 2000. iznosi više od 4% prosječno godišnje. BDP po stanovniku prema paritetu kupovne moći 2005. je iznosio oko €10.000, što je približno 47% prosječnog BDP-a 25 država članica Europske unije. Postoje značajne regionalne razlike u gospodarskom razvoju te je BDP po stanovniku u gradu Zagrebu tri puta veći od onoga u nekim od najsiromašnijih županija stradalih u ratu.

3. Hrvatska je suočena s visokom stopom nezaposlenosti. U skladu s metodologijom Međunarodne organizacije rada (ILO), u 2004. godini zabilježena je stopa nezaposlenosti od 13.6%, najviša među zemljama kandidatkinjama i državama članicama Europske unije, s izuzetkom Poljske i Slovačke. Ovako visoku stopu nezaposlenosti pratila je i niska stopa participacije, posebice žena. Stopa nezaposlenosti je naročito visoka među mladima (od 15 do 24 godina starosti), među stanovništvom starije životne dobi (od 55 do 64 godina starosti),

te među ženama. Uz to, gotovo polovica nezaposlenih imaju takav status dulje od godinu dana. U pogledu trenda, uočava se da je stopa nezaposlenosti u padu, ali vrlo blagom.

4. Hrvatsko gospodarstvo karakterizira visoki vanjski dug s udjelom vanjskog duga u BDP-u od oko 83% i deficitom tekućeg računa platne bilance od preko 6% BDP-a u 2005. Prosječna plaća krajem 2005. iznosila je 6.409 kn, što je približno jednako €870, uključujući poreze i doprinose. Koncem 2005. javni dug dosegao je razinu od oko 45% BDP-a.

5. Hrvatska ima oko 4,4 milijuna stanovnika i taj je broj u stalnom opadanju. Stopa ukupnog fertiliteta je niska, oko 1,35, pa je prisutno izraženo starenje stanovništva. Broj stanovnika u Hrvatskoj se smanjio između popisa stanovništva provedenog u 1991. i onog iz 2001., ne samo kao posljedica starenja stanovništva, već dijelom kao rezultat ratnih zbivanja i njihovih posljedica. Nadalje, udio stanovnika, pripadnika srpske manjine pao je s 12,2% u 1991. na 4,5% u 2001. Demografske projekcije pokazuju da bi se stanovništvo u Hrvatskoj do 2050. moglo smanjiti za 1/5, na nekih 3.7 milijuna stanovnika. Predviđa se da bi se broj radno sposobnog stanovništva (od 15 do 64 godina starosti) mogao smanjiti za gotovo 30% u razdoblju od 2005. do 2050., a njegov udio u ukupnom stanovništvu pasti sa 67% u 2005. na 57% u 2050. Broj osoba starije životne dobi (od 65 godina na više) porast će za nekih 20%, tako da se očekuje da će stopa ovisnosti starijeg stanovništva, tj. odnos broja stanovnika u starijoj životnoj dobi i stanovništvu u radnoj dobi, porasti s 26%, koliko je iznosio u 2005., na 50% u 2050. Ovakvi su trendovi uobičajeni za sadašnje države članice Europske unije.

6. Stopa rizika od siromaštva, izražena kao postotak stanovništva koje živi s dohocima ispod granice od 60% medijana ukupnog dohotka, iznosila je 16,7% u 2004., što je iznad prosjeka Europske unije koji je iznosio 15%. Socijalni transferi smanjuju stopu rizika od siromaštva s 33,7%, koliko bi ona iznosila da ne postoje ovi transferi, što je jedna od najjačih stopa smanjenja u usporedbi s Europskom unijom i ostalim zemljama kandidatkinjama. Razina nejednakosti u Hrvatskoj, mjerena Ginijevim koeficijentom, iznosi 0,29, što je neznatno više od prosjeka u 25 država članica Europske unije.

7. Ukupni rashodi državnog proračuna za socijalnu zaštitu su u postupnom smanjenju od 2002. Prema računovodstvenoj metodologiji GFS 2001, ti su rashodi 2005. godine iznosili oko 18,5% BDP-a, dok su 2002. iznosili 20% BDP-a. Nažalost, službeni podaci koji se odnose na ovo područje prilično su zbunjujući. Podaci o rashodima prema EU metodologiji za izradu integrirane statistike socijalne zaštite (ESSPROS) još uvijek nisu dostupni. Statistički podaci o izdacima države za socijalnu zaštitu su rijetki i podložni promjenama u računovodstvenom standardu. Međutim, čini se da je glavni uzrok nedavnog relativnog smanjenja

ukupnih socijalnih rashoda pad udjela mirovinskih rashoda u BDP-u, koji je 2004. iznosio 12,7%, a 2000. 14,1% BDP-a. Javni rashodi za zdravstvo za 2004. se procjenjuju na 6,8% BDP-a.

Socijalna uključenost i socijalna zaštita – povijesne perspektive, decentralizacija i strateški pravci

8. Suvremena Hrvatska još uvijek nosi obilježja ostavštine bizmarkovskog sustava socijalnog osiguranja i zdravstvene zaštite koji datiraju s kraja 19. i početka 20. stoljeća. Dok su neki elementi tog sustava vremenom nestali, naročito u ranim godinama socijalističkog sustava uspostavljenog nakon 1945., kojeg je obilježila ubrzana urbanizacija i dualna struktura društva podijeljenog između novonastalih industrijskih radnika i malih poljoprivrednih proizvođača, drugi su se elementi razvijali, naročito u smjeru univerzalne pokrivenosti zdravstvene zaštite, univerzalnog javnog obrazovanja i programa za opismenjavanje ukupnog stanovništva. U eri 'samoupravnog socijalizma', za razliku od onih komunističkih zemalja koje su bile dio sovjetskog bloka, postojala je svijest o potrebi za stručnim programima u području socijalnog rada i socijalne pomoći kako bi se riješili socijalni problemi, popraćena razmjerno visokom razinom decentralizacije i određenom tolerancijom prema dobrotvornim aktivnostima nevladinih organizacija. U 80-im godinama niz ekonomskih, a kasnije i političkih, kriza prouzrokovao je veliki pritisak na sustav socijalne zaštite, dok se programima za upravljanje kriznom situacijom pokušao zajamčiti socijalni minimum pružanjem socijalne pomoći i onima koji su bili sposobni za rad.

9. U kontekstu rata i borbe za samostalnost, 1993. godine donesen je novi Socijalni program kojim su uvedene socijalne iskaznice za dokazivanje statusa korisnika socijalne pomoći kao i dobivanje humanitarne pomoći, a koje je koristilo 5,4% stanovništva. Izbjeglička kriza stavila je ogroman pritisak na centre za socijalni rad u ovom razdoblju. Donošenjem novih zakonskih propisa 1997. započela je modernizacija sustava socijalne skrbi, promičući decentralizaciju, premda u ograničenoj mjeri, diversifikaciju uključivanjem pružatelja usluga iz nevladinog sektora, te stavljanjem većeg naglaska na individualni trud i odgovornost.

10. Djelomično kao posljedica rata, ali i svjesnim političkim izborom, Hrvatska je u ranim 90-ima izgradila snažno centraliziran politički sustav. Štoviše, taj proces su poticali zakoni koji su dopuštali brz rast malih, neodrživih općina te složenu raspodjelu odgovornosti između državnih, regionalnih (županijskih) i lokalnih razina vlasti. Do 2003. nakon ograničenih pokušaja decentralizacije, rashodi lokalne i regionalne vlasti iznosili su oko 15,2% svih rashoda iz državnog proračuna, što je još uvijek vrlo niski postotak prema standardima Europske unije.

11. U posljednjem desetljeću pripremljeni su mnogi strateški dokumenti, koji su bili međusobno slabo usklađeni, a čija je primjena često izostala. Za novi Strateški okvir za razvoj Hrvatske 2006.-2013. tek počinje proces konzultacija. Dokument uključuje 'socijalnu koheziju i socijalnu pravdu' kao jedno od deset ključnih područja razvoja. K tome, nacrt Nacionalne strategije regionalnog razvoja, nedavno dovršen uz pomoć sredstava iz programa CARDS, preporuča donošenje Programa za područja s razvojnim poteškoćama s ciljem smanjenja regionalnih razlika u dohocima i životnom standardu. Izvjestan broj drugih dokumenata također se referira na borbu protiv socijalne isključenosti, ali oni su općenito nedovoljno koherentni i premalo međusobno povezani. Određeni se problemi mogu uočiti u uspostavi međusobnog dijaloga između interesnih skupina u borbi protiv socijalnog isključivanja u kojem su se do danas vrlo malo izravno aktivirale skupine isključenih osoba i organizacije koje ih zastupaju, skupine koje predstavljaju mlade i osobe starije životne dobi, skupine iz ruralnog područja, privatnog sektora te profesionalne udruge.

Siromaštvo i socijalna isključenost: profil i pokazatelji

12. U Hrvatskoj ne postoji službena granica siromaštva, a sve do kasnih 90-ih postojao je i vrlo mali broj znanstvenih istraživanja na tu temu. Nadalje, koncepcija 'socijalne isključenosti' tek počinje privlačiti pažnju akademskih krugova, nositelja politike i široke javnosti. Prvo i najutjecajnije istraživanje o siromaštvu provela je Svjetska banka 2000. na temelju podataka o potrošnji u kućanstvima, koje je pokazalo da oko 10% stanovništva ne može pokriti troškove osnovnih životnih potreba. Druga, često citirana brojka je ona koja se odnosi na 'subjektivno siromaštvo', visokih 80%, iako je postotak onih koji izražavaju 'velike poteškoće' pri zadovoljavanju osnovnih potreba znatno niži, približno 10%. Postoji određeni broj „implicitnih" granica siromaštva kao što su troškovi potrošačke košarice koje izračunavaju radnički sindikati, iznos osobnog odbitka (trenutno 1.600 kn mjesečno) pri oporezivanju ili iznos naknada socijalne pomoći koja trenutno iznosi 400 kn mjesečno.

13. Izračuni temeljeni na EUROSTAT metodologiji pojavili su se tek nedavno i još uvijek nije moguće izračunati sve pokazatelja prihvaćene na zasjedanju Europskog vijeća u Laekenu. Kao što smo već naveli, glavni pokazatelj je stopa rizika od siromaštva, koja je iznosila 16,7% u 2004., pri čemu je u definiciju ukupnog dohotka uključen i dohodak u naturi. Rizične skupine koje se javljaju u većim postocima uključuju: osobe starije životne dobi, posebice žene; kućanstva sa samo jednim članom; nezaposlene (pogotovo dugotrajno nezaposlene i osobe s niskim stupnjem obrazovanja). Ostala istraživanja pokazuju da iznadprosječan rizik od siromaštva imaju poljoprivrednici; romsko stanovništvo; stanovništvo iz ruralnih područja te stanovništvo iz područja stradalih u ratu.

14. U pogledu jaza u spoznajama o siromaštvu i socijalnoj isključenosti bitno je spomenuti nedostatak vremenske dimenzije za podatke prikupljene anketnim istraživanjima, tako da ne postoje informacije o tokovima pojedinaca i kućanstava u i/ili iz siromaštva. Također, određeni broj socijalno osjetljivih skupina nije dostatno statistički istražen, naročito se to odnosni na osobe s invaliditetom, nacionalne manjine, stanovništvo iz ruralnih područja i osobe stradale u ratu, kao i na skupine koje su premale ili obično nisu pokrivene anketnim istraživanjima širokog obuhvata kao što su institucionalizirane osobe, beskućnici itd.

Sustav socijalne zaštite

15. Na državnoj razini, odgovornosti za socijalnu zaštitu i socijalnu skrb podijeljene su između tri ministarstva, a glavnu nadležnost ima Ministarstvo zdravstva i socijalne skrbi. Ustrojeno je 80 centara za socijalnu skrb u kojima je zaposleno oko 1.892 ljudi. Nakon reformi provedenih u 2003. došlo je do određene decentralizacije tako da su sada javni starački domovi u vlasništvu županija. Uz to, mnogi gradovi imaju vlastite programe za socijalnu skrb.

16. Novčana naknada za nezaposlenost u iznosu od 797 kn do 1000 kn mjesečno isplaćuje se u trajanju do najviše 390 dana, ovisno o radnom stažu. Rodiljna naknada koja se zasniva na plaći, a iznosi od 1.600 kn do 4.250 kn mjesečno, isplaćuje se u razdoblju od 28 dana prije dana rođenja djeteta do trenutka kad dijete napuni 6 mjeseci. Moguća je dodatna isplata naknade u trajanju od 6 mjeseci i iznosu od 1.600 kn mjesečno. Dječji doplatak je sada vezan za imovinski cenzus i isplaćuje se u iznosu od 166,30 kn mjesečno. Naknada za socijalnu pomoć sastoji se od 400 kn za pojedinca te dodatka za ostale članove kućanstva na temelju ekvivalentne ljestvice od 80%.

17. Ovo izvješće ističe nekoliko postojećih problema u sustavu, naročito preklapanje i miješanje odgovornosti kako horizontalno tako i vertikalno, kao i uvođenje dodatnih, paralelnih socijalnih pomoći od strane lokalnih vlasti koje posjeduju najviše resursa. Općenito, sustav novčane pomoći je pomalo zbunjujuć s velikim brojem naknada, nejasnim troškovima, mogućnostima za 'dvostruko okorištavanje' (tj. kumuliranje naknada), i u nekim slučajevima, niskim učinkom na smanjenje siromaštva. Nadalje, sustav socijalnih usluga se još uvijek previše oslanja na skrb u institucijama koje su, iako broj njihovih korisnika sam po sebi nije uznemirujući, često udaljene od naseljenih središta i teško ih je napustiti. Vrlo je niska razina integracije između novčanih usluga i usluga skrbi te još uvijek premalo i geografski neravnomjerno rasprostranjenih usluga koje pruža lokalna zajednica, pogotovo u organizaciji nevladinih udruga. Nevladine udruge dobivaju vrlo malo financijskih sredstava ili dobivaju sredstva za kratkoročno financiranje projekata bez mogućnosti za dugoročno ugovaranje pružanja usluga. Sustav je

ostao razmjerno snažno birokratiziran, uz razdjeljenost po pojedinim strukama umjesto da se usvoji holistički pristup u skladu s potrebama.

18. Navedeni problemi pokušavaju se riješiti putem nekoliko postojećih i predloženih reformi iako su mnoge od njih koncipirane u cilju smanjenja visokih socijalnih rashoda. Takav je slučaj i s trenutnim Programskim zajmom za prilagodbu (PAL) Svjetske banke kojim Vlada obećava smanjiti ukupne izdatke za socijalne naknade s 4,1% na 3,5% BDP-a, uz istovremeno povećanje udjela najučinkovitijih ciljanih naknada za socijalnu pomoć. Zajmom Međunarodne banke za obnovu i razvoj, bespovratnim sredstvima Švedske agencije za međunarodnu razvojnu suradnju i vladinim doprinosom trenutno se financira ambiciozni Projekt za razvoj sustava socijalne skrbi s ciljem poboljšanja pružanja socijalnih usluga, promicanja inovacija i deinstitucionalizacije te modernizacije postojećih socijalnih službi. Ovaj projekt je trenutno u pilot fazi u tri županije i njegovi rezultati su još neizvjesni.

Mirovinski sustav

19. Mirovinski sustav u Hrvatskoj temelji se na tri stupa. Prvi stup mirovinskog osiguranja čini obvezatan, nedavno reformiran, sustav financiranja tekućom raspodjelom (pay-as-you-go), drugi stup čini obvezno privatno osiguranje u sustavu kapitalizirne štednje, a treći stup čini dobrovoljno mirovinsko osiguranje. Dob za umirovljenje se postupno povećala te je trenutno 60 godina za žene i 65 godina za muškarce. U upravljanje mirovinskim sustavom uključen je veliki broj institucija iako je koncem studenog 2005. ulogu Agencije za nadzor mirovinskih fondova i osiguranja (HAGENA) preuzela Hrvatska agencija za nadzor financijskih usluga (HANFA) koja je nadležna za nadzor većeg broja financijskih usluga.

20. U kontekstu demografskih i ekonomskih poteškoća, javila se potreba za mirovinskom reformom, smanjenjem ovisnosti o državnom proračunu i osiguranjem održivih mirovina i za buduće naraštaje. Mirovinsku krizu je u ranim 90-ima dodatno otežao povećani broj odlazaka u prijevremenu mirovinu. Temeljna zakonska osnova za reformu bio je Zakon o mirovinskom osiguranju koji je donesen 1999. godine.

21. Jedan of glavnih problema s kojim se suočava mirovinski sustav je niska razina mirovinskih naknada. Prosječne mirovine su značajno narasle između 2000. i 2001., a odonda su u tek neznatnom porastu. U 2004. prosječna starosna mirovina iznosila je 1.946,74 kn, a prosječna ukupna mirovina (uključujući mirovinu u slučaju invalidnosti ili bolesti) iznosila je 1.758,12 kn. Koncem 2004, gotovo 44% od ukupno 1.022.282 umirovljenika primalo je mirovinu manju od 1.500 kn, a 17% je primalo mirovinu manju od 1.000 kn. Podaci HZMO-a za kraj 2005. godine pokazuju da je u Hrvatskoj 643.821 osoba životne dobi od 65 i više godina primalo mirovinu. Ukupno stanovništvo u dobi od 65 i više godina

procijenjeno je na 746.500 za 2005. Stoga se može zaključiti da oko 103.000 osoba životne dobi 65 i više godina, ili 13,8% ne prima mirovinu. Uz to, dok je na prijelazu iz 2000. u 2001. udio prosječne mirovine u prosječnoj neto mjesečnoj plaći bio u porastu, sada je pao na 42,1%. Također postoji i bitna razlika u iznosu mirovine za 'nove' umirovljenike u usporedbi s onima koji su već u mirovini. Drugi problemi, kao što su i dalje visoka razina ovisnosti o državnom proračunu te relativno niski iznosi doprinosa zbog sive ekonomije ili prijavljivanja minimalnih plaća od strane poslodavaca radi isplate manjih doprinosa, nisu riješeni navedenim reformama. Na siromaštvo u ruralnim područjima također utječe činjenica da dok su poljoprivrednici koji sada primaju mirovinu u mnogo boljem imovinskom položaju nego što bi to bili u starom sustavu, ali da velik broj osoba koje se bave poljoprivrednom proizvodnjom za vlastite potrebe nije uplatilo dovoljan iznos doprinosa kako bi ostvarili mirovinu.

22. Sa završetkom uspostave glavne, temeljne reforme, provodi se i planira određen broj drugih reformi. Provedeni su pokušaji da se podigne razina mirovinskih naknada. Također postoji zabrinutost u pogledu takozvanih 'privilegiranih mirovina' koje se temelje na nasljeđivanju posebnih prava. Mirovinski sustav je doživio velik broj sitnih preinaka što znatno otežava projekcije njegovih učinaka.

Sustav zdravstvene zaštite

23. Sustava zdravstvene zaštite u Hrvatskoj karakterizira univerzalan pristup primarnoj i sekundarnoj zdravstvenoj zaštiti utemeljen na dugogodišnjoj sveobuhvatnoj strukturi zasnovanoj na solidarnosti. Na nacionalnoj razini, glavni institucionalni nositelji sustava su Ministarstvo zdravstva i socijalne skrbi, Ministarstvo financija i Hrvatski zavod za zdravstveno osiguranje. Postoji i Hrvatski zavod za javno zdravstvo. Primarnu zdravstvenu zaštitu pruža 47 domova zdravlja, 2.657 ambulanti obiteljske medicine, 252 ginekološke ambulante i 145 ustanova za zdravstvenu njegu. U Hrvatskoj su 2004. postojala 2 kliničko bolnička centra, 5 kliničkih bolnica, 7 klinika, 22 opće bolnice, 29 specijaliziranih bolnica, 7 lječilišta, 4 hitne službe i 278 poliklinika. U 2002. Svjetska zdravstvena organizacija procijenila je da Hrvatska za zdravstvenu zaštitu troši oko €560 po stanovniku. Oko 80% sustava financira se putem zdravstvenog osiguranja.

24. Kao što je to slučaj s mnogim sustavima zdravstvene zaštite u razvijenim zemljama i zemljama u tranziciji, sustav pati od nedostatka financijskih sredstava. Uz to, oko 146.000 osoba ili 3,2% stanovništva nije imalo zdravstveno osiguranje u 2003., dijelom zbog propuštanja rokova za prijavu. Također postoje velike razlike u dostupnosti zdravstvene zaštite i broju zdravstvenih ustanova po županijama, a raspoloživi broj bolničkih kreveta na 1.000 stanovnika varira od

2,01 u Ličko- senjskoj županiji do 4,45 u Primorsko-goranskoj županiji i 6,47 kreveta po stanovniku u Gradu Zagrebu.

25. U Hrvatskoj postoje značajne nejednakosti s obzirom na društveni i ekonomski status pacijenta. Istraživanja pokazuju da skupine s niskim primanjima znatno manje koriste specijalističke usluge od skupina s višim primanjima. Također se postavlja pitanje pravednosti zbog porasta izdataka za participaciju i recepte koje iznadprosječno pogađaju skupine s niskim primanjima. Zdravstvena zaštita je i dalje pretjerano centralizirana i do određene granice, pretjerano politizirana. Nadalje, privatizacija određenih usluga dovela je do uvođenja dvostrukog sustava. Glavne rizične skupine u smislu niske razine dostupnosti kvalitetnih zdravstvenih usluga su: osobe s niskim primanjima, nezaposleni, obitelji s većim brojem članova, osobe starije životne dobi i stanovnici udaljenih područja (uključujući obalna područja i otoke).

26. Sustav zdravstva doživio je mnoge reforme, s ciljem promicanja učinkovitosti i osiguranja odgovarajuće zdravstvene zaštite za sve, uz istovremeno osiguranje održivog financijskog stanja. Međutim mjere za smanjenje troškova pokazale su se tek djelomično uspješne te su samo prebacile dio troškova na korisnike. Jedan od očekivanih rezultata trenutne strategije Programskog zajma za prilagodbu jest smanjenje ukupnih rashoda za javno zdravstvo na 6% BDP-a u 2008. što će se postići revizijom osnovnog paketa zdravstvenih usluga, smanjenjem oslobođenja od participacije te na koncu donošenjem novog Zakona o zdravstvenom osiguranju.

Zaključci i preporuke

27. Studija završava nizom preporuka za buduće aktivnosti u borbi protiv siromaštva i socijalne isključenosti u Hrvatskoj. One obuhvaćaju:

ii. Potrebu za čvrstim političkim angažmanom u rješavanju problema socijalne isključenosti, kroz imenovanje tijela, bilo postojećeg ili nekog novog, koje bi preuzelo vodeću ulogu.

iii. Produbljivanje znanja i spoznaja o socijalnoj isključenosti putem planiranih ili potrebnih reformi u statističkom sustavu i provođenjem dugoročnih istraživanja.

iii. Jačanje i modernizaciju sustava socijalne zaštite kroz:

a) poboljšanu horizontalnu i vertikalnu koordinaciju, racionalizaciju naknada i veći naglasak na one naknade koje učinkovito smanjuju razinu siromaštva, te prilagodbu tih isplata u skladu s povećanjem životnih troškova i inflacijom,

b) veći naglasak na inovaciju, mješovito pružanje usluga te socijalno planiranje i angažiranost na lokalnoj razini u sklopu sustava nacionalnih normi kakvoće,
c) hitne aktivnosti u pogledu deinstitucionalizacije, naročito male djece i osoba s teškoćama u učenju, utemeljene na jasnim i ostvarivim ciljevima, te pojačanom financiranju usluga socijalne skrbi koje pruža lokalna zajednica,
d) integriranu strategiju za borbu protiv socijalne isključenosti koja objedinjuje aktivacijske programe, borbu protiv regionalnih nejednakosti i specifične pozitivne akcijske programe.

iv. Osiguranje socijalno uključivog mirovinskog sustava i sustava zaštite osoba starije životne dobi kroz:
a) veću učinkovitost, transparentnost i provedbu sustava prikupljanja doprinosa za mirovinsko osiguranje,
b) jasnu strategiju za smanjenje nejednakosti u mirovinama prouzrokovane nasljeđivanjem posebnih prava,
c) istraživanje mogućnosti povećanja doprinosa u drugi stup mirovinskog sustava,
d) poticanje potpunog poštivanja plaćanja doprinosa za mirovinsko osiguranje,
e) izradu studije o troškovima i koristima uvođenja minimalnog mirovinskog primanja za osobe starije životne dobi koje ne primaju mirovinu.

v. Poboljšanje kvalitete i osiguranje jednake dostupnosti javnih zdravstvenih usluga kroz:
a) transparentnu javnu raspravu iz koje će proizići jasna nacionalna strategija zdravstvene zaštite,
b) decentralizaciju usluga zdravstvene zaštite, objedinjujući autonomiju pružatelja zdravstvenih usluga s mogućnošću isplate poticaja za područja u nepovoljnijem položaju,
c) razradu pozitivnih akcijskih programa zdravstvene zaštite kao i zona za provedbu aktivnosti zdravstvene zaštite s ciljem zadovoljenja zdravstvenih potreba skupina i regija u nepovoljnijem položaju,
d) uvođenje pravednije strukture plaćanja koja bi odražavala mogućnosti plaćanja.

vi. Razradu aktivnih mjera za poboljšanje stanja na tržištu rada i to promicanjem integracije kroz smislen rad putem:
a) omogućavanja fleksibilnijih oblika zapošljavanja,
b) uvođenja lokalnih aktivacijskih mjera od koristi za lokalnu zajednicu,
c) promicanja suradnje između centara za socijalnu skrb i Zavoda za zapošljavanje, kroz sustav tzv. *first stop shop*-a za nezaposlene,

d) uvođenja specijaliziranog savjetovanja i programa prekvalifikacije za ranjive skupine,
e) povećanja broja predškolskih ustanova i ustanova za čuvanje djece školske dobi tijekom radnog vremena.

vii. Promicanje visoko-kvalitetnog obrazovanja za sve, cjeloživotnog učenja i integriranog pristupa obrazovanju djece s posebnim potrebama.

viii. Jačanje uloge nedržavnih subjekata u sprječavanju i borbi protiv siromaštva i socijalne isključenosti.

Chapter 1: Introduction: Economic, Financial and Demographic Background

1.1 Main factors influencing social protection

1.1.1 Economic and financial indicators

1. In the last 15 years Croatia has undergone tectonic changes related not only to the process of economic transition, but also to deep social and political turbulence associated with the war of independence from the Yugoslav Federation (1991-1995). The war affected the early stages of Croatian transition in many respects, not least in terms of the loss of human lives and substantial material damage, and also causing a sharp decline in living standards. It also resulted in increasing social expenditures related to refugees and displaced persons, and considerable costs of post-war reconstruction. Transition depression and war burden at the same time were to pressurise the Croatian economy considerably. In the early 1990s Croatia experienced decline in practically every aspect of economic life and it lost most of its initial advantages over other former socialist economies that stemmed from certain market mechanisms already in place in the self-management type of socialism which prevailed in socialist Yugoslavia. Croatian transition up to 1993 was marked by hyperinflation, rising unemployment and negative economic growth. In that period GDP fell to 60% of the level in 1989.

2. After early shocks, later economic development was fairly successful. In the period from 1994-1998, the average GDP growth rate was 5.6%, which could be attributed to the 'stabilisation and peace dividend' after a successful anti-inflationary programme from October 1993, and the concluding of war operations in August 1995. In 1999 there was a short-lived recession linked to domestic shocks (banking crisis, the introduction of VAT), but also to tales of Russian crises and the negative impact of the Kosovo/a crisis on the tourism industry. GDP declined by 0.9% in that year. In the period 2000-2004 growth was solid again with an average annual rate of 4.1%. In 2005, positive economic development continued with GDP growth of 4.3% (Table 1).

3. Croatian GDP per capita at PPS is estimated to be around 47% of the average of the EU 25 in 2005, or approximately PPS €10,000, higher than that of Latvia of current Member States, comparable to Lithuania and Poland, and well above that of other Candidate Countries (Bulgaria, Romania and Turkey). The raw GDP per capita figure for 2005 is estimated at € 6750, and the total economy was € 30 bn. It could be noted here that an upward adjustment of GDP figures of some 15% is expected as a result of the correction for undocumented flows from the "grey economy".

4. Regional differences in economic development seem substantial in Croatia. In 2003, GDP per capita ranges from €3,400 in the counties of Slavonski brod - Posavina and Vukovar –Sirmium, to more than €10,000 in Zagreb City (Table 3). Some 18% of the Croatian population is residing in Zagreb, but they produce around 31% of Croatian GDP. Negotiations on the statistical regionalisation of Croatia into so-called NUTS-II regions are continuing, while the county level is equivalent to NUTS-III level.

5. In the last five years economic growth was supported by strong household consumption and a pick-up in investment expenditures. Household consumption has grown by around 4.7% per year in the period 2000-2005. Investments in fixed capital grew by two-digit rates in 2002 and 2003, pinpointed by government-led investments in highway construction, and continued to perform strongly thereafter. In that situation, an increasing need for financial assets is fulfilled through foreign borrowing. External debt has been growing quickly, debt to GDP ratio increased from 60% in 2000 to around 83 % in 2005. The Central Bank was forced to conduct a series of measures for curbing foreign borrowing, which finally managed to slow down the pace of indebtedness in 2005, and hopes to stabilise the already high ratio in the next few years.

6. The foreign trade balance is one of the weakest points of the Croatian economy. Merchandise imports of some € 15 bn. in 2005 is twice as high as merchandise exports, while the surplus in trade of services helped to cover a part of the trade deficit. Receipts from international tourism are in that respect of particular interest, helping to bring some € 6 bn. into the country as estimated for 2005. All in all, the current account deficit reached 6.3% in 2005. The deficit of around 5% seems immanent to the Croatian economy for the last 5 years. Part of the current account deficit is financed though net FDI inflow (4.5% of GDP, as estimated for 2005), while the other part is financed by foreign borrowing.

7. Despite promising economic growth, employment responds rather slowly to recovery. The transition years up to 2000 were marked by a considerable decline in employment, but afterwards there was slow improvement. In 2001 and 2002 any rise in employment was hardly evident, but it grew to around 1.5% in 2004 and 2005. Unemployment is still rather high, a bit above 13% of the labour force in 2005, according to figures based on the ILO methodology, or around 18% as based on official registers. However, a declining trend of unemployment is rather evident in both statistics (Table 1) (See also chapter 3).

8. After the curbing of inflation at the end of 1993, Croatia has experienced low to moderate inflation rates subsequently. The recent rise in inflation to levels above 3% is mostly due to the oil price hike in world markets, although a notable rise was recorded in food prices and some administratively regulated prices. The

Kuna exchange rate vis-à-vis the Euro was basically stable in the period after 1993. Having in mind the Euroisation of the Croatian economy, it can be said that the policy choice of a managed floating exchange rate with a rather narrow band of fluctuations has helped to preserve the price and financial stability of the economy.

9. The average wage in Croatia at the end of 2005 was 6,409 kn per month or the equivalent of €870 (inclusive of personal income tax and employees social security contributions), which was the second highest wage rate among all transition economies (behind Slovenia). Relatively high wages in absolute terms make strong pressures on the competitiveness of domestic enterprises which was the main reason behind moderate increases in wages in the 2000s, as compared to rather strong wage hikes that were recorded at the end of the 1990s. A rough calculation shows that wages' growth has been a bit lower than productivity growth in the last several years. In spite of a high average wage as compared to other countries of Central and Eastern Europe, its purchasing power is not in such a favourable position due to the relatively high comparative price level in Croatia.

10. The size of government in Croatia is also relatively high. According to the old accounting rules (Government Finance Statistics Manual 1986), expenditures of the general government were 51.4% of GDP in 2004, and government deficit was 4.9% of GDP (Annual Report of the Ministry of Finance, 2004). The rather high deficit in the presence of relatively high revenues (46.5% of GDP) makes the government position rather vulnerable and strong consolidation efforts have been needed. The recent change of accounting rules to the use of the GFS 2001 Manual makes comparison with the earlier period a bit more complicated, but major changes are quite obvious, at least for the period 2004-2005. The Government deficit or alternatively government net lending has been declining which is a result of a combination of mild decline in both current expenditures and net acquisition of non-financial assets. Public debt has reached a level of around 44% of GDP at the end of 2005, and its growth has slowed down recently as a result of fiscal consolidation.

11. Total government expenditures on social benefits are slowly declining after 2002 (Table 2). According to the GFS 2001 accounting rules, these expenditures account for around 18.5% of GDP in 2005, whereas in 2002 they were at the level of 20% of GDP. Unfortunately, official figures on the matter are often confusing. Data on expenditures on social protection according to the ESSPROS methodology are not yet available. Figures from government statistics are scarce and affected by the change in the accounting standard. However, it seems that the major factor behind the recent drop in overall social expenditures is a lowering of the GDP share of expenditures on public pensions. Reform of the pay-as-you-go system conducted in 1999, where stricter rules for pension

entitlements were introduced, as well as the so called Swiss-formula for pensions adjustments, contributed to such developments (see chapter 5).

12. At the end of 2005 there were 1.08 million pensioners in Croatia (24% of the total population), out of which some 51,000 are retired according to special regulations for the Croatian armed forces and Croatian defenders. In 2005, the number of pensioners increased by 1.4%, which is roughly the rate recorded in the last several years. The average pension in December 2005 was 1,848 HRK or equivalent to €250. The average old-age pension was 2,040 HRK, while average disability and family pensions were some 400 HRK lower on average. Using HZMO data for the end of 2005, shows that there were 643,821 persons aged 65 or over in Croatia receiving pensions, out of a total estimated population aged 65 or over of 746,500. This suggests, therefore, that some 103,321 persons aged 65 or over, or 13.8% of the total, were not receiving pensions. The Annual report from the Croatian Institute for pension Insurance puts pension expenditures at 12.7% of GDP for 2004, although this figure is likely to be revised downwards to 12.2% because of GDP adjustments. Public expenditures on health are estimated at 6.8% of GDP in 2004 (IMF, 2005). As will be clear throughout this report, these figures remain contested and other figures are sometimes stated.

1.1.2 Demographic indicators

1. The population of Croatia is around 4.4 million. The share of the female population is 52% and it seems that this share is on a slight increase over the last 20 years (Table 4), because women tend to live longer and they prevail in the old age population. Women consist of 62% of the population aged 65 and over, while at early ages male are more present.

2. The illiteracy rate is rather low (1.8% in 2001), with most illiterate people aged over 65. A declining natural increase rate was evident ever since the early 1980s, but since 1991 it has turned into negative values. The birth rate, which was around 15 per 1000 inhabitants in 1981, fell to around 9 in 2000, whereas the mortality rate remains rather constant over the whole period at about 11 deaths per 1000 inhabitants. Total fertility rate of around 1.35 is rather low as compared with the average for the EU. Fortunately, or just by coincidence, 2005 saw a marked improvement in that sense: the birth rate increased to 9.8 according to the first estimates. The number of marriages in 2005 also increased significantly, from an average of around 5 per 1000 inhabitants in the period 2000-2004, to 5.9 in 2005.

3. The Croatian population is getting older rather dramatically. The average age of men increased from around 34 years in 1981 to 38 years in 2004, while for women average age increased from 37 to 42 years. Children up to 14 years of age comprised 17% of the population in 2001, whereas in the early 1980s their share was over 21%. At the same time the working–age population has retained roughly the same proportion of population, and the old-age population increased from 11.5% to almost 16%. The old age dependency ratio (ratio of population of age 65+ to population of age 15-64) increased sharply, from 17 to 23.3 in the period 1981-2001. Life expectancy continues to increase substantially; a new-born male in 2004 is expected to live 72 years, while a female could expect to live 79 years. Having in mind the continuously low fertility rate, the ageing population is likely to be one of the main challenges for economic and social development in Croatia.

4. In parallel with the ageing population, there were notable changes in household composition. The average household size has been lowered, from 3.2 in 1981 to around 3.0 in 2001. This could be a result of two trends, one is the increasing number of single households, from 16% in 1981 to 20.8% in 2001, and the other is the lower number of large households (18.8% of households had 5 or more members in 1981, as compared to 16% in 2001).

5. The negative natural increase is partially compensated by positive migration flows. Croatia experienced net inward migration of around 12,000 persons per year in 2003 and 2004 (Table 5). Migration flows are gradually calming down from the relatively high levels recorded in the 1990s, mainly as a result of war events. The number of immigrants fell from more than 40,000 in 1995 and 1996 to 24,000 in 2001, and further to 18,000 in 2004. The number of emigrants was lowered from 15,000 in 1995 to 7,500 in 2001 and to 6,800 in 2004. The majority of immigrants came from Bosnia and Herzegovina (11,000 in 2004) and Serbia (1,500), most of them being ethnic Croats. These two countries also dominate in outward migration, suggesting that war-related migration is still occurring. The strength of immigration in recent history that was intensified by the war could be seen from the Census 2001 data, where 233,000 people report that they came into Croatia in the period 1991-2001, whereas the number of those who entered from 1981 to 1991 was around 66,000 (Table 6).

6. The vast majority of the Croatian population are ethnic Croats, almost 90% according to the 2001 Census (Table 7). Around 4.5% of the population are ethnic Serbs, while other ethnicities comprise a relatively low proportion in the total population. The ethnic composition recorded in the 2001 Census shows notable changes compared to the 1991 Census situation. The population of ethnic Serbs has declined in absolute and relative terms, with their share in the population falling from 12.2% to 4.5%, mostly as a consequence of war-related emigration. Some other factors might be in play too. First, a somewhat different

definition of the 'resident population' was used in Census 2001 as compared to Census 1991 impeding thereby precise comparison, and secondly, self-reporting of ethnicity was probably influenced by political and social considerations that were substantially different in the times these two censuses were conducted. For example, 2.2% of the population declared itself as Yugoslav in 1991 and 0.9% as Muslims, while for 2001 these have declined to such an extent that they are not recorded in the official Census results as specific categories. In the case of 'Yugoslavs', it is likely that they comprise only a very small part of the population in 2001. That part of population declaring itself as Muslims in 1991 tended to declare itself as Bosniacs in 2001 causing a drop in relative share of Muslims in the population. The change in the confessional composition of the population is closely connected with the change in the ethnic composition of the population (Table 9). In 2001 there was 87.8% Roman Catholics (up from 76.6% in 1991), 4.4% Orthodox (down from 11.1% in 1991), 1.3% of Muslims (up from 1.1% in 1991), while the population of other confessions is lower, less than 1% of the total for any particular confession.

1.1.3 Labour market participation indicators

1. The Croatian economy is characterised by relatively low population participation in the labour market. The activity rate for the population aged 15-64 years was around 64% in 2004 (Table 9). There is a notable gender difference in the activity rate, which was 57% for women and around 70% for men. The activity rate in Croatia is among the lowest when compared with the EU25 Member States, although the Candidate Counties (Bulgaria, Romania and Turkey) have even lower rates. The relatively low activity rate could be attributed to a number of factors; the traditional role of women in family life, the "discouraged worker" effect due to stagnant flows in the labour market, the relatively strong practice of early retirement in the 1990s, and the notable disability retirements after the war. Around 10% of the Croatian population reports invalidity in the 2001 Census, and around 1% reports disability caused by the war. The average age of pension recipients (including old-age, disability and family pensions) in Croatia is 66 years, meaning that there is a substantial number of pensioners aged under 65 (see chapter 3).

2. The employment rate for the population aged 15-64 was around 55% in 2004 (Table 9), while the same rate for older workers (55-64 years of age) was 30%. The average employment rate in the EU25 is 63%, and that for the New Member States is 56%. Again, employment rates for women are substantially lower than those for men, especially when it comes to older workers where the employment rate for women is 21% and for men 41%.

3. The unemployment rate in Croatia was 13.6% in 2004, which was, after Poland and Slovakia, the highest rate among Candidate or EU Member countries. Women are in a more disadvantageous position regarding unemployment incidence, with an unemployment rate of 15.6%. The long-term unemployment rate was 7.3%, meaning that nearly half of the unemployed are looking for a job for more than 12 months. This group of unemployed deserves special policy concern due to potential loss of their skills and lower employability if this situation is prolonged, and due to the high risk of their social exclusion.

4. The female share in total registered employment in Croatia was 45% in 2004, while the female share in registered unemployment is 58% (Statistical Yearbook 2005). The gender structure of employment is rather constant in the last ten years, but the share of women in unemployment has been continuously increasing, suggesting increased willingness of women to find a job and actively participate in the economic life of the community. However, employment flows did not match this new structure of labour supply.

5. The young unemployed are another disadvantaged group on the labour market. The unemployment rate for persons aged 15-24 years amounted to above 33% in 2004, meaning more than double the average. The unemployment ratio for the age group, when those in education are also considered, was 13%. Although participation indicators for Croatia reveal an unfavourable situation when compared to the majority of the EU countries, there is a rather clear tendency of improvements in the last several years; activity and employment rates have been rising, and the unemployment rate has been decreasing, albeit only slowly.

6. Rural unemployment is potentially an issue for the Croatian labour market because currently individual agriculture absorbs a disproportional part of the labour force. In 2004, around 16% of ILO employed persons were working in agriculture and the vast majority of them are individual farmers, while only 1/10 of the total are employees with work contracts. For comparison, manufacturing absorbs around 20% of total employment (Table 10). An even higher proportion of female employment is engaged in agriculture – 17.4%. It can be expected that part of this agricultural employment is in fact hidden unemployment, at least if judging from the GDP share of agriculture, which was around 7% in 2005.

1.1.4 Poverty and inequality indicators

1. The Central Bureau of Statistics regularly publishes figures on poverty and inequality that are prepared in accordance with the Eurostat recommendations for calculation of social indicators (Laeken indicators). This implies, among

others, that the main well-being indicator is income, with a relative concept of poverty and modified OECD scale used. In this way, the poverty rate (or at-risk-of-poverty rate) is estimated at 16.7% in 2004, with income in-kind included in total income definition (Table 11). The comparable rate for the EU25 is 15%, the same as for the new Member States (see chapter 3).

2. Women are more exposed to the risk of poverty. Some 18% of women used to live in households with equivalent income below the poverty line. For men this rate is around 15%. The higher poverty risk for women is connected mostly with the age structure of poverty. Namely, poverty among the elderly is disproportionately high, and the high female share in the older population results in a higher poverty risk for women.

3. Social transfers are an important mechanism for cushioning the poverty risk. If all social transfers except old age and disability pensions are exempted from income, then the resulting at-risk-of poverty rate is 33.7% in 2004. In other words, social transfers reduce the poverty rate from 33.7% to 16.7%, which is one of the strongest reduction rates in comparison to the EU or Candidate Countries. In that sense, social transfers in Croatia are rather effective (see also Šućur, 2005). If pensions are taken out of income, the poverty rate would be 41.4%. Reduction in poverty rate due to pensions is not so strong if compared with EU countries. This comes as a surprise having in mind the relatively high volume of pensions in Croatia. This means that pensions are rather unequally distributed (Nestić, 2005).

4. Certain changes in the face value of the main poverty indicators could be noticed in the period 2002-2004, although this period is surely too short for drawing any strong conclusion. At-risk-of-poverty rate for the total population and for males was slightly lower from year to year, while no clear tendency could be discerned for female poverty risk. In general, slow decline or no change scenarios are most likely to depict the recent poverty picture in Croatia. A part of the explanation could be found in the relative nature of these poverty indicators, in which poverty is rather strongly connected to inequality, where changes are mild over time. The other is that the Croatian HBS is not a longitudinal study, so estimates based on it are more suited to snapshot analyses of the current situation than for the study of changes over time.

5. The main inequality indicators published by the CBS are quintile share ratio (S80/S20) which was 4.5 in 2004, and the Gini coefficient with a value of 0.29.[1]

[1] The S80/S20 quintile share ratio is the ratio of total income received by the 20% of the population with the highest income (top quintile) to the total income received by the 20% of the population with the lowest income (lowest quintile). Gini coefficient is a summary measure of inequality in income distribution ranging from 0 to 1, where a value of 0 implies that all the population receives equal income, while a value of 1 implies that one person receives the whole income of the country. A higher value of the Gini coefficient points to a higher level of inequality in income distribution.

Both rates are a little above the EU25 average, but they are not extreme values. Again, no major changes can be discerned for the situation in the last four years for which data are available.

6. In addition to these "official" figures published by the CBS, one more set of findings regarding poverty is often cited in Croatia. The World Bank (2000) study estimated an absolute poverty rate of around 10% for the year 1998. This rate suggests that one tenth of the population cannot satisfy their basic non-food needs and provide themselves with a nutritionally adequate diet at the same time. A new study of the World Bank applying the same concept of poverty is expected to be published by the end of 2006.

1.2. Forecasts and projections

1.2.1. Economic forecasts

1. The mid-term economic forecasts presented in this section are our forecasts on expected economic development in the period 2006-2008, although exact figures are taken from the 2005 Pre-accession Economic Programme (2005 PEP) prepared by the Government, which seem quite realistic (Table 12). Closer comparison with forecasts made by independent analysts in their own publications (for example, the Croatian Economic Outlook Quarterly by the Institute of Economics, Zagreb, RBAnalysis by RBA bank, or the Macroeconomic Forecast by PBZ bank) shows no substantial difference in most segments, except a little more optimism expressed in the deficit and debt figures in the Government's forecasts.

2. The Croatian economy is expected to grow at a rate of around 4.2% in the period 2006-2008, maintaining thereby positive movements from the last several years. Favourable developments are based on the improved business climate caused by the perspective of EU membership, but also the effects of continued reforms needed to improve the functioning of economy. The expected recovery of the EU economy will help to strengthen positive tendencies in the domestic economy. Employment is expected to continue a stable growth at a rate of around 1.2%, while the unemployment rate is forecasted to decline from 12.8% in 2006 to 12% in 2008.

3. The projected stable-growth scenario will be accompanied by a slightly improved foreign trade balance. In 2005 PEP, the current account deficit is expected to shrink gradually to 3.8% in 2008, but our view is that a bit higher deficit (around 5%) is more likely due to relatively high capital inflows needed to maintain the rising investment cycle. The current account deficit will be

increasingly financed by FDI flows, which will also help to stabilise the foreign debt to GDP ratio at about 83-84%.

4. Consumer price inflation is expected to gradually slow down to below 3% in 2007 and 2008. Low inflation will be maintained by a stable exchange rate against the euro, increased competition on the domestic market and relatively weak wage cost pressures. Average wages are expected to grow at a rate of around 3% in real terms in 2006-2008, that is less than productivity growth expected for the same period. Upward pressures on inflation will come mostly from administratively regulated prices of energy, gas and other utilities. Price level convergence to EU levels will also take a part in positive inflation differential vis-à-vis the Euro-zone in spite of a stable nominal exchange rate expected in the period 2006-2008.

5. Fiscal consolidation is expected to continue in the next three years resulting in lower fiscal deficit and lower public debt, both expressed relative to GDP. Net borrowing will decline from 2.4% of GDP in 2006 to 1.9% of GDP in 2008, and public debt will fall by about 1 percentage point to 41.5% of GDP in 2008. Expressed in GFS 1986 accounting standards, the government deficit should fall from 4.2% in 2005 to below 2.8% of GDP in 2008 (2005 PEP). This deficit should be mostly financed through privatisation receipts and by borrowing on the domestic financial market, helping thereby to keep the country's external debt under control.

6. Social benefits absorb the largest share of total government expenditures in Croatia. In the next three years they are envisaged to shrink from 18.5% to 17.4% of GDP. In this scenario, the share of pension in GDP should be lowered due to low inflow of new pensioners and by applying the "Swiss" indexation formula for existing pensions (pension indexation by 50% on wage growth and 50% on inflation). The plan also envisages a drop of health expenditures to 5.3% of GDP, but this part of the 2005 PEP seems hard to reach. The Government also has an ambitious plan within the PAL programme with the World Bank to reduce cash social benefits to 3.5% of GDP by 2008, which should be reached by improved targeting (see chapter 4). Fiscal consolidation was seen by Government as a chance to match increased social benefit requirements with the fiscal sustainability.

1.2.2. Demographic and labour force projections

1. Demographic projections indicate that Croatia's population could fall by almost 1/5 by 2050 to some 3.7 million (Table 13). This is the figure given by the medium variant in demographic projections prepared by the United Nations

(2004). The very recent population projections prepared by the Croatian Central Bureau of Statistics (2006) shows similar projections of population changes in their medium variant incorporating the medium variant of migration flows. The UN projection coupled with labour force projections made by Svaljek (2005) seems appropriate for an illustration of major demographic trends in Croatia.[2]

2. The medium variant in population projection assumes that fertility rates increase gradually from 1.35 in 2005 to 1.85 in 2050. In spite of that, population growth is envisaged to be increasingly negative over time. Fertility rates are too low to ensure natural replacement of the population or to stabilise the age structure. The working age population (15-64 years of age) is projected to fall by almost 30% in the period 2005-2050 and its share in the total population to decline from 67% in 2005 to 57% in 2050. The number of elderly persons (aged 65 years or over) will rise by some 20%, so that the old age dependency ratio (defined as the ratio of the elderly to the working age population) is expected to rise from some 26% in 2005 to 50% in 2050. The implications of this need to be considered alongside the fact that almost the same ratio is projected for the EU population in 2050 (Economic Policy Committee, 2003).

3. UN population projections for Croatia assume net outward migration of about 0.1% of the population. However, a different scenario is also possible. Having in mind that Croatia is relatively well developed in comparison with other countries of South and Eastern Europe, and that it faces depopulation combined with an increased need for labour force of certain skills, one could imagine that Croatia will become an attractive destination for economic migrants from neighbouring countries. On the other hand, possible EU membership for Croatia leads to the possibility of outward migration to richer EU countries. Contrasting these two flows, Mrđen (2004) expects that Croatia will face net inward migration. In all variants, projected migration flows are small compared to projected natural changes that are rather dramatic.

4. Population changes will have substantial impact on labour force structure. Švaljek (2005) projects labour force participation rates to gradually increase from 68% in 2005 to 72% in 2050, where an increased participation rate is expected for older workers (55-64 years) and women. Employment rates are projected to grow even faster, from 60% in 2005 to 67% in 2050. In parallel, the unemployment rate is assumed to gradually fall to 7% by 2020 and to stay constant thereafter. This rate is chosen as to be equal to the structural unemployment rate of EU countries with the highest structural unemployment (Economic Policy Committee, 2003). Projections suggest that the Croatian economy will create increased demand for a workforce that will be satisfied by

[2] Labour force projections made by Svaljek(2005) are based on the UN demographic projections, so the consistency is the reason behind presenting here projections based on the UN, and not those based on the CBS which have just become available.

higher employment rates of the domestic population, but some margin will be open for employing immigrants too.

1.3. Influences of economic, demographic and social trends on the social protection system

1. The relatively favourable economic developments expected for the near future will help to facilitate the social inclusion process in Croatia. However, challenges are numerous and careful design of future steps in the process is needed. The most vulnerable groups could more easily have their demands met, and better targeting should ensure higher efficiency.

2. The labour market is slowly improving. In the long-run, the pressure of unemployment will be lower, but in the near future substantial resources should be used to improve the situation of those most disadvantaged in the labour market. Current poverty risk of the unemployed is twice as high as the average risk. Long-term unemployed, unemployed youth and people with disabilities deserve targeted policy measures. Equal opportunities for women and people regardless of their ethnic origin should be ensured. The policy mix for employment will probably have to change to a higher share for active labour market policy measures, especially education and training. Since paid employment ensures an escape from absolute poverty and exclusion in general, a functioning labour market is the most powerful mechanism for improving the material and social position of the population.

3. The strong demand for social protection due to war related problems is still highly present. Direct costs of rebuilding houses will be lower in the future, but the social inclusion process for people suffering consequences of war, especially disabled persons, returnees, refugees, and displaced persons will remain high on the policy agenda.

4. The ageing population will influence almost every aspect of social and economic life in the long run. However, the pension system, health and long-term care systems will be affected enormously. In Croatia, expenditures on public pensions could be even lowered mostly as a consequence of the recently conducted pension reform i.e. introduction of a three-pillar system (see chapter 5). Švaljek (2005) estimates expenditures on public pensions to drop below 7% of GDP by 2050. However, stronger reliance on private pensions could leave some groups in a vulnerable position. It can be expected that further adjustment of the pension system will be needed. The EU accession will probably influence further policy steps in this area.

5. Expenditures on health and long-term care will be strongly affected by the ageing population and they could expand sharply in the future. The balance

between private and public responsibility in this area still needs to be found (see chapter 6), in order to ensure decent health security for the population and financial stability of the public health system. The long term care system in Croatia is underdeveloped and future policy challenges are high.

References for Chapter 1

Central Bureau of Statistics, (2006), Projekcije stanovništva Republike Hrvatske 2004.-2051." (Projections of the Croatian population 2004-2051), Central Bureau of Statistics, Zagreb.

Economic Policy Committee, (2003), The impact of an ageing population on public finances: overview of analysis carried out at EU level and proposals for a future work programme EPS/ECFIN/435/03 final, Brussels, 22 October 2003.

Government of the Republic of Croatia, (2005), "2005 Pre-accession Economic Programme"

International Monetary Fund, (2005), "First Review Under the Stand-by Arrangement and Request for Waiver of Nonobservance of Performance Criteria and Rephasing of Purchases", European Department of IMF. (http://www.imf.org/external/pubs/cat/longres.cfm?sk=18588.0)

Ministry of Finance of the Republic of Croatia, (2006), "Annual Report of the Ministry of Finance 2004".

Mrđen, S. (2004), "Projekcije stanovništva Hrvatske do 2031. godine" (Projections of the Croatian population by 2031) in *Stanovništvo Hrvatske – dosadašnji razvoj i perspective*, Institut društvenih znanosti Ivo Pilar, Zagreb.

Šućur, Z., (2005), "Poverty and Social Transfers in Croatia", *Financial Theory and Practic*e 29(1), pp.17-38.

Švaljek S., (2005), Ekonomske posljedice demografskih promjena (Economic Consequences of Demographic Changes), paper presented at "XIII tradicionalno savjetovanje" in Opatija November 16-18, 2005.

United Nations, (2004), World Population Prospects: The 2004 Revison, Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat (http://esa.un.org/unpp).

World Bank (2000). *Croatia Economic Vulnerability and Welfare Study.* The World Bank: Washington, D.C.

Statistical Annex for Chapter 1

Table 1. Main economic indicators

	2001	2002	2003	2004	2005e
ECONOMIC ACTIVITY					
GDP at current prices (bn EUR)	22.2	24.5	26.2	28.4	30.9
GDP per capita (at current prices, in EUR)	4,988	5,505	5,906	6,397	6,972
GDP per capita at PPS (EU25=100)	41.8	43.6	45.1	45.9	46.9
GDP growth rate (at constant prices)	4.4	5.6	5.3	3.8	4.3
Employment growth	0.3	0.4	2.6	1.4	1.6
Unemployment rate (registered)	22.0	22.3	19.1	18.0	18.0
Unemployment rate (ILO comparable)	15.8	14.8	14.3	13.8	13.3
PRICES, WAGES AND EXCHANGE RATE					
Consumer price inflation (pa)	3.8	1.7	1.8	2.1	3.3
Average gross wage growth	3.9	6.0	4.8	6.4	4.4
Exchange rate (HRK/EUR, pa)	7.47	7.41	7.56	7.50	7.40
FOREIGN TRADE AND CAPITAL FLOWS					
Export of goods and services (% of GDP)	48.7	45.5	50.1	50.1	49.4
Imports of goods and services (% of GDP)	54.6	56.4	57.9	57.2	56.4
Current account balance (% of GDP)	-3.7	-8.6	-7.1	-5.1	-6.3
Foreign debt (% of GDP)	60.7	61.5	75.5	80.2	82.5
GENERAL GOVERNMENT FINANCE					
Revenues (% of GDP)	-	45.7	45.0	45.3	45.0
Expenditures (% of GDP)	-	44.9	44.0	44.3	43.9
Interest (% of GDP)	-	2.1	2.0	2.1	2.2
Net acquisition of nonfinancial assets (% of GDP)	-	4.0	4.9	4.9	3.9
Net lending/borrowing (% of GDP)	-	-3.1	-3.9	-3.9	-2.8
Overall government balance (% of GDP)	-6.7	-5.0	6.1	4.8	4.1
Public debt (% of GDP)	40.6	40.0	41.0	43.5	44.1

Notes: pa-period average. Government finances are, all except overall government balance, expressed according to Government Finance Statistics Manual 2001 (GFS 2001), as in all recent official documents. Overall government balance is taken as agreed in the Stand-by arrangement with the IMF modified accrual basis, GFS 1986). Public debt is without issued state guarantees.

Sources: Central Bureau of Statistics (Yearbook, various years, Eurostat (Structural indicators from the web site), Croatian National Bank (CNB Bulletin), Government of the Republic of Croatia (Annual Report of the Ministry of Finance, PEP), International Monetary Fund (First Review Under the Stand-by Arrangement) and authors' estimates.

Table 2. General government expenditures on social benefits

	2001	2002	2003	2004	2005e
SOCIAL BENEFITS (% of GDP)	-	19.9	19.3	19.3	18.5
Social security benefits (% of GDP)	-	10.8	15.4	13.7	-
Social assistance benefits (% of GDP)	-	9.0	3.6	5.4	-
Employees social benefits (% of GDP)	-	0.2	0.3	0.2	-

Notes: Government expenditures are expressed according to GFS 2001.
Source: Authors' calculations based on the Ministry of Finance data (Annual Report 2004 and Monthly Bulletin No 123)

Table 3 Population and GDP by counties, 2003

County	Population (in '000)	Population (% of total)	GDP p.c. (in EUR)*	GDP p.c. (HR=100%)	Total GDP (HR=100%)
Zagreb County	316	7.1%	4,385	74.2%	5.3%
Krapina-Zagorje	141	3.2%	4,287	72.6%	2.3%
Sisak-Moslavina	183	4.1%	4,549	77.0%	3.2%
Karlovac	139	3.1%	4,592	77.7%	2.4%
Varazdin	183	4.1%	5,564	94.2%	3.9%
Koprivnica-Krizevci	123	2.8%	5,661	95.8%	2.6%
Bjelovar-Bilogora	131	2.9%	4,414	74.7%	2.2%
Primorje-Gorski kotar	305	6.9%	6,977	118.1%	8.1%
Lika-Senj	53	1.2%	6,109	103.4%	1.2%
Virovitica-Podravina	92	2.1%	4,453	75.4%	1.5%
Pozega-Slavonia	85	1.9%	4,264	72.2%	1.4%
Slavonski Brod-Posavina	176	4.0%	3,398	57.5%	2.3%
Zadar	166	3.7%	4,734	80.1%	3.0%
Osijek-Baranja	329	7.4%	4,447	75.3%	5.6%
Sibenik-Knin	114	2.6%	4,115	69.7%	1.8%
Vukovar-Sirmium	203	4.6%	3,397	57.5%	2.6%
Split-Dalmatia	471	10.6%	4,446	75.3%	8.0%
Istria	209	4.7%	8,122	137.5%	6.5%
Dubrovnik-Neretva	124	2.8%	5,225	88.4%	2.5%
Medimurje	118	2.7%	4,736	80.2%	2.1%
City of Zagreb	780	17.6%	10,586	179.2%	31.5%

Note: * at current prices and current exchange rate.
Source: Central Bureau of Statistics (First Reports and CBS working tables).

Table 4. Demographic profile

	1981c	1991c	2001c	2002e	2003e	2004e
Population (in '000)	4,601	4,784	4,437	4,443	4,442	4,439
- men (in % of total)	48.4	48.5	48.1	48.1	48.1	48.1
- women (in % of total)	51.6	51.5	51.9	51.9	51.9	51.9
Birth rate (per 1000 inhabitants)	14.6	10.8	9.2	9.0	8.9	9.1
Mortality rate (per 1000 inhabitants)	11.2	11.5	11.2	11.4	11.8	11.2
Natural increase rate (per 1000 inhab.)	3.5	-0.6	-1.9	-2.4	-2.9	-2.1
Fertility rate	-	-	1.38	1.34	1.33	1.35
Average age of population (in years)				39.6	39.6	40.2
-man	33.8	35.4	37.5	37.8	37.8	38.4
-women	37.1	38.7	41.0	41.3	41.3	41.8
Population by age groups (% of total)						
0-14	21.1	19.7	17.1	-	-	-
15-64	67.4	68.5	67.2	-	-	-
65 and over	11.5	11.8	15.7	-	-	-
Old age dependency (ratio 65+ to 15-64)	17.0	17.2	23.3	-	-	-
Average household size	3.2	3.1	3.0	-	-	-
Households by size (% of total)						
single	16.0	17.8	20.8	-	-	-
2-4 members	65.2	66.2	63.5	-	-	-
5+ members	18.8	16.0	16.0	-	-	-
Life expectancy at birth (in years)				74.8	74.9	75.5
-men	66.6	68.6	71.1	71.2	71.4	72.0
-women	74.1	76.0	78.1	78.3	78.4	79.0

c- census data, e-mid-year estimates.
Source: Central Bureau of Statistics (Statistical Yearbook, Statistical Information, Monthly Statistical Report)

Table 5. International Migrations

	2001	2002	2003	2004
Immigrants to Croatia	24,415	20,365	18,455	18,383
-Bosnia and Herzegovina	15,188	11,869	10,869	11,141
-Serbia and Montenegro	2,140	1,854	1,440	1,550
-Germany	1,756	1,340	1,278	1,354
Emigrants from Croatia	7,488	11,767	6,534	6,812
-Bosnia and Herzegovina	1,300	2,011	1,794	1,247
-Serbia and Montenegro	589	401	885	1,877
-Germany	1,015	1,446	1,020	939
Saldo	16,927	8,598	11,921	11,571

Source: Central Bureau of Statistics (Statistical Yearbook).

Table 6 Immigrated population by time of migrations, as of March 31, 2001

	1981-1991	1991-2001
Immigrants to Croatia	65,882	232,966
-Bosnia and Herzegovina	45,262	189,039
-Serbia and Montenegro	10,690	27,117
-Slovenia	4,280	4,303
-Macedonia	1,921	1,523

Source: Central Bureau of Statistics (Statistical Yearbook).

Table 7 Population by ethnicity, census data

	1991	2001
Total population	4,784	4,437
Composition by ethnicity (in % of total)		
Croats	78.1%	89.6%
Serbs	12.2%	4.5%
Bosniacs	na	0.5%
Italians	0.4%	0.4%
Hungarians	0.5%	0.4%
Albanians	0.2%	0.3%
Slovenes	0.5%	0.3%
Czechs	0.3%	0.2%
Roma	0.1%	0.2%
Austrians, Bulgarians, Jews, Montenegrans, Macedonians, Germans, Poles, Romanians, Russians, Ruthenians, Slovaks, Turks, and Ukrainians	0.7%	0.7%
Others	3.2%	0.5%
o/w Yugoslavs	2.2%	na
o/w Muslims	0.9%	na
Ethnically uncommitted	2.5%	2.0%
Unknown	1.3%	0.4%

Source: Central Bureau of Statistics (Statistical Yearbook)

Table 8 Population by religion, census data

	1991	2001
Catholic Church	76.6%	87.8%
Orthodox Church	11.1%	4.4%
Islamic Religious Community	1.1%	1.3%
Greek Catholic Church	0.3%	0.1%
Jehovah's Witnesses	0.1%	0.1%
Evangelic Church	0.1%	0.1%
Adventist Church	0.1%	0.1%
Other religions and uncommitted	4.9%	3.3%
Non-believers	3.9%	2.2%
Unknown	1.8%	0.6%

Table 9. Labour market indicators

	2002	2003	2004
Activity rate (15-64 years)	62.9	62.4	63.7
-women	56.2	55.6	57.1
-men	69.9	69.5	70.5
Employment rate (15-64 years)	53.4	53.4	54.7
-women	46.7	46.7	47.8
-men	60.5	60.3	61.8
Employment rate of older workers (55-64 years)	24.8	28.4	30.1
-women	16.9	20.3	21.0
-men	34.2	38.1	40.9
Unemployment rate (in % of act. pop.)	14.7	14.1	13.6
-women	16.5	15.6	15.6
-men	13.2	12.8	12.0
Long-term unemployment rate (in % of act. pop.)	8.9	8.4	7.3
-women	10.7	9.5	8.9
-men	7.4	7.4	6.0

Source: Central Bureau of Statistics (Statistical Reports -Labour Force Survey Results) and Eurostat webpage.

Table 10. Composition of employment by sector (NACE), 2004

	Total	Female	Male
Agriculture (A-B)	16.4%	17.4%	14.7%
Industry (C-F)	29.8%	18.6%	36.8%
o/w Manufacturing (D)	19.3%	16.0%	20.7%
Services (G-Q)	53.8%	64.0%	43.0%
Total (A-Q)	100.0%	100.0%	100.0%

Source: Authors' calculations based on the Central Bureau of Statistics (Labour Force Survey Results: Croatia , 2004 – Europe, 2004)

Table 11. Poverty and inequality

	2001	2002	2003	2004
POVERTY				
At-risk-of-poverty rate	17.2	18.2	16.9	16.7
-women	18.7	18.6	17.9	18.1
-men	15.4	17.7	15.8	15.1
At-risk-of poverty rate before social transfers				
-income excl. all social transfers	34.7	33.7	33.3	33.7
-income incl. pensions and excl. other transfers	42.9	40.0	42.3	41.4
INEQUALITY				
Quintile share ratio (S80/S20)	4.3	4.5	4.4	4.5
Gini coefficient	0.28	0.29	0.29	0.29

Note: At risk of poverty rate is defined as percentage of population with an equivalised disposable income below 60% of the median. Income in-kind is included in total income definition.
Source: Central Bureau of Statistics (Statistical Yearbook 2004, and 2005).

Table 12. Macroeconomic forecasts

	2006	2007	2008
ECONOMIC ACTIVITY			
GDP growth rate (at constant prices)	4.0	4.1	4.3
Employment growth	1.4	1.2	1.2
Unemployment rate (ILO comparable)	12.8	12.4	12.0
INFLATION, WAGES AND EXCHANGE RATE			
Consumer price inflation (pa)	3.2	2.8	2.6
Average real wage growth	2.5	2.9	3.0
Exchange rate (HRK/EUR, pa)	7.45	7.45	7.45
FOREIGN TRADE AND CAPITAL FLOWS			
Current account balance (in % of GDP)	-5.3	-4.5	-3.8
Foreign debt (in % of GDP)	83.1	83.2	83.4
GENERAL GOVERNMENT FINANCE			
Net lending/borrowing (in % of GDP)	-2.4	-2.2	-1.9
Expenditures on social benefits (in % of GDP)	18.5	18.0	17.4
Public debt (in % of GDP)	42.7	42.1	41.5

Source: The Government of the Republic of Croatia (2005 Pre-accession Economic Programme).

Table 13. Population and labour force participation projections

	2005	2010	2020	2030	2040	2050
TOTAL POPULATION						
Population (in '000)	4551	4532	4367	4164	3926	3686
Population growth (%, average per year)	-	-0.08	-0.37	-0.47	-0.59	-0.63
Fertility rate	1.35	1.35	1.49	1.63	1.77	1.85
WORKING AGE POPULATION						
Working age population (15-64)	3060	3088	2857	2583	2364	2102
Working age/ total population (in %)	67.3	68.2	65.4	62.0	60.2	57.1
Old age dependency (ratio 65+ to 15-64)	25.6	25.5	31.5	38.8	43.3	50.0
ACTIVE POPULATION						
Participation rate (active/working age pop.)	68.1	69.0	71.8	72.3	71.5	72.0
Employment rate (empl./working age pop.)	59.3	61.4	66.8	67.3	66.5	67.0
Unemployment rate (unemployed/active)	14.0	11.0	7.0	7.0	7.0	7.0

Notes: Population projections are taken as medium variant projections from UN (2004). Projections of active population are based on census data and are not strictly comparable with data that are based on Labour Force Surveys.

Sources: UN World Population Prospects: The 2004 Revision (http://esa.un.org/unpp) and Švaljek (2005) for active population projections.

Chapter 2: Social Inclusion and Social Protection – fiscal and institutional structures and strategic directions

2.1 Overview of the system

2.1.1 Historical perspectives

1. Looking at social protection and social inclusion historically is important not least because, even in periods of rapid social change and so-called transition, cultural legacies and memories, sometimes enshrined institutionally but always relevant in terms of everyday encounters within the system, continue to have an impact on policies, practices, procedures and outcomes. As noted on a number of occasions in this report, Croatia's position within the Austro-Hungarian empire until 1918 is important for subsequent social protection. The first social laws at the end of the 19th century followed a Bismarckian social insurance model (Puljiz, 2005), although covering only a small number of privileged workers. In the Kingdom of Serbs, Croats and Slovenes (from 1918-1929) and in the first Yugoslavia (1929-1941), the first Law on Social Insurance was passed in 1922, but not applied in practice until the late 1930s (Rismondo, 2003).

2. Health care reforms began even earlier, with the territory of today's Croatia passing laws from 1874 in order to ensure the same level of public health care as had been initiated in other parts of the Austro-Hungarian empire (Belicza and Szabo, 2000). As early as 1926, the "Andrija Štampar" School of Public Health was founded in Zagreb under the initiative of a group of public health workers. In the first years of its functioning the School was integrated with the Institute of Hygiene into one institution which directed the work of health institutions. The School was the top element of a public health and hygiene service entrusted with the task to study conditions which might have favourable or unfavourable impacts on people's health. In 1947, after World War II, the School became an independent institution of the Medical School, University of Zagreb, taking over teaching for medical students in preventive subjects.

3. In socialist Yugoslavia from 1945 to 1990, a number of distinct phases can be discerned which are relevant in terms of the development of social policy. In the first phase, legislation was introduced with clear socialist characteristics based on the social ownership of production. As Puljiz points out (Puljiz, 2005), at the time a kind of dual social structure was created, with those employed in the socialist sector having a privileged status and work-based benefits, whereas those in the private sector, particularly small farmers, were excluded from benefits and left to traditional mechanisms of family and neighbour solidarity. This, itself, contributed to a massive urbanisation, encouraged by the state, with young people leaving the countryside and agricultural work for the new socialist production in the emerging towns and cities. Alongside this, however, went major initiatives in

terms of literacy and preventive public health. Health services of a universal, Beveridge-type character, were introduced in the same period.

4. The later phase of so-called 'self-management socialism' is important for a number of reasons. Firstly, unlike in communist societies within the Soviet bloc, there was a recognition that socialism did not, always, solve all social problems. Rather, professional social work, in terms of the opening of a High School for Social Workers in Zagreb, began in 1952, although there are roots in the work of women's organisations in the 1920s and 1930s (Prlenda, 2005). From 1957, a two year programme was introduced and, in the context of the founding of Centres for Social Work, a four year programme of university education for social workers began in 1972. The programme has been based in the Law Faculty of the University of Zagreb since 1983. Secondly, the system exhibited a high degree of decentralisation and, although dominated by state provision, there was non-governmental activity by the Church and by the Red Cross. Radical change was consolidated in 1974 with a new law on Social Protection which abolished Republic-based funds for social protection and introduced local self-managed communities of interest (SIZ) (cf Šućur, 2003).

5. Both Šućur (2003) and Puljiz (2005) point to the economic crises of the 1980s as placing a particular strain on social protection services. A new Law on Social Protection was passed in 1983 which placed almost all responsibilities on the municipal level, with the Republic responsible only for resocialisation of juvenile delinquents and institutional adaptation. Centres for Social Work were thus part of the municipal structure. The law introduced, for the first time, social assistance based on an equivalence scale. Social assistance was reserved for those incapable of work and was set at a minimum of 30% of the average worker's pay (42% for a two-person household; 54% for three; 66% for four persons) (Šućur, 2003). In the context of economic crisis, these payments were inconsistent and often late. In 1988, a crisis Social Security programme was introduced based on a concept of a 'social minimum' encompassing eleven rights and forms of assistance from six different systems: employment; pension and disability insurance; pre-school facilities; housing; social assistance and social services; and utilities. In 1990, the possibility of those fit for work receiving social assistance was introduced.

2.1.2 Social Protection Post Independence

1. The post-independence period is covered in more detail in chapter 4. The basic law from 1983 was amended in 1991 (NN 19/1991), mainly in terms of clarifications regarding entitlements and definitions. In the context of war, an emergency Social Programme was introduced in 1993. Introduced as a crisis programme, it gave more discretion to social workers and introduced new additional benefit categories. It introduced, for the first time, 'social cards' which identified social assistance beneficiaries and which were used to access

humanitarian aid. In 1993 5.4% of the Croatian population had such cards, ranging in different places from 1.2% to 17.7% (Šućur, 2003; 14).

2. As noted in chapter 4, the crucial document in the modernisation of the social protection system was the 1997 Social Welfare Act which came into force at the beginning of 1998. It was meant to be the beginning of decentralisation of social welfare based on the principle of subsidiarity and, in this sense, marked an important change of direction from the centralisation of the early 1990s. Amendments to the Law in 2001 were more concerned with the governance structures of CSWs, but also sought to further promote decentralisation.

2.1.3 Local and Regional Governance and Decentralisation

1. In a series of Laws passed from 1990 to 1992, Croatia actually developed a much more centralised form of government, whilst allowing the number of municipalities to increase considerably. These Laws introduced a three tier system of government, national, regional (20 counties and the City of Zagreb), and local towns/cities and municipalities. It was three tier because, essentially, there were no differences between towns and municipalities. The number of cities and municipalities continues to increase. Currently there are 123 cities and 426 municipalities. Some 70% of the Croatian population live in the towns and cities. Over half of all municipalities have a population of 3,000 or less, and, indeed almost half the towns/cities have 10,000 inhabitants or less (Jurlina-Alibegović and Šišinački, 2004; 624).

2. The actual allocation of responsibilities between the different tiers is complex and contested. Table 1 shows the most reliable estimate of the division across different sectors, following the partial decentralisation measures of 2001, as signalled by the new Law on Local and Regional Self-Government which entered into force in July 2001. In some ways the table overstates the role of smaller units of local self-government in matters relating to social protection and health. In reality, the system remains quite centralised. In addition, the devolution of some responsibilities to the county (regional) level is not without problems. The boundaries of Counties were established according to administrative convenience and, to an extent, political expediency, rather than according to any natural or historical boundaries of Croatia regions (Perko Šeparović, 2001). As such, they serve to diminish the influence of some of the larger towns and cities over the rural areas. The counties vary also greatly both in terms of area covered and size of population.

3. The new Government elected in the year 2000 made decentralisation a key priority. As part of the 'Strategy for Croatia in the 21st century' it commissioned a project from the Croatian Legal Centre 'Decentralisation of Public Administration' consisting of 10 inter-connected studies, including decentralisation of elementary and high school education, health care, and social services (Perko Šeparović,

2001). Whilst the project was formally completed, very little was implemented, and the new Government elected in 2003 was much less pre-disposed to wholesale decentralisation, mentioning only decentralisation of culture in its initial programme priorities, although public administration reform per se was a major priority.

4. The problem of politicisation remains highly pronounced at local and regional levels (Vidačak, 2004), with the need to ensure a more clear-cut distinction between political appointees and professional local civil servants remaining a problem. It is not clear what impact proposals for the direct election of mayors and County prefects will have on this, since it could encourage choice based on abilities but also lead to a crude mixture of politicking and cult of personality. More constructive is the establishment of a Central State office for Administration, which still needs to become fully operational (Vidačak, 2004) Within the agenda of European integration, a strengthening of public administration at al levels is called for.

2.2 Financing of Social Inclusion

2.2.1 Sources of Finance and Patterns of Expenditure

1. The latest figures on government revenues and expenditures show that revenue growth has reached 10.1% year on year in the first month of 2006, driven by tax revenues, which grew by 10.6% y/y. The largest growth was reported in VAT collection, where revenues were up by 12.1% y/y. Expenditures have fallen by 2.5% year on year, which indicates tight fiscal policy. The overall consolidated central budget deficit now stands at 709 mn. HRK or 0.4% of GDP. Social expenditures increased by 3.4% whilst the wage bill rose 6.8%. In 2005, the public sector deficit was 4.2% of GDP, compared to a target of 3.7% of GDP. The overall target is 3.3% of GDP. (See Table 2 below).

2. The OECD and other international agencies have suggested that, despite improvements, the public expenditure management system in Croatia has a number of deficiencies. In its June 2005 report the OECD noted twelve mid-term objectives, including earlier submission of the state budget to Parliament; legal requirement of date for submission of statement of accounts to state audit office; earlier start for budget process in MoF; the integration of some extra-budgetary operations into the state budget; and better co-ordination of external assistance projects to ensure full reporting.

3. As noted throughout this report, the extent of social expenditures in Croatia is the subject of debate and diverse interpretations. A recent ILO text (ILO, 2005) compares Croatia with other countries in South Eastern Europe, although the Croatian figures date from 2001, as reported in the 2004 IMF financial yearbook.

This showed Croatia as committing 30.7% of GDP to social expenditure (7.2% health; 19.3% other social protection; and 4.2% education) (ILO, 2005; 19). More up-to-date figures are given in Chapter 1. In any case, this is the highest in the region and considerably above Romania (20.1%) and Bulgaria (21.5%). Croatia has the highest proportion of non-health social security programmes in total social expenditures (64%). Importantly, 59% of non-contributory social expenditures are means tested, the highest in the region, although this figure refers only to central government.

2.2.2 Fiscal Administration and Fiscal Decentralisation

1. Within the context of problems of decentralisation noted above, the financing of local and regional self-government also needs to be addressed. It has been estimated that almost one third of local government units have fiscal capacities that do not enable them to cover even their basic expenses (Vidačak, 2004). Most programmes are, therefore, still financed from central budgets, although there is greater autonomy in the field of pre-school education (Bajo and Bronić, 2005). Local and regional authorities raise revenues in a number of ways: from their own sources; joint taxes; grants from state and county budgets; equalisation subsidies; and joint revenues (Jurlina-Alibegović and Šišinački, 2004). Local government has limited discretion in terms of the determination of base and rates of tax revenue, with most taxes determined by central government or with restriction on discretion, the only exception being the municipal tax on public land (Bajo and Bronič, 2005).

2. After the 2001 reform, all local government units are permitted to introduce a surtax on income tax to a maximum of 10% for municipalities, 12% for towns with up to 30,000 citizens; 15% for those with more than 30,000 citizens; and up to 30% for the city of Zagreb. In the two years following the law 61 cities and 159 municipalities had introduced a surtax (Bajo and Bronić, 2005, Tax Administration statistics 2005). In addition, tax sharing was changed so that central government retained less than half of that which it used to retain of income tax (from 60% up to 2001 to 24.6% in 2003). 21% of income tax went to a newly established Equalisation Fund to support local government units that took on the financing of decentralised functions but are unable to finance them from tax revenues alone (Bajo and Bronić, 2005).

3. In terms of expenditures, local and regional governments accounted for some 15.2% of all government expenditures in 2003, an increase from 11.8% in 2000, or an increase from 6.4% to 7.5% of GDP. This remains low by European standards. Of total expenditures health care accounted for only 562 m. HRK in 2003 (3.9% of the total), and welfare some 671 m. HRK (4.6%) (Bajo and Bronić, 2005).

4. The extent of regional inequalities is a recurrent theme throughout this report. There are significant methodological problems still to be overcome in the calculation of regional GDP, although CBS figures are noted in Chapter 1. Bajo and Bronić (2005, 14) have attempted to combine GDP figures and subsidies for all counties plus the city of Zagreb (Figure 1 below). This shows 9 counties receiving subsidies whose GDP was above average. Excluding Zagreb, average GDP per capita was 30,000 HRK.

2.3 Strategic Direction and Stakeholder Analysis

2.3.1 Development Strategies and Social Inclusion

1. In the Human Development Report 2001 for Croatia, it was noted that "In the second half of the 1990s … an inclination (some would call it a fascination) with strategies became prominent (such that) Croatia was teeming with decisions and intentions about drafting strategies" (UNDP, 2002; 49). In many ways, the coalition government elected in December 2000, and the new Government elected in November 2003, both continued this process. In the reorganisation of Government following the last election, an increased role was given to the Central State Office for Development Strategy first established in 1993 (NN 75/93), now headed by a State Secretary and given the pivotal role in outlining and co-ordinating development strategy (NN11/04). The head of the office now also has the role of co-ordinator in terms of the European Union's Lisbon process (Samardžija, 2006).

2. At the time of writing (mid-May 2006), a new strategic development document, the Strategic Development Framework for 2006-2013 is entering into a consultation procedure. The document, in part at least, seeks to adjust Croatia's broad development goals to the Lisbon agenda, incorporating a number of existing strategy documents. As Samrdžija notes, however, the text "does not cover all the areas that are on the refined Lisbon agenda", and she points to "an urgent need to develop action programmes for specific areas (measures, deadlines, responsibilities) in order to get closer and implement specific Lisbon strategy goals during the process of accession" (ibid; 1).

3. Crucially, the latest draft of the document includes 'Social cohesion and social justice' as one of the ten key elements of achieving a modern competitive economy incorporating a European social model, although the three dimensions which are seen as most problematic in this regard in Croatia are the business climate; privatisation and restructuring; and a new role for the state. In the chapter on Social Cohesion and Social Justice, six main goals are stated:
i. to increase the proportion of income received by the poorest 10% of the population and to reduce the proportion of the population at risk of poverty

ii. to increase the efficiency of the system of social transfers
iii. to promote social dialogue and resolution of conflicts by agreement
iv. to pay special attention to child protection and child development
v. to promote all forms of creative and recreational activities, and
vi. to promote policies of corporate social responsibility.
Among the instruments and actions are the importance of clear statistical data, agreement on what poverty is and, interestingly, the importance of maintaining the social dimensions of health care in the context of health reform. Whilst the actions remain vague and are not connected to other developments, including the JIM and NAP/Incl process, this emphasis on social cohesion and social justice in such a document may lead to a greater emphasis on such issues in the future (Central State Office for Development Strategy, 2006).

4. In addition, a draft National Strategy for Regional Development has just been completed under a CARDS 2002 project, implemented by ECORYS from October 2003 to January 2006, in collaboration with the Ministry of the Sea, Tourism, Transport and Development (MSTTD) (see web page: http://www.mmtpr.hr/UserDocsImages/CARDS_2002%20(D)/intro_en.html), providing technical assistance to the development of a regional development strategy in line with EU principles and practice in regional and cohesion policy. The draft summary report (ECORYS, 2005) points to large and widening socio-economic disparities between the counties noting five, not necessarily mutually exclusive, areas with significant development needs: the war-affected areas; traditional industrial areas; hilly and mountainous areas; the islands; and border areas. The report suggests a number of remedial actions based on the premise that existing support to disadvantaged areas has been too small and poorly co-ordinated.

5. The Vision Statement of the strategy includes the pledge to reduce significantly "the gap in internal income and living standards between all counties, wider regions and social groups across the country" by 2013 (ECORYS, 2005). Whilst most of the focus is on broad capacity building, institutional strengthening and multi-stakeholder partnerships, the proposal to establish a Programme for the Development of Disadvantaged Areas (PDDA) is of particular interest. It envisages an integrated Government plan for these areas (under the leadership of the MSTTD), a unified definition of disadvantaged areas, to retain that status for 7 years, and an integrated focus on economic, human capital and infrastructural components. Whilst one of the 'human capital' components is 'tackling poverty and social exclusion' no details are provided, nor are there links to existing strategies which also have this as part of their objectives.

6. Until the completion of the Joint Inclusion Memorandum, the main strategic document which addressed social exclusion and social inclusion in an holistic way was the Programme to Combat Poverty and Social Exclusion. This is referred to

in both chapters 3 and 4 below but, here, it is important to seek to trace something of its history, content and (lack of) implementation. The programme was drawn up by an expert group in the first half of 2001 under the aegis of the (then) Ministry of Labour and Social Welfare. It was edited by a leading academic researcher on poverty and social exclusion, presented to a public meeting held in Varaždinska toplice on 7-8 June 2001, and most of it, except for conceptual and statistical parts based on texts previously published, was published in the Croatian Journal of Social Policy the same month (MLSW, 2001). It suggested measures in the fields of Employment; Health; Education; Social Housing; Family Policy; Areas of Special Interest; and Social Assistance and Welfare, and included a note on monitoring. As noted in chapters 3 and 4 below, the document was amended but never formally adopted by the Government. To all intents and purposes, since 2004 it has not been an active document, so that it is extremely surprising to see it mentioned as part of the Government's programme for Integration into the EU in 2005.

7. A number of other strategic documents are relevant in terms of promoting social inclusion, although their origins are all different and there is little or no co-ordination or cross-referencing between them. Here we set out some of the most relevant in broad terms.

i.
Document: National strategy for a unified policy for people with disabilities 2002-2006
Drafted/Adopted: 2002/2003
Reference: NN 13/2003, full text in Croatian language on web: http://hidra.srce.hr/arhiva/18/5093/nacional_strateg_za_osobe_s_invaliditetom_2002-2006.pdf
Responsible body: Formerly State Institute for the Protection of the Family, Maternity and Youth, now Ministry of Family, Veterans and Inter-generational Solidarity.
Main Aspects: Includes sections on health, education, employment and professional rehabilitation, mobility, pension insurance, social assistance and welfare, and co-ordination. Established a Governmental Commission which, in 2005, had a range of tasks including monitoring of the strategy (web: http://www.mobms.hr/download.asp?f=dokumenti/Razno/POSI-programradaza2005-konacnaverzija.doc).
Status: Under evaluation, although most measures related to actions in 2003 and 2004.
Comments: 18 page document, meant to be a catalyst for a range of Ministries to develop action plans but many commitments vague. Some local authorities (e.g. Zagreb, Križevci) produced their own action plans with clearer goals and responsibilities outlined. Status of future strategy document not known.

ii.
Document: The National Programme of Action for Youth
Drafted/Adopted: 2002
Responsible Body: Originally State Institute for the Protection of the Family, Maternity and Youth, now Ministry of Family, Veterans and Inter-generational solidarity.
Reference. English language version available on web: http://hidra.srce.hr/arhiva/18/5093/National_Programme_of_Action_for_Youth.pdf
Main aspects: Situation analysis, goals and work plan focus on: Education; Employment; Social Policies; Health and reproductive health; Youth Participation; Civil Society; Youth Culture and Free time; and Mobility, Information and Counselling.
Status: Still current
Comments: One of the more comprehensive strategic documents, with an inclusive focus combined with concern with particular marginalised groups of young people (Roma and other minorities; young people with disabilities; young people in care). Strategy was developed and has been reviewed with full participation of young people. However, whilst all of the 110 recommendations had a named key implementer, many were vague with no clear time scales or benchmarks.

iii.
Document: The National Programme for Roma and the Draft Roma Decade Action Plan 2005-2015
Drafted/Adopted: Respectively, October 2003 (adopted version) and September 2004 (not yet formally adopted)
Responsible Body: Office for National Minorities
Reference: former is available in Croatian language at web: http://hidra.srce.hr/arhiva/10/512/www.vlada.hr/Download/2003/10/16/069-03.pdf. Latter is available in English at: http://www.romadecade.org/en/download.php?action=20&id=2
Status: both are current although the latter has incorporated much of the former.
Main aspects: Former is concerned with political participation, preserving cultural traditions, legal status and discrimination, education, health, employment, social welfare, family and youth, spatial planning and monitoring. Latter focuses on education, employment, health and housing.
Comments: Former is a more comprehensive document and attempts costings. Latter is more selective but very uneven, not least in terms of the elaboration of indicators. Both have a clear focus on social inclusion. Very low proportion of funding required in the former has actually been realised. There are also doubts and concerns regarding participation of Roma, follow-up, and the gender dimension (cf. Papa, 2006; Bogdanić, 2005).

iv.
Document: National Family Policy
Drafted/adopted: 2002/2003 as part of the previous Government's programme.
Responsible body: State Institute for the Protection of the Family, Maternity and Youth.
Reference: Croatian language version is available on the web at: http://hidra.srce.hr/arhiva/18/5093/NOP.pdf
Main aspects: Provides a general overview regarding the measures of family policy and sets a number of priorities in Croatian family policy including demographic policy, family services, labour market policies, health protection, financial support, and affirmation of successful parenting.
Comments: A serious attempt to develop an holistic family policy, with some focus on vulnerable groups. Little follow up.

8. A number of other documents, including the National Employment Action Plan (discussed in chapter 3), a Strategy for Adult Education, a recently developed National Plan of Action for Children's Rights and Interests 2006-2012, and an earlier National Strategy for Protection Against Family Violence 2005-2007 are all pertinent in terms of social exclusion, but are difficult to obtain. It s also worthy of note that the strategic document which is most often referred to in public, and which is on the web page of the Government, is that of the National Competitiveness Council and the 55 recommendations to strengthen Croatian competitiveness, which is almost completely silent on issues of social exclusion (web: http://www.vlada.hr/Download/2004/04/13/55_preporuka.pdf).

2.3.2 Stakeholders in combating social exclusion

1. A thorough stakeholder analysis in terms of the role of different groups and institutions in combating social exclusion in Croatia is beyond the scope of this text. However, given the importance in the JIM and subsequent NAP/Incl. process of the development of strategies based on a broad partnership involving the national, regional and local authorities, the social partners and all stakeholders, it is important to attempt to map key stakeholders, at least in broad terms here.

2. In part, of course, an implicit or, perhaps explicit, stakeholder analysis was undertaken in order to plan the consultation exercises regarding Croatia's JIM, two of which have already been held (on 20 September 2005 and 14 March 2006). In the programme for the latter, 32 stakeholders were noted. The first eight were Government Ministries (Health and Social Welfare; Finance; Economy, Labour and Entrepreneurship; Foreign Affairs and European Integration; Family, veterans and Inter-generational Solidarity; Science, Education and Sport; Sea, Tourism, Transport and Development – Office for Displaced persons and Refugees; and Environment). The next three were Government Institutes or

Bureaux (for Statistics; for Employment; and for Pension Insurance). Another four were Government Offices (for National Minorities; for Gender Equality; for NGO Co-operation; and for Human Rights). Five were academic institutions (the School of Social Work; the Special Education Faculty; the Institute of Economics; the 'Ivo Pilar' Institute for Social Research; and the Institute for Public Finance). Others were as follows: Representatives of social welfare institutions (Centres for Social Welfare; Children's Homes; Old People's Homes; Educational Centres, …); The Council for Civil Society; The Economic and Social Councils; The Croatian Employers Association; Trades Union representatives; Non- Governmental Organisations; UNDP, UNICEF, the World Bank, and the European Commission delegation in Croatia; The Croatian Mission to the EU; and Croatian Cities (Zagreb, Varaždin, Vukovar, Knin, Split, Gospić, Čakovec, Pula, Korčula, Mali Lošinj).

3. In reality, this understates the involvement of Civil Society Organisations who have been present in both of the consultative meetings, although perhaps not sufficiently represented. In broad terms, CSOs consulted can be divided into the following:
a. Identity-based organisations of excluded persons, such as disability organisations (individual groups and coalitions); minority groups; etc
b. Faith-based and/or charitable humanitarian organisations
c. Professionally-led service providing organisations
d. Advocacy-based groups.

4. Overall, the following points can be made in terms of the range of stakeholders and their role in the process thus far:
i. There has been little input directly by excluded groups and their organisations. In particular, there has been limited direct input by poor people and those who are unemployed, reflecting their relative invisibility in society.
ii. Young people's voices, and those of older people and their organisations, have also not been sufficiently present in the process.
iii. The private sector, particularly the emerging private care sector, has been under-represented in each consultative meetings.
iv. There has been something of a weighting towards urban areas, and a consequent under-representation of rural areas.
v. Whilst professional voices have been heard, the professional associations (e.g. social workers) have not themselves been consulted in their own right.

5. In an earlier text, one of the authors of this report noted a more general concern regarding social policy making in Croatia:
"In fulfilling many of its international obligations on questions of social policy …, Croatia tends to be minimalist in terms of producing reports which resemble internal governmental or expert documents, rarely conceived as a part of a wider process of awareness raising and of consultation with stakeholders. (Stubbs and

Zrinščak, 2005). This continues to be a concern in the context of strategic capacity and the possibility of effective multi-stakeholder consultation and ownership, although at the time of writing (May 2006) it appears that there will be efforts made, through the auspices of UNDP office in Croatia, to consult more widely regarding the JIM amongst CSOs.

References for Chapter 2

Bajo, A. and Bronić, M. (2005) Fiscal Decentralisation in Croatia. Occasional Paper 25. Zagreb: IJF.

Belicza, B. and Szabo, A. (2000) Public Health Reform and the Development of Health Services in Đakovo district 1820-1899, in Croatian Medical Journal 41 (1); 81-95.

Bogdanić, A. (2005) 'The Croatian national programme for the Roma: an example of gender inequality', in Eu.map, August. Web: http://www.soros.org/initiatives/roma/articles_publications/publications/overcomingtwo_20050916/bogdanic_2005.pdf

Central State Office for Development Strategy (2006) Republic of Croatia, Strategic Development Framework 2006-13. Draft.

ECORYS et al (2005) Staregy and Capaicty Building for regional development (draft). Zagreb: MSTTD.
web: http://www.mmtpr.hr/UserDocsImages/CARDS_2002%20(D)/summary.pdf

ILO (2005) Social Security Spending in South-Eastern Europe: a comparative review. ILO: Budapest.

Jurlina-Alibegović, D. and Šišinački, J. (2004) Intergovernmental Fiscal Relations and Decentralisation Process in Croatia. In Teodorović, I. et al (eds.) Croatia on the road to the European Union. EIZ; Zagreb; 620-41.

MLSW (Ministry of Labour and Social Welfare) (2001) The Programme of Combatting Poverty and Exclusion in Croatia (Croatian language text), in Revija za socijalnu politiku 8 (2); 181-93.

Papa, J. (2006) 'Discrimination – a mechanism of social exclusion' in UNDP Poverty, Unemployment and Social Exclusion. Zagreb: UNDP.

Perko Šeparović, I. (2001) The Croatian Public Administration Reform and the Decentralisation Perspectives. Zagreb: World Bank.

Prlenda, S. (2005) 'Women and the First Organized Forms of Social Work in Croatia' (Croatian language text), in Revija za socijalnu politiku 12 (3); 319-332.

Puljiz, V. (2005) Croatia: searching for a new social model, in Kuhnle, S. (ed.) Social Policy Development in South Eastern Europe. Bergen: Stein Rokkan Centre for Social Studies.

Rismondo, M (ed.) (2003) 80 Years of Pension Insurance in Croatia (Croatian language text). Zagreb: HZZO.

Samardžija, V. (2006) 'Croatia and the Lisbon Strategy: convergence towards goals?', Paper presented to conference 'Reforms in Lisbon Strategy Implementation: economic and social dimensions', Zagreb: 3 May.

Stubbs, P. and Zrinščak. S. (2005)

Šućur, Z. (2003) The Development of Social Assistance and Social Care in Croatia After World War II (Croatian language text), in Revija za socijalnu politiku 10 (1); 1-22.

Vidačak, I. (2004) Croatia: in search of a public administration reform strategy, in Reforming Local Public Administration, Proceedings of Sofia Regional Workshop, Friedrich Ebert Stiftung.

Statistical annex for Chapter 2

TABLE 1 Distribution of Functions According to Levels of Government (Bajo and Bronić, 2005)

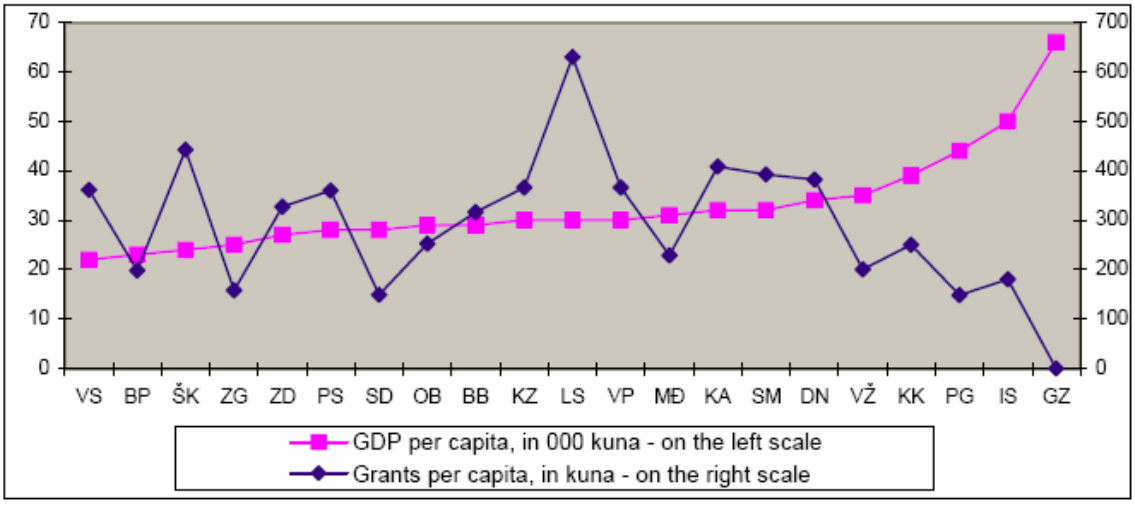
		Central Govt	Regional Govt (Counties)	Towns/Cities	Municipalities
1.	General public services	X	X	X	X
2.	Defence	X			
3.	Public order	X		X	X
4.	Education	X	X	X	X
4.1	Pre-School			X	X
4.2	Elementary	X	X	X	X
4.3	Secondary	X	X		
4.4	Tertiary	X			
5.	Health Care	X	X		
6.	Social Welfare	X	X	X	X
7.	Housing/ Communal infras.			X	X
8.	Recreation, culture & religion			X	X
9.	Agriculture	X	X		
10.	Mining, industry, construction	X	X	X	X
11.	Traffic & communications	X	X	X	X
12.	Other ec. matters	X	X	X	X

Table 2: Consolidated central government budget, January 2006

	HRK mn	Change, y/y	% of plan
Revenues	**7,043.6**	**10.1%**	**7.1%**
Taxes	3,912.6	10.6%	6.9%
income taxes	561.8	7.3%	7.5%
property tax	28.9	19.6%	7.2%
VAT	2,277.8	12.1%	6.7%
sales tax	10.5	n.a.	6.6%
excise tax	837.0	4.5%	7.2%
external trade tax	108.2	4.6%	7.1%
other	26.8	26.8%	4.5%
Social security contributions	2,622.4	5.5%	7.8%
Aid	0.9	n.a.	0.2%
Other	507.8	n.a.	6.1%
Expenditure	**7,752.6**	**-2.5%**	**7.4%**
Social expenses	3,487.9	3.4%	7.9%
Primary balance	331.7	n.m.	n.m.
Interest expenses	377.4	n.a.	7.0%
Total balance	**-709.0**	**n.m.**	**n.m.**

Source: Ministry of Finance

Figure 1: Regional GDP and Subsidies 2001



Chapter 3: Poverty And Social Exclusion: Profile and indicators

3.1 Poverty and Social Exclusion in Croatia

3.1.1. Research on poverty and social exclusion

1. In the socialist era in Croatia, poverty was virtually unresearched because its existence was unthinkable from the perspective of the then political elite. Therefore, relevant statistical monitoring was not developed, nor was there support for research, which could not have been initiated without political support. However, annual and somewhat more comprehensive five-year household budget surveys were carried out. The surveys contained a lot of data on food consumption, household expenditures, and household appliances, although greater attention was paid to average income and expenditure growth than to the problems of households on the lower end of the income distribution scale.

2. The process of transition which has, in Croatia, run in parallel with the war for independence, has considerably changed the social picture of Croatia. The interest in researching poverty increased but, because of the lack of reliable statistical data, there were no influential studies carried out in the initial period of transition. Indeed, former surveys ceased and new ones were not introduced. The World Bank presented its research on poverty in Croatia in 2000, which was based on data from the first new HBS from 1998. This study was prepared in co-operation with the Croatian Bureau of Statistics, and was extremely influential and offered a number of quantitative data which continue to be cited to a large extent today.

3. The CBS has, from 2001, begun to publish independently poverty indicators according to the Eurostat methodology for the calculation of monetary poverty (the Laeken indicators). Although this is a relatively large group of data, it seems that they have not attracted significant public interest thus far. One can speculate that this is the case as a result of the fact that relative measures of poverty related to those indicators does not attract the interest of the public which is still more geared to understanding poverty in absolute terms, as the inability to meet basic needs. Similarly, the published statistical indicators did not show any significant changes over the recent period. In this sense, too, there has been little public debate. However, in expert circles, data of the CBS is used regularly, primarily in order to illustrate the profile of poverty.

4. In the political sphere, the awareness of the need to undertake actions to alleviate poverty, as a contemporary and important social phenomenon, appears relatively late, not until the late 1990s. Indeed, earlier actions were concentrated on the most vulnerable groups, primarily those affected by war: refugees, displaced persons, those disabled in the war, and the families of the killed or

disappeared. Regarding those affected by transitional economic hardship, the group of the unemployed was seen as the most vulnerable, and the initial responses to this problem were policies of early retirement and a toleration of the grey economy. However, this did not solve the problem, so that the time was ripe for a more consistent and comprehensive approach to the problem of poverty. The Croatian Government, in 2002, adopted The Programme to Combat Poverty and Social Exclusion. The programme set out main activities and measures to be implemented with the goal of reducing poverty and social exclusion, setting out a series of measures, time lines, and responsible bodies. Although the programme was important at the time, it seems that its implementation as well as monitoring of implementation of activities was not sufficiently high on the scale of political priorities. At the end of 2003, changes and additions to the programme were prepared but the Government did not adopt the document. It could be argued that the current Government's activities in the area of poverty and social exclusion are not co-ordinated according to any active plan or programme; rather, the approach to different activities remains ad hoc and isolated.

5. In the framework of the activities of the pre-accession strategy of the European Union for the Republic of Croatia, during 2005 two significant activities began in terms of co-operation in the fields of employment and social inclusion. The first was the drawing up and concluding of the «Joint Assessment of Employment Policy Priorities», JAP; and the second is the «Joint Inclusion Memorandum», or JIM. From these documents, it is to be expected that some of the gaps in terms of the co-ordination and synchronisation of the Government's activities regarding strengthening of social inclusion will be filled.

6. The activities of the Government itself in specific areas important for social inclusion are implemented primarily under the auspices of three different Ministries: the Ministry of Health and Social Welfare; the Ministry of Employment, Labour and Entrepreneurship; and the Ministry of the Family, Veterans and Inter-Generational Solidarity. In this context, specific action plans and programmes, such as the National Action Plan for Employment 2005-2008; the National Programme for Roma; and the National Strategy for a Unified Policy for People with Disabilities, exist, and are noted in chapter 2 above.

7. In addition to official statistical data on poverty and social exclusion, there has been a revival of research in this field, and a number of articles and texts by Croatian researchers has appeared. Independent field researches (Croatian Caritas, Croatian Red Cross, UNDP) were initiated, which should fill some of the gaps regarding our social picture of Croatia.

8. One of the gaps that should be filled in the future concerns the sub-national/regional and urban/rural dimension of poverty. The World Bank (2000a)

found substantial regional variation in poverty rates, for the year 1998. The study analyses 10 regions in total - 5 geographical regions, each of which is split between an urban and a rural part. The poverty rate in rural Eastern Croatia (Slavonia) and in rural Central Croatia was twice as high as the national average, and 4 times higher than in Zagreb Region. Coastal areas in general faced a lower poverty risk than the continental part of Croatia, with the sole exception of Zagreb Region. However, the study finds that educational attainment, labour force participation and dependency of children/elderly explain a large part of the regional differences in poverty rates, meaning that the characteristics of the population and not that of regions per se could be primary causes of regional variations in living standards. A new study is meant to be available shortly.

8. A number of texts address economic inequalities and poverty in Croatia (Nestić 2002, 2004; Šućur 2000, 2001 2003 i 2004), the profile of the poor and subjective perceptions of poverty (Croatian Caritas, 2004), differences between objective poverty indicators and subjective poverty perception (Bićanić and Franičević, 2005), and the efficiency of the system of social transfers in alleviating poverty and economic inequalities (Šućur, 2005). It is a widespread belief that inequalities in Croatian society are high. It would seem that public perception results from a conviction that these inequalities are unjustified. Badly managed privatisation process with a significant proportion of illegal privatization cases has deepened the gap between rich and poor. This could be the source of high subjective poverty perception in Croatia. (Bićanić and Franičević, 2005). According to Šućur (2005) the total system of social transfers is not less effective than the transfer systems of most countries in the EU. If we exclude old-age and family pensions from social transfers, Croatia has the most effective social transfers of any of the countries observed. However, on the other hand, the rate of the reduction of poverty thanks to old-age and family pensions is one of the lowest among the countries compared.

3.1.2 National Definitions of Poverty and Social Exclusion

1. In Croatia, no official definition of poverty is adopted, nor is any particular poverty line set for official purposes. However, there is research which has produced certain measures and poverty lines, and data exists on monetary poverty calculated and published by the CBS according to Eurostat methodology. These are considered in policy making and implementation, but are not directly linked with social assistance or social transfers.

2. The first, and the most influential, study on poverty in Croatia is the one prepared by the World Bank (2000). It employed an absolute notion of poverty, calculated on the basis of consumption data, and found that the poverty rate is around 10%, for the year 1998. This result means, by the construction, that 1/10 of population cannot satisfy their basic non-food needs and provide itself with a nutritionally adequate diet at the same time. This finding draws considerable attention of experts and the general public. If someone is asked the question "what is the poverty rate in Croatia", it can be expected that most respondents would choose to answer on in terms of this 10 per cent rate.

3. The other figure that is often cited is the one on subjective poverty – i.e. a subjective poverty rate of some 70-80%. This figure needs a bit closer inspection since it actually depicts the percentage of households reporting whose disposable income is lower than is their perception of the income needed to meet minimum needs. An addition to this subjective poverty figure could be found by taking into account answers to the following statement: "With your disposable monthly income, your household meets its needs ... (with great difficulties/difficulties/ some difficulties/easily/fairly easily/very easily)", as asked in the Household Budget Survey. Results for 2001 show the following: 11.7% of households report "with great difficulties" and 29% report "difficulties" (Table 1). Subjective poverty is probably closely associated with these two answers.

4. Two trade union federations, the Federation of Independent Trade Unions of Croatia, and Independent Croatian Trade Unions, publish the 'trade union basket' value as a kind of poverty line. Thus, for example, the ICTU has calculated that the minimum expenditure of a four-person household with two school-age children is 6,433 HRK (€880) per month (February 2006). That basket cost is usually compared with the average net monthly wage which in January 2006 was 4474 HRK. The conclusion is drawn, therefore, that a single average wage covers less than 70% of the value of the consumer basket. In addition, trends in terms of the value of the basket month on month are published, which is usually interpreted as the rate of increase of living expenses. In public discussion, these trends are perceived more as measuring changes in living expenses than as an indicator of poverty.

5. Two more indicators in Croatia can be considered as implicit poverty lines, although they are rarely considered as such. The first is the value of the personal tax allowance which in Croatia in 2005 was 1,600 HRK a month or 19,200 HRK annually. The other is the level of social assistance benefit, as the social assistance measure of last resort, which is 400 HRK a month for an adult person. This threshold stands at odds with all other measurements except that of the cost of a minimum food basket which the World Bank estimated at 506.70 HRK per adult person for 1998. Although this calculation is eight years old, it is

important to mention that this was a period of only moderate inflation; food and beverages prices increased in the 1998-2005 period by around 10%, accumulatively, so it cannot influence calculated food costs significantly.

6. The concept of social inclusion is relatively new for the Croatian expert public, and its greater use recently is directly connected with the process of EU accession. Contemporary official documents still do not directly mention social inclusion as a process or as a policy goal. However, it can be expected that the concept will enter more and more into policy discourse. The public appears to understand intuitively, and ever more strongly, specific components of social exclusion: poverty, unemployment, lack of education, poor health status, and so on. Therefore, when monitoring the situation and defining policies and communication with the public, it will be desirable to make reference to these known concepts.

3.1.3 Laeken indicators of social exclusion

1. In Croatia in mid-2004 the first indicators of monetary poverty according to the methodological recommendations of Eurostat were published. The CBS at that time published data for the period from 2001-2003, and a year later for 2004. Data based on the HBS appears in one place, and data based on the Labour Force Survey appears elsewhere and in different data bases and documents. In Table 2 below, indicators from these two sources are combined, where data based on the LFS is taken from Eurostat. Eurostat data differs somewhat, although largely insignificantly, from CBS data, but are comparable with other EU member states and candidate countries, whilst some of the data has not actually been published in Croatian statistical documents. In addition, the HBS in Croatia is carried out on an annual basis but this is not a panel survey. It is for this reason that some Laeken indicators cannot yet be calculated, such as the persistence of poverty. The LFS is undertaken on a half-yearly basis but, also, does not include a consistent panel sample; rather, every six months different respondents are chosen which does, in part at least, have an impact on the reliability of the estimates of employment and unemployment trends.

2. Table 2 shows those Laeken indicators which exist for Croatia. The at-risk-of-poverty rate for the population was 16.7 % in 2004. In this is included income in-kind (e.g. own production of food from farming households; withdrawals from stocks by trades people, etc.), because it is considered that this part of income remains a significant contributor to the livelihoods and welfare of Croatian citizens, particularly in rural areas and that its omission would over-estimate considerably and distort the picture of poverty. If in-kind income was excluded, the at-risk rate of poverty would be 18.8%.

3. Women in Croatia are exposed to a somewhat higher risk of poverty, with a rate of 18.1% in 2004, compared to the male rate of 15.1%. Comparison of poverty rates according to age reveals that the disadvantaged position of women stems from the high rate of poverty of women aged 65 years or over, with a rate of almost 33%, while the rate for men of the same age is 25%. In general, the at-risk of poverty rate is above average only in the 65 and over age group, where the total rate is 29.5%. The high risk of poverty rate in later ages, particularly amongst women, is connected with household type of older persons. Indeed, single person households aged 65 years or over face a risk of poverty rate of over 40%. Given that women in Croatia live longer than men and, therefore, are more often in single person households, the risk of poverty for older women in single person households is very high. Households with more members, and especially if there are no older people, as a rule have a below average risk of poverty, and only households with five or more persons face an increased risk of poverty. These results are partly influenced by the choice of applied equivalence scale (modified OECD scale), but more detailed discussion of this is beyond the scope of this paper.[3]

4. Those employed have the lowest at-risk of poverty rate of 4.4%, with no significant gender difference in this rate. In other words, regardless of all the problems facing workers, from low and sometimes irregular wages to long working hours, having a work place essentially removes the risk of poverty. Those who are self-employed have an above average risk of poverty, with a rate of 22.6% in 2004, which primarily reflects the relatively high risk of poverty for those living in households reliant on agriculture. Those who are unemployed have a very high risk of poverty, some 32%, which is even above that of retired persons or non-active persons. This suggests that those who are unemployed must be a major policy concern, especially in the context of this social group not being a strong lobby, with only relative weak associations representing their interests.

5. Retired persons have an above average at-risk of poverty rate of 20.5%, with no appreciable gender differences. It is interesting that this rate is considerably below that of those aged 65 and over. There are two reasons for this. Firstly, there is a considerable number of retired persons under 65, our estimates being up to 40%. And, secondly, there is a significant, if small, number of older people who do not have any pension.

[3] Equivalence scales are used to produce comparable incomes among households of different size and composition. In poverty calculations, household–level incomes are divided by the coefficient based on equivalence scale. In the case of the modified OECD scale, a coefficient of 1 is attributed to the first adult, 0.5 to other persons over 13 years old and 0.3 to children aged 13 years or under. Income of each household is divided by the sum of coefficients attributed to the household. Use of some other equivalence scales could result in different equivalent income, changing thereby the ordering of households, especially if households of various sizes are compared.

6. Tenure status has a limited impact on the at risk of poverty rate, but bearing in mind that only a small proportion of the Croatian population pay the market price for renting an apartment, some 2-3%, this is not of great importance in terms of the overall poverty profile.

7. The at risk of poverty threshold in 2004 for a single person household was 20,713 HRK annually (c. €2,800), or around 1,726 HRK a month (€233), whilst for a household with two adults and two children the amount was 43,499 HRK annually (c. €5,800).

8. The quintile rate (S80/S20) shows the relationship between equivalent incomes of the top and bottom 20% of the population. In 2004 in Croatia the figure was 4.5. A similar indicator of income distribution is the Gini coefficient which was 0.29. Based on the Gini coefficient, in terms of inequality measures, Croatia is close to the average for the EU 25.

9. The at risk of poverty rate before social transfers expresses the proportion of the population who would be at risk of poverty based on net income excluding social transfers. With this indicator, it is important to distinguish between two definitions of income, depending on whether pensions are considered as a social transfer or not. If pensions are considered as a social transfer and excluded from such income, then the at risk of poverty rate in Croatia is 41.4%, whereas when pensions are included, whilst excluding all other forms of social transfers, then the at risk of poverty rate is 33.7%.

10. Indicators which are related to the labour market show the rather worrying state of Croatia in relation to the 25 EU member states. The long-term unemployment rate in Croatia is 7.3%, and the very long-term unemployment rate is 5.7%, which after Slovakia and Poland, and alongside that of Bulgaria, is the highest rate amongst member states and candidate countries. This indicator is symptomatic of the proportionately slow dynamic of the labour market (a fact supported by studies such as Rutkowski, 2003), and of the possible lack of fit between the skills which the unemployed have compared with those which the economy needs. Similarly, the proportion of persons living in jobless households is also amongst the highest in European countries. Some 7.4% of children up to 17 years of age, and 11.2% of adults up to 59 years of age were living in jobless households in 2004,

11. In terms of the labour market, all indicators are worse for women. It is important to note that all elements of this have not yet been sufficiently investigated. One of the possible underlying causes is the somewhat lower educational attainment of women generally. Approximately 35% of women in the 25-64 year age group have, as their highest level of completed education, lower secondary education (ISCED level 0-2), while for men the equivalent figure is

22%. The Croatian labour market is relatively efficient in terms of absorbing the work force with post-secondary education, such that more highly educated women find a job easily. Employed women are, on average, better educated than men. Around 25% of employed women have post-secondary education, compared with 16% of employed men (Nestić, 2005).

12. In conclusion, we can note that most of the Laeken indicators on social exclusion are now applied in Croatia, allowing for comparisons with EU member states. However, some indicators are still not available because the appropriate statistical sources do not exist. The persistent at-risk-of-poverty rate is not calculated because the Croatian HBS is not based on a panel sample; low reading literacy performance is not calculated because Croatia until very recently was not included in the PISA project; life expectancy exists only as a national estimate, but is not included in Eurostat demographic statistics, as required by the methodology of the Laeken indicators. Regional cohesion indicators are not calculated because the LFS so far does not give reliable estimates at the sub-national level.. On the other hand, the at-risk-of-poverty-rate by work intensity and the in-work poverty risk are new Laeken indicators, and these will in all probability be included in the next round of monitoring of monetary poverty in Croatia. It should also be noted that self-defined health status was included in the HBS last year.

3.2 Policy Challenges and Policy Responses

3.2.1. Labour markets

1. The process of transition brings great changes in terms of the labour market. The structure of the labour force under a socialist system needs to be transformed into a structure more appropriate to a market economy. One striking change is the re-allocation of employment from large firms towards new, privately-owned small and medium enterprises, as well as the growth of self-employment (Table 3). Although employment in the private sector grew relatively quickly, it was not sufficient, in the first years of transition, to absorb the loss of work places in the state sector. This led to a rapid rise in unemployment in the first years of transition (Table 3).

2. Early transition was marked with decreasing labour force, with many people leaving the formal labour market, through early retirement or inactivity, with others turning to the grey economy. The administrative rate of unemployment rose rapidly in the early 1990s, although this was later ameliorated somewhat by an improved economic situation and improvements in the labour market. Institutional reforms in 2002 also have had effects. Figure 1 shows the rate of registered unemployed and the rate according to ILO methodology since 1999.

Whilst the former is significantly higher, trends are broadly similar, with the ILO figure being 13.1% in the first half of 2005.

3. A significant problem in terms of social exclusion and poverty is the large proportion of long-term unemployed within the overall figure. According to the LFS figures for 2004, more than half of all unemployed have been waiting for a job for longer than one year, and almost 30% for two years or more (CBS, 2006). Women are more likely to stay longer in unemployment; around 57% of women are the long-term unemployed while the same is with 39% of men. In the youth unemployed population, some 40% are long-term unemployed. The population of long term-unemployed are 55% women, and around 20% youth (15-24 years). More than a quarter of total unemployed have been without job for more than two years.

4. The unemployed in Croatia tend to have less education than those employed, such that education appears to be a major determinant of unemployment (Table 4). The Croatia system appears to generate a rather large number of people with secondary school education, such that a full 75% of unemployed persons in Croatia have completed secondary education only, compared to 60% amongst those employed. The difference in education structure of the employed and unemployed is also an indicator of skill mismatch between the supply and demand for labour.

5. Unemployment amongst young people is a great challenge in policy terms. The rate of unemployment amongst young people (aged 15-24 years) reached 33.1% in the first half of 2005, with the rate of employment of young people being relatively low (25%). One of the reasons for the low employment rate is relatively high enrolment rate with secondary schools. The youth unemployment ratio (number of young unemployed persons divided by the total youth population in the country) of 13% shows the proportion of youth that was looking for a job in 2004. The age structure of the employed and employed shows their over-representation among the unemployed (28.9%) and under-representation among the employed (9.0%), both compared with their population share of around 13% (Table 5).

6. Whilst, over time, the rate of youth unemployment has fallen, it has stagnated for those aged 30-40 years, whilst the rate of unemployment of older people (50-60 years old) has risen in the recent period. The overall rate of youth unemployment remains extremely worrying; at almost double the rates in the EU 15 (16.6%) and EU 25 (18.6%). As noted above, the unemployed as a whole are at the greatest risk of poverty in Croatia, more than double the overall rate, and are more at risk than even those who have retired and inactive persons.

7. In Croatia, there are considerable variations in rates of unemployment regionally (Table 6). The rate of unemployment according to counties shows that, at the end of 2005, Vukovarska-srijemska county had the highest rate (32.1%), followed by Sisaćko-moslovačko county (29.9%), Virovitičko–podravskoj (29.6%), and Slavonski brod-Posavina (29.5%). The lowest rates can be found in the City of Zagreb (7.8%) and Istria county (8.0%). Regional inequalities in the labour market appear to be an indicator of the very different social situation in different parts of the country. Better employment prospects and a reasonably functioning housing market enabled migration from deprived regions to Zagreb. Both conditions are not fulfilled for migrations in any other directions, but very local ones, from rural parts to the nearest city. Traditionally strong family and other social linkages are thereby preserved which is a factor limiting the social exclusion risk even in the case of unemployment (Šverko et al. 2004)

8. In early 2002, reforms to the legal regulation of the labour market were initiated. The reforms were aimed at restructuring the labour market in line with EU directives. It introduced a more active approach to employment, and introduced tougher criteria in terms of registering with the Employment service, and accepting or rejecting job offers. It also allowed for private employment agencies to be established.

9. Discussion on reform of the Labour Law took two years and concluded with a new Law which concentrated on liberalizing restrictions on firing workers. The Law introduced universal worker participation in supervisory boards in firms employing more than 200 workers, instead of only those with significant public ownership.

10. In addition, revisions were made to passive measures. The overall level of unemployment benefit was reduced compared to average wages (the rate fell from 33.1% in 1996 to 24% in 2002). The right to unemployment benefit is now limited to those who have a minimum of 9 working months in the last 24. The maximum time for receiving benefit is one year. Benefits range from minimum 800 HRK (about €107) to a maximum of 1,000 HRK (€133). Currently, about 24% of those registered as unemployed receive benefit. This is a further indicator of the low rate of employment of young people.

11. In addition, new active labour market measures were introduced in 2002. These relate to re-training, subsidies, and so on. Given that 95% of those unemployed are targeted as recipients of some training, the programmes seem of a general rather than a truly goal-oriented nature, so that their effectiveness remains questionable (Babić, 2003).

12. During 2003 and 2004 the National Employment Action Plan was created in line with the European Employment Strategy. The plan analysed the labour market situation and existing labour market policies, and outlined policies aimed to strengthen the labour market. With some amendments, this was accepted by the Government on 2 December 2004 as a national Action Plan for 2005 to 2008.

13. Within the scope of this plan, the Government adopted in March 2006, the annual plan for promoting employment in 2006. New measures include subsidies to employers and various training and re-training programmes. The measures are targeted at the long-term unemployed and those groups which find employment most difficult to secure, notably older persons, the less well-educated, the young, and those lacking work experience. Co-financing arrangements were established for employing war veterans and war disabled, single mothers, women victims of violence or trafficking, recovering addicts, parents with four or more children, those granted asylum, and Roma. Responsibility for monitoring is shared between five Ministries and the Croatian Employment Service. The complexity of this raises the risk that the programme and its monitoring become rather complicated and non-transparent. Indicators for measuring performance are only listed in the Plan as "efficiency indicators" , but no quantitative targets are set (except in general terms of increases or decreases in some cases), which hampers the competent monitoring of the appropriateness of particular measures. However, the Government has announced that implementation of the programme will be closely monitored.

3.2.2. Guaranteeing Adequate Income/Resources

1. In the Croatian tax system there is no system of tax credits through which people on low incomes would be subsidised to reach a minimum income level. The only tax concession which people with low incomes receive is the personal tax allowance, the amount of income on which personal income tax is not paid. This was 1,600 HRK per month in 2005, which can be increased for dependent persons in the family (children, spouse or parent with no income).

2. Although there is no legally defined minimum wage in Croatia, there are a number of legal decisions which resembles this. According to the Law on Compulsory Insurance Contributions the baseline for social contributions is set, so that de facto, this is the minimum wage in Croatia.

3. Thus, according to the regulations in the Law on Pension Insurance Contributions, the baseline is set by the Ministry of Finance on the basis of CBS statistics on average gross monthly wages for July-August of the previous year, multiplied by a coefficient of 0.35. For 2005, the baseline was set at 2,080.74 HRK monthly (€280). This is the base line for paying all contributions.

4. This forms a de facto minimum wage because under the Collective Agreement on a Minimum Wage (NN 37/98), based on a decision by the Minister responsible for Work, and applicable to all employers in Croatia, the minimum wage is set at the level of the base for contributions for pension insurance.

3.2.3 Education

1. Every national economy and its long-term development depend considerably on the quality of human capital which, in turn, depends on the quality of the educational system, investments in education, and educational participation. Deficiencies in the educational system are a limiting factor in sustainable development in all countries. In addition, within the framework of the EU's Lisbon strategy, and the process of Croatia's accession, investment in education appears crucial both to strengthening competitiveness and to overall development.

2. Croatia has a significantly low level of enrolment in pre-school education, a very high rate of enrolment in primary schools, a high rate of enrolment in secondary education, and a fairly high rate of enrolment in tertiary or higher education (Table 7). However, the total number of years of education which an average five year old in Croatia can expect to complete during her/his life is some 4-5 years less than the average in the EU 25.

3. In Croatia in 2004 there was a total of 503 pre-school institutions in 1,203 buildings, 290 of which were founded by the municipality and 49 private kindergartens founded by religious organisations. Overall, in regular five-hours a day or ten hours a day programmes, 35% of all pre-school age children were included. Shorter programmes meet the needs of 25% of children. 1,834 national minority children were included in pre-school provision. 1,411 children with light developmental difficulties were also included in the context of regular pre-school programmes. A further 639 children with disabilities were included in 26 special kindergartens. In the year prior to starting school, all children in Croatia attend pre-school programmes.

4. There are considerable regional variations in the availability of pre-school provision in Croatia. In addition, since the economic price of a pre-school place ranges from 850 HRK to 1,700 HRK per child, and to 4,200 HRK for a child with developmental difficulties, then parents are required to co-finance kindergarten placements up to 30-40% of the economic price.

5. In comparison with the EU15, Croatia has a smaller percentage of pupils who finish only elementary or lower secondary education. This is also reflected in the relatively high number who complete some form of secondary education, be it academic, professional or semi-professional, which is 58% compared to 44% in

the OECD countries. However, in terms of completed tertiary education, Croatia's rate is about half that of the OECD countries.

6. Tertiary education is characterized by long periods of time to finish studying and a large numbers of students who do not complete their higher education. Only a little over 40 percent of students enrolled in tertiary education finally obtain their degree, meaning that reasonably high enrolment rates are not transferred to completed tertiary education (Table 8). Among other consequences, this means a substantial loss of government resources devoted to higher education.

7. Expenditures on education in Croatia is below that found in the countries of the EU. In the EU25, public expenditure on education on average is 5.2% of GDP in 2002, while for Croatia the figure is 4.3% (Eurostat database). Private expenditures on education are quite low. The Household Budget Survey reports that less than 1% of total household expenditures are devoted to education.

8. One of the consequences of this is the very low participation rate of the adult population (25-64 years old) in so-called 'life-long learning'. The average for the EU 25 is above 19% and for the post-communist new members 7%. In Croatia, according to the LFS, only 2% of the adult population participates. According to research (Pološki-Vokić and Frajlić, 2003), it appears that Croatian companies invest very little in the continuing education of their workers. Based on a representative sample, the study revealed that 46.6% of companies in 2002 had no additional education programmes for any of their workers.

9. In the field of inclusive education, crucial for the social inclusion of those with special needs (Topping, et al, 2005), some 2% of children need to be specially evaluated in order to secure special conditions and educational programmes which are based on their potential. It is thought that up to 20% of children and young people have some special educational needs which require additional programmes. The right of people with special needs to integrated education was established in law as early as 1980. Education and work preparedness programmes of persons with learning disabilities is organised in Croatia in residential institutions, special schools and in mainstream schools based on a special programme.

10. In other words, the very measures to promote an inclusive education system taken themselves can contribute to social exclusion (UNDP, 2006). It appears that, because of the influence of prevailing attitudes and institutional limitations, the positive role of education in this sphere is very limited. The national strategy for a unified policy for people with disability (Republic of Croatia, 2003) states that the level of educational integration is unsatisfactory despite the regulatory framework because of multi-causal factors (low level of educational financing;

architectural barriers; poor spatial and material work conditions; an uneven network of services). It is important to note that special residential schools deal with educational needs of children with disabilities but create social exclusion through a separation from family environments and often require long distance travel for the family to maintain any contact.

11. There appears to be a lack of co-ordination of relevant bodies in this field. Work with pupils with moderate and severe disabilities in special primary schools is also geared to teaching of a cognitive nature with a lack of emphasis on the principle of individual plans and with low expectations of the environment (Igrić, 2001).

12. Croatia is currently engaged in reform of the educational system, beginning with primary education, based on a plan of educational sector development 2005-2010. On this basis a Croatian national educational standard (HNOS) has been defined. The issue of inclusivity appears in various guises in this reform. Overall, the aim is secure equal educational opportunities through Croatia, based on improvements in educational governance and strengthening of networks of educational institutions. Curriculum reform, continuing education of teachers, improved equipment and infrastructure, and ensuring equality of access, are all necessary (UNDP, 2006).

13. Most significant changes are needed in the segment of technical or vocational education in order to produce a competent workforce for the modern production and service sectors. Key goals are adjustment of vocational programmes, curriculum modernisation, modernisation of methods, and the introduction of basic skills and subsequent specialisation. The enrolment rates for specific vocations needs to be tailored to labour market conditions and there needs to be a thorough analysis and re-organisation of the network of vocational schools which should prevent over-concentration on certain vocations in certain regions (Berryman and Drabek 2002; Babić, 2004).

3.2.4 Family and Child Protection

1. Studies show that the family remains one of the most highly valued institutions in Croatian society. Despite this, the number of marriages continues to fall, albeit slowly. In 1990, there were 6 new marriages per 1000 people, whilst in 2004 only 5.1. This remains a higher rate than in the EU with a rate of 4.8 in the EU25 and 4.7 in the EU15. There are 219 divorces per 1000 marriages or, expressed differently, a rate of 1.1 per 1000 persons, compared to 2.1 in the EU15 and EU25.

2. There has been a rise in single parent families in Croatia, accounting for 11.5% of all families in 1971, 12.4% in 1991 and 15.0% in 2001. Of this figure in 2001, 83% are female headed households and 17% male-headed. In the same period the number of marriages without children has risen from 24.8% in 1971 to 27.1% in 1991. In 2001 the figure fell slightly to 27.0%. In 1991, 17.8% of all households contained only one person, whereas in 2001 this was 20.8% (Statistical Yearbook 2001).

3. Croatia, in comparison with Western European and post-socialist countries has a smaller number of children born outside of marriage. In 1980 this accounted for 5.1% of all children, in 1985 5.9%, in 1995 7.5% and in 2000 9.0%. Comparative data for 2000 in other countries illustrates this: Poland 12.1%; Slovakia 18.3%; Czech Republic 21.8%; Hungary 29.0% and Slovenia 37.1% of children outside marriage.

4. When referring to instruments of family policy, it is possible to distinguish between (1) financial transfers (2) subsidies and tax relief (3) services (4) time allowed for family functions (maternity, parental and other leave) (Puljiz & Zrinščak, 2002).

5. According to the Law on Income tax, in force since January 2001, every person liable for tax has a 1,600 HRK tax allowance, which is increased based on the number of dependent family members. For spouse and other dependent family members and for the first child, this is 0.5 of the base allowance. For a second child the coefficient is 0.7 of the base, for the third 1.0, for the fourth 1.4, fifth 1.9, all cumulatively. For each subsequent child there is a further progressive increase.

6. As a result of demographic changes and, in particular, the decreased birth rate in the 1990s, Governments sought to broaden the right to child benefit and to increase its amount. Until 2000, only children of employed parents had the right to child benefit. The Law on Child Allowance from 1999, entering into force in 2000, broadened the right to all children. However, a new Law, entering into force on 1 January 2002, conditioned the right to child allowance based on family income. Children now have the right to allowance until 15 or 19 if in full time education based on a means-test. Children with severe health problems do not face a means test, but have the right to an allowance of 831 HRK per month until age 27. Trends in receipt of benefit are discussed further in Chapter 4 below.

7. In Croatia only about 40% of pre-school age children attends some form of early learning in kindergarten. Mandatory pre-school education programmes in the course of the year before the start of primary schools are attended by practically 100% of children of appropriate ages (Ministry of Education data for

the school year 2003-04). In addition to public kindergartens, there are also 45 private kindergartens founded by religious communities and 80 private kindergartens founded by others.

8. According to the existing law all mothers (employed, self-employed, unemployed and students-pupils) in Croatia have the right to maternity leave of up to one year and those with twins or with three or more children, have the right to up to three years of maternity leave. More details on this can be found in chapter 4. (NN 30/04).

9. According to indicators of perinatal mortality, Croatia in 2002 had a rate of 7.0/1000 newly born babies, while the average for the EU for 2001 was 6.5 and in Central and Eastern Europe in 2002 9.2 (UNDP, MDGs).

3.2.5 Housing

1. Standards of housing is a crucial part of the social standard and is connected with the overall level of national development. Table 9 shows trends in some housing standards from 1951 to 2001, showing clear improvements but still some problems. According to the census data from 2001, 82.9% of households lived in their own or co-owned flat or house. 2.86% of households rent with a protected rent (i.e. those who have not yet exercised their right to buy); 7.45% rented privately.

2. In Croatia, the average market price of 1 sq. m. of flat is 2.5 to 3 times the average net monthly salary, whilst in developed countries the ratio is closer to 1:1. Cadastre records still complicate building investment. The situation facing young families and socially vulnerable groups is very difficult. Credit is costly and replete with regulations and required guarantees.

3. The Government has made several policy projects and measures to support the housing conditions of population. In 1997 a Law on the Fund for Long-term Financing of Housing with State Support was introduced, which goes together with a Law on Housing Savings Institutions. With substantial subvention from the state budget, these savings institutions managed to attract substantial resources for housing construction. The second attempt is with the Law on Socially Supported Housing which gave local and central government the role of organizing housing construction aimed at providing dwellings that are less expensive than others on the market. The goal is to create favourable conditions for credit to meet housing needs, which has been partially achieved although conditions were not strikingly more favourable than market ones, if quality and location factors are taken into account. It can be noted that socially supported housing is not "social housing", but a kind of support to those who already are

close to having sufficient resources to be able to afford decent housing. It can be said that middle-income groups benefited most from current government housing policy, so that a truly social dimension of housing policy is still needed.

4. According to the Strategy of the development of Croatian housing policy (Stanovanje, 2001; Hrvatska u 21. stoljeću), future priorities include:

- creating a not-for-profit 'social' rental sector and creating legal security
- supporting housing, including family housing, social flats, and investment into existing housing fund
- development of institutional infrastructure
- creation of a system of non-profit and low-profit housing organisations
- housing of vulnerable groups
- improvement of management and maintenance of the housing fund
- housing financing.

5. The housing conditions of poor people are significantly worse than those of the rest of the population. Table 10 shows differences on a number of dimensions. Poor people live, on the whole, in significantly smaller flats; lack basic communal facilities (electricity, water, sewage); have no telephone; and lack household appliances (refrigerator, washing machine, TV set). A 2004 study of Roma households (Šućur, 2005b; 368-369) shows 26% lacking electricity, compared to 2% of the general poor population; 49.9% with no washing machine (32.6% of the poor); and 66% with no indoor toilet (37.2% of the poor).

3.2.6. National Minorities

1. According to the Croatian Constitutional Law, national minorities are those with 'ethnic, linguistic, cultural or religious characteristics different from other citizens and who wish to preserve these characteristics' (NN 155/2002). According to the 2001 census national minorities made up 7.5% of the Croatian population. The largest minority community is Serbs with 4.5% of the population. This is a significant decrease on the 1991 census when those who declared themselves Serbian amounted to 12.1% of the population.

2. National minorities have the right to elect Parliamentary representatives, based on their numbers in the population. They also have equal rights to language and script in the executive and administrative offices of those municipalities where they are at least a third of the population, and in deconcentrated state bodies. Minority councils are elected in local government units where members of national minorities are at least 1.5% of the population, or where more than 200 persons of any particular minority reside, and in counties were this number is more than 500.

3. From the state budget between 2000 and 2003, 77.5 m HRK (€10.5 m) was allocated to programmes for national minorities. The funds are allocated on the recommendation of the Office for National Minorities (founded in 2001) and, since 2003, the decision is brought by the state Council for National Minorities whose members are entirely minority representatives.

4. Roma, officially numbering 9,463 according to the 2001 census, but with real numbers estimated at around 40,000, face discrimination in terms of citizenship, policing, housing and, above all, education (cf. Mehmedi and Papa, 2001). Despite some initiatives in terms of pre-school programmes, enrolment rate in primary schools remains low and drop-out rates are high. The National Programme for Roma adopted in 2003 also notes Roma, less than 1% of the population, represented 13.56% of all social assistance benefit claimants.

5. Based on the analysis of the council for national minorities regarding the report on the Convention of the protection of national minorities in 2004, it appears that there are improvements in the situation facing national minorities in Croatia, through initiated administrative, political and social changes in the last four years. A number of criticisms were made, however, including:

- relatively slow implementation of parts of particular Laws regulating the right of national minorities, including refugee return; implementation on the law on use of language and script of national minorities; participation in the judiciary and state administration
- the need to improve the condition for work of the national minority councils and their representatives, and to ensure financial and infrastructure support
- insufficient media coverage of national minority issues.

6. It is hard to assess whether national minorities are hit by poverty and social exclusion in Croatia in a disproportionate way compared to the majority population. There has been no serious research on this topic. However, it is a fact that Roma are, certainly, the group with the highest risk of poverty in all countries in the region. At risk of poverty rates can be up to ten times higher than poverty rates of non-Roma. According to the report *Faces of poverty, faces of hope (UNDP, 2005)*, poverty rates of Roma in Croatia is 2.5 times higher than the non-Roma population in the same geographical area. In fact, this is lower than the rate in neighbouring countries (see figure 1).

7. It can be estimated that the returnee population of both Serbian and Croatian nationalities have an above average at risk of poverty rate. Again, there is no serious research and in official figures the rate is not calculated based on return, either of Croats or of Serbs. Estimates are based on the fact that people are returning to economically under-developed areas with low possibilities for employment.

3.2. 7. Areas of Special State Concern

1. After the end of the war and the re-integration of previously occupied territory into the Republic of Croatia, in 1996 a law on Areas of Special State Concern has been passed, which has been amended on several occasions up to now. These areas were chosen in order to alleviate the war consequences, promote faster return of populations, support for demographic and economic recovery, and in order to achieve as much as possible equal development of all Croatian regions.

2. The areas are divided into three categories. The first and second categories are classified according to the nature of occupation and war events, the third group according to four criteria: economic development; structural difficulties; demographics; and others. Group 1 and 2 territory is includes the war affected territories no more than 15 km from the state border as the crow flies, and with no more than 5,000 inhabitants according to the 1991 census, and all the previously occupied Croatian Podunavlje.

3. There are special tax incentives on a range of activities in each of the categories. Those liable to tax who work in the areas of special state concern, employing more than five people on permanent contracts, with more than 50% of employees registered as living in these areas, pay a lower rate of profit tax for ten years from the date of introduction of the Law on Profit Tax. Instead of the 20% in the Law, the rates are as follows:

Areas of special state concern	**Profit tax rate**
Group 1	0%
Group 2	25% of prescribed rate
Group 3	75% of prescribed rate

4. The tax base allowance is also higher for all those who reside in the areas. Instead of the basic tax allowance of 1,600 HRK monthly, the allowances are as shown below:

Areas of special state concern	**Tax threshold**	**allowance**

Group 1	3.840,00 kn
Group 2	3.200,00 kn
Group 3	2.500,00 kn

5. In the areas of special state concern, around 15.3% of the Croatian population live (Lovrinčević et al, 2004). The authors analyse the demographic characteristics of those living in the Areas of Special State Concern, suggesting these are extremely worrying, although within a wide range for different groups. Analysis of rank correlation (Spearman coefficient) shows a significant correlation between a proportion of population living in the areas in some counties and the overall level of development of those counties. Certain counties with a preponderance of Group 1 and Group 2 areas show a wide range of differences in development. This is not the case in Group 3 because the criteria are more developmental. The authors suggest that the entire criteria for deciding these areas should be closer to the clear criteria of the third group.

6. There is also a need to draw attention to the fact that differences between the economic development of particular counties are high and growing. This results in different degrees of integration into the labour market as shown in Table 8. Rates of unemployment in Counties show a range of more than 20%. In Istria the rate is 6.1%, in Zagreb 7.8%, compared to 32.2% in Vukovar-Srijem county.

7. All this points to the conclusion that the territorial dimension of poverty and social exclusion is extremely important in Croatia. There is a need for more research on this and, in particular, an exploration of the effectiveness of existing measures needs to be undertaken.

3.2.8 Gender and Gender Equality

1. There has been a trend in which the rate of poverty of women in the last three years has increased. In 2004, the at risk of poverty rate for women was 18.1%, considerably higher than that of men (15.1%) (See Table 2). Two years earlier the difference was only 1%. The gender differences in at risk rates are highest in the older age groups. Women over 64 years of age have 8.5% higher risk of poverty than men of the same age group. This is probably a consequence of the fact that, in Croatia, a certain percentage of persons over 65 have not realised the right to a pension, usually agricultural workers who have not contributed to the pension fund, and women are over-represented in that group. In addition, women tend to live longer than men and this affects at risk of poverty rates.

2. Participation in the labour market is one aspect of social life where women in Croatia are seeking equal treatment. The employment rate for women is substantially lower than that for men (see Table 9 from the Statistical Annex to Chapter 1), while the female unemployment rate is higher than that for men. Women are a majority among the long-term unemployed. In terms of salaries, the Labour Law forbids gender discrimination and the principle of equal pay for equal work is accepted by employers, at least declaratorily. Data which exists shows that, in different ways, the principle is not matched by reality. Nestić (2005) reports a gender pay gap of 10%, meaning that the average wages for women are 10% lower than average wages for men. However, when differences in education, experience, occupation and sector of employment are controlled, the gap is even wider, around 15%. In spite of a higher education attainment of employed women, as compared to that of men, they are often employed in low-wage sectors and kept out of top managerial positions. The Ministry of Labour reports that there are six women in every 100 managers in Croatia. Women are under-represented in the top government official positions of the public sector.

3. In Croatia in the last few years, a number of institutional mechanisms have sought to promote gender equality policies at the national and local levels. For the first time, Croatia has introduced special laws to prevent gender discrimination including the 2003 Law on Gender Discrimination (NN 116/03).

3.2.9 People with Disabilities

1. According to the census of 2001, there are 429,421 persons with disabilities in Croatia (9.7% of the population). Some 10% of this figure have disabilities arising from the war. People with disabilities are faced with great difficulties in obtaining employment, although legally they have the right to professional rehabilitation and preparation for work in an adapted workplace. At the end of 2004, 7,322 people with disabilities were registered as unemployed, 2.3% of all unemployed. In the field of social security, in an attempt to promote deinstitutionalisation, the Law on Social Welfare was changed and adapted, and through a special Law on Professional Rehabilitation and Employment of Persons with disabilities, conditions for special care of persons with disabilities were created. Article 7 of the latter Law states that the right to professional rehabilitation will be decided by the Croatian Employment Service or its regional office.

2. Professional rehabilitation consists of a number of measures and activities: assessing employability; information and advice; counselling; labour market

analysis; opportunities for employment and inclusion into work; assessment of possibilities for development and additional training; work training; pre-qualification support; and so on. All of these require a good inter-institutional approach. The Law also gives the CES the right to create a register of persons with disabilities which opens up the possibility of a new data base to ensure efficient monitoring and support.

3. From 1 March 2002 to 31 August 2005, through employment subsidies, only 337 persons with disabilities were employed. The Government has now regulated a quota in state bodies and public services, so those bodies should have, by 2020, 6% persons with disabilities among their employees.

3.2.10 Data and knowledge gaps

1. The statistical monitoring of poverty and social exclusion in Croatia is still evolving. There remains a lack of knowledge and research resources devoted to the issue. As mentioned above, the main gaps relate to a lack of statistical indicators for specific themes, little correspondence between different data bases, many of which have a low public accessibility, inadequate statistics, insufficient research capacity, and gaps in knowledge of causes, profiles, longevity, and policy effectiveness.

2. In Croatia, it is still not possible to trace trends in poverty and, in particular, to trace the length of time people spend in poverty. This is because there are still no panel studies in Croatia. In addition, indicators of poverty and social exclusion are still not consistently available on the regional level.

3. Some of the most vulnerable groups are partially or completely out of statistical coverage, i.e. without special statistical treatment. This applies to people with disabilities, minorities, and regional profile of living standard, especially for people living in rural areas or areas affected by war. There are no figures on homelessness or research on the nature and response to homelessness in Croatia. In addition, school drop out figures are not sufficiently developed..

4. Policy oriented research is still lacking in Croatia. Despite the best efforts made by individual researchers, long-term research is not yet well developed. An evaluation of the effectiveness of social transfers in alleviating poverty is still missing. We return to some of these points in chapter 7.

REFERENCES FOR CHAPTER 3

Babić, Z. (2003). Uloga aktivne politike na tržište rada u Hrvatskoj (The role of active labour market policies in Croatia). *Financijska teorija i praksa*, 27 (4); 547-566.

Babić Z., (2004)., Participacija i ulaganje u obrazovanje u Hrvatskoj (Participation and investment in education in Croatia). *Privredna kretanja i ekonomska politika*, 101; 28-53.

Berryman, S. and I. Drabek, (2002), *Mobilizing Croatia's Human Capital to Support Innovation-Driven Growth.* Washington: World Bank.

Bićanić, I. i V. Franičević (2005) Izazovi stvarnoga i subjektivnoga siromaštva i porasta nejednakosti u ekonomijama jugoistočne Europe u tranziciji. (Objective challenges and subjective poverty and growing inequality in the economies of SEE), *Financijska teorija i praksa* vol. 1/2005; 13-37.

Central Bureau of Statistics (2006) "Labour Force Survey Results: Croatia 2004 – Europe 2004. Statistical Reports No. 1277. Zagreb: Central Bureau of Statistics.

Europsko istraživanje vrednota – European Value Survey –1999. Podaci za Republiku Hrvatsku – djelomično izvješće, *Bogoslovska smotra* 70 (2000.), 2; 173. - 503.

European Commission, (2005), „Report on social inclusion 2005: An analysis of the National Action Plans on Social Inclusion (2004-2006) submitted by the 10 new Member States", European Commission, DG for Employment, Social Affairs and Equal Opportunities, Unit E2.

Hrvatski Caritas, (2004) Rezultati istraživanja siromaštva u Hrvatskoj. www.glas-koncila.hr (The results of poverty research in Croatia).

Igrić, LJ. (2001). Djeca s mentalnom retardacijom u društvu (Children with mental handicaps in society). *Dijete i društvo,* 3(3).

Institute of Social Sciences Ivo Pilar, (2003), „Strengthening Poverty Monitoring Capacity: Final Report", Zagreb: ISS Ivo Pilar.

Lovrinčević Ž. Budak. J., Mikulić. D. (2004), Područja posebne državne skrbi u hrvatskoj - razlike u regionalnoj razvijenosti i demografsko - obrazovne karakteristike (The areas of special state concern in Croatia). *Ekonomski pregled*, Vol. 55, No. 5-6, 389-412, Zagreb.

Mehmedi, R. and Papa, J. (2001) 'Croatia' in Save the Children (ed) *Denied A Future?: the right to education of Roma/Gypsy and Traveller Children in Europe*. Volume 1 South-Eastern Europe, pp. 114-143.

Nacionalno vijeće za konkurentnost (2004). 55 preporuka za povećanje konkurentnosti Hrvatske. (National Competitiveness Council, 55 recommendations).

Nestić, D. (2002) Ekonomska nejednakost u Hrvatskoj 1998.: manja od očekivanja (Economic inequality in Croatia). *Ekonomski pregled*. 53, (2002) , 11-12; 1109-1150.

Nestić, D. (2004.) Raspodjela dohotka u hrvatskoj: što nam govore podaci iz ankete o potrošnji kućanstava? (Income distribution in Croatia). *Financijska teorija i praksa* vol. 1/2005*; 59-75.*

Nestić, D. (2005), "The Determinants of Wages in Croatia: Evidence from Earnings Regressions" u 65th Anniversary Conference of the Institute of Economics, Zagreb, Proceedings, Zagreb: Institute of Economics, Zagreb, pp. 131-162.

Puljiz, V., S. Zrinščak (2001). Hrvatska obiteljska politika u europskom kontekstu (Croatian family policy in a European context). Revija za socijalnu politiku vol.9; br. 2.

Pološki-Vokić, N. and D. Frajlić, 2004, Pokazatelji konkurentnosti hrvatske radne snage: rezultati empirijskog istraživanj. in J. Lowther, i P. Bejaković, eds., *Konkurentnost hrvatske radne snage*: zbornik radova IJF 2004.

Rutkowski, J., 2003, „Analiza i prijedlozi poboljšanja tržišta rada u Hrvatskoj." (Analysis and Suggestions for Improving Functioning of the Labour Market in Croatia), *Financijska teorija i praksa,* 27 4; pp. 495-513.

Šverko, B., Galešić, M., Maslić-Seršić, D. (2004). Aktivnosti i financijsko stanje nezaposlenih u Hrvatskoj. Ima li osnove za tezu o socijalnoj isključenosti dugotrajno nezaposlenih osoba? (Activities and financial status of the unemplyed in Croatia) *Revija za socijalnu politiku,* 11, 3-4, 2004, pp 283-298.

Šućur, Z. (2005a) Siromaštvo i socijalni transferi u Hrvatskoj (Poverty and social transfers in Croatia). *Financijska teorija i praksa* 29, 1; 37-58.

Šućur, Z. (2005b) 'Poverty as a Component of the Socio-Cultural Identity of the Roma', in Štambuk, M. (ed) *How Do Croatian Roma Live?* Zagreb: Institute Ivo Pilar.

Šućur, Z. (2000.) Socijalna pomoć (Social Assistance), in: Puljiz, V. (ur.) *Sustavi socijalne politike*, Zagreb: Studijski centar socijalnog rada Pravnog fakulteta.

Šućur, Z. (2000). Romi kao marginalna grupa (Roma as a marginal group), *Društvena istraživanja,* 9 (2-3); 211-227.

Šućur, Z. (2001). *Siromaštvo: teorije, koncepti i pokazatelji*. (Poverty: theory, concepts and indicators) Pravni fakultet. Zagreb, Hrvatska.

Šućur, Z. (2004). Socijalna isključenost: pojam, pristupi i operacionalizacija (Social Exclusion). *Revija za sociologiju,* 35 (1-2); 45-60

Šućur, Z. (2004). Pristup pravima opće socijalne pomoći (The right to social assistance), *Revija za socijalnu politiku vol* 1: pp. 21- 38.

Šporer, Ž. (2004). Koncept društvene isključenosti (The concept of social exclusion). *Društvena istraživanja,* 13 (1-2); 171-193.

Šverko, B., Galešić, M., Maslić-Seršić, D. (2004.). Aktivnosti i financijsko stanje nezaposlenih u Hrvatskoj. Ima li osnove za tezu o socijalnoj isključenosti dugotrajno nezaposlenih osoba? (Activity and financial situation of unemployed in Croatia: Is there is a ground for the theses on social exclusion of long-term unemployed) // *Revija za socijalnu politiku* **11** 3-4: pp 283-298.

Topping, K., Maloney, S. (eds.) (2005). *Inclusive Education.* Routledge Falmer. London, United Kingdom.

UNDP, (2004.) Nacionalno izvješće o milenijskim ciljevima razvoja. National Report on the Millenium Development Goals.

UNDO (2006) Aspects of Unemployment, Poverty and Social Exclusion in Croatia. Zagreb: UNDP.

Vlada Republike Hrvatske/ The Government of Croatia (2002). *Program borbe protiv siromaštva i socijalne isključenosti./ Programme for Combating Poverty and Social Exclusion.*

Vlada Republike Hrvatske/ The Government of Croatia (2003). *Nacionalna strategija jedinstvene politike za osobe s invaliditetom 2003.-2006./ National Strategy for the Integrated Policy for Persons with Disabilities 2003-2006*

Vlada Republike Hrvatske. (2004). *Strategija obrazovanja odraslih/Startegy for adult education.* Zagreb, Hrvatska.

World Bank (2000). *Croatia Economic Vulnerability and Welfare Study.* World Bank. Washington, D.C., USA.

World Bank (2000a). *Croatia Economic Vulnerability and Welfare Study - Volume II: Background Papers.* Document of the World Bank. Washington, D.C., USA.

STATISTICAL ANNEX FOR CHAPTER 3

Table 1. Households' opinion about their income (% of total households)

	2000	2001
With its monthly income, the household meets its end ...		
With great difficulties	14.9	11.7
With difficulties	28.9	29.0
Households whose actual income in lower than those reported as needed for living without difficulties	79.8	82.2

Source: Institute of Social Sciences Ivo Pilar (2003).

Table 2. Laeken indicators of poverty and social exclusion, 2004

No.	Indicator	Value	Data source
	PRIMARY INDICATORS		
1	At-risk-of poverty rate (by age and gender)		HBS
	Total	16.7	
	-men	15.1	
	-women	18.1	
	Breakdown by age and gender		
	0-15 years	14.8	
	-men	13.7	
	-women	15.9	
	16-24 years	13.1	
	-men	13.5	
	-women	12.7	
	25-49 years	12.3	
	-men	12.3	
	-women	12.4	
	50-64 years	15.0	
	-men	14.8	
	-women	15.1	
	65 years and more	29.5	
	-men	24.4	
	-women	32.9	
1a	At-risk-of poverty rate (by household type)		HBS
	One person household (total)	35.9	
	-men	27.6	
	-women	40.5	
	One person household, between 30 and 64 years	28.1	
	One person household, between 65 years and more	41.9	
	2 adults, no dependent children, both adults under 65 years	14.4	
	2 adults, no dept children, at least one adult 65+ years	28.7	
	Other households without dependent children	9.0	
	Single parent hh, one or more dependent children	21.0	
	2 adults, one dependent children	9.8	
	2 adults, two dependent children	10.5	
	2 adults, three and more dependent children	24.2	
	Other households with dependent children	13.1	

No.	Indicator	Value	Data source
1b	At-risk-of poverty rate (by the work intensity of households)	na	
1c	At-risk-of poverty rate (by most frequent activity and gender)		HBS
	Employed	4.4	
	-men	4.5	
	-women	4.3	
	Self-employed	22.6	
	-men	21.7	
	-women	23.8	
	Unemployed	32.0	
	-men	39.4	
	-women	25.7	
	Retired	20.5	
	-men	20.5	
	-women	20.5	
	Other economically inactive	19.7	
	-men	14.8	
	-women	23.0	
1d	At-risk-of poverty rate (by tenure status)		HBS
	Owner or free rent	17.0	
	Tenant	10.5	
2	At-risk-of-poverty threshold (illustrative values)		HBS
	One person household (in kunas)	20714	
	One person household (in euros, current ex. rate)	2764*	
	Two adults with two children younger than 14 (in kunas)	43499	
	Two adults with 2 children (in euros, current ex. rate)	5804*	
3	Inequality of income distribution S80/S20 quintile share ratio	4.5	HBS
4	Persistent at-risk-of-poverty rate	na	
5	Relative median poverty risk gap	22.4	HBS
6	Regional cohesion	na	
7	Long-term unemployment rate	7.3	LFS
	-women	8.9	
	-men	6.0	
8a	Population living in jobless households; children	7.4	LFS
8b	Population living in jobless households; prime age adults	11.2	LFS
	-women	12.0	
	-men	10.3	
9	Early school leavers not in education or training	6.2	LFS
	-women	5.2	
	-men	7.1	
10	Low reading literacy performance of pupils	na	

No.	Indicator	Value	Data source
11	Life expectancy	na (only national estimates)	
12	Self-defined health status by income level	na	
	SECONDARY INDICATORS		
13	Dispersion around the at-the-risk-of-poverty rate		HBS
	40% of national eq. disposable income	5.2	
	50% of national eq. disposable income	10.5	
	70% of national eq. disposable income	24.3	
14	At-risk-of-poverty rate anchored at a moment in time	na	
15	At-risk-of-poverty rate before social cash transfers		HBS
	-excluding all social cash transfers	41.4	
	-incl. retirement and survivors pensions and excl. all other	33.7	
16	Gini coefficient	0.29	HBS
17	Persistent at-risk-of-poverty rate (50% of median eq. income)	na	
18	In-work poverty risk	na	
19	Long-term unemployment share	7.3	LFS
	-women	8.9	
	-men	6.0	
20	Very long-term unemployment rate	5.7	LFS
	-women	6.9	
	-men	4.7	
21	Persons with low educational attainment	28.6*	LFS
	-women	34.8*	
	-men	22.1*	

Notes: * Authors calculations (for poverty threshold 1€ = 7.4952 kn); Income in-kind included in total income definition. Indicators are listed according to European Commission (2005).
Sources: Central Bureau of Statistics (for HBS-based data, Statistical Yearbook) and Eurostat (for LFS-based data, structural indicators)

Table 3. Rate of Registered Employment and Unemployment TREBA LI NAM TO

Year	Total Employed		Employed in the Private Sector		Employed in Total
	Carfts and Professions	Active insured and agricultural workers			
Unemployed					
1991	1701688	1358038	128654	214996	283308
1992	1481107	1187385	123370	170352	261050
1993	1446606	1148463	130452	167691	243096
1994	1437059	1124041	149172	163846	247555
1995	1417427	1099264	168682	149481	249070
1996	1329547	1012379	182739	134429	269263
1997	1310918	995437	192434	123047	287120
1998	1384841	1071220	200481	113140	302731
1999	1364495	1058439	205070	100986	321866
2000	1340958	1053260	204501	83196	357872
2001	1348308	1056141	216395	75772	380195
2002	1359016	1060108	228737	70171	389740
2003	1392510	1087710	241932	62868	329799
2004	1409634	1103093	252091	54451	309875
2005*	1405367	1098001	258332	49034	308739

Source: CBS [*1] From 1998 police and defence workers were included.[*] 2005 figures are provisional

Table 4. Composition of labour force by educational attainment, 2005 (first semester)

	Employed	Unemployed
	in % of total	
Unfinished primary school	4.7	2.1
Primary school (8 years)	17.0	16.6
1 to 3-year vocational secondary school	31.8	41.4
4-year vocational secondary school	24.7	26.7
General secondary school	3.5	4.9
2-year non university degree	6.8	2.9
University and postgraduate degree	11.5	5.4

Source: Central Bureau of Statistics (First Release on the Labour Force Survey Results)

Table 5. Composition of labour force by age, 2005 (first semester)

	Employed	Unemployed	Employment rate
	in % of total		*in %*
15-24 years	9.0	28.5	24.9
25-49 years	66.2	55.3	74.3
50-64 years	24.8	16.2	43.0

Source: Central Bureau of Statistics (First Release on the Labour Force Survey Results)

Table 6 Registered employment and unemployment by counties, December 2005

County	Employed	Unemployed	Unemployment rate
Zagreb County	66983	13432	16.7
Krapina-Zagorje	35055	6058	14.7
Sisak-Moslavina	42783	18290	29.9
Karlovac	35454	13546	27.6
Varazdin	60825	10099	14.2
Koprivnica-Krizevci	38843	7870	16.8
Bjelovar-Bilogora	35747	12302	25.6
Primorje-Gorski kotar	114954	17832	13.4
Lika-Senj	12950	3730	22.4
Virovitica-Podravina	23261	9771	29.6
Pozega-Slavonia	20750	5470	20.9
Slavonski Brod-Posavina	37777	15788	29.5
Zadar	42995	11361	20.9
Osijek-Baranja	88508	31288	26.1
Sibenik-Knin	27325	9850	26.5
Vukovar-Sirmium	40755	19260	32.1
Split-Dalmatia	138213	39653	22.3
Istria	80829	7076	8.0
Dubrovnik-Neretva	37186	8314	18.3
Medimurje	38292	7020	15.5
City of Zagreb	469908	39841	7.8

Note: Number of employed is approximated by the number of insured persons at Croatian Pension Insurance Fund, without insured persons employed abroad and persons with prolonged insurance. Number of unemployed persons by counties is taken from Croatian Employment Service. Total numbers for Croatia are slightly different than those from official sources. Data for this table result in unemployment rate of 17.1% for Croatia, while CBS figure for registered unemployment rate at that time was 18.0%.
Sources: Croatian Pension Insurance Fund, Croatian Employment Service and authors' calculations.

Table 7. Rate of participation in different levels of education in Croatia

	2002. / 2003.	**2003. / 2004.**	**2004. / 2005.**
Participation rate (% of relevant age group)			
- Preschool (3-6 years old)	44,9	46,0	48,4
- Elementary school (7-14)	95,0	95,5	96,2
- Secondary education (15-18)	83,3	84,5	84,8
grammar school	25,8	26,0	26,2
technical school	74,2	74,0	73,8
- Higher education (19-23)	37,8	39,4	42,2

Source: UNDP Millenium development goals report 2005.

Table 8.Total registered students, first year students and graduates in higher education in Croatia

Year	Total registered.	Total yr 1	Graduates	Proportion graduating of all starters*
	(1)	(2)	(3)	(4)
91/92	68720	26024	8680	
92/93	75514	27536	7856	
93/94	80410	33162	8275	
94/95	80185	31057	8394	
95/96	84208	31599	9298	
96/97	85752	32131	11311	43,5
97/98	90021	35712	11460	41,6
98/99	91874	34939	13286	40,1
99/00	96798	39558	13315	42,9
00/01	100297	41524	13510	42,8
01/02	107911	44038	13810	43,0
02/03	116434	47225	14868	41,6
Total		370945	117527	

Note: Proportion of graduates is calculated as column (3) divided by column (4) with a 5-year lag.

Source: CBS staitstical year book

Table 9. Indicators of housing standards in Croatia

Indicator/Year	1951	1971	1991	2001
No of Flats in 000s	882	1.189	1.576	1.660
Average size of flats m2	38.108	62.569	110.972	120.973
Average m2 per inhabitant	9,8	14,1	23,2	27,2
Avge no of people in a flat	4,4	3,7	3,0	2,74

Source: CBS Census

Table 10. Housing conditions of the poorest

Housing conditions	Total population (%)	Poor population (%)
Flats with less than 10m2 per person	8,1	25,0
No connection to electricity	0,3	2,1
No WC in the flat	8,8	37,2
No bathroom	7,9	38,1
No running water	5,7	22,0
No sewage connection	24,0	45,2
No telephone	10,7	40,1
No tv	3,2	17,0
No fridge or freezer	5,9	16,6
No washing machine	8,9	32,6

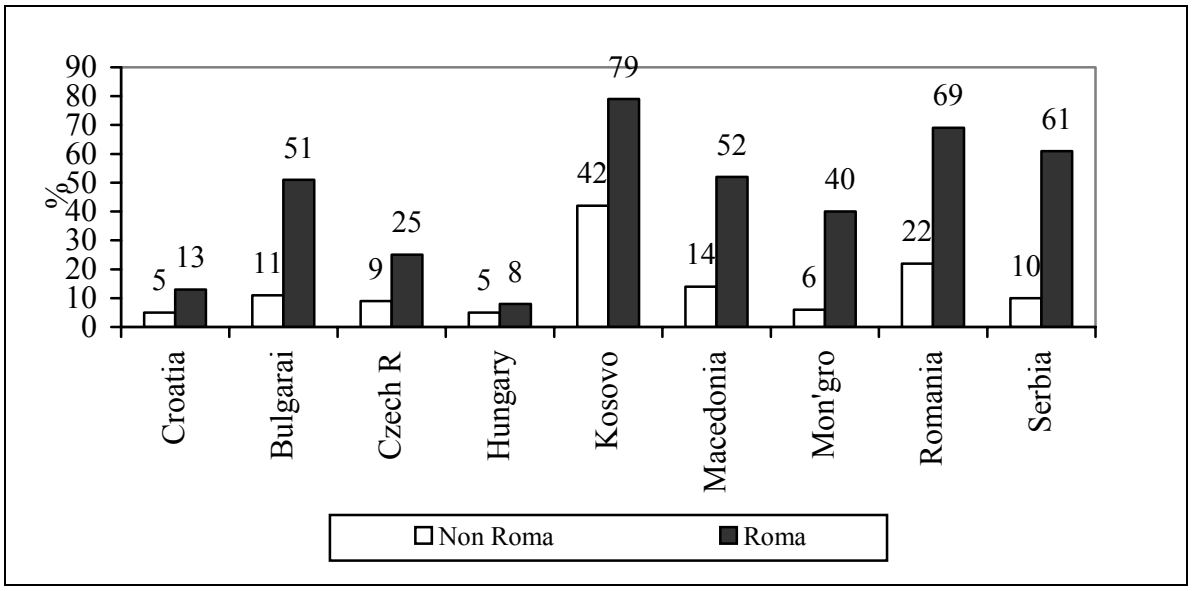
Note: Poor are defined as those in absolute poverty.
Source: World Bank (2000)

Table 11. Rate of risk of poverty according to gender

	2001.		2002.		2003.		2004	
Income	Money + In-kind		Money	Money + In-kind		Money	Money + In-kind	
	Money	Money + In-kind		Money				
At risk of poverty rate	17,2	20,5	18,2	21,9	16,9	18,9	16,7	18,8
Gender rate								
M	15,4	19,1	17,7	21,6	15,8	17,7	15,1	17,0
F	18,7	21,8	18,6	22,2	17,9	20,1	18,1	20,5

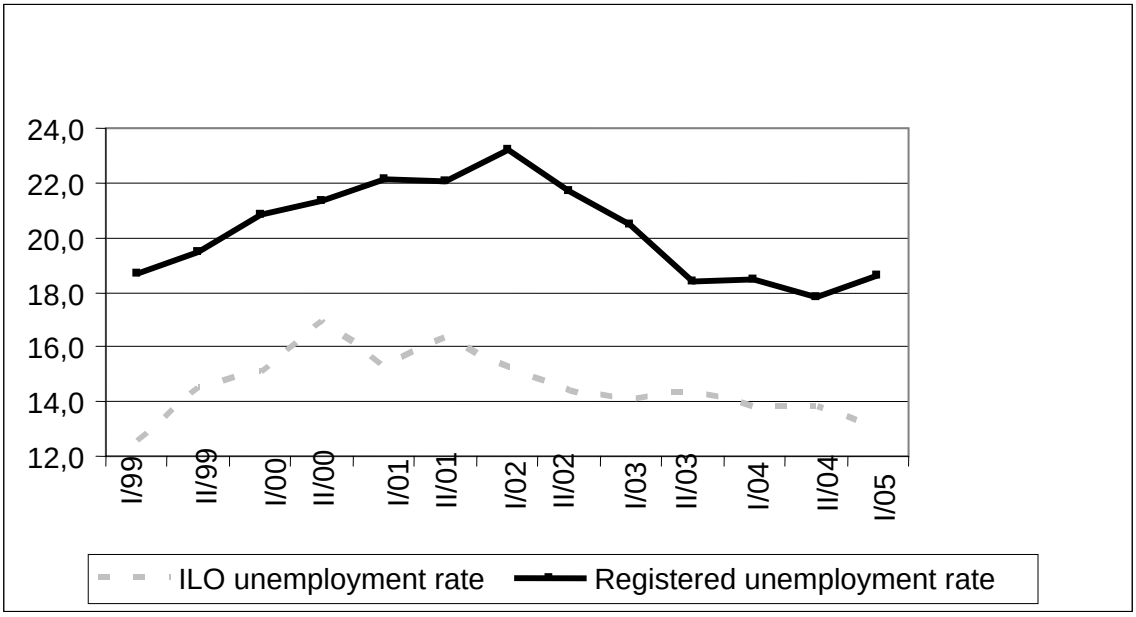
Source: CBS

Figure 1: Rates of poverty of Roma and nearby non-Roma



Source: Faces of Poverty, Faces of Hope, http://vulnerability.undp.sk
Note: Using internatinal poverty line of 4.3 USD per person at PPP

Figure 2: Trends in Unemployment Rates



Chapter 4: The Social Protection and Social Welfare System

4.1 Current Structures

4.1.1 Organisation of the State Social Protection System

1. At the national, state level, the main responsibilities for social protection and social welfare are divided between the Ministry of Health and Social Welfare (MHSW) and the Ministry of the Family, Veterans and Inter-Generational Solidarity (MFVS). Employment services are the responsibility of the Ministry of Economy, Labour and Entrepreneurship (MELE). Pension Services are the responsibility of the Croatian Pension Insurance Fund (PIF). In addition, the Croatian Counties, cities, and municipalities also hold some social welfare responsibilities and carry out social programmes some of which, as in the City of Zagreb, are significant enough, but independent of central programmes, to merit the description of parallel social protection systems.

Ministry of Health and Social Welfare (MHSW)
2. This Ministry, newly created after the 2003 election, is responsible for health services, as well as for most social welfare services (see also chapter 6). The key institutional structures for the delivery of social welfare services are the Centres for Social Welfare (CSWs), created in the early 1960s, which administer social assistance payments, manage placements in social service institutions, and support home care services. Currently, in Croatia there are 80 CSWs and 24 smaller sub-offices, usually in geographically distant locations, linked to a total of 15 main CSWs. Zagreb City CSW consists of 11 sub-offices and an administrative office. The CSWs are de-concentrated units of the MHSW and, as such, cover the territory of one or more municipalities. At the end of 2004, some 1,892 persons worked in CSWs, an increase on 2000 of only 0.4%. The breakdown of staff in terms of tasks and professional expertise is shown in Table 4.1 below. In terms of residential care, there are three types of residential facilities: State-run homes, County-run homes (formerly state-run until a legal change which came into effect on1 January 2002) and non-state, privately run homes, either on a not-for-profit or for-profit basis. The structure of residential care is outlined in Table 4.2 below.

Ministry of the Family, Veterans and Inter-Generational Solidarity (MFVS)
3. This Ministry, newly created after the 2003 election, has responsibility for policies, strategies and services regarding the family, children and youth, people with disabilities, war veterans and victims of war, and old age pensioners. The Ministry has opened a number of Family Counselling Centres, offering a number of services including marital and divorce counselling, previously offered by CSWs. Thus far, seven centres have been opened, with five more planned to be opened in 2006.

Ministry of Economy, Labour and Entrepreneurship
4. Again, a newly created Ministry in 2003, this Ministry is responsible for the work of the Croatian Employment Services (CES) which registers the unemployed, administers unemployment benefit, and provides training, advice and placement services. The CES consists of a Central Office, 22 Regional Offices and 93 Local Sub-offices. At the end of 2004, it employed some 1,197 people.

Regional and Local Units of Self-Government
5. Each County, or regional unit of local self-government has an Office for Health and Social Welfare, as do the cities and larger municipalities. Counties are now the owners of formerly state-run homes for older people, and municipalities make a contribution to the running costs of CSWs. Otherwise, little is known about the work of regional and local governments in the social welfare field, other than that spending varies greatly and, in the context of the richer areas being able to afford more, seems likely to be in an adverse relationship to needs (cf. Bežovan and Zrinščak, 2001).

4.1.2 Benefits and Allowances

1. Unemployment benefit
Unemployment benefit is paid to all insured persons who have worked for at least 9 months in the last 24 months (women with children under 1 year of age are exempt from this condition), providing they register with the Employment service in the first 30 days of unemployment. A monthly sum of between 797 HRK (c. € 110) and 1000 HRK (c. € 137), calculated on the basis of the last three months salary, but never more than 20% of the person's average wage, is paid for a period between 78 and 390 days, depending on years of employment. A lump sum amount of between 2 and 6 monthly benefits is also paid. Those with the longest service (over 32 years for men, rising to over 35 years by 2007; and 27 to 30 years for women) receive benefit until re-employed. Unemployment assistance of 797 HRK is paid to those who participate in vocational training (NN 32/02 as amended in NN 1576/03 and 2187/03, translation at http://www.hzz.hr/DocSlike/ActJobPlacement.doc).

2. Maternity Benefit
Obligatory parental leave for mothers begins 28 days before the expected date of childbirth. Maternity benefit, between 1,600 HRK and 4,250 HRK per month, based on salary, is payable until the child is 6 months old. After the child is 42 days old, the father can opt to take parental leave in place of the mother. Additional benefit of 1600 HRK per month, can be claimed until the child is one year old (2 years old in the case of twins). Unemployed mothers receive 900 HRK

per month for the first 6 months maternity period. In addition, a lump sum maternity grant of 1,360 HRK is payable to all mothers.

3. Child Benefits

This topic is also dealt with in paragraph 3.2.4.6 above. The Law on Child Allowance from 1999, entering into force in 2000, broadened the right to child benefit to all children, replacing an earlier law which restricted it only to the children of those employed. In addition the manner of financing the allowance was changed. Instead of financing through contributions, it became financed through from the state budget, i.e. through general taxation. After the new law was introduced the number of beneficiaries increased significantly (there was a 60% increase between 1999 and 2001). Faced with a significantly increased fiscal burden, the Government prepared a new Law conditioning the right to child allowance based on family income, which entered into force on 1 January 2002. Now, child benefits are means-tested, although still funded from taxation and paid only to households with income less than an equivalent of 1,330.40 HRK for each individual, to an amount of 166.30 HRK per month for each child up to the age of 15, or 19 if in higher education. In households with income of less than 665.20 HRK per month, child benefit of 299.34 HRK is paid for each child up to 19 years of age. Child support for children with severe health problems is payable at a rate of 831.50 HRK per month up to age 27. In December 2005, 236,986 households received child benefits, for a total of 445,954 children, representing approximately 45% of all children in Croatia. This is a reduction of some 4.4% on 2004 and a significant decline from the peak figure of 628,654 children in 2001 under the old law.

4. Social Assistance Benefits

A basic social assistance benefit (or maintenance allowance) of up to 400 HRK for a single person, or for a family (based on an equivalence scale of 80% of the base) is paid if, according to the assessment of CSWs, a person has insufficient income. The amount was raised from 350 HRK in 2001 but has not been raised subsequently. In addition, single payments, housing allowances and in-kind benefits can also be paid (cf Šućur, 2004).

5. Sickness Benefits

Sickness benefits can be paid to insured persons for up to 6 months of consecutive illness, with the employer paying for the first 42 days. Usually, sickness benefit is paid at a level of 70% of average salary earned in the previous 6 months, but can be 100% if the sickness results from a work injury, occupational disease, participation in the war, pregnancy or childbirth, or nursing a sick child up to age 3.

6. City and County Benefit Schemes – the example of the City of Zagreb

As an example of the additional benefits which can be paid by regional and local self-government, the (untypical) example of the City of Zagreb serves as a useful case example (see web http://www.zagreb.hr/Dokument.nsf/VPD/317A33FD1385DA6AC1256F8E002EA297?OpenDocument&08). The City pays additional pensions and also the following benefits:

i. Financial support to new born children. From 1 March 2006, non-means tested one-off payments of 3,000 HRK for the first child; 6000 HRK for the second child and 9,000 HRK for the third or subsequent child replace top-ups of child benefits.
ii. In-kind support to families with three or more children.
iii. Milk to children from 0-12 months old.
iv. Funeral expenses for those with no means.
v. Health protection for unemployed persons
vi. Free school books for all primary school pupils.

4.1.3 Financing of the Social Protection System

1. As is to be expected given its origins in the Bismarck-influenced Austro-Hungarian empire, the Croatia social protection scheme is largely insurance-based, with rights related to contributions made during employment, supplemented by certain direct central budget financing. The details of health (chapter 6) and pension insurance (chapter 5) financing are discussed elsewhere but are included in brief here in order to ensure a complete picture.

2. Following a change in the Law, employees do not pay contributions towards unemployment benefits, whereas employers pay 1.7% of payroll up to a limit of 31,860 HRK (a lower limit of 2,080.75 HRK applies with contributions for employees with lower earnings paid as though they earn this amount). Child benefits are now paid from central funds. Sickness benefits are funded through employer contributions, 15% of payroll, plus 0.5% of payroll for work injury and occupational diseases. Employees do not contribute, except for farmers who contribute between 7.5% and 15% and self-employed persons who also contribute 15% plus 0.5% as for employers. County and local authority benefits are financed through tax revenues. Pension contributions are explained in greater detail in chapter 5 below. Employee pension contributions are 20% under the first, compulsory state insurance, pillar or, if the employee is in the second pillar, 15% to the first pillar plus 5% to the second, compulsory private, pillar. The total rate of contributions in 2005 is, therefore, 37.2%, made up of 20% employee and 17.2% employer contributions (Kesner-Škreb and Kuliš, 2005 web: http://www.ijf.hr/eng/taxguide/05_05/social_security.pdf - see table 4.3). The relevant Laws on Insurance are NN 147/02; 175/03; and 177/04, with NN 167/04 regulating the bases for contributions in 2005.

3. The costs of social protection have risen considerably between 2000 and 2004, as shown in Table 4.4 below, even when taking into account falls in salary and material costs between 2001 and 2002, largely as a result of transferring costs of old people's homes from state to county level. Jurčević calculates that, overall, the costs of social protection covered by the relevant central Ministry has fallen as a percentage of Croatia's GDP from 1.29% in 2000 to 1.07% in 2004. When the cost of decentralised social welfare functions (mainly old persons homes) are added back in, the fall is less, from 1.29% to 1.19% in 2004. In any case, the proportion of GDP spent on social welfare benefits has risen from 0.59% of GDP in 2000 to 0.71% of GDP in 2004.

4. A truer picture of total social protection expenditures would need to add a number of other costs including the administration and payment of child allowances; maternity benefits; unemployment benefits; and war veterans. A recent World Bank document attempts to put all these together although the basis of the calculation is not given and, in addition, figures for social welfare spending differ somewhat from those above. Nevertheless, it does give an indication of the special circumstances of social expenditures in Croatia in terms of the proportion spent on veteran's benefits. Even when these are included, social benefit expenditures in Croatia seem stable at around 4% of GDP (see table 4.5).

4.1.4 Social Services Provision: the balance between residential and community-based approaches

1. As Figure 4.1 demonstrates, every social protection system has to strike a balance between institutional forms of care and non-institutional or community-based care. In Croatia, various Laws have sought to facilitate and strengthen community-based approaches to social protection. In addition, a number of Laws have sought to make it easier for non-state providers to open institutional care facilities. Finally, as noted above, from 1 January 2002, state-owned homes for Older and Infirm Persons became formally owned by County authorities.

2. At the present time in Croatia, according to the official statistics of the Ministry of Health and Social Welfare, there are eleven different types of social welfare institutional care facilities in Croatia. Numbers in each type of care at the end of 2003 and the end of 2004 are shown in Table 4.6 below. The eleven types of care are:

i. State-owned homes for children lacking parental care. At the end of 2004, there were 14 such homes caring for 1073 children, ranging from the largest with 294 children to the smallest with 33 children. Most of these children are, either, orphans or come from at-risk families. All are, technically, under the

supervision of a social worker from a CSW. The age structure of children in care in these homes is shown in Table 4.7 below, comparing numbers at the end of 2003 with numbers at the end of 2004. the figures show some small reduction in overall numbers, including children under 3 years old. Figures from the end of 2001 (Stubbs and Warwick, 2003) show 1,024 children in this type of institution, including 139 aged 3 or under. This suggests that there has been no significant deinstitutionalisation, particularly amongst the most vulnerable population. In addition, there is no information about the amount of time spent in institutional care although the numbers suggest that there is not a large in- and out-flow of children each year. The numbers of young people aged 18 or over in these homes is also a cause for concern, indicating the lack of adequate after-care of half-way-house facilities to promote re-integration into the community.

ii. State-owned homes for children and young people with behavioural difficulties. At the end of 2004 there were 11 such homes in Croatia, caring for a total of 1,103 children and young people, varying in size from 29 residents to 488 (the large complex in Zagreb). Residents range in age from 10 to 21 years, and are subject either to court orders for offending behaviour or are deemed by social workers to be at risk. Again, length of time in care is not known. The majority in care (838) are boys. Just as with homes for children lacking parental care, there has been little systematic reduction in numbers of institutionalised children and young people, with 1,212 in care in 2001. Most worryingly, there has been a rise in children aged from 10 to 12 years from 157 in 2001 to 273 at the end of 2004.

iii. State-owned homes for physically and mentally disabled children and adults. 17 such homes in Croatia had a total of 3,052 residents at the end of 2004, ranging in size from 17 to 463. Perhaps most worrying, a significant proportion of residents aged 8 and under (a total of 257) or between 9 and 15 (a total of 569). Indeed, in these homes, notwithstanding deinstitutionalisation efforts, there appears to have been an increase in numbers since 2001 when there were 2,867 residents. The nature of the disability, and its extent, is not noted from the figures, although many residents are in care as much for social reasons, lacking a carer, as for any rehabilitation or therapeutic purpose. In addition, there is little co-ordination between health and social welfare institutions so that a number of children and adults are 'lost' in health care institutions.

iv. State-owned homes for mentally ill adults. There are 18 such homes, part of the social welfare system, looking after 3,471 adults, ranging in size from 16 to 456. Over one third of all residents are 65 years of age or over with 343 aged over 80. Again, length of time in care is not known but appears likely to be extremely long.

v. Non-state owned homes for children lacking parental care. There are four such homes in Croatia, caring for 503 children. All are run by NGOs, two by SOS Children's Village, one by Caritas and one by Nuevo Futuro. All were built in the 1990s. There are only 31 babies and infants under three years old in these homes. Interestingly, though, the vast majority of residents have their costs wholly (433) or partly (32) covered by the state.

vi. Non-state homes for physically and mentally disabled children and adults. There are 15 such homes ranging from 14 to 370 inhabitants. There ownership is not clear from Ministry figures, many being termed 'Centres for Work Therapy and Rehabilitation' just like their state-owned counterparts. 191 residents are 8 or under and an additional 173 are between 9 and 15 years old. Again, the overwhelming majority have their costs wholly (1,106) or partly (247) covered by the state.

vii. County-owned homes for older and inform persons. 10,168 persons live in 46 County homes, with size varying from 42 to 648. Almost half of all residents are classified as mobile (4,734) and many of these live in semi-independent flats within a complex. 2,530 are classified as semi-mobile and 2,904 as immobile. 37 residents are under 40 years of age with a further 115 between 40 and 50 years old and 334 aged between 50 and 60. Just over half of all residents (5,404), or their families, pay for their accommodation.

viii. Non-state-owned homes for older and infirm persons. This category, a combination of private for-profit and not-for-profit facilities, has experienced the largest recent growth. In total, there are now 57 such facilities, from only 10 in 2000, with numbers of residents ranging from 8 to 157. Hence, clearly, on average, these institutions are on a more human scale than the county-owned homes. The state covers all (275) or part (262) of the costs of a relatively small number of residents.

ix. Non-state-owned homes for adults with mental illness. Four such homes exist, accommodating in total 323 residents, ranging from 30 residents to 133. All are new, and the state pays full costs (158) or part costs (106) of the majority of residents.

x. Non-state homes for people addicted to drugs, alcohol or other substances. Two such institutions exist, one in Split accommodating 104 persons, and in Đurmanec accommodating 15. The state pays full costs (91) or part costs (18) of the overwhelming majority of residents.

xi. Non-state homes for children and adults, victims of family violence. There are two such institutions recorded in the Ministry statistics, although others have recently opened. The two are a Caritas run home in Rijeka (with 105 residents)

and a home in Rovinj (with 25 residents), all of whom are paid for by the state. 83 inhabitants are children and 47 adults.

3. In short, there is little or no evidence to suggest that Croatia has made progress in terms of deinstitutionalisation. Table 4.8, based on the State Bureau of Statistics Yearbook for 2005, shows trends in the numbers of children and adults in institutional care since 1980. This shows a consistent rise of adults in care (primarily older persons) and a worrying rise in children in care, after a sharp fall between 1990 and 1992, itself related to war events. Apart from in 2002, levels of children in care in 2004 are higher than at any time since 1990. Whilst, in some senses, the numbers of older people in care can be expected to rise, it is more important to note the absence of any significant deinstitutionalisation for all other client groups.

4. There are no similar statistics regarding community-based services or their usage. Here we note what is known regarding non-institutional support services for each client group:

i. Children without adequate parental care. In recent years, there has been increasing attention to placement of young children in foster families rather than in institutions. A campaign 'Every Child Deserves a Family' run by UNICEF and the Ministry has succeeded in raising awareness of the importance of substitute family care and in increasing applications. There remain, however, significant shortfalls of foster families in Croatia and significant regional variations in the willingness of families to come forward. The latest figures from the National Bureau of Statistics suggest that, in total, 2,297 children were in foster care at the end of 2004, including 360 physically or mentally disabled children. In addition, a number of NGOs and some local authorities offer a range of community-based services ranging from counselling centres to emergency 'crash-pad' facilities. In addition, there is increasing awareness, reflected in a range of services, of child abuse and sexual abuse.

ii. Children and young people with behavioural difficulties. A small number of NGOs are specialised in offering community-based services to this group, including young people in trouble with the law. Recent changes to the Law on Juvenile offending mean, in fact, that NGOs can offer non-custodial treatment sanctioned by the courts. In addition, there are a range of preventive services being offered. There remain real shortfalls in services for young people leaving care (aftercare services) with very few half way houses or sheltered accommodation for highly institutionalised young people. A small number of local authorities, working with NGOs, have made available housing units for this purpose.

iii. People with mental and physical disabilities. Gradually, there is increasing awareness reflected, to some extent in provision, of the need for a range of community-based, flexible, services for both physically and mentally disabled persons. With regard to persons with intellectual disabilities, there has been a drastic reduction in the provision of state-supported sheltered employment workshops, declining from 39 such workshops for some 3,500 people in 1993 to just 4 workshops for some 400 people today (OSI, 2005; 77). For both groups, assessment of disability is over-medicalised and, in terms of services, there is insufficient co-ordination between health, education and social welfare services. Again, it is left to a few more enlightened local authorities and innovative NGOs to offer a range of services including counselling, job coaches, day care, and so on.

iv. People suffering from mental health problems. This group is largely hidden from view, with insufficient community-based support services. Very few NGOs focus on this group. A recent report concluded that the lack of community-based services is, in part at least, traceable to the fact that "Croatia is missing a formulated and comprehensive mental health policy" (Jané-Llopis and Anderson, 2006; 39).

v. Older people. There are now a range of home-based care services available from state, NGO, and for profit providers. Sometimes, existing County-run old persons homes also offer day care, drop-in and community-support services.

4.1.5 The Emerging Welfare Mix: the role of not-for-profit and for-profit service providers

1. Croatia had 27,260 registered Associations of Citizens in 2004, equal to 6.1 per 10,000 population. These associations cluster in or near Zagreb and the other three largest cities (Bežovan et al, 2005; 29). There is a long tradition of civil society in pre-independence Croatia and one important group remains the long-standing social welfare NGOs, often representing the interests of people with disabilities which, whilst often in receipt of state funding, often suffer from a lack of innovation and pro-active stance. Other types of NGOs have emerged since independence, including largely professionally-led social welfare NGOs, human rights and advocacy-oriented NGOs, and smaller, voluntary based self-help local organisations. The latest CIVICUS report on the civil society sector in Croatia suggests that very few Croatian NGOs are active in issues of poverty reduction (ibid, 56-7), although there is increasing emphasis on work with women and with marginalised groups. The report notes the slow erosion of a monopoly by state agencies over social services and the increasing activity of NGOs in the fields of therapeutic communities for addicts; shelters for abused women; home care services; legal advice services; and support to people with

disabilities. Certainly, a small number of leading NGOs such as the Association for the Promotion of Inclusion, the Centre for Social Policy Initiatives, BaBe, Mirta, and others have managed to merge advocacy activities with demonstration projects on the value of community-based services.

2. The funding of NGOs to engage in social welfare activities in Croatia remains uneven and insufficient. Most importantly, notwithstanding initiatives under the CARDS programme, little funding is long-term contract based. At the central level, one of the priorities of the new national Foundation for Civil Society development, funded by lottery money, is to promote the role of NGOs in the social welfare field. This remains, however, on quite a small scale. In addition local and regional government funding to NGOs, with some notable exception such as the city of Split, is short-term, inconsistent and, most importantly, non-transparent. Split has an annual competition for social and health projects, linked to a clear strategic plan and set of priorities. Elsewhere, local social planning and longer-term partnerships between CSWs, NGOs, and local authorities are not well developed. There is increasing business interest in supporting NGOs and in engaging in community partnerships, with some leading business, notably Zagrebačka banka (2005), holding an annual competition for NGO projects. The extent of parts of the sector's continued dependence on foreign funding is also important in terms of sustainability.

3. In many ways, the role of the private for-profit sector in social protection in Croatia is less understood than that of the not-for-profit sector. As noted above, the private sector has moved into the institutional care of older people in a significant way in recent years. There are still, however, unresolved questions regarding pricing, cross subsidisation and licensing which need to be resolved.

4.1.6 Coverage

1. At the end of 2005, a total of 118,943 persons were in receipt of permanent social assistance in Croatia, including 25,201 persons living alone and 27,126 families. As Table 4.9 shows, this is a slight decrease on the previous year but still a significant increase since the year 2000. Jurčević (2005) has analysed recipients in 2004 in great detail, showing that some 24% of all beneficiaries had been receiving the benefit for between 2 and 5 years; 30% for between 5 and 10 years; and 4% for over 10 years. The largest category of recipients (45.3%) were unemployed but capable of work. Of these 38.4% had no education or had not completed elementary school (Jurčević, 2005; 354).

2. In total, 257,335 persons, or 5.8% of the population were in receipt of some state social assistance in 2004, 43% more than in 2000. Jurčević, however, compares this with an at-risk of poverty rate of 16.7%, and the fact that a family

of four needed 3,624.92 HRK per month to reach 60% of median income. Particularly noteworthy is the regional distribution of social assistance claimants, as Table 4.10 shows, proportionate to their contribution to the total population, with those in bold, mainly the war affected areas, where social assistance beneficiaries are over-represented in the population.

3. The National Programme for Roma in 2002 included an estimate that 13.56% of all social assistance beneficiaries were Roma although the basis of this figure, presumably social workers' judgements is not questioned. Officially, Roma are 0.21% of the Croatian population although most estimates suggest that the real figure is up to four times this.

4.1.7 Public awareness and acceptance

1. There has been very little systematic study of public attitudes towards the social protection system and the professions who work within it in Croatia. One study by Knežević and Butler (2003) covers a fairly large sample of 852 respondents but this is very skewed towards people like the social work students who administered the questionnaire. Hence, the finding of a large degree of understanding of, and positive appreciation of, the professional of social work may not be generaliseable. It is also important to note that, in the study, the context of actually practising social work in CSWs was not addressed.

2. Studies of public opinion and of values (cf. Milas, 1997; Baloban (ed), 2005) show high levels of awareness of social issues amongst the Croatian population, as well as somewhat contradictory adherence to social solidarity and to individual independence. Again, however, there are no studies of perceptions towards benefit recipients or to social protection services. In addition, it is important to note that media coverage of social protection issues tends to be framed in terms of individual cases and to involve explicit or implicit criticism of the functioning of CSWs and/or social welfare homes.

4.2 Evaluation of recent and planned reforms

4.2.1 Recent Reforms in Social Protection

1. It is possible to divide post-independence Croatian social protection, and its reform, into four distinct phases (cf. Puljiz, 2005; Stubbs and Zrinščak, 2005) as follows:

Phase 1: War, Crisis and State-Building (1991-1995): This period saw an immense challenge to the social protection system, in terms of the war crisis reflected, not least, in massive reductions in GDP per capita, damage and destruction, and the influx of large numbers of refugees and displaced persons. The response was, largely, one of crisis management, with some reduction of

social rights but, also, a scheme to encourage earlier retirement as a way of reducing unemployment. Most importantly, the Social Programme of 1993 extended the system on the basis of the principle of solidarity. Humanitarian assistance to forced migrants was channelled through CSWs and through emerging international and national NGOs. Hyper inflation was brought under control by a 1993 fiscal stabilisation package.

Phase 2: Post-war social claims and initial reforms (1996-1999): Elements of a 'captured' social policy emerged in response to claims by both war veterans and their families and by pensioners. Pension reform began relatively early in this phase, with emphasis on a three-pillar system. A set of demographic policies were also introduced but proved difficult to finance. In addition, action was taken towards the end of this period to improve the legal and financial position of NGOs, in the context of an earlier repressive climate (Cf. Stubbs, 1997). Crucially, in 1997 and 1998, a series of linked reforms in social protection emerged, including a new Social Welfare Act (NN 73/97), introduced in 1998, which sought to rationalise and modernise the Croatian social security system. Crucially, it established the principle of individual responsibility for their livelihood and that of their family, with state and local authority intervention only in cases where people could not meet this responsibility. It also added NGOs and religious associations as providers of social welfare, and sought to ensure that local authorities spent at least 5% of their budgets on social services in the form of subsidised housing.

Phase 3: Democratic change and social reforms (2000-2003): With the election of a reform-minded coalition government in 2000, pension reforms were completed. In addition, EU membership began to be pursued as a clear policy goal. In April 2002, a comprehensive Social Welfare Reform project was initiated. The first phase, lasting a year, was funded by the World Bank, DFID and the Government of Japan. The initiative was a follow-up to a broad reform document drawn up by the Assistant Minister in the Ministry of Labour and Social Welfare, and a leading social policy scholar (Puljiz and Žganec, 2001) which sought to set out an agenda for the modernisation and increased efficiency of the system, in terms of principles of decentralisation, de-institutionalisation and a broadening of participation by non-state actors. Some elements of decentralisation were introduced in the amendments to the Social Welfare law in February 2001 but the document envisaged a much more comprehensive overhaul of the system. Consequently, teams of foreign and local experts worked on six-inter-related reform themes: fiscal and decentralisation issues; social assistance; social services; employment and labour policies; IT and database issues; poverty monitoring and statistics. Whilst a final synthesis document was produced from this work (Žganec et al, 2003), the ambitious and, at times, contradictory, agenda was interrupted by the election. At the same time, social protection issues began to appear in a number of strategic documents produced in this

period including National Family Policy; National Youth Policy; Strategy for Persons with Disabilities; National Strategy for Roma; and so on, which are also noted above in Chapter 2.

Phase 4: Consolidated Democratic Transition (2004 – date): As noted above, wholesale reform created new Government Ministries. In terms of social protection, after a brief hiatus, the main initiative has been the continuation of Social Welfare reform through a World Bank Specific Investment Loan of 40 m. USD (€31 m) from October 2005 to September 2009. The details of this are discussed below. In addition, some of the policies and strategies noted above have been updated. An Institute for mental health has been created, and there is discussion on new legal provision regarding persons with disabilities.

The Social Welfare Development Project (SWDP).

2. This project was signed by the Government of Croatia and the World Bank on 6 July 2005. Total cost of the four year project is 60.3 m USD made up of an IBRD loan of 40 m USD (€31 m), Government of Croatia contribution of 18.3 m USD (c. €14. 2 m) and a SIDA grant of 2 m USD (€1.5 m). The Project has three components, as follows:

i. Improving social services delivery (cost €5.3 m, IBRD loan €3.9 m). This will seek to make social services more inclusive, family oriented and efficient. It will introduce a new organisational model for social welfare, including reorganised CSWs and new Methodological centres. It will focus on three selected counties (Splitsko-Dalmatinsko; Zadarska; Osječko-Baranska).

ii. Strengthening social welfare management information system (cost €7.0 m, IBRD loan €4.3 m). This will finance a new organisational model for CSWs as a 'One-Stop-Shop', bringing together cash and non-cash benefits. It will also finance a new management information system to ensure a common register of beneficiaries.

iii. Upgrading of existing social services facilities (cost € 34.0 m, IBRD loan € 22.8 m). In response to a specific request of the new Government, following a review of residential care which suggested that 70% of all residential institutions fail to meet public health standards, this component will finance repairs to residential institutions and finance renovation or construction of CSWs.

3. The SIDA grant will not be used, as originally envisaged, to support a UNDP-implemented Policy Monitoring Unit within the Ministry. Rather, it is now a direct contribution to the IBRD and will finance most of technical assistance and training activities under the SWDP Project related to reorganisation and modernisation of social service delivery and streamlining and simplification of social benefits and their administration. The grant agreement was signed on 21 February 2006, and supports a number of SWDP outcomes including:

a. A certain number of people will be deinstitutionalized, whether by being returned to their own families or by organizing independent living.

b. Referrals to residential institutions in pilot areas will be reduced by 10 percent.

c. At least 15 percent more clients than today will be served in programs that prevent institutionalization and help integration into society.

d. Social workers will have more time to provide social services rather than to focus on administrative work.

e. Social benefits will be better targeted and the errors of inclusion and exclusion will be minimized through continued policy and administrative development. (World Bank Croatia web site, 21 February 2006).

4. There are still many unknowns within the project including the nature of new Methodological Centres, the precise role of County-level CSWs; and the exact nature of the piloting process. In addition, the relationship between this reform and a proposed restructuring of cash benefits is not clear. The nature of the programme in relation to deinstitutionalisation remains vague and there is little emphasis on local social planning. The programme does little to tackle the importance of expanding a welfare mix in Croatia. In addition, following a lengthy consultative process up to the initial draft of the programme, it could be argued that later versions have introduced changes for which there has been very little consultation with staff in the field.

Social protection components of the Programme Adjustment Loan (PAL)

5. Part of the proposed PAL agreed between the World Bank and the Government of Croatia in 2005 envisages the development of a common, rational, effective and efficient sustainable social benefit policy, in particular between those benefits administered by the MHSW and those by the MFVS. One part of pillar III 'Enhancing Fiscal Sustainability of Sector Programs' relates to Reform of Social Benefits. Following the establishment of an inter-ministerial working group, and agreed social benefit strategy is meant to be in place, with the goal of reducing total spending on social benefits from 4.1% of GDP to 3.5% of GDP, whilst increasing the share of the best-targeted and means-tested social support allowance (World Bank, 2005b). The strategy is meant to be in place very soon. The concern is that the political problems relating to reducing veterans' expenditure might lead to reductions in other programmes.

CARDS 2002, Social Services Delivery by the Non-Profit Sector

6. An EU-funded project costing some 1.5 m Euro combines technical assistance and a grant scheme in the field of social services delivery by the non-profit sector. The Danish consultancy company PLS Ramboll runs the programme in

partnership with the National Foundation for Civil Society development which manages the grant projects. Ten projects by NGOs were chosen to last 12 months with EC funding of between 35,000 and 72,000 Euros (http://www.delhrv.cec.eu.int/files2006/06-01-20/Grants_CARDS_2002_SSD_en.pdf)

The Programme of Combating Poverty and Social Exclusion

7. During the first half of 2001, the then Ministry of Labour and Social Welfare developed this programme, based on the advice of an expert working group. A shortened version of the text was published in the Croatian Journal of Social Policy (Ministry of Labour and Social Welfare, 2001). Measures were grouped into the following categories: Employment programmes; Health: Education; Social housing; Family policy; Refugees, Displaced and Areas of Special State Concern; and Social Assistance and Social Services. The measures were of a very general nature. As noted above (chapters 2 and 3), the programme was amended and added to in 2003 but, as a result of a change of Government, it was never ratified nor presented in any systematic way to the public.

4.2.2 Political and Policy Direction of Future Reforms

1. The next period will be important in terms of the need to develop a more holistic, 'joined-up', integrated approach to reform based on inter-Ministerial co-operation. Only in this way will the social protection system be rationalised and begin to strike more of a needs-based response to the competing claims of war veterans and their families, pensioners, the unemployed, and others in need. In general terms, the main 'driver of change' in the system is a sense that costs are increasing. However, the rationalisation of services would be at the expense of powerful lobby groups so that there remains, in many ways, a status quo position. In many ways, then, social protection is a somewhat marginal theme in the context of discussions about reductions of public expenditures and of decentralisation in Croatia. Most worrying is a real lack of public debate on these issues.

4.3 Future Challenges

4.3.1 Main challenges

1. The table reproduced below is a simplified listing of the Strengths, Weaknesses, Opportunities and Threats within the current operation of the Social Protection system in Croatia from the perspective of promoting social inclusion.

STRENGTHS	**WEAKNESSES**
• High level of formal social rights • Well-developed accessible system (network of CSWs) • Comparatively low rates of institutional care • Absence of deep, visible poverty • Some cities (Split, Rijeka, ?Zagreb) have good social programmes • Effective coverage through social cards and insurance system • High level of professional training of social workers	• Complicated benefit system • Category-based not needs based system • Hard to get out of poverty • Heavily bureaucratised system • Institutional care is remote and long-term • Low levels of funding of social benefits • Poor targeting of benefits • Low poverty alleviation effect of social transfers • Welfare Parallelism (Govt and Local authorities) • Low informatisation • No quality standards • Monitoring and evaluation is poor • Little recognition of NGOs and private sectors within emerging welfare mix
OPPORTUNITIES	**THREATS**
• EU Accession – JIM • Reform Projects – World Bank/Ministry of Health and Social Welfare • Traditional family support (but see threats)	• Ageing infrastructure • Reform Gap in terms of impacts • Some evidence of decline in traditional family structures • Lack of co-ordination (Horizontal and vertical) • Danger of long term excluded (Zones of exclusion) – deepening regional inequalities

2. Here we note each of the weaknesses and threats in turn, given that the strengths are, on the whole, more easily recognised and addressed elsewhere in this report :

Weaknesses

i. Complicated benefits system: despite plans to simplify the benefit system, there are still too many different benefits, with overlapping and inconsistent

criteria, many of which are quite discretionary based. This leads to a relatively low take up of some benefits. In particular, there is no necessary linkage between receipt of national benefits and receipt of benefits based on a local social protection programme. Hence, possibilities for 'double dipping' exist. Elements of the World Bank's PAL (see above) are meant to deal with this, by first clarifying the range of benefits available and, subsequently, seeking to rationalise them.

ii. System is category-based not needs-based: a refinement and elaboration of weakness i. above, this is particularly important in terms of differences in benefits depending on different causes of disability rather than the extent of need. More generally, however, much of the existing assessment work in CSWs is based on psycho-medical models in which people are not treated holistically in terms of social needs but are, rather, the sum of their problems defined by various professionals.

iii. Hard to get out of poverty: The system pays insufficient attention to poverty traps particularly in terms of disincentive effects caused by low paid work. There is insufficient research on this issue and on the issue of targeting, in the context of a proliferation of benefits. It should be remembered, however, that the Croatian system still shows a rather significant reduction in the at-risk-of-poverty rate after social transfers.

iv. Heavily bureaucratised system: A once innovative system now appears somewhat old-fashioned, with paper requests and decisions often involving duplication and bureaucratisation of effort. Some of the initiatives under the SWDP are meant to tackle this problem. In addition, there has been a modernisation of social work training programmes, but insufficient attention to continuing education of staff of CSWs and institutional care homes.

v. Institutional care is remote and long-term: There is a formal commitment to de-institutionalisation but, often, this is not taken forward with sufficient will in practice. There have been pilot initiatives to ensure greater links between institutional care facilities and the wider community but these remain marginal. In addition, there is insufficient preparation for young people to leave care. A thorough going transformation of residential care for each client group, including children and adults with disabilities, combining prevention, community-based alternatives, gatekeeping and de-institutionalisation programmes is needed.

vi. Low levels of funding of some benefits: In particular the 400 HRK monthly maintenance allowance which is the best targeted benefit, bears little relationship to real costs and is not adjusted in line with inflation or the cost of living for poor people.

vii. Welfare parallelism: there is a lack of efficiency and co-ordination between central and local systems and a great deal of unfairness in terms of additional

benefits in some richer cities which cannot be matched in poorer and/or smaller municipalities. Decentralisation of social welfare remains very limited in effect.

viii. Low informatisation: the issue of low levels of ICT use and the lack of sharing of databases appears to be addressed in the SWDP.

ix. No quality standards: there has been no consistent attempt to introduce standards into the system beyond the physical dimensions of facilities which, at times, themselves inhibit innovation. Quality standards need to be drawn up for all client groups, for residential care and for social services. In many countries in transition, the participatory exercise of introducing quality standards has raised awareness amongst a range of stakeholders of the wider need for modernisation.

x. Monitoring and evaluation is poor: linked to the problem of standards, there is no routine monitoring of services from the perspective of quality care and, in particular, state services face little incentive to improve.

xi. Little support for welfare mix: Whilst there are more non-state providers, their role is not sufficiently institutionalised both in terms of financing and in terms of the development of across the board standards providing a 'level playing field' for new providers..

Threats

i. Ageing infrastructure: many of the existing facilities, particularly residential care institutions, are old and have not been repaired or renovated sufficiently often. To an extent, this is being addressed in the SWDP, although there is a need to build in a budget for repairs in running costs.

ii. Reform gap in terms of impacts: the gap between intended reforms and impacts on the ground remains extremely large. The slow and partial nature of reforms envisaged in the SWDP may even compound this problem.

iii. Evidence of decline in traditional family structures: combined with an ageing population structure, these threats are difficult to counter with policies but, rather, need to be understood as background factors built into policy planning.

iv. Lack of co-ordination (horizontal and vertical); this has been a major theme throughout this report and is particularly important in social protection in terms of the relationship between social and health services; between state and non-state actors; and between central, regional and local levels of governance.

v. Danger of long-term excluded (zones of exclusion) and increased regional inequalities: there is insufficient attention paid thus far to the problems of deprived regions in terms of social protection. Indeed, welfare parallelism compounds the problem with additional services only available in the less deprived areas.

4.3.2 Social Protection and EU accession

1. Unlike in the sphere of employment (pp. 205-208), there are no specific measures or timelines in the field of social protection listed in the National programme for the Integration of the Republic of Croatia into the EU 2005 (Republic of Croatia, 2005). However, a number of commitments are contained in the text. In addition to the employment and vocational training of persons with disabilities, the document notes that „special attention should be devoted to creating the possibility of deinstitutionalised care for and protection of disabled persons by more open co-operation between the public and private sectors (institutions and cooperatives of disabled persons)…" (ibid; 210). However, there are no specific measures or timelines proposed here. In addition, the importance of collaboration between health and social welfare institutions is not noted. No targets are set. There is no discussion of the deinstitutionalisation needs of other vulnerable groups, other than to note the existence of a draft Study on Deinstitutionalization of the Social Welfare System which appears to relate to a study commissioned some time ago but never acted upon. It also surprising to see the document note the Programme on Combating Poverty and Social Exclusion since, as noted above, this is effectively moribund.

2. In our view, above and beyond this, there is a need to focus more specifically on the need to restructure cash benefits and social services; on specific targets for deinstitutionalisation; on measures to support the role of non-state actors; and on clearer standards and monitoring of outcome-based targets. The question remains whether there are sufficient drivers for change for these aspects to be developed consistently and strategically. The social protection system still seems ill-equipped to deal with the consequences of restructurings elsewhere, in the broader economy, in the health service, and elsewhere, which create greater stresses on the most vulnerable populations.

REFERENCES FOR CHAPTER 4

Baloban, J. (ed) (2005) 'In Search of Identity' (U potrazi za identitetom) Zagreb: Golden marketing.

Bežovan, G. and Zrinščak, S. (2001) The Possibilities of Decentralisation in Social Policy and the New Role of Local Authorities' (Croatian language text) in Revija za socijalnu politiku 8 (3/4); 239-58.

Bežovan, G., Zrinščak, S. and Vugec, M. (2005) Civil Society in Croatia: gaining trust and establishing partnerships with the state and other stakeholders. CIVICUS and CERANEO.

ILO (no date) NATLEX – translations of relevant Laws and procedures. For Croatia see web: http://www.ilo.org/dyn/natlex/natlex_browse.country?p_lang=en&p_country=HRV

Jané-Llopis, J. and Anderson, P. (eds.) (2006) Mental health promotion and mental health prevention across European member states. Luxembourg: European Communities. http://europa.eu.int/comm/health/ph_projects/2004/action1/docs/action1_2004_a02_30_en.pdf

Jurčević, Ž. (2005) 'Social Welfare System in Croatia 2000-2004: analysis of situation indicators and development' (Croatian language text) in Revija za socijalnu politiku 12 (3/4); 345-75.

Kesner-Škreb, M. and Kuliš, D. (2005) *The Citizens' Guide to Taxation* (updated in parts from 2002 edition), Zagreb: Institute for Public Finance.

Knežević, M. and Butler, L. (2003) 'Public Perceptions of Social Workers and Social Work in the Republic of Croatia', in International Journal of Social Welfare 12; 50-60.

Milas, G. (1997) 'Basic Dimensions of the Perception of Local Social Issues in Croatia' (in Croatian language), in Društvena istraživanja (J of General Social Issues), 32; 695-710.

Ministry of Labour and Social Welfare (2001) The programme of Combating Poverty and Social Exclusion of the Republic of Croatia (Croatian language text), in Revija za socijalnu politiku 8 (1).

OSI (2005) Rights of People with Intellectual Disabilities: Croatia Monitoring Report. http://www.soros.org/initiatives/mhi/articles_publications/publications/romania_20050902/croatia_2005.pdf

Puljiz, V. (2005) 'Croatia: searching for a new social model', in Kuhnle, S. (ed.) Social Policy development in South Eastern Europe. Bergen: Stein Rokkan Centre; 79-92.

Puljiz. V and Žganec, N. (2001) Reform of the Social Assistance and Welfare System, Government of Croatia, April.

Republic of Croatia (2005) National Programme for the Integration of the Republic of Croatia into the EU. Government of Croatia.

Stubbs, P. (1997) 'Croatia: NGO Development, Globalism and Conflict', in Bennett, J. (ed.) NGOs and Governments, pp. 77-87. INTRAC/ICVA.

Stubbs, P. and Warwick, J. (2003) Social Services in a Reformed Social Welfare System, in Croatian J of Social Policy 10 (3).

Stubbs, P. and Zrinščak, S. (2005) 'Structures and Cultures of Welfare in Transition: Europeanisation and Croatian social policy'. Paper presented to UACES Conference, Zagreb, September.

Šućur, Z. (2004) 'Access to General Social Assistance Rights' (Croatian language text), in Revija za socijalnu politiku 11 (1); 21-38.

World Bank (2005) Project Appraisal Document: Social Welfare development project, Republic of Croatia. Report no. 317245-HR, 5 May. Web http://www-wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2005/05/27/000112742_20050527145541/Rendered/PDF/31724.pdf

World Bank (2005b) Programme Document for a Proposed Pal of 150m Euro. Report no. 30293-HR, 10 August.

Zagrebačka banka (2005) Social Report. Web: http://www.zaba.hr/info/abo/zaba/socijalno/Socijalno%20izvjesce.pdf

Žganec, N./Social Protection Project Teams (2003) Recommendations for Forming and Implementing Social Welfare reform in the Republic of Croatia. (Croatian language version). Ministry of Labour and Social Welfare, June.

STATISTICAL ANNEX CHAPTER 4

Table 4.1 Structure of functions and professional qualifications of those employed in CSWs in Croatia 31 December 2004 (source: Jurčević, Ž, 2005).

Title/Profession	**Number**	**Percentage**
Directors and Heads of Sub-offices	110.5	5.8%
Professional Staff	1251.5	66.1%
Graduate Social Workers	*333*	*17.6%*
Non-Graduate Social Workers	*511.5*	*27.0%*
Lawyers	*172.5*	*9.1%*
Psychologists	*116*	*6.1%*
Social pedagogues	*33.5*	*1.8%*
Administrative lawyers	*32.5*	*1.7%*
Defectologists/Special educators	*29.5*	*1.6%*
Sociologists	*8*	*0.4%*
Other professions	*15*	*0.8%*
Finance and Administrative Staff	413.5	21.9%
Technical and Ancillary Staff	116.5	6.2%
TOTAL	**1892**	**100%**

Table 4.2 Residential Care Facilities in Croatia by Type of Client and Type of Ownership (source: Jurčević, Ž, 2005)

TYPE OF RESIDENTIAL FACILITY	**Number (No. in 2000)**
STATE RUN	
Homes for Children without Parental Care	14 (14)
Homes for Children and Young people with behavioural problems	11 (11)
Homes for Physically and Mentally Disabled Children and Adults	25 (25)
Homes for Mentally Ill Adults	18 (18)
COUNTY-RUN	
Homes for Older People	46 (46)
NON-STATE RUN	
Homes for Older People	57 (10)
Homes for Children without Parental Care	4 (1)
Homes for Physically and Mentally Disabled Children and Adults	15 (0)
Homes for Mentally Ill Adults	4 (0)
Homes for Alcohol and Drug Addicted persons	2 (0)
Homes for Children and Adults, Victims of Family Violence	2 (0)
TOTAL	**198 (125)**

TABLE 4.3 RATES OF INSURANCE CONTRIBUTIONS CROATIA 2005

CONTRIBUTION TYPE	**EMPLOYEE RATE**	**EMPLOYER RATE**
Pension Insurance I Pillar I and II Pillar	 20% 15% + 5%	
Health Insurance		15%
Accident insurance		0.5%
Employment		1.7%
TOTALS	**20.0%**	**17.2%**

Source: Kesner-Škreb and Kuliš (2005).

TABLE 4.4 Costs of Social Welfare at Central Govt level in Croatia 2000 – 2004

Type of Cost (HRK)	2000 (index 100)	2001	2002	2003	2004
Social Welfare Benefits	881,750,000 (100)	1,066,258,422 (121)	1,196,779,954 (136)	1,361,071,054 (154)	1,450,094,237 (164)
Salaries and other employee costs	721,854,617 (100)	664,065,627 (92)	428,728,474 (59)	460,927,388 (64)	505,657,161 (70)
Material costs	146,781,295 (100)	141,184,046 (96)	116,763,474 (80)	161,275,590 (110)	133,636,933 (91)
Capital Investments	21,398,906 (100)	43,439,298 (203)	---	93,596,441 (437)	49,892,045 (233)
TOTAL (State budget costs)	1,771,784,818 (100)	1,914,947,393 (108)	1,742,271,902 (98)	2,076,870,473 (117)	2,139,280,376 (121)

Source: adapted from Jurčević, 2005; p. 364.

TABLE 4.5 Current and Projected Benefit Spending in Croatia (non-pension)

	2003		**2004 (est)**		**2005 (budget)**		**2006 (MTEF)**		**2007 (MTEF)**	
	% GDP	% total benefits	% GDP	% total benefits	% GDP	% total benefits	% GDP	% total benefits	% GDP	% total benefits
1. Child allowance	0.83	21.2	0.75	18.4	0.71	17.8	0.72	18.0	0.72	18.5
2. Maternity benefits	0.22	5.7	0.24	6.0	0.28	7.1	0.28	7.2	0.29	7.3
3. War veterans	1.36	34.8	1.63	40.2	1.66	41.7	1.58	39.9	1.49	38.5
4. Unemployment	0.40	10.2	0.41	10.2	0.37	9.2	0.39	9.7	0.38	9.9
5. Social Welfare	1.01	26.0	0.91	22.5	0.86	21.5	0.92	23.1	0.90	23.3
6. Other	0.08	2.2	0.11	2.8	0.11	2.7	0.08	2.1	0.10	2.5
TOTAL	**3.90**	**100**	**4.06**	**100**	**3.99**	**100**	**3.97**	**100**	**3.88**	**100**

Source: World Bank (2005)

FIGURE 4.1 Structure of types of social welfare (adapted from Šućur, 2004; 22)

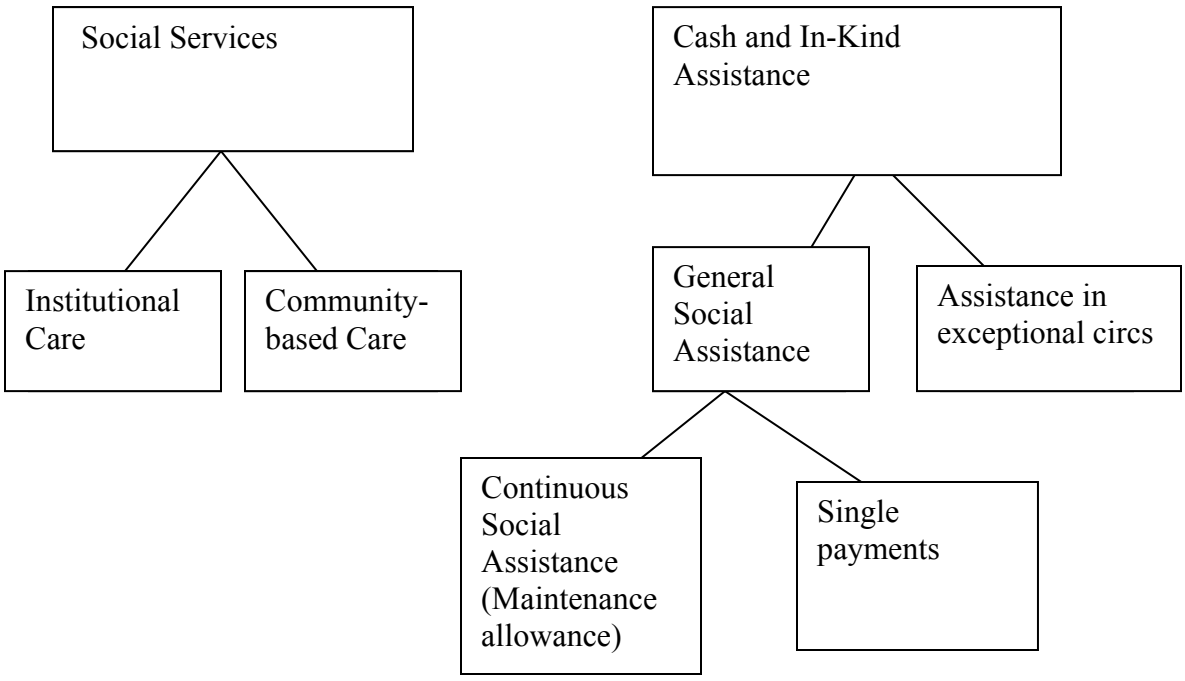


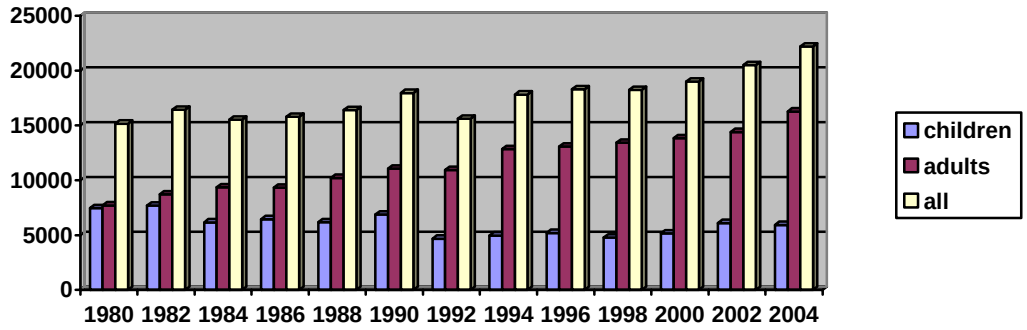
TABLE 4.6 Institutional Social Welfare Population in Croatia 2003 and 2004

Type	**No. at end 2004**	**No. at end 2003**	**Index 2004/2003**
TOTAL	**23,672**	**22,575**	**104.9**
STATE HOMES	**8,699**	**8,950**	**97.2**
Homes for children without parental care	1,073	1,111	
Homes for children and youth with behavioural problems	1,103	1,163	
Homes for physically or mentally disabled children and adults	3,052	3,086	
Homes for adults with mental illness	3,471	3,590	
NON-STATE HOMES	**14,973**	**13,625**	**104.0**
Homes for children without parental care	503	487	
Homes for physically or mentally disabled children and adults	1,416	969	
County homes for older people	10,168	9,965	
Other homes for older people	2,314	1,829	
Homes for adults with mental illness	323	194	
Homes for persons addicted to drugs, alcohol and other substances	119	123	
Homes for children and adults, victims of family violence	130	58	

TABLE 4.7 Age Structure of Residents in State Homes for Children 2003 and 2004

AGE	2004	2003	INDEX 2004/2003
Under 1	46	53	87
1 – 3 yrs	78	88	89
4 – 7 yrs	104	87	120
8 – 14 yrs	389	399	97
15 – 16 yrs	176	190	93
17 – 18 yrs	191	180	106
19 – 21 yrs	76	90	84
Over 21 yrs	13	24	54
TOTAL	1073	1111	97

TABLE 4.8 Trends in Institutional Care for Children and Adults in Croatia 1980 – 2004



Source: State Bureau of Statistics 2005 yearbook Table 30-6.

Table 4.9 Recipients of State Social Assistance (as at 31 December each year)

	2000	2001	2002	2003	2004	2005
Total individuals	93472	112034	121778	121515	120916	118493
Total claims (Individuals and families)	44413	50406	53119	52656	52513	52327

Source: Jurčević (2005) and MHSW (2006)

Table 4.10 Geographical Distribution of Croatian population and recipients of social assistance

COUNTY	No of social assistance beneficiaries	Proportion of total	Proportion of total Croation pop in 2001 census
1. Zagrebačka	3615	3.0%	7.0%
2. Krapinsko-zagorska	1475	1.2%	3.2%
3. Sisačko-moslovačka	**9046**	**7.5%**	**4.2%**
4. Karlovačka	**6536**	**5.4%**	**3.2%**
5. Varaždinska	3660	3.0%	4.2%
6. Koprivničko-križevačka	3074	2.5%	2.8%
7. Bjelovarsko-bilogorska	**4604**	**3.8%**	**3.0%**
8. Primorsko-goranje	3038	2.5%	6.9%
9. Ličko-senjska	1199	1.0%	1.2%
10. Virovitičko-podravska	**5010**	**4.1%**	**2.1%**
11. Požesko-slavonska	**3018**	**2.5%**	**1.9%**
12. Brodsko-posavska	**8607**	**7.1%**	**4.0%**
13. Zadarska	**4680**	**3.9%**	**3.7%**
14. Ošječko-baranjska	**14985**	**12.4%**	**7.4%**
15. Šibensko-kninska	**11673**	**9.7%**	**2.5%**
16. Vukovarska-srijemska	**7846**	**6.5%**	**4.6%**
17. Splitsko-dalmatinska	8045	6.7%	10.4%
18. Istarska	1281	1.1%	4.7%
19. Dubrovačka-neretvanska	1582	1.3%	2.8%
20. Međimurska	**5843**	**4.8%**	**2.7%**
21. City of Zagreb	12099	10.0%	17.6%
Total	120916	100%	4437460

Chapter 5: The Pensions System

5.1. Current Structures

5.1.1. Organisation of the Pensions System

Organization

1. The Croatian pension system is now *a three pillar system*. The first pillar is a mandatory defined benefit reformed pay-as-you-go system, the second pillar is a mandatory defined contribution and the third pillar is voluntary defined contribution.

2. The first pillar is a mandatory pay-as-you-go public pension system based on intergenerational solidarity. The first level of the pension system (reformed first pillar of the pension system) is based on the current financing of pension expenditures and an in-advance defined amount of pensions or retirement benefits (Pension Insurance Act - Official Gazette 102/98, 127/00, 59/01, 109/01, 147/02 i 92/05). The manner of determining the amount of pensions has been changed, so that:

- the age limit for acquiring rights to an old-age pension was gradually increased, to 60 years of age for women and 65 for men, and for the rights to an early retirement pension, to 55 years of age for women and 60 for men,
- the period included for calculating the amount of pension is extended to include the entire working period,
- the manner of adjusting pensions was changed so that pensions are being adjusted twice a year for half of the index of the growth of salaries and living costs (as of 1 January 2004, the consumer price index),
- the early retirement pension is decreased,
- the disability definition was made stricter, and the ability to work is evaluated according to all jobs that are appropriate to the physical and mental abilities of the insured person,
- a series of rights arising from the pension insurance were revoked, and replaced by new forms of rights, harmonised with the entire system: the right based on the remaining ability to work (disability pension), the right to a protective allowance with the pension (minimum pension), the right to a compensation allowance due to physical damage caused by illness and a non-employment injury, as well as an accelerated pension plan based on this, and the right to allowance for assistance and attendance (social care system).

3. The first, public pillar is mandatory, and covers the risks of old-age, disability and survivors. It encompasses all employees and all other beneficiaries covered by the pension scheme. However, the current mandatory pension scheme changed regarding the retirement age for old-age retirement, disability definition,

the ways of retirement payment establishment and some other characteristics. A person is entitled to old-age pension when 65 years old in addition to 15 years service pre-retirement. The main innovation is the so-called basic retirement allowance that is based on the average salary of all employees in the Republic of Croatia. Indexation of retirement allowances has also been introduced. The retirement allowances are financed through the contributions of employees and employers, while the expenditures not covered by contributions would be financed by the government budget.

4. The first pillar rigorously observes the implementation of the principles of reciprocity and solidarity. This portion of the pension scheme is, as before, based on generation solidarity and financed through a pay-as-you-go system.

5. *The second pillar* is a mandatory individual capitalized savings system The second pillar commenced on 1st January 2002, pursuant to the Mandatory and Voluntary Funds Act (Official Gazette 44/99, 63/00, 103/03 and 177/04). All those under age 40 at the time of the reform had to participate (they had to participate in the first mandatory pillar too; i.e. they had to participate in both pillars at the same time). Those between ages 40 and 50 could opt either to remain in the pay-as-you go system or to divert part of their contributions to one of a number of competing individual savings funds (those who have chosen the first pillar, do not have to participate to the second pillar; those who have chosen the second pillar have to participate in both pillars). By law, these savings funds must invest at least 50 percent of their assets in conservative government securities issued by the Republic of Croatia or the Croatian National Bank. In addition, no more than 15 percent of pension fund assets may be invested outside the Republic of Croatia. All contributions are exempt from taxation, and the pension is subject to personal tax allowances. According to the Income Tax Act (Official Gazette 177/04), a personal tax allowance amounting to the total pension realised within the taxation period of a minimum of HRK 1,600 and a maximum of HRK 3,000 per month, is accepted as a non-taxable part of income.

6. The second pillar in the framework of a compulsory pension scheme also encompasses all the compulsory pension scheme beneficiaries from the previous system, under the condition that the beneficiaries under 40 years are covered by the new pension scheme. This pillar is financed by capitalized cover and based on the savings of each beneficiary in the case of old-age, disability or death. The World Bank suggested a solution according to which all the employees under 40 years would pay their contribution to the account of individual capitalized savings, whereas the other portion would be directed to the current pension scheme. All employees over 40 would continue with contributions according to the principle of intergeneration solidarity.

7. The pension scheme of the second pillar assumes the foundation of several investment funds which would be topped up with contributions from the beneficiaries according to their own choice (those under 40 years of age). Pension investment funds would invest the capital collected from contributions into shares and other assets in the framework of the privatization process and would compete on the financial markets. The financing of a pension scheme in the framework of the second pillar is based on the capitalized cover. The total retirement income is determined only after the beneficiary has retired. In the finance system of such a pension scheme the amount of retirement allowance depends on how long and how much was invested at the moment of retiring.

8. *The third pillar* is a voluntary savings system based on capitalization for those who want even more insurance against the risks of old age, disability, and death. The third pillar commenced on 1st January 2002, pursuant to the Mandatory and Voluntary Funds Act (Official Gazette 44/99, 63/00, 103/03 and 177/04). The insurance operates according to the same principles as the second pillar with one exception – the insured person decides on the amount of the contributions she or he makes. In addition to private pension companies, these third pillar funds may be established by trade unions and employers. The state provides an annual subsidy of up to HRK 1250 (Official Gazette 49/99, 63/00, 103703).

9. The third pillar based on free choice encompasses those beneficiaries who, along with the compulsory contribution for pension scheme in the first and second pillar, are willing and able to pay an additional sum for themselves and their family members and in return are granted higher quality social security in case of disability, old-age or death. The third pillar as a voluntary system of the pension scheme is financed by capitalized savings. It is up to the employees to decide on the amount and the type of the pension funds. Moreover, such a system is meant to lead to a more active involvement of the pension funds in the financial markets where they would obtain one part of their funds by investment income. The prerequisite for investment income is the foundation of the fund portfolio. The portfolio would be founded with two objectives: to increase the value in the long term and to provide liquidity in the long term in order to regularly cover the current fund liabilities.

Institutions

10. Pension services are the responsibility of *the Croatian Pension Insurance Institute* (Hrvatski zavod za mirovinsko osiguranje - HZMO). There are several other important institutions that are responsible for the pension system:

1. The Agency for Supervision of Pension Funds and Insurance (Hrvatska agencija za nadzor mirovinskih fondova i osiguranja - HAGENA), now replaced by HANFA

2. The Central Registry of Insured Persons (Središnji registar osiguranika - REGOS),
3. Mandatory and Voluntary Pension Companies and Funds,
4. Pension Insurance Companies,
5. The Tax Office.

11. The Croatian Pension Insurance Institute - HZMO is the major institution for the first reformed pillar. It ceded its responsibilities for collection of contributions to the Tax Administration and REGOS. The Croatian Pension Insurance Institute maintains records of insured persons for the first pillar, and its main data provider is REGOS.

12. The Agency for Supervision of Pension Funds and Insurance - HAGENA was responsible for the monitoring and regulating of pension funds. Its major task was to protect the interests of pension fund members and participants in mandatory and voluntary pension insurance. It issued licenses for pension funds, monitored their operations and that of REGOS, and enforced the laws governing the second pillar. In late November 2005 HAGENA was replaced by the Croatian Agency for Supervision of Financial Services (Hrvatska agencija za nadzor financijskih usluga - HANFA).

13. The Central Registry of Insured Persons - REGOS was established by *the Decree of the Croatian Government on Establishing the Central Registry of Insured Persons* (Official Gazette 101/99), with the task of providing quality and efficient technical support to the entire pension reform and the new pension system that became effective on 1 January 2002, by the introduction of the second and third pillars of pension insurance. The main activities of REGOS are:

- registering insured persons with the second pillar individual savings funds, receiving applications of insured persons who apply for or change their compulsory pension funds, as well as allocating the insured persons that failed to join a compulsory pension fund in the given time,
- collecting data and managing the records on calculated and paid compulsory contributions, taxes and the surtax to the income tax,
- controlling other mandatory payments, including contributions for the first pillar, health insurance contributions, unemployment contributions, and personal income tax and surtax,
- managing a unique accounting system for personal accounts of compulsory pension fund members, which includes: receiving total payments for individual capitalized savings and allocating them to personal accounts of pension fund members, forwarding payments to appropriate pension funds, managing records of personal accounts of pension fund members, transferring assets from one pension fund to another, and setting up systems for the flow of necessary data,

- maintaining a central database of all individual accounts, employers, and pension funds,
- providing information to mandatory fund members and authorized institutions,
- reporting to the mandatory funds on the structure of their membership and provide them with relevant data from employer reports.

14. REGOS does not perform on-site inspections because this is the responsibility of the Tax Administration. REGOS is financed from the state budget and not from contribution revenues.

15. Mandatory and voluntary pension companies – A pension company is a company established as a joint stock company or a limited liability company; its scope of activities is establishing and managing one mandatory or several voluntary pension funds. The founders of a pension company are obliged to receive HAGENA's authorization (now HANFA's) for founding the pension company; upon the payment of the equity capital and the registration in the court register, the pension company has to receive an operating license.

16. The equity capital of the pension company amounts to minimum HRK 40 million, in the case of the mandatory fund. The assets of a pension company are managed separately from the fund assets, since the ownership of those assets is separate.

17. The pension company is entitled to four types of compensations, which may be collected from the fund's assets:
- up to 0.8% of paid contributions,
- up to 1.2% annually from the fund's assets in 2003, HAGENA stipulates a lower percentage for each year that follows,
- a fee for cancellation of membership in a mandatory fund, if a member withdraws before 5 years of membership have expired (in addition, the fee is not paid in the first year the system has been functioning, as well as in case a pension company's licence has been withdrawn),
- a fee for successful business operation in the amount of 25% of the annual real return of the fund.

18. Mandatory and voluntary pension fund – A pension fund is a fund of a particular kind, i.e. a separate asset, owned by its members. The pension fund is founded and managed by a pension company with the aim to collect contributions from the fund members and to invest such funds so to increase the value thereof. Every member of the fund participates in the ownership of the fund in proportion to his/her personal account balance. Mandatory pension funds, that are required to have a minimum of 50,000 members two years after their foundation, are founded within the second pillar.

19. There are four registered pension funds in Croatia, six voluntary pension funds and nine closed-end voluntary pension funds.

20. Pension insurance companies – A pension insurance company is founded as a joint stock company or a limited liability company. A founder must, prior to foundation, receive an operating licence from HANFA. Besides the articles of incorporation and other documents certifying the financial and operating capacity, the founders are obliged to submit to HANFA also the rules of the insurance company on pensions that will be paid in the framework of the mandatory pension insurance, and the pension schemes within the voluntary pension insurance. Prior to registration at the commercial court, the founder must pay-in the equity capital in the amount of minimum HRK 5 million, and the equity capital must be increased for HRK 1 million for each 1,000 users.

21. A pension insurance company at the market offers and pays off pensions and other pension payments to the members of mandatory and voluntary pension funds. An insured person, a member of a mandatory or a voluntary pension fund, selects an insurance company that he/she will close a pension agreement with, and to which he/she will transfer pension savings. These funds, when transferred, are free from payment of taxes or any similar fees. The pension insurance company, by way of operating compensation, may charge a single amount of maximum 5% of the remitted funds, and cannot charge the beneficiary for any expenses in the course of the payment of pension.

22. Regarding the Act on the Tax Administration (Official Gazette 67/01) the Tax Office of the Ministry of Finance is responsible for the control of collections for all mandatory social insurance contributions (health insurance contributions, unemployment insurance contributions, and first pillar pension contributions). Since January 2003, it has been responsible for on-site control of second pillar contributions (the Act on Collection of Data on Insured Persons, Mandatory Contributions, Personal Income Tax and Surtax – Official Gazette 114/01). The Tax Administration is supposed to receive and use REGOS data for this purposes. In reality, this arrangement does not work very well. The main reason is the overlapping legal statutes of two agencies. The result is that REGOS collects own data and at the same time the Tax Administration collects its own data.

Pension Reform

23. This current pension system is the result of *a comprehensive three-pillar reform* initiated in late 1995. Implementation of the reform started in 1997, introducing of the mandatory and voluntary funded pillars was announced in 1998 and implemented in 2002.

24. The Croatian Government with the assistance of the World Bank has proposed a new model of the pension scheme which is, like in some other European countries, based on three pillars. The three-pillar pension reform concept was first announced at the end of 1995 at a conference in Opatija organized by the Government of Croatia, the World Bank and the East-West Institute. Proceedings are published by the Ministry of Finance (1997). The timetable for reform, as presented by the Government, included introduction of three-pillar legislation in 1996 and its implementation from 1997. During 1996, work began on pension system forecasting, and drafting of legislation. Activities regarding pension forecasting (applying the PROST model framework to Croatia), initial legal work on funded pillars and annuities, different conferences and round tables, training and specialized consultancy were financed from the Japanese A grant to the Public Sector Adjustment Loan (PSAL) requested by the Government of Croatia from the World Bank to support health reform, pension reform, public finance reform, and social assistance reform. Although the loan was never realized, the funds from the grant played an important role in organizing the preliminary work on pension and other reforms in the period 1995-1997 (Anušić, O'Keefe and Madžarević-Šujster, 2003).

25. The pension reform was adopted in two acts: *The Mandatory and Voluntary Pension Funds Act* (Official Gazette 49/99) and *The Act on Pension Insurance Companies and Benefit Payments Based on Individual Fully-Funded Retirement Savings* (Official Gazette 106/99, 63/00). The new system includes a privately-managed individual account scheme with a contribution rate of 5 percent in addition to downsized pay-as-you-go, defined benefit component.

26. *The basic reasons for the reform of the pension system* in Croatia, as is the case of many other countries, were demographic and economic reasons (Jurlina Alibegović, 1998 and 2000). *The demographic reasons* are related to the ageing of the population, the result of which is an increased burden on the state guaranteed pension funds. The demographic picture of Croatia has significantly changed owing to the war that caused a further increase in the number of pensioners (pension system beneficiaries) in relation to the number of employees paying pension contributions (pension system contributors). The dependency ratio (number of the employed persons paying contributions relative to the number of pensioners) is constantly falling (see Table 5.1). The ratio between the number of employed persons and pensioners was so low (1,38 in 1999) with the tendency of further decline (1,37 in 2004). The result is an increased gap between the inflow and outflow of money. The solution to this problem can be found either in higher contributions or in constant compensations for the difference from the budget (eventually leading to a potential rise of the budget deficit).

27. The introduction of the second pillar had a strong impact on the total number of insured persons. Number of insured persons in the first and the second pillar has been constantly increasing (see Table 5.2). In the total number of insured persons in the second pillar are included persons that receive "other income" and pay contributions to the second pillar regarding *Amendments to the Law on Pension Insurance* (Official Gazette 147/02, 177/04) and *the Act on Contributions for Mandatory Pension Insurance* (Official Gazette 147/02, 175/03, 177/04). It should be noted here that with the increase of the number of pensioners, the total rate of contributions for the pension scheme keeps changing (see Table 5.3). Croatian contribution rate for the pension scheme is one of the lowest among European countries. Contribution rates for the pension schemes are the following: Romania 35%, Italy 32,7%, Poland 32,52%, Serbia and Montenegro 32%, Bulgaria 295, the Netherlands 28,05%, Czech Republic and Russia 28%, Finland 27,35%, Hungary 26,5%, Slovak Republic 26%, Slovenia 24,35%, Switzerland 23,8%, Greece 20%, Germany 19,5%, Sweden 18,91% and France 16,45% (Vuković, 2005).

26. The economic reasons for the reform of the PAYG system were that all the contribution money is spent on supporting the present generation of pensioners, without any guarantee that in the future there will be sufficient funds to sustain the present level of pensions or to raise the standard of living of the pensioners. Similar to other PAYG systems in the region, the Croatian system featured low retirement ages (60 for men and 55 for women), full old-age pension entitlement based on 40 and 35 years of service for men and women respectively, and various supplements to years of service irrespective of contributions actually paid (additional service for bodily injuries, hard work conditions, special privileged occupations, doubling the service period for veterans and political prisoners).

27. Moreover, during 1990s, Croatia was faced with some additional problems related to its adjustment to the market economy, recession, privatisation and economic restructuring:

- an increase of early retirement and the disability retirement as an attempt to solve the problem of unemployment as well as the disability retirement as the consequence of the war,
- evasion of paying contributions as a result of the growth of a "grey economy", moonlighting, inefficient civil service, etc.,
- delays in retirement payments and in readjustments of pensions with the rate of inflation because of the lack of funds in the state budget.

28. One of the key reasons for the pension scheme reform in Croatia was to reduce its dependence on the state budget.

5.1.2. Benefits

1. The Pension Insurance Act, of 1 January 1999, introduced very important changes in the first pillar of the public pension scheme of the intergenerational solidarity in relation to the former system of pension insurance, which was effective until 31 December 1998. The following needs to be mentioned:

- the age limit for old-age and early retirement pension was raised by five years, with the interim period from 1999 until 2007; the age limit for acquiring rights to an old-age pension was gradually increased (until the end of the year 2007), to 60 years of age for women and 65 for men, and for the rights to an early retirement pension, to 55 years of age for women and 60 for men (this means that in year 2005 an old-age pension can be obtained by men aged 63 years and 6 months and women aged 58 years and 6 months, with a minimum of 16 years and 6 months of service period,
- the early retirement pension is permanently reduced even up to 20.4%,
- a new definition of disability, which is substantially different and more restrictive than the former definition (occupational inability to work and general inability to work),
- an occupational rehabilitation as the only right based on the residual ability to work,
- authorised specialists (in place of a disability board),
- obligatory revision of every expert evaluation and report on disability,
- obligatory medical re-examination of the insured person who acquired the right to a disability benefit,
- revocation of rights based on the residual ability to work,
- conversion of former rights to be assigned to, or employed in another job, and the right to short-time working hours as of 1 January 1999, to a disability pension due to occupational disability to work,
- a new retirement formula for determining the amount of pension includes the following mode for computing the pension: pension = most favourable average value points x total qualifying periods x initial factor = personal points x pension factor x actual value of pension (P = MFAVP x TQP x IF = PP x pf x AVP),
- extension of salaries accounting period taken for determining the pension, gradually extending from the most favourable ten years in 1999 to the entire working life in 2009, thus gradually decreasing the level of new pensions (in 1999 – 10, in 2000 – 13, in 2001 – 16, in 2002 – 19 years).

2. The Act mentioned above revoked the following rights:

- a minimum pension,
- a compensatory supplement to the pension,
- a compensation allowance for physical damage as a result of a non-employment disease or injury, as well as qualifying period benefits acquired on that ground,

- a right to training of children with difficulties in psychological or physical development is revoked in the pension insurance system (it is granted within the social care system),
- an allowance for assistance and attendance.

3. The Act stipulates the following:
- an old-age and early retirement pension,
- a disability pension due to general or occupational (partial) inability to work,
- a survivor's pension,
- a minimum pension, granted only to the pension beneficiaries in the first pillar of pension insurance,
- a differently regulated highest pension (the Highest Pension Act) Pmax = 3.8 x TQP x IF = PP x pf x AVP
- basic pension for pension beneficiaries from the first pillar who are insured in the second pillar,
- occupational rehabilitation and salary compensation during rehabilitation,
- compensation for physical damage due to an employment injury or occupational disease.

Eligibility and benefits

4. The basic feature of pensions in Croatia is that they are relatively low (see Table 5.4), and approximately half of the retired persons get pensions lower than the average pension in Croatia (see Table 5.5). A particular problem is the difference in the average amount of pension of those pension system beneficiaries who acquired the right to pension before 31 December 1998, that is before the beginning of the pension system reform, in relation to those pension system beneficiaries who acquired the right to pension after 1 January 1999, i.e. in the beginning of the pension system reform. The pensions of the "new" pension beneficiaries are, on average, approximately 25% lower as compared to the "old" pensioners, tending towards an even worse ratio in future. The most important reason for this is the extension of the accounting period of paid salaries when determining the amount of pension to a longer period of work (tending to be extended to the entire period of work).

Replacement rate

5. To compare the amount of pensions, an indicator of the share of the average pension in the average net salary (replacement rate) is important as well. An increase of the share of an average pension in an average salary of about 3.5% was recorded in 2001 as the result of *the Act on Increase of Retirement Benefits in order to Eliminate Differences in Retirement Benefits Acquired in Different Periods* (Official Gazette 127/00). After 2001, the decreasing trend in the share

of pensions in the salary has continued. The replacement ratio was 42.13% at the end of 2004, tending to fall below 40% (see Table 5.6).

Indexation

6. A system of adjusting (indexing) pensions every 6 months (1 January and 1 July of the current year) was chosen in Croatia and was regulated by the Internal regulations of the Croatian Pension Insurance Institute. The system of adjustments of pensions was changed several times. Started of 1 January 2006 pensions are now being adjusted with 50% of the salaries growth index, and 50% of the consumer price index.

5.1.3. Financing of the Pension System

1. The principal source of financing the pension system is revenues from gross salary contributions. Assistance from the state budget covers the difference of the lack of revenues from contributions for payment of pensions, as well as the payment of pensions for special categories of pensioners. Regarding *the Pension Insurance Act*, privileged pensions are financed from the state budget and not from contribution revenues. Privileged pensioners are pensioners that belong to the Croatian army, Croatian defenders, Parliamentarians, ex- Yugo-army soldiers, police, ex political prisoners, ex Yugoslav pensioners, Croatian Academy of Science and Arts.

2. Pension contributions and payments were part of the Central Pension Insurance Institute balance sheet until July 2001. From July 2001 pension contributions and payments were directly included into the central government budget. The gap between expenditures and revenues became an inherent responsibility of the state budget.

3. The revenues from contributions paid for pension insurance have increased considerably, and particularly so since the introduction of the second pillar of pension insurance (see Table 5.7). One of the reasons for increase of revenues from contributions paid for pension insurance is the introduction of personal pension accounts that influenced a better discipline in paying contributions (decrease of grey economy, particularly in the area relating to decrease in paying off net salary in cash.)

4. The largest share (64%) in the structure of total pension insurance revenues and receipts is revenues from contributions, 35% is revenues from state budget, and 1% other revenues and receipts. Total revenues and receipts in 2004 totalled HRK 23.347 billion, out of which revenues from contributions amounted to HRK 14.873 billion, state budget revenues to HRK 8.323 billion, and other

revenues and receipts to HRK 1.500 billion (Croatian Pension Insurance Institute, 2004).

5. The state budget revenues cover those expenditures that are legally defined as a budget obligation. This means that it is not the case of a huge lack of revenues from contributions for financing expenditures for current pensions of the public pension insurance.

6. The expenditures for pensions and pension payments constitute 97.4% of the structure of expenditures and expenses (without expenses for the pensions of the Croatian War veterans), the expenditures for employed persons are 1.2%, and other expenditures are 1.4% of the total expenditures, so that the total expenditures for 2004 amounted to HRK 23.284 billion.

5.1.4. Coverage of the system

1. According *the Pension Insurance Act* (Official Gazette 102/98, 127/00, 59/01, 109/01, 147/02, 117/03, 30/04 and 92/05) pension coverage in Croatia is broad and applies to all employees, self-employed persons, and farmers. In addition it is extended to:
- members of management boards, unless they are insured on another basis,
- priests, monks, nuns an other clerical officers, during their service in a religious community, unless they are insured on another basis and
- parents who stay home to take care of a child during their first year of life, provided that the parent is not insured on another basis.

2. The Pension Insurance Act also provides an option for voluntary insurance for persons whose mandatory pension insurance has terminated. They may insure themselves under the so-called «prolonged insurance scheme» within 12 months of termination. This option applies to persons who are:
- on unpaid leave,
- caring for a child under age three,
- receiving vocational training following the termination of the employment contract or cessation of self-employment,
- unemployed and registered with the Croatian Employment Service, and
- sailors after cessation of a temporary employment contract (Bejaković, 2004).

3. Data on the total number of people that are not covered by pension insurance are not published. Here we explain some of examples of groups that are not covered by pension insurance. The first example is the result of the Pension Insurance Act which regulate general conditions for old-age pension insurance – the age limits for men (65) and women (60) and the work period limit (15 years), as well as conditions for early retirement – the age limit for men (60) and

women (55) and the work period limit to 35 years for men and 30 years for women. Those who do not fulfil the above conditions are not able to be included in pension insurance. Using HZMO data for the end of 2005, shows that there were 643,821 persons aged 65 or over in Croatia receiving pensions, out of a total estimated population aged 65 or over of 746,500. This suggests, therefore, that some 103,321 persons aged 65 or over, or 13.8% of the total, were not receiving pensions. Ministry of Health and Social Welfare figures for 2004 show 8,692 people aged 65 to 75 and 5,526 people aged over 75 receiving social assistance benefit (pomoć za uzdržavanje) at end of 2004 (Jurčević, 2005; 353). This sugests that almost 89,000 older people (65 plus) are receiving neither pensions nor social assistance. Caution needs to be shown here since the same study (Jurčević, 2005; 354) shows that 2,489 of social assistance beneficiaries have the status of pensioner (umirovljenik) so there is a raisk of double counting.

4. A second example is that disability and survivor's pensions are not provided in the second pillar. In case of activation of a disability or a survivor's pension, an individual or his successors are entitled to draw the higher of two benefits: the regular first pillar or a combined basic pension and annuity. If the regular PAYG disability and survivors benefit exceeds the combined pillars benefit, the total accumulation in the second pillar is transferred to the Pension Institute in exchange for a pension that would be received by an individual that participated only in the first pillar.

5. The total number of active insured persons in the public pension system decreased during the period 1995-2001 (see Table 5.2). The number of contributors started to increase in 2001.

5.1.5. Public awareness and acceptance

1. There have been published several public opinion surveys on the new pension system and pension reform. Some of the results have been seen at the Internet pages of the Croatian Pension Insurance Institute, REGOS and HAGENA as well as several pension companies at their web sites implemented short public opinion surveys on different issues regarding the pension system.

2. An intensive and broad public education and information campaign was an important element of the pension reform in Croatia. Initial public relations efforts during the legislation building process in 1998 were aimed at educating on basic concepts of a three-pillar system, explaining the necessity to revise the parameters and downscale the PAYGO pillar, and presenting expectations of introduction of the mandatory second pillar. During the initial period, for example, the polls indicated that more than 70 percent supported the pension

reform, while approximately the same percentage had no knowledge of the reform concept.

3. The second stage of the public relations campaign intensified with the creation of regulatory institutions and the emergence of the pension fund management industry. Public knowledge on pension reform rapidly improved from 32 percent in mid 2001 to 55 percent at the beginning of the registration period, and further to 86 percent at the beginning of 2002. In the first period, the public campaign was oriented towards education about the second pillar and promotion of a funded pension system. From November 2001, the focus was on information about individual accounts registration process for mandatory participants and particularly population between 40 and 50 years of age who could had an option of joining the second pillar. In order to provide them a tool to make a qualified choice, HAGENA made available and publicized a computer program for calculating expected pension levels in the new system versus the levels in the old system. Finally, the pension fund managers made a significant contribution to public education on pension reform besides the widespread marketing activity for a acquiring membership (Anušić, O'Keefe and Madžarević-Šujster, 2003).

5.2. Evaluation of recent and planned reforms

5.2.1. Recent reforms in pensions

1. The amendments made to four legal acts heavily influenced the pension system, primarily the amount of pensions and pension insurance expenditures:

I. The first is the *Act on the Increase of Pensions in order to eliminate Differences in Benefits Acquired in Different Periods*, which improved the social position of the largest number of pensioners, older ones in particular.

II. The second is the *Act on Amendments to the Act on Executing of the State Budget of the Republic of Croatia for the Year 2001*, which decreased pensions earned under more favourable conditions, and achieved some savings, and decreased differences in the level of pensions earned under general acts and those earned under more favourable conditions.

III. The third is the *Act on the Right to a Supplement to a Pension for Certain Categories of Pension Beneficiaries*, which improves the financial position of Croatian nationals who earned pension in former republics of the SFRY, which was valid until 31 December 2004.

IV. The fourth is the *Act on Amendments to the Pension Insurance Act*, stipulating that a supplement of HRK 100 + 6% is included in the pension, and changing the manner of adjusting pensions – instead of adjusting pensions to

half of the salaries increase and half of the cost-of-living increase, as of 1 July 2004 the pensions are adjusted exclusively to the salaries increase.

2. Moreover, since 1 April 2004, the basic personal deduction for pension beneficiaries was raised from the up-to-then HRK 2,550 to HRK 3,000. The inclusion of the HRK 100 + 6% supplement in the pension and the increase of pensions from 0.5% to 20% pursuant to the *Act on the Increase of Pensions for the Purpose of Eliminating Differences in the Level of Pensions Earned in Various Periods,* improved considerably the social status of pensioners who earned pensions until 1998. The adjustments of pensions to the salaries growth and the increase of personal deduction to HRK 3,000 improved the situation of all the pensioners.

3. The *Act on Implementing the Decision of the Constitutional Court of the Republic of Croatia of 12 May 1998* was passed in 2004, pursuant to which the beneficiaries will be determined the amount of difference between the paid pension payments for the period from September 1993 until December 1998, pursuant to regulations of the Government of the Republic of Croatia on determining the highest amount of the stock of funds for the payment of pensions of the Regulation on Determining the Monthly Supplement to Pensions and the Act on the Adjustments of Pensions and other Cash Benefits from Pensions and Disability Insurance, and management of pensions and disability insurance funds. The indemnification of pension beneficiaries will be carried out through a special fund.

4. The so-called 'Pensioners' debt' was accepted by this act. The Act resulted in additional financing obligations imposed as a result of the Constitutional Court decisions related to the operations of the pension system in the mid 1990s. This created significant and long term obligations for additional compensatory spending on pensions. The Constitutional Court decisions were based on two sets of claims. The first was that for some years after the 1993 stabilization programme, the state budget did not transfer the amounts due to the pension system for privileged pensioners. The second was that both valorisation and indexing should have been done on the basis of changes in wage levels throughout the 1990s, rather than the ad hoc price level changes in effect from October 1993 through 1998.

5. The Government at the time dealt with the Constitutional Court decisions on privileged pensions by enacting limited retroactive payments for eligible pensioners during the period 1993-1998 when the state budget failed to transfer the due money to cover privileged pensioners. This was the so-called "Small Law" restitution. It entitled eligible pensioners to an additional 100 HRK plus 6 percent of their benefits from July 1998 through to the end of 2002.

6. With respect to the valorisation and indexing issue, the Constitutional Court held that price indexing introduced in 1993 was invalid on both procedural and equity grounds. In the Court's view, all benefits in payment status or awarded before January 1999 should be adjusted for changes in wage levels since October 1993. As result, the Government committed itself to payment of restitution on this second set of claims, with payments initiated in January 2001. (Anušić, O'Keefe and Madžarević-Šujster, 2003).

7. Besides the already realised, other legislation shall also, over the long term and with a stabilizing effect, influence the movements in pension insurance based on intergenerational solidarity. In the first place, this refers to the effects of the implementation of the *Act on Mandatory Insurance Contributions*, that regulates the rate of mandatory insurance contribution as of 1 January 2003, and introduces the obligation to pay contributions also to the up-to-then not included receipts and forms of work (other incomes), increases the lowest and introduces the highest contribution base, maintains the obligation for the payment of contribution with the payment of salaries, and the system of mandatory insurance financing is simplified and made uniform.

8. Croatian Agency for Supervision of Financial Services (Hrvatska agencija za nadzor financijskih usluga - HANFA) is a newly established institution for supervision of all financial services. HANFA was established according to *the Act on Croatian Agency for Supervision of Financial Services* published on November 28th 2005 (Official Gazette 140/05). According to that law Insurance Companies Supervisory Authority, Croatian Securities Commission and Agency for Supervision of Pension Funds and Insurance have stopped their work. At the same date the Croatian Agency for Supervision of Financial Services (HANFA) commenced its work as their legal successor (see more on Internet page www.hanfa.hr).

5.2.2. Political and policy direction of future reforms

1. The strategic goals and principles of the pension insurance system based on intergenerational solidarity are rooted in the overall reform of the pension system, which should establish a sustainable system adequate for the economic and social development of Croatia, and ensure an adequate level of social security for the population in case of old age, disability and death. In realising this, the strategic goal of the pension insurance system based on intergenerational solidarity is to ensure an adequate level of social security for current pension beneficiaries and for the insurees who are insured only through this insurance type, as well as to ensure a minimum social security (through a basic pension) for insurees who will, in addition to such insurance, be insured by the individual capitalised savings insurance.

2. In order to achieve this, and in particular to achieve the second goal, the pension insurance system based on the intergenerational solidarity should undergo additional adjustments. In the first place these additional adjustments refer to certain changes in insurance, changes in the level of rights, the insurees encompassed, tighter relation between rights and contributions paid, and reorganisation of the insurance implementation bodies.

3. In this respect, the adjustment of the pension insurance system based on intergenerational solidarity would be achieved by the following measures:
- a more realistically determined minimum pension and a minimum pension insurance contribution base,
- lowering the early retirement pension,
- the extension of the contribution collection base and the introduction of the maximum pension insurance contribution base,
- a more efficient collection of contributions, and binding rights arising from the pension insurance with the payment of contribution,
- a reform of pensions earned under more favourable conditions,
- the introduction of a single maximum pension for all pension beneficiaries,
- arresting the fall in the level of pensions,
- active inclusion of the first and the second pillar pension system in co-financing of occupational safety and health measures and occupational rehabilitation. (see more on Internet page www.mirovinsko.hr)

5.3. Future challenges

5.3.1. Main challenges

1. In the late 1990s the Croatian government introduced a lot of measures to improve the efficiency and transparency of pension contribution collection. This will lead to a more efficient system of control and enforcement of contributions (Anušić, O'Keefe and Madžarević-Šujster, 2003). It remains an open question regarding the overlapping roles of REGOS and the Tax Authority in collecting pension contributions revenues.

2. The pension system movements are affected to a large extent by economic growth and the number and movement of the employed persons- It can be expected that in future these factors will have a decisive effect on the pension system in Croatia. Demographic movements influence also the pension system. Croatia has a high share of older population and very unfavourable movement of the working population (low fertility rate, high emigration rate), that all together affect negatively the total demographic movement.

3. Demographic factors will play a major role in future challenges of the reformed pension system in Croatia. Because of this pension expenditures (measured as a percentage of GDP) will gradually increase in the next period.

4. A large problem of Croatian pension system is the wide spectrum of different categories of pensioners that have inherited a lot of special rights regulated under special legislation. Regarding the *Pension Insurance Act* (article 152), privileged pensions are financed from the state budget and not from contribution revenues. Privileged pensioners are pensioners that belong to Croatian army, Croatian defenders, Parliamentarians, ex- Yugo-army soldiers, police, ex political prisoners, ex Yugoslav pensioners, Croatian Academy of Science and Arts. (see Table 5.9).

5. Constant changes of legislation, without the existence of a comprehensive data base, have led to the impossibility of evaluating new solutions for the overall pension system.

6. The Table below shows broad strengths, weaknesses, opportunities and threats in the Croatian pension system.

STRENGTHS	WEAKNESSES
• Three pillars: (1) defined benefit – reformed pay-as-you-go system; (2) defined contribution – mandatory pillar and (3) defined contribution – voluntary pillar recently introduced and accepted by the general public • Fiscal sustainability of reformed pension system enhanced • Greater transparency - Future pension benefits depend on previous paying contribution and investments • Decrease of early retirement and the disability retirement as an attempt to solve the problem of unemployment • Solving problem of evasion of paying contributions as a result of the growth of a "grey economy" in private sector • Relatively wide coverage of pension benefits	• High transition costs • Most farmers do not receive minimum of pension • People employed in "grey economy" do not contribute to pension system (first and second pillar) • Average pension now a lower proportion of average wage • New pensioner cohort feel deprived in relation to earlier retirees • Absence of private pension funds for low income people
OPPORTUNITIES	**THREATS**
• Cost-effective and good enough for the present and future generations • EU Accession - good practice exchange • Modern pension system in comparison to most developed European countries • Prospect for economic growth • Globalization will encourage investment in foreign pension funds • Proposal for one Supervision Agency for pension funds, pension insurance companies, insurance companies and other institutions from capital market (except banking sector)	• Demographic threats related to: - the ageing of the population (increased life expectancy) - increase in the number of pensioners in relation to a number of employees paying pension contributions - constantly falling - consequences of war - the disability retirement as the consequence of the war • Economic threats related to: - transition and adjustment to the market economy - increase of early retirement and the disability retirement as an attempt to solve the problem of unemployment - evasion of paying contributions as a result of the growth of a "grey economy"

High transition costs

7. Transition costs are defined as the difference between the total contribution to the second pillar and the total savings in the first pillar. It is assumed that the total

pension contribution rate will remain unchanged and the savings in the reformed PAYG pillar would be fully used to finance the shortfall in the PAYG pillar.

8. Diverting 5 percent points of the contribution payments for the second pillar participants will result in a financing gap for the first pillar. The shortfall in first pillar revenues would have to be financed by additional financing of the first pillar. The size of additional transfers depends on how much of the additional deficit is to be financed by PAYG savings, current budget or debt. The financial principle promoted by the Government was to achieve a high level of intergenerational equity by spreading the transition costs similarly across generations, suggesting a mixed strategy on filling the financing gap for the first pillar.

9. Total cumulative transition costs in the first decade of the second pillar operation would amount to 7.85 percent of GDP (Anušić, O'Keefe and Madžarević-Šujster, 2003).. According to the Pension Insurance Act, funds to cover the transition deficit have to be transferred from the state budget to the PAYG system.

Most farmers receive minimum pension

10. On the one hand, introducing the service-based minimum pension has been particularly beneficial for farmers and the self-employed whose benefits almost doubled because of the method of calculation of a service-based minimum pension. The service-based minimum pension was calculated at 0.825 percent of the average 1998 gross salary of all employees for each working year. There are large numbers of farmers and self-employed people that do not receive minimum pension. The reason for this is because of the definition of mandatory pension insurance for farmers defined by the Pension Insurance Act. Regarding to this act they would received much less retirement benefits because they contributed to pension system at lower contribution rate and shorter period of contribution time.

People employed in "grey economy" do not contribute to pension system (first and second pillar)

11. There are many examples of people working in the private sector (especially in the building industry, hotels and catering, retail trade and other private services) but who are not formally employed. Employers pay wages in cash and do not pay any contributions for people working for them. The consequence of this is that people working for these employers do not contribute to the pension system. In the same time they are not covered by health insurance.

Average pension now a lower proportion of average wage

12. The most important reason for this is the extension of the accounting period of paid salaries when determining the amount of pension to a longer period of work (tending to be extended to the entire period of work). The fact is that the "new" pensions (after 31 December 1998) are, on average, approximately 25% lower as compared to the "old" pensions. The replacement ratio was 42.13% at the end of 2004, tending to fall below 40%.

New pensioner cohort feel deprived in relation to earlier retirees

13. New pensioners feel deprived in relation to earlier pensioners (before 31 December 1998). The reason for this is because of the extension of the accounting period of paid salaries when determining the amount of pension to a longer period of work (tending to be extended to the entire period of work). This resulted in high decrease of the average retirement benefits of the "new" pensioners.

Absence of private pension funds for low income people

14. This is particularly important for women whose retirement benefits are lower in comparison to male retirement benefits (20 percent on average) because of shorter work period and lower average wages.

Evasion and arrears

15. Evasion, week and partial compliance of contributions for pension insurance in the formal sector of economy is one of the most important problems inherited in the Croatian economy. There are many examples of employers that pay contributions for employees on the minimum contribution base. These employers tend to be concentrated in the building industry, hotels and catering, and the retail trade. All of these employers employ younger workers who must also be insured in the second pillar. Since benefits from the second pillar will depend directly on contributions paid and, under the accumulation system, those contributions paid earlier in life will normally yield greater investment returns, this form of evasion can be expected to cause a significant reduction in future pensions (Bejaković, 2004).

16. There is an additional area in which evasion occurs – employers have been paying contributions at the minimum contribution base for some number of insured persons. This is the case particularly for the SME sector. The problem of arrears in the Croatian pension system is serious, but there is a lack of relevant information and data. Total amount of arrears have been changing from year to year. In the last few years arrears amount up to 20% of the funds of the Croatian Pension Insurance Institute. One of the tasks of the Croatian Pension Insurance Institute is to analyse and monitor this phenomenon. According to the internal publications of the Croatian Pension Insurance Institute the largest part of arrears come from legal entities (more than 50%), while the remainder was

attributable to craftsmen, farmers and self-employed. The largest share of arrears by legal entities was that of shipyards.

5.3.2. Fiscal sustainability and institutional framework

1. The costs of the pension insurance system based on the intergenerational solidarity, i.e. the first pillar system, are high in Croatia. In Croatia currently there are only payments of retirement benefits from the first pillar of the pension system. Payments of retirement benefits from the second and third pillar of the pension system are to be expected in 15 years time. The share of pension expenditures in GDP in the period from 1990 until 1992 decreased, so that it was around 7.7% in 1992. Afterwards, a constant increase has been recorded (with an exception in 1998). The total pension system expenditures in the GDP totalled 13.3% in 2000, and rose to 13.9% in 2001, dropping down to 12.6% in the end of 2004 (see Table 5.8).

2. After the year 2002, the GDP growth rate is higher than the growth rate of the total pension expenditures. The result of this is a decrease of the share of pension expenditures in gross domestic product, being the consequence of the manner of adjusting (indexing) pensions every 6 months that is for 50% of the salaries growth index, and 50% of the cost-of-living increase index (consumer price index). The share of pension expenditures in the gross domestic product is lower also because the total amount of pensions after 1999 is lower (due to the extension of the period included for calculating the amount of pension). Total pension expenditures include special categories of pensioners (privileged pensioners are Croatian army, Croatian defenders, Parliamentarians, ex- Yugo-army soldiers, police, ex political prisoners, ex Yugoslav pensioners, Croatian Academy of Science and Arts that received pension benefits directly from the state budget, and not from contribution revenues). Expenditures for privileged pensioners in Croatia account for 15% of total pension expenditures or 2% of GDP (Vuković, 2005).

3. Croatia has been faced with negative population growth rate and a total fertility rate (children per woman) below 2.0. Regarding United Nations demographic projections, projected demographic trends are similar to those in the European countries (United Nations, 2003) and could in the long-run place Croatian public finances on an unsustainable path, and imply the necessity of adopting fiscal policy actions aimed at avoiding the negative budgetary consequences of an ageing population.

4. Regarding demographic projections, the size of the Croatian population will fall with the size of the population being almost 20 percent lower in 2050 than in 2005. The number of elderly persons aged 65 and above will rise by almost 20

percent, and their share in the total population will grow from 17 percent in 2005 to 25 percent in 2050. At the same time, the working age population is projected to fall by almost 30 percent and its share in the total population will decline from 67 percent in 2005 to 59 percent in 2050. The old-age dependency ratio will rise from 26 percent in 2005 to 42 percent in 2050.

5. Projected public pension expenditures as percent of GDP are expected to reach 13.1 percent in 2005 and 6.3 percent in 2050. The budget balance resulting from the projections will reach a level of 11.8 percent of GDP, and a level of debt of 167 percent of GDP in 2050. (Svaljek, 2004)

6. According to the last available data (the Croatian Pension Insurance Institute, 2006) total number of pensioners' receive minimum pension according to different laws (the Pension Insurance Act which was valid until December 31st 1998 and the Pension Insurance Act which was applied since January 1st, 1999) is 255.987; 137.879 person receive old-age retirement benefit, 64.858 persons receive disability retirement benefit and 53.250 persons receive survivors retirement benefit. The average amount of different categories of minimum pensions is shown in table 5.10.

6. For the long-term sustainability of the future pension system in Croatia, there is a need to improve the budget balance and debt reduction, and increase compliance of contributions. If the present retirement situation continues in the future, it is highly likely that the demand for an increase of transfers from the budget to the State guaranteed pension funds will also continue, as will the need to raise the contribution rate.

References for Chapter 5

Anušić, Z., Jurlina Alibegović, D. et al, (2000). Mirovinska reforma – druga i treća razina mirovinskog osiguranja. Komentari i objašnjenja Zakona o obveznim i dobrovoljnim mirovinskim fondovima. (Pension Reform – the Second and Third Pillars) Zagreb: Inženjerski biro d.d.

Anušić, Z., O'Keefe, P. and Madžarević-Šuster, S. (2003). Pension Reform in Croatia. Social Protection Discussion Paper Series No. 0304. Washington: the World Bank.

Barac, Z., Jurlina Alibegović, D. at el (2001). Provedba mirovinske reforme – II. i III. stup mirovinskog osiguranja. Zagreb: RRiF-plus d.o.o. i Raiffeisen Bank Austria d.d.

Bejaković, P., (2002). Evazija doprinosa za mirovinsko osiguranje (Evasion of pension insurance contributions). Financijska teorija i praksa, 26 (1), 317-349.

Bejaković, P., (2004). The Collection of Pension Contributions in Croatia. in: Collection of Pension Contributions: Trends, Issues, and Problems in Central and Eastern Europe. Budapest: International Labour Office Subregional Office for Central and Eastern Europe.

Bilić, D., (2001). Mirovinska reforma : drugi i treći stup osiguranja (Pension Reform the Second and Third Insurance Pillars). Zagreb: TEB Poslovno savjetovanje d.o.o.

Buneta, A. et. al., (2001). Mirovinska reforma (Pension reform). Zagreb: Hrvatska zajednica računovođa i financijskih djelatnika.

Copić, J., (1998). Novi sustav mirovinskog osiguranja (The New Pension Insurance System). Zagreb: Hrvatska zajednica računovođa i financijskih djelatnika.

Croatian Pension Insurance Institute (2004). Annual Report for the 2004. Zagreb: HZMO.

Croatian Pension Insurance Institute (2006). Statističke informacije Hrvatskog zavoda za mirovinsko osiguranje. Zagreb: HZMO.

Document (2001). "Expected Trends in the Pension System of the Republic of Croatia to 2040", in Croatian Journal of Social Policy 9 (2).

Jurčević, Ž. (2005) 'Social Welfare System in Croatia 2000-2004: analysis of situation indicators and development' (Croatian language text) in Revija za socijalnu politiku 12 (3/4); 345-75.

Jurlina Alibegović, D., (2000). "Reforma mirovinskog sustava: Zašto i kako? (Pesion System Reform: How and Why?)". Privredna kretanja i ekonomska politika, 79/2000, Zagreb: Ministarstvo financija Republike Hrvatske i Ekonomski institut, Zagreb, pp. 60-88.

Jurlina Alibegović, D., (1998). "Reports on Pension System in CEES's: Croatia Case." Monthly Report. The Vienna Institute for International Economic Studies (WIIW), 1 (1), pp. 1-5.

Lindeman, D., Rutkovski, M., and Sluchynskyy, O., (2000). The Evolution of Pension Systems in Eastern Europe and Central Asia: Opportunities, Constraints, Dilemmas and Emerging Best Practices. Washington, D.C.: The World Bank.

Puljiz, V. et al (1998). Croatian Pension Reform: Challenges of the New Three-Pillar System. In Croatian Journal of Social Policy (Revija za socijalnu politiku 5 (2/3).

Rismondo, M. (2002). "Pension Insurance in Croatia and the Successor States", in Croatian Journal of Social Policy 9 (1).

Schmaehl, W., and Horstmann, S. (eds.), (2002). Transformation of Pension Systems in Central and Eastern Europe. Cheltenham; Northampton: Edward Elgar.

Škember, A., (2005). Demografska tranzicija, promjene u strukturi tržišta rada i kriza mirovinskog sustava (Demographic Transition, Changes in the Labour Market, and the Crisis of the Pension System). Ekonomski pregled, 56 (1-2), 102-116.

Švaljek, S. (2004). Fiscal Implications of the Ageing Population in Croatia. In: Proceedings of the Institutet of Economics, Zagreb 65th Anniversary Conference, November 18-19, 2004, Zagreb, Croatia, 105-131.

United Nations (2003). World Population Prospects: The 2002 Revision, Population Division of the Department of Economic and Social Affairs of the Unitied Nations Secretariat, http://www.un.org/unpp.

Vuković, S., (2005). "Pension System in the Republic of Croatia: fundamental trends and indicators", in Croatian Journal of Social Policy, 12 (3-4), 377-391.

World Bank, (2000). Program mjera za gospodarsku reformu i rast (Programme of Measures for Economic Reform and Growth). Zagreb: World Bank, str. 43.

World Bank, (2000). Croatia. Economic Vulnerability and Welfare Study. Volume II. Technical Papers. Washington, D. C.: World Bank.

..., (1997). Reforma hrvatskog mirovinskog sustava i prikaz međunarodnih iskustava (Reform of the Croatian Pension System). Zbornik radova sa skupa održanog u Opatiji, 13.-16. studenog 1995. Zagreb: Naša djeca offset tisak.

Selected Acts and Regulations

Pension Insurance Act (Official Gazette 102/98, 127/00, 59/01, 109/01, 147/02, 117/03, 30/04, 177/04 and 92/05).

Act on the Highest Pension (Official Gazette 162/98 and 82/01).

Act on Pensions for Pension Beneficiaries that Realize Pension Benefit in Former Republics of the SFRJ (Official Gazette 96/93).

Act on Increase of Pensions in order to Eliminate Differences in Retirement Benefits Acquired in Different Periods (Official Gazette 127/00).

Act on Amendments to the Act on Executing of the State Budget of the Republic of Croatia for the Year 2001 (Official Gazette 82/01).

Act on the Right to a Supplement to a Pansion for Certain Categories fo Pension Benefits (Official Gazette 45/02).

Act on Collection of Data on Insured Persons and Mandatory Contributions (Official Gazette 147/02, 175/03 and 177/04).

Act on Collection of Data on Insured Persons, Mandatory Contributions, Personal Income Tax and Surtax (Official Gazette 114/01).

Act on Pension Insurance Companies and Benefit Payments Based on Individual Fully-Funded retirement Savings (Official Gazette 106/99 and 63/00).

Act on Tax Administration (Official Gazette 67/01).

Act on Croatian Agency for Supervision of Financial Services (Official Gazette 140/05).

Decree of the Croatian Government on Establishing the Central Registry of Insured Persons (Official Gazette 101/99).

Income Tax Act (Official Gazette 177/04).

Mandatory and Voluntary Funds Act (Official Gazette 44/99, 63/00, 103/03 and 177/04).

Statistical Annex for Chapter 5

Table 5.1 **The dependency ratio**

Year	Pensioners in the public pension system	Insured persons	Ratio
1980	449.080	1,816.191	4,04
1985	524.154	1,931.254	3,68
1990	655.788	1,968.737	3,00
1995	865.769	1,567.981	1,81
1999	1,017.801	1,406.091	1,38
2000	1,018.504	1,380.510	1,36
2001	1,032.120	1,402.102	1,36
2002	1,042.192	1,421.981	1,36
2003	1,054.549	1,443.995	1,37
2004	1,065.655	1,460.105	1,37

Source: Croatian Pension Insurance Institute.

Table 5.2 **The number of insured persons, end of year**

Year	Insured persons in the 1st pillar	Index	Insured persons in the 2nd pillar	Index
1995	1,567.981			
1996	1,478.975	94,3		
1997	1,468.938	99,3		
1998	1,471.509	100,2		
1999	1,406.091	99,6		
2000	1,380.510	98,2		
2001	1,402.102	101,6		
2002	1,421.981	101,4	938.310	
2003	1,443.995	101,5	1,070.932	114,1
2004	1,460.105	101,1	1,170.092	109,3

Source: Croatian Pension Insurance Institute.

Table 5.3 **The contribution rate for the pension scheme, % of gross wages**

Year	Total contribution rate		
	1st pillar (PYGO)	2nd pillar	Total
1990	24,1		24,1
1991	18,5		18,5
1992	22,0		22,0
1993	22,0		22,0
1994	27,0		27,0
1995	25,5		25,5
1996	25,5		25,5
1997	25,5		25,5
1998	21,5		21,5
1999	21,5		21,5
2000	21,5 (19,5)*		21,5 (19,5)*
2001	19,5		19,5
2002	14,5	5,0	19,5
2003	15,0	5,0	20,0
2004	15,0	5,0	20,0

Source: Croatian Pension Insurance Institute.
Note: *Contribution rate was changed June 1st, 2000.

Table 5.4 **Average retirement benefit, HRK***

Year	Old age retirement benefit	Disability retirement benefit	Survivors retirement benefit	Total
1999	1.475,16	1.172,94	1.119,90	1.322,44
2000	1.553,96	1.235,45	1.182,51	1.395,66
2001	1.792,86	1.394,96	1.366,13	1.604,11
2002	1.841,12	1.430,28	1.410,91	1.649,93
2003	1.888,70	1.501,85	1.452,09	1.702,24
2004	1.946,74	1.558,83	1.503,41	1.758,12

Source: Vuković (2005).

Note: *Income tax and surtax on income tax are deducted from retirement benefit.

Table 5.5 **Number of pension system beneficiaries* regarding the amount of retirement benefit, 31.12.2004.**

Amount of retirement benefit, HRK	Number of retirement beneficiaries	%
up to 500,00	71.594	7,00
500,01 – 1.000,00	101.722	9,90
1.000,01 – 1.500,00	276.312	26,99
1.500,01 – 2.000,00	230.762	22,61
2.000,01 – 4,000,00	239.235	30,89
4.000,01 – 8.000,00	26.885	2,60
more than 8.000,00	295	0,03
Total	1,022.282	100,00

Source: Croatian Pension Insurance Institute.
Note: Pension system beneficiaries from Croatian army and Croatian veterans are not included in total number of pension system beneficiaries. Income tax and surtax on income tax are deducted from retirement benefit.

Table 5.6 **Replacement rate, HRK***

Year	Average monthly net wages and salaries paid off	Average monthly pension benefit	Replacement ratio %
1999	3.055	1.309	42,86
2000	3.326	1.382	41,56
2001	3.541	1.592	44,96
2002	3.720	1.648	44,29
2003	3.940	1.702	43,20
2004	4.173	1.758	42,13

Source: Vuković (2005).

Note: *Income tax and surtax on income tax are deducted from retirement benefit.

Table 5.7 **Revenues from pension contributions, Million of HRK, end of year**

Year	1st pillar	Index	2nd pillar	Index	Total	Index
1995	9,687					
1996	10,871	112,2				
1997	12,214	112,4				
1998	11,766	96,3				
1999	12,459	105,9			12,459	
2000	12,854	103,2			12,854	103,2
2001	13,261	103,2			13,261	103,2
2002	12,530	94,5	1,970		14,500	109,3
2003	13,845	110,5	2,503	127,1	16,349	112,7
2004	14,875	107,4	2,815	111,2	17,690	108,2

Source: Croatian Pension Insurance Institute.

Table 5.8 **Public pension expenditures as a percentage of the GDP, Millions of HRK, end of the year**

Year	GDP current prices	Total pension expenditures		Pension expenditures		Financial expenditures for pension pay off	
1995	98.382	10.667,3	10,8				
1996	107.981	12.343,3	11,4				
1997	123.811	15.448,1	12,5				
1998	137.604	16.535,6	12,0				
1999	141.579	19.046,5	13,5				
2000	152.519	20.225,1	13,3	19.470,3	12,8	754,8	0,5
2001	165.639	22.967,1	13,9	22.281,4	13,5	685,7	0,4
2002	179.390	23.722,8	13,2	23.090,0	12,9	632,8	0,4
2003	193.067	24.690,6	12,8	24.110,8	12,5	579,8	0,3
2004	207.082	26.010,7	12,6	25.411,7	12,3	599,0	0,3

Source: The Ministry of Finance and Croatian Pension Insurance Institute.

Table 5.9 **Number of persons with privileged pension rights in Croatia, end of the year 2004**

Pension beneficiaries	Number of persons with privileged pension rights	Average monthly retirement benefit (income tax and surtax on income tax are deducted)
World war II veterans	63.712	2.183,60
Some category of employees in police and justice	16.633	3.226,49
Croatian war veterans 1941-1945	28.584	1.860,52
Ex political prisoners	5.807	3.360,72
Ex Yugoslav army soldiers	14.057	2.512,79
Croatian Academy of Science and Arts	163	6.825,92
Executive Council of Parliament	486	2.060,00
Parliamentarians	336	8.585,30
Employers in Yugoslav Parliament	71	3.223,35
Miners in Istrian mine in Labin	253	2.736,04
Croatian Army	6.814	2.942,43
Croatian defenders	36.559	5.479,22
TOTAL	173.475	

Source: Croatian Pension Insurance Institute.

Table 5.10 **Number of persons with different categories of minimum pensions, March 2006**

Type of retirement benefit	Number of persons	Average pension (income tax and surtax on income tax are deducted)
1. Number of persons that receive minimum pension according to the Pension Insurance Act which was valid untill December 31st 1998		
Old age retirement benefit	20.773	2.075,75
Disability retirement benefit	984	2.035,84
Survivors retirement benefit	2.284	1.518,01
Total	24.041	2.021,13
2. Number of persons that receive minimum pension according to the Pension Insurace Act which was applied since January 1st, 1999		
Old age retirement benefit	76.633	1.209,82
Disability retirement benefit	39.272	1.171,65
Survivors retirement benefit	13.218	914,99
Total	129.123	1.168,03
3. Number of persons that receive pension supplement according to the Pension Insurance Act which was valid untill December 31st 1998		
Old age retirement benefit	40.473	395,26
Disability retirement benefit	24.602	376,14
Survivors retirement benefit	37.748	368,62
Total	102.823	380,91

Chapter 6: The Health Care System

6.1. Current structures

6.1.1. Organisation of the Health Care System

Public Health Services

1. In Croatia, public health services are delivered through a network of institutes of public health: the state founded Croatian National Institute of Public Health-CNIPH (*in Croatian: Hrvatski zavod za javno zdravstvo; HZJZ*) and 21 county founded institutes of public health (*in Croatian: Županijski zavodi za javno zdravstvo*). Their activities are predominantly funded directly from the state budget and from regional – county budgets. Some of the services they provide are paid for by the Croatian Institute for Health Insurance or charged directly to users.

2. The central Croatian National Institute of Public Health is responsible for the collection, analysis and presentation of health statistics and epidemiological data and for health promotion and health education programmes on the national level. It is also responsible for the coordination of 21 County public health institutes It maintains a number of public health registers such as the Croatian Cancer Register, the TB Register, the HIV Register, the Register of personnel employed in health care, and so on. Additionally, the Croatian National Institute of Public Heath monitors the work of health care providers in terms of numbers of services provided, geographic distribution of personnel, and so on. CNIPH is responsible for the national health promotion programmes such as are: smoking cessation, HIV-AIDS prevention, healthy diet programmes, as well as number of prevention programmes: from drug addiction prevention to prevention of hypertension and cardiovascular diseases.

3. All institutes of public health have the following departments: epidemiology, social medicine, ecology, microbiology and school and university medicine. The network of public health institutes provides the following services: epidemiology and quarantine of communicable diseases, epidemiology of non-communicable diseases, water, food and air safety, immunizations, sanitation, health statistics and health promotion. Public health institutes are also responsible for overseeing compulsory immunisation programmes. These programmes are carried out by primary health care doctors (family doctors and primary health care paediatricians) and school doctors for school-aged children. Non-compulsory vaccination programmes are delivered through family medicine doctors or county public health institutes. The National Centre for Addiction Prevention works under the HZJZ and runs the national register of treated psychoactive drug addicts. From 2003, County Centres for Addiction Prevention form a part of County Institutes of Public Health.

4. Several other institutes also have a stake in public health issues. These include the Croatian National Institute of Toxicology, the Institute of Medical Research, the Institute of Occupational Health, the Croatian Institute of Transfusion Medicine, the institute of Mental Health, and others.

Primary health care

5. In Croatia, primary health care is delivered through a network of first-contact doctors - gatekeepers. Primary health doctors work in individual offices or health centres that provide general medical consultations (family medicine), primary care gynaecological services, care for pre-school children, and dental care. All health-insured citizens are legally required to sign up with a specific General Practitioner (GP). Currently, most primary health care is provided through private practices (a doctor and a nurse). Health centres which, prior to the 1993 privatisation reform, were the exclusive providers of primary health care with salaried employees, currently predominantly represent administrative bodies that lease offices, and (depending on the availability of equipment) provide emergency medical care, laboratory and radiological diagnostics. Presently over 80% of primary health care practices operate in leased facilities.

6. Although primary health care is currently organised around several medical specialisms, it is gradually moving towards a family physician system. All currently practising GPs are required to specialise in family medicine by 2015 (Katic et al 2004). In 2004, primary health care was provided by 47 health centres, 2657 teams providing general/family medicine or preschool health services, 252 teams providing gynaecological services and 145 nursing care institutions (Croatian National Institute of Public Health 2005). At the beginning of the health care reform (in the early 1990s), financial management of health services provision was introduced to control expenditure. Health providers were contracted by the Croatian Institute for Health Insurance and paid only for providing the determined standard of services. Limiting services was thus established as a control mechanism, mainly in primary health care, and doctors became responsible for any over-use of services. However those measures were not accepted by patients, who saw it as reduction of their health care rights.

Secondary and tertiary health care

7. Secondary care facilities include hospitals, polyclinics and sanatoria. Hospitals are divided into general hospitals and special hospitals. All general and the majority of special hospitals are public-county owned. While general hospitals primarily serve the population of their respective counties, special hospitals serve the entire population of Croatia. At the minimum, general hospitals are obliged to have facilities for obstetrics and gynaecology, internal medicine, and surgery. Other departments, such as paediatric care, are optional, depending on the

vicinity of other hospitals or polyclinics providing those services (Health Care Act 2003 /NN 121/03). Special hospitals are organised around specific diseases, chronic illnesses or patient groups. In addition to inpatient facilities, hospitals also have outpatient departments providing ambulatory services. Polyclinics provide outpatient specialist consultations and diagnostic and rehabilitation services. Most public polyclinics are linked to general and clinical hospitals. Others include private polyclinics and privatised specialist practices in health centres.

8. Tertiary care is provided in state owned facilities: clinical hospitals and clinical hospital centres. Besides providing care, these take part in medical education and clinical research. In order to be awarded the status of a clinical hospital, hospitals are required to have at least four departments at teaching hospital level (clinics). Clinical hospital centres are required to have more than half of their departments at teaching hospital level (clinics), and to carry out at least 50 % of graduate curricula for schools of medicine, dentistry, pharmacy or biochemistry (Health Care Act 2003). The National Health Council controls whether hospitals meet certain normative standards set by the Ministry of Health and Social Welfare and medical associations (number of specialists per bed, etc.).

9. In 2004, Croatia had 2 Clinical hospital centres, 5 clinical hospitals, 7 clinics, 22 general hospitals, 29 special hospitals, 7 health resorts, 4 emergency care stations and 278 polyclinics (Croatian National Institute of Public Health 2005).

6.1.2 Institutional Stakeholders

Ministry of Health and Social Welfare

1. The Ministry of Health and Social Welfare is responsible for health policy and planning; implementation of public health programmes and regulation of capital investments in publicly owned health care providers. In particular, the Ministry draws up legislation for consideration by the parliament, produces the annual national health plan for the country, monitors the population's health status and health care needs, sets and regulates standards in health facilities and supervises professional activities such as training and licensing. The Ministry also appoints the majority of board members in state owned health care facilities. The National Health Council, consisting of nine members nominated for their expertise, advises the Minister of Health on health policy and planning issues.

The Ministry of Finance and the State Treasury

2. Since 2002, the State Treasury has been responsible for collecting all state finances, including social health insurance payroll contributions. Furthermore, the Ministry of Finance is responsible for the planning and management of the government budget. This includes the approval of central budget transfers to the Croatian Institute for Health Insurance and the Ministry of Health. Therefore, the

Ministry of Finance plays a key role in determining the overall level of public spending on health care.

Croatian Health Insurance Institute (HZZO)

3. Established in 1993, the HZZO is a public body in charge of managing the health insurance fund and contracting health care services. As the main purchaser of health services, the HZZO plays a key role in the definition of basic health services covered under mandatory insurance, the establishment of performance standards and price-setting for services covered under the umbrella of state provided health insurance. The HZZO is also responsible for the distribution of sick leave compensations, maternity benefits and other allowances as regulated by the Croatian Health Insurance Act. The HZZO is overseen by a governing council, which consists of representatives of the insured population, the Ministry of Health and Social Welfare, the Ministry of Finance, health institutions and private practices (independent general practitioners).

Croatian National Institute of Public Health (HZJZ)

4. The Ministry of Health consults the HZJZ on all matters pertinent to public health policy. The HZJZ proposes national anti-epidemic measures, supervises compulsory immunisations and pest control, monitors environmental pollution and waste maintenance, sets standards and monitors food and drinking water safety. It monitors the health care system and publishes reports and implements health promotion and prevention programmes. It also supervises and coordinates all county institutes of public health. Figure 1 shows the general organogram of the system.

Counties and the city of Zagreb

5. Local governments own and operate most of the public primary and secondary health care facilities, including health centres, general and special hospitals, polyclinics, public health institutes and emergency care units. While these facilities receive operating expenditures through their contracts with the HZZO, local authorities are responsible for infrastructure maintenance and increasingly for capital investments. Resources are collected from decentralised state funds, local taxes and rental income.

Chambers

6. Croatia has statutory professional chambers for physicians, dentists, pharmacists, biochemists and nurses, established by relevant faculties and professional associations. All practicing university-educated health professionals and nurses are legally bound to enlist. The chambers are responsible for professional registration and maintenance of professional standards. They also express professional opinions on a variety of issues, advise on licensing private practices and on opening or closing health institutions

7. Privatisation of health care has created a two-tier system of public and private care, with more than 30% of providers already working in the private sector (See Table 1). In the present situation there is no coordination between the public and private systems, except on the level of the medical chambers.

6.1.3 Benefits

1. The compulsory social health insurance scheme provided exclusively by the Croatian Institute for Health Insurance covers (Croatian Institute for Health Insurance 2006):

Rights to health care, rights to prosthetics and orthotics, rights to medicines from the positive list, and allowances.

2. The volume of guaranteed rights is:
<u>100% of the costs for</u>
- preventive care for children under 18 and full time students
- preventive care for adults (except services that are legally determined to be paid for by employers or local and regional authorities)
- curative care and medical rehabilitation for children under 18 and full time students
- orthopaedic devices for children under 18
- preventive and curative primary health care for adults (except for services determined otherwise)
- preventive and curative gynaecological care related to family planning, pregnancy, delivery and screening for malignant diseases
- preventive and curative dental care for children under 18 and pregnant women
- preventive and curative treatment for HIV infected patients and others with communicable diseases potentially threatening to the general population (as defined by law)
- comprehensive vaccination, immunization and chemoprophylaxis programs
- diagnostic procedures (laboratory, radiology and others) provided at the primary health care level
- medical services provided in hospitals (not including accommodation and food costs)
- accommodation and food hospital costs for patients with chronic psychiatric diseases
-chemotherapy and radiotherapy procedures (including related hospital food and accommodation costs)
-medical care relating to organ transplantation procedures (including medical treatment, food and accommodation costs)
- urgent medical care (including food and accommodation costs during intensive medical care)

- urgent dental care
- urgent medical transportation
- home visits for acute diseases
- medical services provided in patients' homes
- community nursing programs
- medical transportation for a defined list of patient categories
- a defined list of pharmaceuticals prescribed during hospital treatment
- a defined list of pharmaceuticals prescribed in primary health care
- medical treatment and rehabilitation for injuries related to workplace and professional diseases (including hospital medical treatment, food and accommodation costs and orthopaedic devices)
- nursing provided in patients' homes

At least 85% of the costs for
- Outpatient medical treatments and counselling provided by specialists (not including medical rehabilitation
- Diagnostic procedures that can not be performed at the primary health care level
- Orthopaedic devices;
- Medical treatment abroad (only for those diagnostic procedures and treatments that can not be preformed in Croatia)
- Medical rehabilitation in patients' homes
- Outpatient dental care provided by specialists of paradontology and oral surgery

At least 75% of the costs for
-accommodation and food costs during hospital care for chronic diseases;
-a defined list of pharmaceuticals prescribed in primary health care
-dental prosthetic medical care for people over 70

At least 70% of the costs for
- Outpatient medical treatments provided by specialists in medical rehabilitation
-accommodation and food costs during hospital care for acute diseases;

At least 50% of the costs for
-dental prosthetic medical care for people over 18
-a defined list of pharmaceuticals prescribed in primary health care

At least 25% of the costs for:
- a defined list of pharmaceuticals prescribed in primary health car

3. The difference between the full price of the listed services and products and the amount covered by Elementary health insurance can either be paid through

co-payments or can be covered by Complementary insurance premiums, currently issued solely by the Croatian Institute for Health Insurance (HZZO).

4. Compulsory insurance (provided by the Croatian Institute for Health Insurance) does not cover:
-experimental treatments and medical treatments, pharmaceuticals and devices that are undergoing clinical trials
-reconstructive and plastic surgery (except for treatment of congenital diseases, patients which underwent mastectomy or those with heavy injuries)
-surgical treatment of obesity
-fertility treatments for patients that voluntarily underwent sterilization
-treatment for conditions caused by medical treatments not covered by Compulsory insurance
- specific services provided by specialists of occupational medicine that have to be paid for by employers

5. Supplementary/private health insurance is provided by private insurance companies. Premiums cover services such as higher standard amenities or better quality of care and faster access (i.e. by avoiding waiting lists in public hospitals) through private providers, extra services and drugs excluded from the elementary insurance plan and hotel facilities in publicly owned hospitals.

6. Private health insurance in Croatia plays a marginal role in funding health care as it does in most European Union countries (Mossialos and Thompson 2002). In 2002 private health insurers reported annual revenues of 962 m. HRK or roughly 6% of total health expenditure (WB Croatia Health Finance Study 2003). Prior to 2002, individuals with annual income over € 30,000 were allowed to opt out from the compulsory health insurance system and to insure with privately owned insurers instead. The 2002 Health care law prohibited opt-out and confined the benefits of private insurers' schemes to supplementary insurance benefits such as providing a higher standard or quality of care and faster access (i.e. by avoiding waiting lists in public hospitals) through private providers, extra services and drugs excluded from the compulsory insurance plan, and hotel-like amenities in publicly owned hospitals. It was recognized that international experience suggests that opting out of statutory health insurance threatens the long term financial sustainability of standardised health insurance schemes as it tends to attract younger and healthier people, leaving the former with a disproportionate number of large families, older people and people in poor health (Thompson and Mossialos 2004). As a consequence, the 2002 Health Care Law severely undermined the market for private insurance (Addenda 2003). Currently around 20 insurance companies in Croatia offer private health insurance. Due to a loose regulatory framework they are able to offer risk rated premiums with benefits designed in order to drive away high risks and maximize profits. Additionally,

they support the creation of a two tiered system for the better off (who can afford private insurance) and the poor who cannot.

6.1.4 Financing of the Health Care System

Expenditure

1. For 2002, the World Health Organisation estimates Croatia's per capita total expenditure on health at 630 USD or €560 (World Health Organization 2005). In comparison to other South Eastern European countries, current candidates for membership or countries aspiring to become candidates for membership in the European Union, this figure is above average. However, Croatia significantly lagged behind most of the newly admitted countries into the European Union and even more so behind the old member states (see Table 2).

2. Current estimates suggest Croatia spent 8.7% of GDP spent on health in 2005 (Ministry of Health and Social Welfare 2006), Croatia spends a relatively large proportion of its GDP on health care in comparison to other Central and Southern European countries and the majority of EU member states. However, through GDP growth and cost containment efforts, the proportion of GDP spent of health has been on a slow but steady decline in the last several years, from 10.2% in 2000 to 8.7% in 2005 (See Table 3). These figures are for total spending, with public expenditures on health estimated at 6.8% of GDP in 2004.

3. The rise in proportion of expenditure in 2004 is attributed to the settlement of HZZO and hospital arrears from 2000, 2002 and 2003, which amounted to more than HRK 3 billion (more than €473 million) (Ministry of Health and Social Welfare 2006)

Funding health care

4. Croatia operates a Social Health Insurance system (Elementary health insurance) that covers the major part of public expenditure for health care services, with a single publicly owned sickness fund for the entire population of the country – the Croatian Institute for Health Insurance (HZZO). However, the total amount of funds allocated for health care is annually determined by the state budget and collected through the state treasury. The HZZO receives funds for compulsory insurance from the state budget. Those funds originate from two main sources: contributions for compulsory health insurance and funds collected by general taxation. According to the Croatian Ministry of Health, salary contributions form more than 80% of the total of funds the state allocates to health care. (Ministry of Health and Social Care 2006). Therefore, the Croatian funding system displays characteristics specific to both Bismarck and Beveridge-like models.

5. HZZO dispenses the majority of compulsory health insurance funds for provision of health services and a small proportion for infrastructure investments in publicly owned providers. In order to receive public funds for providing health services, all providers regardless of ownership are required to enter into annual contracts with the HZZO that dictates prices for services and forms of payments (Health Insurance Act 2001)

6. Funds for health care providers' infrastructure and funds for capital investment and technical equipment are collected and distributed separately from the health insurance fund (HZZO). Conceptually, responsibility for those expenses is distributed on the ground of ownership. Thus, the central government ought to fund expenses for clinical hospitals and clinical hospital centres, and counties should fund expenses for general and special hospitals and primary health care centres in their ownership etc. However, the central government annually distributes the so called "decentralised funds" for capital investments primarily on the basis of the size of covered population, but also on the basis of the number of facilities and beds in each county. Available data for 2004 indicate that the central government allocated roughly 0.2 percent of GDP for capital investments into all publicly owned health care providers in Croatia (Croatian Institute for Health Insurance 2005).

7. The 2002 Health Care law introduced voluntary Complementary Health Insurance into the funding system. Until 2004 legally offered exclusively by the HZZO, the premium for complementary insurance is community rated, higher for those employed than for retired persons, and is currently set at HRK 80 (EUR 10.80) per month for the active population, and at HRK 50 (EUR 6.75) per month for retired persons. It restores full rights to free health care at the point of use in HZZO contracted providers. It can be paid by employers or employees and is fully tax deductible. In 2003 Complementary health insurance was purchased by 729,915 citizens, roughly 16 % of the Croatian population (Croatian Institute for Health Insurance 2004).

8. The inflow of private funds and user charges into the Croatian health care system originates from four sources: private health insurance, co-payments to providers contracted by HZZO, out of pocket payments to providers not contracted by HZZO and informal payments. In 2002, the World Health Organisation estimated private expenditure on health at 18.6% of total expenditure on health (World Health Organisation 2005). According to the Croatian Ministry of Health and Social Welfare, private consumption in health care has remained at 2% of total GDP until 2005 (Ministry of Health and Social Welfare 2006).

9. Patients are required to pay out of pocket to privately owned providers (not contracted by HZZO), and if they do not have complementary health insurance,

co-payments to providers contracted by HZZO for services not fully covered or not covered by elementary health insurance. HZZO collects premiums for complementary health insurance on its own through a separate account. Although informal payments do not form a part of the official funding system and are furthermore illegal, based on published research (Mastilica, Božikov 1999), it would not be realistic to deny their existence in Croatia, as seems to be the case in the greater part of Central and Eastern Europe (Lewis 2002). Private insurers collect premiums for supplementary insurance that can be used with contracted private or publicly owned providers.

10. Private health insurance in Croatia plays a marginal role in funding health care as it does in most European Union countries. In 2002, private health insurers reported annual revenues of HRK 962 million (EUR 130 million) or roughly 6% of total health expenditure (World Bank 2004). Prior to 2002, individuals with annual income over a certain limit (annually determined by the Minister of Health) were allowed to opt out from the compulsory health insurance system and to insure with privately owned insurers instead. The 2002 Health care law prohibited opt-out and confined the benefits of private insurers' schemes to supplementary insurance benefits. Currently six insurance companies in Croatia offer private health insurance. They mostly contract private and public health care providers, but some have started to develop networks of providers of their own.

Paying providers

11. The HZZO distributes resources for services according to agreed contracts with health care providers. These contracts fix the list, quality and scope of services, schedules, requirements for cost accounting and payment subject to the guidelines set out in the government's national health plan. Private providers such as private polyclinics not contracted by the HZZO, charge for their services directly and/or contract with private insurers offering supplementary health insurance.

12. The 1993 reforms introduced capitation payment as the provider payment mechanism for the primary care sector. As of 2004, GPs receive additional FFS reimbursement for preventive checkups (for adults over 45) and for a restricted number of services for which they are allowed to charge (from 2005) according to a DRG schedule (in Croatia referred to as the PPTP). The total of funds additional to the capitation payment may not exceed 7% of annual capitation (12% for GPs working in retirement/nursing homes) (Croatian Institute for Health Insurance 2005).

13. In parallel with the existing FFS system, in 2002, the government started introducing a Diagnostic Related Groups (DRG) based payment system. By 2005, the number of services charged by the DRG system grew to 118 selected

diagnoses. Under this system, referred to as PPTP (Plaćanje po terapijskom postupku), in order to encourage a more efficient use of resources, the HZZO negotiates the volume of contracts prospectively with all hospitals for these selected interventions, using case-based reference. This strategy is intended to reduce the waiting list while improving control over the total costs.

14. In secondary and tertiary health care, medical services are paid for by the HZZO, according to a combination of a point-based hospital payment system and a DRG system. The point-based hospital payment system is essentially a fee-for-service reimbursement system (FFS). The hospital payment system consists of three separate components: hotel services, paid by a flat per diem payment, physician services, paid by procedure using the WHO point system, and pharmaceuticals and other materials which are paid separately, depending on the cost of each item. In addition, the total of funds each hospital can charge is limited by an annual budget cap.

6.1.5. Incentives

1. The shift to capitation payments and privatisation of primary care physicians was intended to give physicians incentives to provide more efficient and effective care. Findings from a study analysing the effects of the privatisation process in primary health care in Croatia indicated that privatised practices performed better in improving access to their services for patients as they increasingly offered the possibility for first and follow-up appointments at precise times, scheduled visits by telephone and provided telephone advice outside working hours (Hebrang et al 2003). They also showed greater intention to honour appointment times in order to lower their patients' waiting times.

2. In terms of cost containment efforts and their role as gatekeepers, primary care physicians should play an influential role in determining the costs of health care. However, analyses of GP referral vs. treatment practices are largely lacking. However, alongside capitation and privatization, reports from the Croatian National Institute of Public Health have indicated substantial reductions in numbers of rendered preventive services and home visits as well as galloping increases in numbers of referrals to secondary and tertiary health care providers (Croatian National Institute of Public Health 2004). The Croatian Institute for Health Insurance has attempted to react through limiting allowed numbers of referrals by patient but has failed to check the trend.

3. In particular, a number of statistics are worthy of note:

- Number of GPs' home visits reduced by 35% between 1990 and 2003
- Other primary care physicians' home visits reduced by 92% between 1990 and 2003
- Number of Referrals increased by 25% between 1995 and 2003

- Number of GP preventive checkups reduced by 72% between 1990 and 2002

Source: Croatian National Institute of Public Health 2004

4. The FFS hospital payment system does not allow hospitals to be rewarded for productivity gains. Hospitals are motivated to keep beds full and extend lengths of stay, since high occupancy results in steady funding through per diem payments and since high costs tend to be accumulated in the first days of hospital stays. Low occupancy rates also increase the risk that the HZZO will lower the global budget ceiling. The nature of personnel employment contracts makes it hard to adjust staffing levels in response to potential shortened lengths of stay and other efficiency gains. Cost overruns are likely to result in the imposition of arbitrary internal controls, e.g. by restricting the use of medications or procedures, rather than a response to improve productivity, such as reorganization of staffing and other systemic reforms. Table 4 below shows that Croatia has a much higher average length of hospital stay per patient than other countries in Central Europe, with the exception of the Czech Republic. For the reasons described above, the Government intends to eventually fully move towards a comprehensive prospective case-adjusted payment system based on the Australian Diagnostic Related Groups system.

6.1.6 Coverage of the system and access to health care

1. Although the Croatian Health Care Act proclaims that all Croatian citizens have the right to health care and thus that the health care system should strive towards universal compulsory health insurance coverage, this has however not been fully achieved. In 2003 HZZO provided compulsory health insurance to a total of 4,296,955 citizens (HZZO report 2004). According to a mid year estimate by the Croatian Central Bureau of Statistics, in 2003 Croatia had a total of 4,442,000 citizens (Central Bureau of Statistics 2004). Thus, around 146 000 citizens or roughly 3.2 % of the population did not have compulsory health insurance in 2003. One of the possible contributors might be HZZO's rather short deadlines (30-60 days according to the 2002 Health Insurance Law) in which citizens have to apply for free compulsory insurance in situations such as after loosing employment, graduating from school or university etc.

2. Raw indicators of equity in access to secondary health care (such as number of beds and doctors per 1000 inhabitants, number of patients treated per 1000 inhabitants etc.) reveal that significant variations exist between individual Croatian counties (See Table 5). These differences may be caused by a long history of non systematic resource allocation patterns between Croatian counties,

which have so far been primarily based on historic arguments, rather than analyses of regional needs.

3. Furthermore, analyses of the territorial distribution of health care institutions indicate that large disparities exist in regional geographic access to hospitals. For example, over 140 000 of inhabitants of southern Dalmatia and mostly on islands have to travel more than 40 kilometres (air distance) to reach the nearest hospital (Ministry of Health and Social Welfare 2006).

6.2 Evaluation of Recent and Planned Reforms

6.2.1 Recent reforms in health care

1. Since the early nineties, Croatia's health care system has undergone a series of reforms that attempted to tackle some of the issues that contributed to the escalating crisis; the most notable ones for funding health care carried out in 1990, 1993 and 2002. The 1990 reform centralised the previously decentralized system of collecting funds and separated the previously unified regional systems of managing health care providers from collecting compulsory health insurance in an attempt to facilitate state control over management and financing. The 1993 and 2002 reforms focused on cost containment. The 1993 reform set the stage for the privatisation of primary health care, reduced the scope of health care services free at the point of use citizens previously enjoyed on the basis of compulsory health insurance and introduced private health insurance for services and providers not covered under compulsory health insurance. Furthermore, the 1993 reform allowed opting out of compulsory health insurance to individuals with income over 30000 Euro per annum (Dzakula et al 2005). The 2002 reform further decreased the scope of health care services free at the point of use, introduced complementary health insurance into the funding system and prohibited opting out of compulsory health insurance.

2. The World Bank had a significant role in financing the projects related to healthcare reform in Croatia. The first project financed by them was "The Health System project" (1999-2004) based on a USD 29.0 m. loan. The second grant, amounting to USD 425,000, has been provided by the Government of Japan, and the grant is intended for the Ministry of Health and Social Welfare for the preparation of the Sustainable Health System Project. The main objective of the project is to enhance the performance of the health system in Croatia by improving its efficiency and securing sustainable financing and adequate health protection for the population, as well as introducing new incentives, which should serve as a catalyst of change in the health service delivery system.

3. Centralisation of financing resulted in the establishment of a central insurance fund in 1990, responsible for implementation of health policies and financing and control of health services. New standards of insured rights were established. Compulsory health insurance covered a restricted range of health services, reducing the volume of services covered, and the list of prescribed drugs.(Hebrang 1994)

4. Financial management of health services was introduced to control expenditure. Health providers were contracted by the state insurance fund and paid only for providing the determined standard of services. Limiting services was thus established as a control mechanism, mainly in primary health care, and doctors became responsible for any overuse of services. Cost sharing (co-payments) was introduced for almost all health services and drugs. Exemptions were made for children and students, people receiving the minimum income, the unemployed, elderly people aged 65 or more, war veterans, people in military service, and those with chronic mental illness or communicable diseases.

5. Voluntary health insurance was introduced either as supplementary insurance (for higher standard or quality of care, such as for extra services and drugs excluded from the compulsory insurance plan, and amenities) or as private health insurance (limited to the highest income groups). Privatisation of services, as one of the main goals of health reform, took two basic forms—private practice in privately owned facilities provided by self employed doctors, and private practitioners in rented offices of public health institutions.

6. Various measures aimed at cost containment—such as rationing of services, limitation of services provided, penalties for excessive prescribing or referrals, a limited list of approved drugs, reductions in health budgets, increases in co-payments, have been implemented over the past 10 years in the Croatian healthcare system, but with only limited success and acceptance from providers and the public. The growing scarcity of resources and limited health services and drugs covered by the basic health insurance have led to a lower standard of health care. This is particularly noticeable in the provision of preventive services. The drastic decline in numbers of preventive check ups and home visits has potential negative consequences for the health of vulnerable groups such as children, women, workers in hazardous occupations, and elderly people.(Oreskovic et al. 1997)

7. At the same time, the increase in cost sharing, reduction in the list of prescription drugs, the rise of the private medical sector, and other forms of personal costs for health care have shifted a proportion of health costs on to users. Out of pocket payments for health care have increased to such an extent that they are a substantial burden to many people, particularly those in lower socioeconomic groups. (Mastilica, M. Chen 1998, Mastilica, Bozikov 1999)

8. Privatisation of health services has created a two tiered system. In the growing private sector wealthy people can buy easy access to high quality services, whereas in the public healthcare system patients have to wait even for the basic services and have difficulties in obtaining the necessary drugs. With the restricted services covered by compulsory insurance and increased cost sharing, low income groups are at particular disadvantage in terms of access to health care.(Chen M., Mastilica 1998, Mastilica M. Babic-Bosanac S. 2002).

9. Thus, although the objectives of the health service reforms had been clearly set, no account was taken of users' needs, attitudes, and expectations. In pursuing the macroeconomic goals of the reforms, the government often neglected the interests and needs of those for whom the health service is created—the people themselves.

6.2.2. Public awareness and acceptance

1. In central and eastern European countries, as in more developed countries, healthcare systems are rarely evaluated from users' perspectives (Mastilica, Kušec 2006). This might be because governments' objectives in reforming health policy are primarily to reorganise financing and to contain costs, which is often reduced simply to cutting spending,(Maarse 1995) whereas users' interests are often not high on the political agenda. However, the World Health Organization European Regional Office has drawn up principles for healthcare reform that emphasise consumer rights and people's views.(Vienonen 1995, World Health Organization 1996a) Thus, the Ljubljana Charter on Reforming Health Care stresses that the fundamental principle of healthcare reforms should be to address people's needs, taking into account their expectations about health and health care. The public's views should be as important in shaping health services as those of decision makers.(World health Organisation 1996 b)

2. In 1994, soon after the start of the healthcare reforms, a large proportion of Croatian citizens were dissatisfied with health services in general (44%) and with the quality of health facilities and equipment in particular (48%) (Mastilica M., Chen 1998). The commonest reported reasons for dissatisfaction were the behaviour of healthcare staff (20%) and long waiting times (19%). More than a half of the respondents (56%) did not understand the objectives of healthcare reform, and a large proportion (40%) believed that reform had worsened their position as patients (Mastilica and Chen, 1998).

3. The study revealed substantial social inequalities in access as reported by citizens. Those with lower education (up to primary school level) were more likely to report dissatisfaction with health services, difficulties in obtaining drugs, and social inequalities in access to services. On the other hand, those with

university level education were more dissatisfied with the quality of facilities and equipment. Lower income groups were more dissatisfied with health services and reported more difficulties in access. Also, a high proportion (31%) of respondents—particularly older people, women, and those with lower education or lower income—considered patients' co-payments for various health services to be high or very high. Overall, 50% of respondents—particularly women and those with lower education—thought that co-payments for health services and drugs were a major problem (Mastilica M., Chen M.1998)

6.2.3 Health Care Out-Of-Pocket Costs

1. To describe the burden of out of pocket healthcare costs on individuals in different income groups, researchers used data from the 1994 study (Mastilica M., Bozikov J, 1999). Most respondents (66%) reported having considerable costs, but people with low incomes were significantly more likely to do so. Analysis of different forms of direct payments revealed that 52% of respondents reported co-payments for any kind of public health service, 49% reported payments for visiting a general practitioner, and 43% reported payments for prescribed drugs, whereas only 9% reported having co-payments for hospital care. Analysis by income showed that low income groups reported more co-payments than did high income groups (for example, 37% as opposed to 30% for visits to specialists, and 64% compared to 55% for prescribed drugs).

2. Other expenses included various forms of private payments for discretionary and elective health care, such as paying for private medical care and over the counter drugs or traditional medicine. Respondents also reported informal payments to healthcare providers such as gifts (14%) and "gratitude money" (8%). Low income groups reported significantly more expenses for drugs, private medical practice, private dental care, traditional drugs, and gifts and gratuities to healthcare providers.

3. The results showed that the burden of out of pocket costs were not equally distributed among different socioeconomic groups, with lower income groups bearing a heavier burden than higher income groups (see Tables 6 and 7 and Figures 2 and 3). The problem of informal/unofficial payments is still significant. Prior to their transition to market economy, informal (under the counter) payments were an important feature of health care systems in most Central and Eastern European countries (Szende and Culyer 2005). Unfortunately, there are plenty reports that testify to their continued presence in more recent times (Delcheva et al. 1997; Thompson and Witter 2000; Ensor 2004). Due to the fact that informal payments are illegal and thus hidden in Croatia, very few reliable data on them can be found. A study implemented in Croatia in 1994 found that 14% of all respondents reported giving gifts and 8% reported giving "gratitude" money for services received from publicly owned providers of health care (Chen and Mastilica 1998). Besides having an undesirable impact on the efficiency of

their provision (Thompson and Witter 2000, Ensor 2004), informal payments have been found to represent a highly regressive way of funding health care services (Szende and Culyer 2005).

4. To reduce the financial burden of 'out-of–pocket payments' on disadvantaged groups, the exemptions schemes in health legislation are provided for children under 18 years, disabled persons, war invalids, pregnant women, persons with a monthly income under certain minimum, and pensioners (Health Insurance Act 2002). However there is public-political disagreement regarding whether to increase or reduce co-payments in the new national health strategy, According to the Minister of Health there will be no increase in direct payments or co-payments for health care services. On the other side the public and unions are afraid that the new reform will abolish the exemptions and significantly increase the 'out-of pocket-payments' of all patients

6.2.4 Perceived quality of health care

1. A study from 1999-2000 collected data through face to face interviews with 500 randomly selected adults aged 40 years or more from all regions of Croatia The questionnaire, based on the MOS-20 and QUOTE (version for the elderly) questionnaires, asked interviewees about their satisfaction with health services, health insurance, private payments for health care, and background information. The net response was 393 (79%).

2. The QUOTE analysis revealed what respondents considered to be the most important aspects of health services: healthcare providers should work efficiently; their waiting and consultation rooms should be easily accessible for disabled people; they should always respect patients' privacy; they should always inform patients, in understandable language, about drugs prescribed; and they should always explain the risks involved in any treatment. Those aspects each scored 8.1 or higher on a 10 point scale.

3. The aspects of health care that scored lowest (<3.7) were communication between healthcare providers, assessment of the costs and benefits of treatment, and arrangements about what to do in emergencies. Almost half of the respondents believed that healthcare reform had had a negative impact on the quality of health services (table 8), and the greatest dissatisfaction was reported with hospital care (table 9).

6.2.5 Health inequalities

1. Inequalities existed even in the ideologically egalitarian socialist healthcare system of the former Yugoslavia (Mastilica 1990, 1992). However, despite the new democratic Croatian government accepting the basic principles of a welfare state, the health care reforms oriented towards privatisation of the health services have increased social inequalities in health and use of health services.

2. In the recent adult health survey of a representative sample of the Croatian population in 2003 (Beland et al 2004), significant inequalities were found between different social groups in self reported health status (table 10). Because of the policy measures aimed to protect the most vulnerable groups, there were no significant inequalities in the use of health services. However, when the use of health services was controlled for by health status, significant inequalities between low and high income groups were observed. People reporting poor health and low incomes used significantly less specialist services than those reporting poor health but higher incomes (table 11).

3. Healthcare reform in Croatia might be seen as a transformation of a system based on a national health insurance model (with a high degree of equity and a virtually "free" services but with insufficient financial resources) into a system in which health services are considered market goods for which consumers have to know and pay the price. (i.e. formal equality of access but, in reality unequal access) The Croatian government decided to rationalise the healthcare system without taking much account of the impact of the reforms on its citizens. The dissatisfaction among Croatian citizens with these reforms indicate that decision makers should consider users' opinions during health service reform if they wish to build a system that is not only cost efficient but is also responsive to citizens' needs, expectations, and health status.

6.3 Future challenges

6.3.1. Main challenges

1. The major challenges facing the Croatian health care system can be summarised as follows:

- Continued crisis in health care financing and lack of clear direction in terms of the balance between health insurance contributions, additional insurance, state support, patient participation, and private insurance.
- Unforeseen negative consequences of health care privatisation in terms of misuse of public facilities for private practice.
- Continued emphasis on expensive in-care treatment at the expense of well developed primary health care and preventive health awareness.
- Lack of public trust in the health care system, and in its reform, combined with evidence of access being controlled through under-the-counter payments or in-kind contributions. These out-of-pocket payments disproportionately impact on lower income groups (Mastilica and Božikov, 1999)
- Limited access to good quality health care for significant groups in the population including the elderly, women and low income groups (Mastilica and Chen, 1998).
- Corruption and the continued use of out-of-pocket payments

The table below is a simplified listing of the Strengths, Weaknesses, Opportunities and Threats within the current operation of the Health care System in Croatia from the perspective of promoting social inclusion.

Table: Strengths, Weaknesses, Opportunities and Threats within the current operation of the Health care System in Croatia

STRENGTHS	WEAKNESSES
• Compulsory universal health insurance system in principle includes everyone • Cost does not inhibit access • Well-developed system • Network of geographically accessible primary health care institutions (GPs) • Dr:Patient ratio in line with European standards • Specific guarantees re health care for vulnerable categories (No participation charges; supplementary insurance) • Good preventive and public health services	• Hidden problem of significant no (c.100,000 in 2003) on uninsured persons • Holes in health safety net • Out of pocket payments disproportionately affect the poor • Regressive fee structure • Regional Geographic and social inequalities in provision and outcomes (e.g. islands) • Two tier system • Confused nature of health care privatisation
OPPORTUNITIES	THREATS
• EU Accession – good practice exchange; increased income; structural funds • professionalisation; Regulation • Prospect of economic growth	• Series of partially or non-implemented reforms • Rising health care costs • Ageing facilities and equipment • Ageing population

6. 3. 2 Fiscal sustainability and institutional framework

1. Although certain temporary decreases have been achieved in 2001 and 2002, health care expenditure (as a percentage of GDP) in Croatia is still considerable and in 2003 it was once again on the rise (Croatian Institute for Health Insurance 2004). While, compared to other countries Croatia spends a disproportionate amount of its resources on health care, the system continues to struggle with high public expectations and financial deficits.

2. Over the past ten years the government has attempted to stimulate cost containment through various measures aimed at providers including rationing of services, limitation of services provided, penalties for excessive prescribing or referrals, a limited list of approved drugs, reductions in health budgets; but with only limited success and acceptance from providers and the public (Mastilica 2005; Hebrang 1994). Thus, pressured with constant health care deficits, the

impression is that the government has kept the weight of its focus on the demand side of the market reducing the public part of expenditure and increasing co-payments in order to address excessive demand for unnecessary health care services and to collect additional revenue. From a sustainability and efficiency point of view, there is controversial evidence regarding how beneficial cost sharing arrangements can actually be. The current PAL strategy has, as an expected result, a reduction in total public health expenditure to 6% of GDP in 2008, through revision of the basic health benefit package, reduction of co-payment exemptions and, eventually, a new Health Insurance Act.

3. The Government's continuing reliance on increasing private funding in addressing financial insolvency in the system also raises considerable concern with regards to its conceptual social foundations. Out of pocket expenditure adversely affects equity in the system as it necessarily puts a heavier strain on household budgets of lower income individuals and families against of those with higher levels of wealth (Barer et al. 1998; Kutzin 1998; Evans 2002; Robinson 2002). To continue, out of pocket charges have been shown to discourage lower income individuals from seeking necessary care (D'Onofrio and Muller 1977; Kutzin 1998); thus reducing equity of access (Rice 1998) and potentially negatively affecting their health status.

4. Croatia should, when addressing health care funding invest additional efforts into fighting the informal economy, thus enhancing the inflow of funds into the system. The government should also more strictly enforce the 2002 Health Care Law with regards to its obligations of subsidising financially non contributing categories of the population and insist on a higher level of financial discipline in health care expenditure instead of continuing the practice of covering cumulated deficits.

6 3. 3. Health care policy and EU accession

1. Most of the attention in the SAA and in the avis regarding health care has been focused on health and safety at work, on communicable disease control, on cell tissues, and on tobacco products, requiring alignment of Croatian legislation and practice with that of the EU.

2. Within the CARDS programme, support for NGOs has been made available in the sphere of preventative health. In addition a focus on health protection has concentrated on cardiovascular diseases, disabilities, addictions, malign, chronic and infectious diseases, improvement of dental health; preventive health services for vulnerable groups (children, youth, pregnant and breast-feeding mothers, elderly), and services of mental health protection.

3. In addition, the National programme for the Integration of the Republic of Croatia into the EU 2005 (Republic of Croatia, 2005) notes ingoing programmes

on HIV/AIDS, progress on the Integrated Policy for Persons with Disabilities 2003-2006, and work on preventive health care.

References for Chapter 6:

Barer M, Evans RG, Hertzman C and Johri M (1998) Lies, Damned Lies and Health Care Zombies: Discredited Ideas that will not die*. HPI Discussion Paper #10* (March). Texas: Health Policy Institute, University of Texas – Houston Health Science Center.

Beland Y, Baile L, Page J. (2004) Statistics Canada, Croatian Ministry of Health, and Central Bureau of Statistics: joint effort implementing the 2003 Croatian adult health survey. Proceedings of the American Statistical Association meeting, survey research methods. Toronto: American Statistical Association, 2004.

Central Bureau of Statistics. (2004) Republic of Croatia, Statistical Information 2004; Zagreb; 2004 www.dzs.hr

Chen M-S, Mastilica M. (1998) Health care reform in Croatia: for better or for worse? *Am J Public Health* 88:1156-60.

Croatian Institute for Health Insurance – online; 2005 www.hzzo-net.hr/odluke/17.htm Accessed on 20 February 2006

Croatian Institute for Health Insurance (2004). Financial report for year 2003; Zagreb, 2004 www.hzzo-net.hr

Croatian Institute for Health Insurance (2004), Decree on contracting health care institutions and private health care professionals for year 2005, Official Gazette of the Republic of Croatia No 188.

Croatian Institute for Health Insurance, online www.hzzo-net.hr, Accessed on 20 February 2006

Croatian National Institute of Public Health. Health Services Yearbook 2004, Zagreb 2005

Croatian National Institute of Public Health. Croatian Health Service Yearbook 2003, Zagreb 2004

Croatian National Institute for Public Health 2004– Report on hospitalizations in Croatia in 2004.

Croatian Parliament. Health Care Act. Official Gazette of the Republic of Croatia No 121; 2003

Croatian Parliament. Health Insurance Act. Official Gazette of the Republic of Croatia No 94; 2001, No 88; 2002, No 149; 2002, No 117; 2003, No 30;2004 and No 177; 2004

Delcheva E, Balabanova D and McKee M (1997) Under-the-counter payments for health care: evidence from Bulgaria. *Health Policy*;42(2):89–100.

Dzakula A, Oreskovic S, Brborovic O and Voncina L (2005) Decentralization and Healthcare Reform in Croatia 1980-2002 in Shakarishvili E. (editor) *Decentralization in Healthcare – Analyses and Experiences in Central and Eastern Europe in the 1990s.* Local Government and Public Service Reform Initiative, Open Society Institute – Budapest

Evans RG (2002) Financing healthcare: taxation and the alternatives, In: Mossialos E, Dixon A, Figueras J and Kutzin J (editors) *Funding Health Care: Options for Europe*, Open University Press.

Ensor T (2004) Informal payments for health care in transition economies. *Social Science and Medicine*; 58(2):237–46.

Katic M, Juresa V, Oreskovic S. (2004) Family medicine in Croatia: past present and forthcoming challenges. Croatian Medical Journal 2004; 45(5):543-549

Kutzin J (1998) The appropriate role for patient cost sharing, in Saltman R, Figueras J and Sakellarides C (editors) *Critical Challenges for Health Care Reform in Europe.* Buckingham: Open University Press.

Hebrang A., Henigsberg N, Erdeljic V, Foro S, Vidjak V, Grga A, Macek T. (2003) Privatization in the health care system of Croatia: effects on general practice accessibility. Health Policy Plan; 18(4): 421-8.

Hebrang A. (1994) Reorganization of the Croatian health care system. *Croatian Med J* 35:130-6.

Lewis M. (2002) Informal Health Payments in Central and Eastern Europe and the Former Soviet Union: Issues, Trends and Policy Implications in Mossialos E, Dixon A, Figueras J, Kutzin J (editors) Funding Health Care: Options for Europe. Buckingham: Open University Press.

Maarse H. (1995) Cost containment in health care: a brief overview. *Antidotum Supplement* 1:56-65.

Mastilica M. (1990) Health and social inequities in Yugoslavia. *Soc Sci Med* 31:405-12.

Mastilica M. (1992) Health inequalities and health system change in former Yugoslavia. *Int J Health Sci* 3(3-4):195-203.

Mastilica M, Chen M-S. (1998) Health care reform in Croatia: the consumers' perspective. *Croatian Med J* 39:256-66.

Mastilica M, Božikov J. (1999) Out-of-pocket payments for health care in Croatia: implications for equity. *Croatian Med J* 40:152-9.

Mastilica M, Babić-Bosanac S. (2002) Citizens' views on health insurance in Croatia. *Croatian Med J* 43:417-24.

Mastilica M, Bozikov J. (1999) Out-of-pocket payments for Health Care in Croatia: implications for equity. Croatian Medical Journal 1999; 40(2): 152-9

Mastilica M. and Kusec S. (2005) Croatian Healthcare system in transition, from the perspective of users *British Medical Journal* 331:223-226

Ministry of Health and Social Care, National Strategy for the Development of Health Care from 2006- 2011, Zagreb 2006

Orešković S. (1995) Health system reorganization in Croatia in the light of major reform tendencies in OECD countries. *Croatian Med J* 36:47-54.

Orešković S, Kuzman M, Budak A, Vrcić-Keglević M, Ivanković D. (1997) Doctor in the house: trends in GPs home visiting in Croatia 1990-1995 compared to current trends in USA and UK. *Coll Antropol* 21:595-608.

Rice T (1998) *The Economics of Health Reconsidered*. Chicago: Health Administration Press.

Robinson R (2002) User Charges for Health Care In: Mossialos E, Dixon A, Figueras J and Kutzin J (editors) *Funding Health Care: Options for Europe*, Open University Press.

Szende A and Culyer AJ (2005) The Inequity of Informal Payments for Health Care: the Case of Hungary, *Health Policy*, in press

Šarić M, Rodwin VG. (1993) The once and future health system in the former Yugoslavia: myths and realities. *J Public Health Policy* 14:220-37.

Thompson R, Witter S (2000) Informal payments in transitional economies: implications for health sector reform. International Journal of Health Planning Management; 15(3):169–87.

Thompson SMS. and Mossialos E (2004) What are the equity, efficiency, cost containment and choice implications of private health-care funding in western

Europe? Health Evidence Network Report; World Health Organization - Office for Europe

Vienonen M. (1995) Overview of the principles in health care reforms on the European scene. *Antidotum Supplement* 1:107-10.

World Bank (2004) *Croatia Health Finance Study*, Europe and Central Asia Region, Human Development Department, The World Bank, Washington, D.C. April 19, 2004

World Health Organization. (1996a) *European health care reforms: analysis of current strategies*. Copenhagen: WHO Regional Office for Europe.

World Health Organization. (1996b) *European health care reforms: The Ljubljana charter on reforming health care*. Copenhagen: WHO Regional Office for Europe.

World Bank Europe and Central Asia Region, Human Development Department. Croatia Health Finance Study. World Bank, Washington, D.C.; 2004 online http://www-wds.worldbank.org/servlet/WDS_IBank_Servlet?pcont=details&eid=000012009_20040616103200 Accessed on 20 February 2006

World Health Organization. (2005) The World Health Report 2005: Make Every Mother and Child Count, Statistical annex.

STATISTICAL ANNEX FOR CHAPTER 6

Figure 1: ORGANISATIONS IN THE HEALTH SECTOR in 2004.

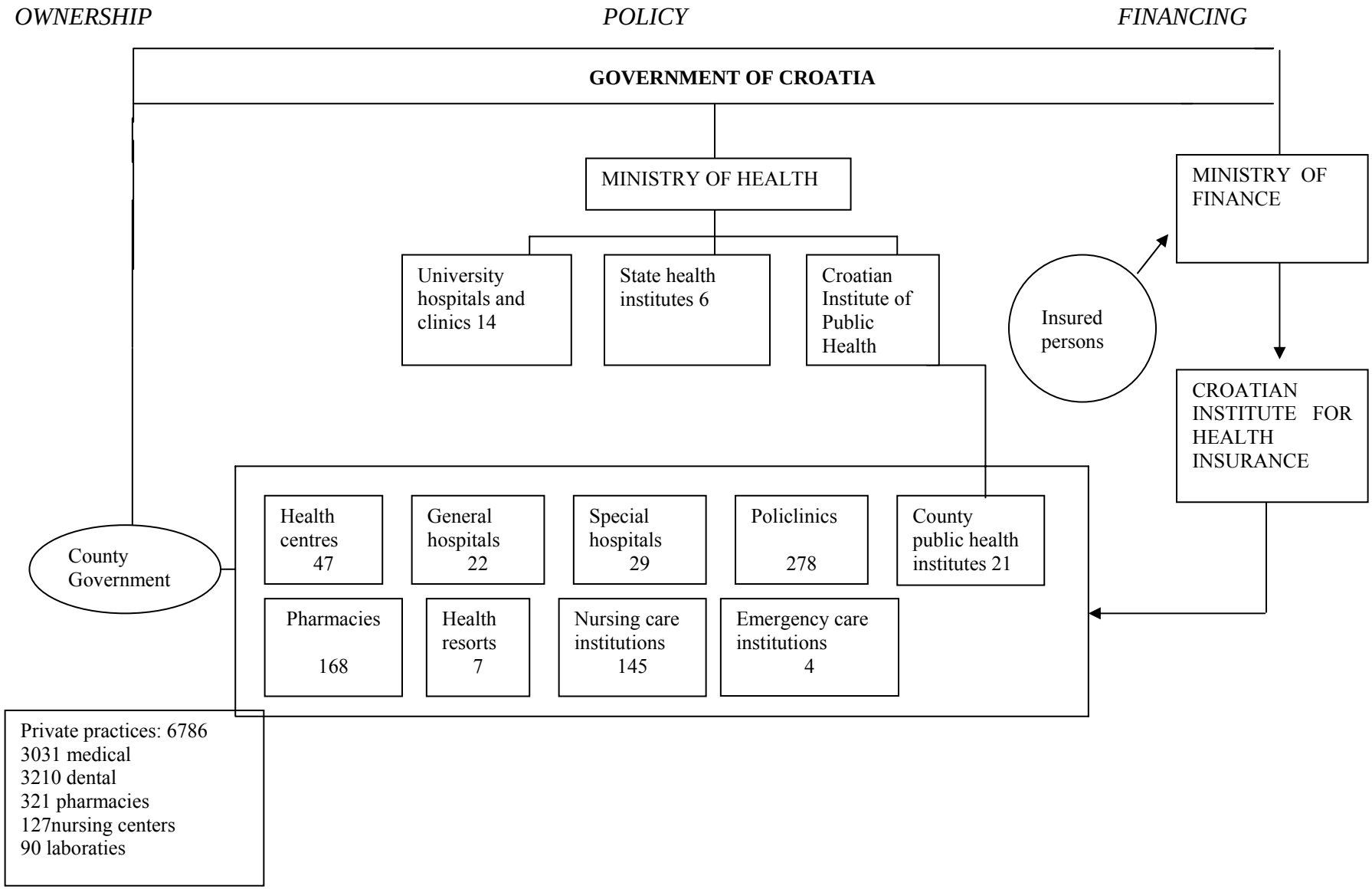


Table 1. Public – private split in health care provision(in 2004)

	In public services (%)	In private sector (practices) (%)
Medical doctors	74-72	26-28
Stomatologists	22-18	78-82
Pharmacists	70-43	30-57
Nurses	83-75	17-25
TOTAL	77-69	23-31

Source: (Croatian National Institute of Public Health 2005)

Table 2. Per capita expenditure on health – International dollar rate.

State	2000	2001	2002
Croatia	689	674	630
Romania	378	429	469
Bulgaria	381	450	499
Slovakia	608	652	723
Hungary	847	961	1078
Czech Republic	977	1083	1118
Slovenia	1356	1487	1547
Austria	2147	2174	2220
Italy	2001	2107	2166

Source: World Health Organisation. The World Health Report 2005: Make Every Mother and Child Count, Statistical annex; 2005

Table 3. Total expenditure on health as percentage of GDP in Croatia

Year	Proportion of GDP spent on health
2000	10.2%
2001*	9.5%
2002*	9.1%
2003	8.9%
2004	9.7%
2005	8.7%

*Source: Croatian Ministry of Health and social Affairs 2006 and * (World Bank 2004)*

Table 4. Average lengths of stay per hospitalization, 2003

Country	Average length of stay per hospitalization in days, all hospitals, year 2003
Croatia (2004)	10.68
Czech Republic	11.2
Slovakia	9.1
Hungary	8.36
Austria	7.97
Poland (2002)	7.9
Slovenia	7.4

Source: Croatian National Institute for Public Health – Report on hospitalizations in Croatia in 2004 (Croatian National Institute for Public Health 2004)

Table 5. Acute hospital beds per 1000 inhabitants, 2004

County	No of acute hospital beds per 1000 inhabitants
Croatia - average	3,63
City of Zagreb	6,47
Zagrebačka	-
Krapinsko-Zagorska	1,66
Sisačko-Moslavačka	2,64
Karlovačka	4,01
Varaždinska	2,64
Koprivničko-Križevačka	3,03
Bjelovarsko-Bilogorska	2,61
Primorsko-Goranska	4,45
Ličko-Senjska	2,01
Virovitičko-Podravska	3,21
Požeško-Slavonska	4,42
Brodsko-Posavska	3,94
Zadarska	2,83
Osječko-Baranjska	4,02
Šibensko-Kninska	3,96
Vukovarsko-Srijemska	3,13
Splitsko-Dalmatinska	3,53
Istarska	2,61
Dubrovačko-Neretvanska	2,72
Međimurska	2,96

Source: Croatian National Institute of Public Health, Croatian Health Service Yearbook 2004, Zagreb (Croatian National Institute of Public Health 2005)

Table 6. Proportion of direct payments for health care by income quartiles (1994)

		Direct health care payments		
Income quartile	Proportion of income %	Proportion of co-payments %	Proportion of other direct payments %	Proportion of total direct payments %
Bottom	11.3	37.7	30.3	32.1
2nd	23.3	22.6	27.1	26.0
3rd	24.3	18.9	15.5	16.3
Top	41.1	20.8	27.2	25.6
% of total direct payments		24.7	75.3	100

Figure 2. Comparison of the out-of-pocket payments and income: proportions of income quartiles in studied population (Croatia 1994)

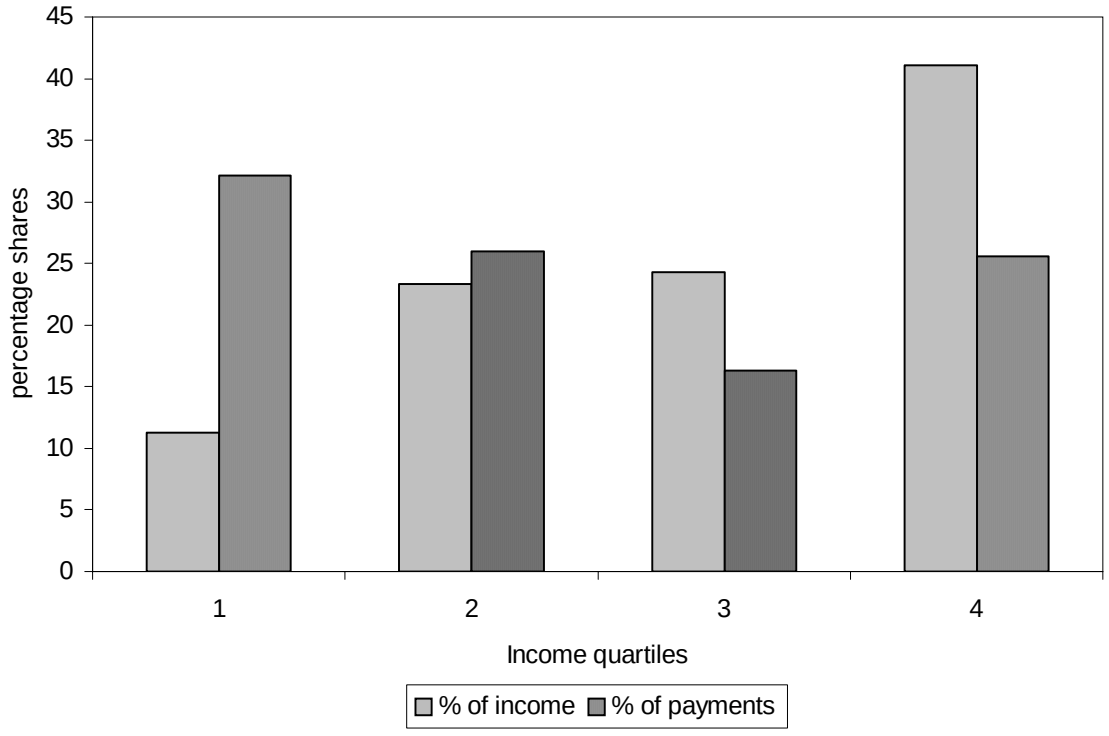


Table 7 .Distribution by quartiles of direct payments for health care

		Direct health care payments		
Income quartile	Proportion of income %	Proportion of copayment %	Proportion of other direct payments %	Proportion of total direct payments %
Bottom	11.3	37.7	30.3	32.1
2nd	23.3	22.6	27.1	26.0
3rd	24.3	18.9	15.5	16.3
Top	41.1	20.8	27.2	25.6
% of total direct payments		24.7	75.3	100
Gini	0.226			
Concentration		-0.136	-0.052	-0.073
Kakwani		-0.362	-0.278	-0.299

Figure 3 Lorenz Curve for income and out of pockets payment curve
(Mastilica and Bozikov 1999)

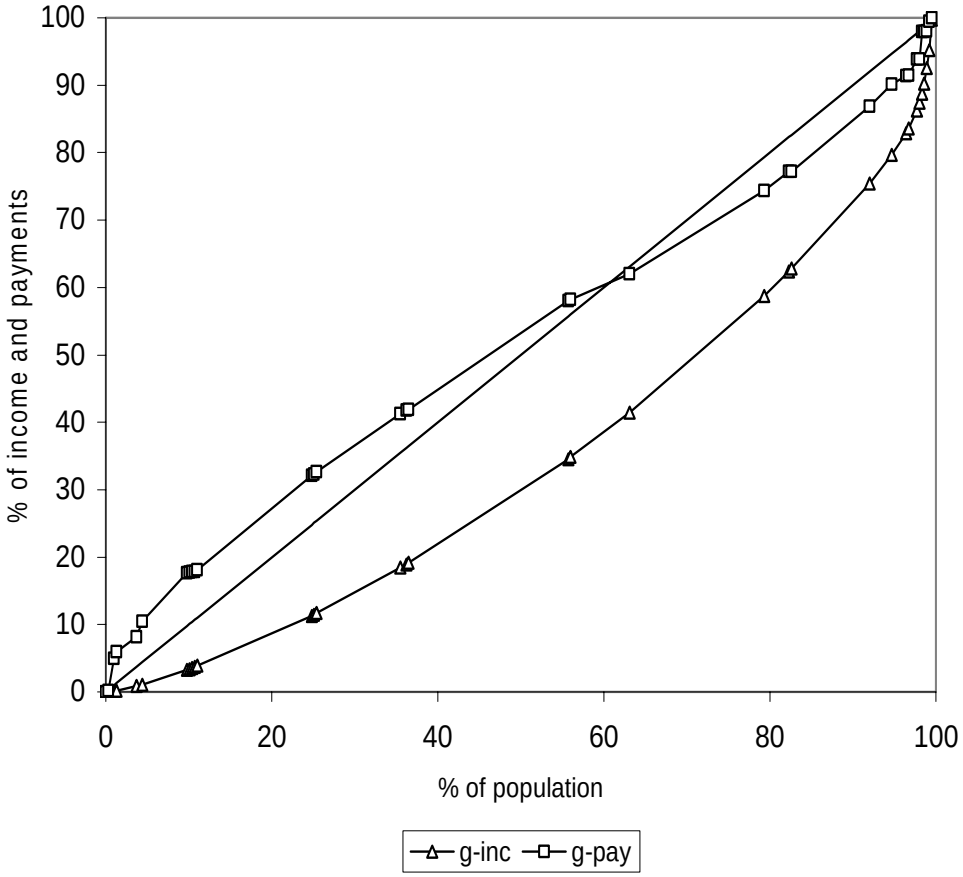


Table 8. Perceived impact of health reforms on provision and quality of care in Croatia (%) in 2000 (Mastilica and Kušec 2005)

	%
Health care is better now than before changes	13.7
Health care is the same now as before changes	29.6
Health care is worse now than before changes	40.8
Don't know	15.8

Table 9. Users' dissatisfaction with health services in Croatia in 2000(Mastilica and Kušec 2005)

	Dissatisfied%
Health care services in general	34
Family medicine	19
Specialist care	39
Dental care	30
Hospital care	47
Pharmacy	16

Table 10. Inequalities in self-reported health status in 2003 (N=11,250) (Mastilica and Kušec 2005)

	Income group		
Health status	**low**	**Middle**	**high**
Excellent	13.8	29	57.3
Very good	11.9	28	60.1
Good	25	33.8	41.2
Fair	32.7	35.7	31.6
	51.1	30.8	18.1

$p<0.001$

Table 11. Inequalities in utilisation of specialist care during 2003 when controlled by health status (N=11,250) (Mastilica and Kušec 2005)

	Income group		
Bad Health status group	**low**	**Middle**	**high**
Not visited specialist in past year	36,5	29,5	26,1
Visited specialist 1-2 times	26,3	22,9	26,1
Visited specialist 3-4 times	17,1	17,7	20,7
Visited specialist 5-10 times	12,7	16,3	13,0
Visited specialist more than 10 times during past year	7,4	13,5	14,1

$p<0.001$

Chapter 7: Conclusions and Recommendations

7.1 Conclusions

1. This study has provided an overview of social protection and social inclusion in the Republic of Croatia, in the context of economic, demographic and social trends. In particular it has addressed the role of the social welfare system, health care system and pensions system. Throughout, it has addressed current and proposed reforms seeking to improve the efficiency and effectiveness of the system. It has also traced gaps in knowledge and the strengths and weaknesses of existing institutional, legislative and administrative structures. It has explored the significance of social inclusion issues in strategic documents of the Government, and addressed, albeit briefly, the importance of multi-stakeholder dialogue and inclusive consultation processes.

2. In identifying key challenges in the fight against social exclusion, the report has addressed the adequacy and future modernisation of the social protection, pensions and health systems. In some ways, the report has confirmed that key issues lie elsewhere and have not had sufficient coverage in this report. This is particularly important in terms of two, inter-linked, themes. The first is the functioning of the labour market and the importance of strategies to combat high levels of unemployment in Croatia, particularly unemployment amongst the young, the old, and the problem of long-term unemployment. The second issue is the role of formal and informal education, in terms of the length and quality of education received, the availability of re-training opportunities, and the importance of life-long learning. Both of these figure strongly in recent statements regarding strategic directions of the Government of Croatia and are likely to receive continued emphasis in the process of accession to the European Union. I this chapter, however, they are noted briefly and sketchily.

3. Overall, compiling this report has reinforced an awareness that Croatia has a very well developed statistical system which, on the whole, provides timely, accurate, and informative social statistics. The report has shown, however, that there are still a number of gaps in knowledge about social exclusion, particularly in terms of trends over time for individual households (exclusion paths and careers); meaningful regional statistics and trends; with groups of the population still missed by statistically-based analyses, notably people with disabilities, national minorities, those in rural areas, and those affected by war; and groups whose needs remain hidden or which are too small to be captured by general statistical aggregates (such as the homeless, ex-prisoners, and institutionalised populations). Perhaps even more importantly, policy relevant statistics regarding the precise pattern of social expenditures and, in particular, the effectiveness of social transfers is either lacking, relatively under-developed, or quite contested.

4. As a middle income country on the path to European Union membership, Croatia does not appear, at the moment, to face high levels of social exclusion. Nevertheless, there are a number of problems still emerging as a result of the triple transition from war to peace, from a planned to a market economy, and from a one party political system to a pluralist democracy. In particular, the demographic consequences of the war and the under-development of significant parts of the territory of the Republic of Croatia are likely to become increasingly important if not addressed in the short-term.

5. Above and beyond this, the complexity of institutional arrangements and a general lack of administrative capacity for tackling social exclusion mean that there are a number of administrative, policy, and, perhaps even, political obstacles to a concerted and co-ordinated response. This has four different, but related, dimensions: the importance of inter-Ministerial co-ordination; the importance of multi-agency co-operation; the importance of consistency between central, regional and local responses; and the importance of multi-stakeholder dialogue. The cumulative effects of this can be seen in a proliferation of strategies many of which are in name only, a set of competing and overlapping jurisdictions, a relatively low priority given to the issue of social exclusion, and a lack of wider participation and ownership in terms of specific targeted interventions. This is, in large part, in keeping with the European Commission's synthesis report following the first JIMs for the then candidate countries, which emphasised "the need to co-ordinate and mainstream antipoverty actions, to mobilise all actors, and to ensure the effective implementation of policies" (European Commission, 2004; 7).

6. These issues are, in a sense, not confined to questions of social cohesion and social justice. The process of accession to the EU highlights structural problems but also capacity problems. As an influential commentator remarked recently:

"The Government is on paper at least dedicated to reforms, but changes are often made without previous analyses of needs, evaluations of effects, and it is difficult to foresee the results. We are witnessing superficial reforms without real contents and new laws and amendments without proper care for their implementation and enforcement. There is no long-term strategy and often no necessary co-ordination." (Ott, 2005; 23).

7. The challenge facing Croatia in terms of social inclusion on the path to European Union membership is one of how to develop policies and practices which are in keeping with the specific features of the Croatian economy and society, and how to balance the promotion of social inclusion and raising levels of (meaningful) employment along with raising overall living standards and ensuring proper care is taken regarding levels of public expenditures. As in other European countries, the development of a raft of policies to secure desired

outcomes is an art rather more than a science. In terms of adding value to the JIM process in Croatia, this report ends with a series of suggested policy intervention areas based, in large part, on existing proposals from elsewhere, combined with a deliberate attempt to pursue 'an exercise in ambition' (Vandenbrouck, 2002) in terms of social inclusion. The proposals are, either, broad suggestions or comments on existing proposals which may need amendment in terms of fine tuning, in order to have the desired results.

7.2 Recommendations

7.2.1 Leadership in, and mainstreaming of, social inclusion

1. The development of a strong political commitment to tackling social exclusion requires both political leadership and the designation of a body, either existing or newly created, to play a leadership role[4] which ensures, amongst other things:
a) that tackling social exclusion is a key policy goal across all relevant Government departments
b) that there is heightened awareness, at all levels of society, of the importance of tackling social exclusion
c) that decisions regarding the national budget pay explicit attention to the need to fight social exclusion
d) that there is clear, and agreed, division of responsibilities between national, regional and local government bodies in the development and implementation of social inclusion policies
e) that mechanisms for consultation with social partners, with civil society organisations, and with groups representing the excluded are themselves inclusive, meaningful, sustainable and effective
f) that policy measures are developed, for the short-, medium and long-term which have clear time lines, appropriate allocation of responsibilities, and measurable outcomes
g) that priorities for accessing EU Structural Funds are developed in a similar way, in close relationship to these priorities
g) that these measures are monitored, evaluated and refined in a systematic, timely and transparent way.

2. The designation of such a body needs to extend beyond the writing and signing of the JIM, and should have the resources needed, both financial and human, to ensure that the tasks are carried out in the best possible way. The dilemma here is that, in the context of the competing priorities and low prioritisation given, thus far, to social inclusion, such a body needs to have credibility and power. Whether this can be achieved within an existing department of a Ministry or whether a new body needs to be established, is also a matter of political choice.

[4] Most of these are adapted from European Commission (2004) p. 7 on 'Strengthening the Social Inclusion Process'

7.2.2 Improving the knowledge base on social exclusion

1. Issues directly related to the collection of social and demographic statistics by official bodies, in terms of administrative strengthening, statistical harmonisation, improving consultative procedures, enhanced co-ordination, confidentiality, and technical specifications are all subjects which have been, and continue to be, dealt with in the context of negotiations concerning Croatia's accession to the European Union. One part of this, the development of an agreed division of Croatia into NUTS-II regions, remains unresolved. The elaboration of meaningful statistical comparisons at regional levels above those of the counties is a major priority for the future.

2. Other missing dimensions in terms of statistics have been noted throughout this text. Crucially, it is important that a Panel Survey on the incomes and living standards of the population be introduced as soon as possible in Croatia. In addition, in the context of continued capacity building and planned implementation of ESSPROS methodologies, there is a need to ensure that data is disaggregated more clearly in terms of disability and in terms of minorities.

3. Above and beyond the 18 standardised primary and secondary indicators of social exclusion (the Laeken indicators), there is a need to establish a clear set of tertiary indicators which are meaningful in the Croatian context and agreed to by all stakeholders. There is a need, in addition, to establish a programme of research which collects knowledge regarding poverty and social exclusion in Croatia over a longer time period. This programme of work, which could be undertaken by a number of independent research institutions, involving collaborations between Croatian and international researchers, could include applied research to evaluate measures proposed to combat social exclusion and, in particular, to monitor systematically the effectiveness of various social transfers. One part of this should include participatory research on the social status and quality of life of vulnerable groups, undertaken with the closest possible collaboration with members of vulnerable groups themselves (as recommended in UNDP, 2006; 70).

7.2.3 Strengthening and modernising the social protection system

1. It should be remembered that Croatia has one of the highest rates in Europe of reduction of at-risk-of-poverty rate after social transfers are taken into consideration. More work is needed on outlining the range of social assistance benefits which are available, and particularly, to ensure that there is a rationalisation of benefits and a minimising of the possibilities of claimants accessing a number of benefits without their being any cross-checking between the levels of government responsible for paying these benefits. In particular, there is a need for improved horizontal and vertical co-ordination through the establishment of shared databases. Beyond this, there is a need to place greater

emphasis on those benefits with a demonstrable poverty alleviation effect or those which have such a potential. This should not be seen as a recommendation to privilege only means-tested benefits above universal or insurance-based benefits. What is important is that those benefits which can alleviate poverty, including the social assistance minimum should be paid at a level which relates to some minimum food basket and is raised based on the cost of living and inflation.

2. In terms of the modernisation of social protection and, in particular, a new mix of cash and care services, there is a need for reform to be based on four-inter-linked components. The first is the importance of promoting social innovation or "the implementation of initiatives to produce qualitative improvements in different fields of social life ... based on calculated risk" (Gryga et al, 2002), instead of the current over-bureaucratised approach. The 'risk' here needs to involve the development of genuine inter-disciplinary and teamwork approaches beyond narrow professional boundaries, stimulating the work of para-professionals and volunteers and, above all, giving service users a much larger say in the services they receive. The role of the social worker in the centre for Social Work needs to change to one of being a case manager, assessor and case manager. The second crucial change is the need to promote a welfare mix involving a far greater role for the non-state sector, in particularly Civil Society organisations but, also, the private sector. Some moves have been made in this direction but a truly mixed provision is some way away. Thirdly, there is a need to establish local social planning and contracting at the heart of the system, building on the islands of good practice which currently exist, and moving away from an over centralised system without replacing it by non-transparent and inequitable varied local provision. Underpinning all of these is the need to develop, institutionalise and monitor progress against national quality care standards.

3. Deinstitutionalisation and the transformation of institutions to become part of a more appropriate continuum of care, in which the balance is shifted perceptibly towards community-based care services, is a major reform priority. Thus far, a number of policy statements and projects have paid lip service to this commitment but there has been insufficient change on the ground. In part, this may be because of a failure to present deinstitutionalisation as an opportunity rather than a threat to key stakeholders. In addition, the need to turn the commitment into a strategy based on achievable targets is important. In our view, the two priorities for action, both in terms of the possibility of achieving positive results quickly because alternative services and projects exist or are in the pipeline, and because they would remove some of the most exclusionary and detrimental practices, should be young children in institutions and adults with learning difficulties.

4. In making the combating of social exclusion a more central objective of the social protection system, there is a need to move towards more activation programmes for those capable of work, alongside targeted social action programmes for the most vulnerable groups and a real commitment to implementing the programme for the Development of Disadvantaged Areas within the proposed national programme for regional development (see chapter 2 above).

7.2.4 Ensuring a socially inclusive pension and old age protection system

1. Whilst the fundamental pension reform initiated and implemented in the last ten years in Croatia has provided strong foundations for a sustainable pensions system, the implications in terms of socially excluded older people are less clear. There is a need to both improve the overall functioning of the pension system and to build in safeguards for poorer pensioners. Above all, there is an urgent need to tackle the poverty of those older people outside the pension system, which we estimate at around 14% of those aged 65 or over, or around 103,000 persons.

2. Considerable gains can still be made from improving the efficiency, transparency and enforcement of pension contribution collections. In addition, there is a need for a clear strategy to reduce inequalities in pensions caused by inherited special rights. The possibility of increasing contributions to the second tier should be explored. Strategies to ensure full compliance regarding contributions to the pension insurance fund should also be developed.

3. There have been calls made for the introduction of a social (state) pension for those older people who receive no pension and who rely primarily on welfare assistance (UNDP, 2006; 72). At the very least, there is a need for a feasibility study on the costs and benefits of introducing a social old-age minimum benefit for those old people not in receipt of a pension. This should be combined with strategies to ensure that rates of non-inclusion decline over time.

7.2.5 Improving the quality of, and ensuring equality of access to, public health services

1. Health care reform is clearly needed but Croatia has experienced a number of partial reforms which have either had limited success or have had unintended consequences. Above all, there is a need for amore transparent public debate leading to a consensus-based national strategy on health care in Croatia, truly nationally owned and led.

2. As a part of this, the importance of creating decentralised health care services, at a level which ensures efficiency and social justice would seem to be crucial. This strategy should combine greater autonomy for regional health care

managements, combined with the development of clear subsidies for disadvantaged areas. Part and parcel of this, linked to a clear national strategy as noted above, is the need for depoliticisation of health care and its reform.

3. Linked to the broad strategic goals above, and the point made regarding regional programmes to combat social exclusion, there is a need to elaborate positive and preventive health care action programmes for all, and to combine these with the elaboration of health care action zones to promote the health needs of disadvantaged groups and regions. A prior necessity is the need to develop a better system of gathering and interpreting sub-national health care statistics.

4. Whilst recognising the need to introduce a degree of marketisation into the health care system, there is a need to ensure that this is transparent and, most importantly, that informal out-of-pocket payments are reduced. Overall, there is a need to introduce a fairer payment structure more progressive in terms of reflecting ability to pay.

7.2.6 Expanding active labour market measures to promote integration into meaningful work

1. Whilst the whole issue of labour market policy has not been central to this study, the issue of stimulating employment is central to the fight against poverty and social exclusion. In line with the European Employment Strategy, active labour market measures have an important role to play here. Many of the points noted below are derived from Policy recommendations in a recent text (UNDP, 2006; 71). They include:

a) facilitating more flexible forms of employment
b) introducing locally based activation measures of benefit to the local community
c) promoting closer collaboration between Centres for Social Work and Bureaux for Employment, through a first stop shop system for those out of work
d) introducing special counselling and re-training programmes for vulnerable groups
e) optimising coverage of pre-school and school-based child care facilities during working hours

7.2.7 Promoting quality education for all, life-long learning, and an integrated approach to the education of children with special needs.

1. Again, educational policies have not been highlighted in this report but are crucial in combating social exclusion. Three inter-liked sets of reforms are noted in a recent study (cf. UNDP, 2006; 73-74) and need to be priorities. Some, including extending the years of compulsory education, are currently being considered and others, such as integrated education, remain commitments on

paper. There is a need for the collection of meaningful regional statistics on educational achievement and, if necessary, the development of educational action zones alongside health action zones to promote educational opportunities and enhance quality education in disadvantaged areas.

7.2.8 Strengthening the role of non-state actors in preventing and alleviating poverty and social exclusion.

1. Throughout the report, the importance of new forms of partnerships between state and non-state actors has been emphasised. The development of the role of NGOs in the spheres of health, education and social services has been aided by EU funds. There is now a need to 'scale up' this work to ensure that NGOs and CSOs, including organisations representing marginalised groups themselves, play a much greater role, not only in the provision of services, but in terms of policy development and advocacy.

References for Chapter 7

European Commission (2004) 'Social Inclusion in the New Member States: a synthesis of the joint memoranda on social inclusion. Brussels: European Commission, SEC (2004) 848, 22 June.

Gryga, I. et al (2002) 'Innovations in Social Services' Kiev: Pulsari.

Ott, K. (2005) 'Croatia and the European Union: accession as transformation, in Ott, K. (ed) Croatian Accession to the European Union: facing the challenges of negotiations. Zagreb: IJF and FES, pp. 1-30.

UNDP (2006) Poverty, Unemployment and Social Exclusion. Zagreb: UNDP

Vandenbrouck, F. (2002) 'Foreword', in Atkinson, T. et al Social Indicators: the EU and Social Inclusion. Oxford: University press, pp. v-xi.