ESPN Thematic Report on work-life balance measures for persons of working age with dependent relatives

Croatia

2016

Paul Stubbs and Siniša Zrinščak
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European Social Policy Network (ESPN)

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The European Social Policy Network (ESPN) was established in July 2014 on the initiative of the European Commission to provide high-quality and timely independent information, advice, analysis and expertise on social policy issues in the European Union and neighbouring countries.

The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

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Summary / Highlights

Croatia has a 'patchwork' of long-term care benefits and services marked by a lack of co-ordination and, crucially, the lack of a 'key worker' or 'case manager' system. Carers of those with significant long-term care needs are often faced with a choice between caring at home with very limited support from public services or placing the person in need of care in a long-term social welfare or health care facility. Assumptions that the extended family will provide care may no longer be accurate nor functional. Croatia has an ageing population such that the care of ageing and infirm parents is also becoming a significant issue. Croatia's labour market is rather rigid with relatively low rates of part-time and flexible work which can pose a problem for work-life balance.

The Croatian system provides for carers' leaves only in the case of children with disabilities or who need special care, after the expiry of statutory maternity and parental leave. There is a time-limited right to work half-time until a child reaches three years of age; a right to extended parental leave until a child reaches the age of eight; and unlimited right to work half-time in cases of severe physical or mental incapacities which can extend into the time when a child reaches adulthood. All three leaves are assessed by medical commissions who may recommend shorter periods and may regularly re-assess. In each case, the carer automatically receives health insurance and basic pension insurance. The Croatian system does not provide cash benefits to carers directly but only to the cared-for person. Cash benefits include: disability benefit which is individually means-tested; assistance and care allowance which is household means-tested; child benefits which are means-tested for children with health difficulties and not means-tested for children with severe health difficulties; and tax allowances which are increased for those with disabilities or severe disabilities. Benefits in-kind are also primarily targeted to the cared-for not the carer. The most relevant of these are: assistance in the home for people with disabilities; assistance at home or day care for vulnerable old people, not available on a national basis, thus far; and respite care in public care institutions.

There are no statistics on the numbers of carers taking leave nor regarding trends over time. The possibility of taking advantage of the right to work part-time is, most likely, limited in practice. Many of the schemes appear rather inflexible with rigid time limits and some appear unlikely to support reintegration in the formal labour market at a later date. In terms of benefits, there are no publically available figures on the proportion of child benefits claimants which relate to disability. The number of recipients of disability benefit has increased, this remains relatively low whilst the numbers receiving assistance and care allowance has decreased. Those receiving support services remains relatively small, representing only a very small proportion of those who may need assistance.

The structure of benefits leads to a kind of 'dual' labour market of care regimes in terms of benefits and services, different from the traditional dual labour market in which the poorest members of society receive small amounts of benefits and few formal services which are likely to have very limited effects in terms of improving well-being. The sums involved are too low to be of more than marginal significance in terms of the choices made by either carers or the recipients. They are certainly too low to enable those in need of care to pay for quality care services within the formal labour market. Instead, they are likely to increase vulnerable people's dependence on unregulated, low quality, and even exploitative or predatory informal care services. In-kind benefits are also mainly focused on those in need of care and are enjoyed by relatively small numbers of beneficiaries. At the other end of the spectrum, those with significant resources can pay for services on the market although, even here, the quality may not be assured.

As in much of Croatian social policy, there appears to be little coherence and integration between a number of rather disparate and 'stand-alone' measures and a lack of integration between social protection, personal social services, health care and employment services. There is no system of 'case management' in place establishing 'packages' of care for those in need.

The report makes seven broad policy recommendations:

- There is a need to improve the evidence base through release of official statistics and commissioning of independent research;
- Carers as a rights-bearing category should be recognised in Croatian Law and practice, including the labour law and, crucially, social welfare law;
- There is a need for far more flexibility in leave schemes for carers in formal employment;
- Croatia needs to establish a much wider range of community-based services for carers and the cared-for;
- Croatia should establish a 'case management' service tasked with assessing needs and putting appropriate 'packages of care' in place;
- There is a need for more services, including support services, targeted to carers.
- Croatia needs to work much more on a clear, coherent and sustainable long-term care strategy as well as considering the introduction of long-term care insurance.

1 Description of main features of Work-Life Balance measures for working-age people with dependent relatives

1.1 Overall description of long-term care regime[1]

Croatia's long-term care regime may best be termed a 'patchwork' of various benefits and services which tend to be in relatively short supply with access based on criteria other than need, such as: ability to pay; place of residence, and even informal contacts and insider knowledge. There is a similar 'patchwork' of legal provisions which, potentially, could support carers but there is a lack of knowledge by carers of many of these rights, a lack of any proactive programmes to inform carers of their rights and, above all, a lack of resources to ensure that entitlements in theory are matched in practice. The system is marked by a lack of co-ordination between diverse services and, crucially, the lack of a 'key worker' or 'case manager' system which could oversee a 'package' of care services for individual beneficiaries. Often, carers of those with significant long-term care needs are faced with a stark choice between caring at home with very limited support from public services or placing the person in need of care in a long-term social welfare or health care facility which, often, resembles a 'total care institution' with services not tailored to individual needs. There is also a 'dual' care system in which the needs of those disabled by war, and in particularly war veterans with disabilities, receive enhanced benefits and rights compared to other groups of persons with disabilities.

Croatia, as a Southern European country, is marked by limited community-based services based on a historical assumption that care by the family, often by extended family members, is commonplace. This assumption is not in keeping with the need for labour mobility and the erosion of traditional three-generation households. Nevertheless, it remains the case that many adults of working age still rely on care by grandparents, notably grandmothers, who belong to a generation which tended to retire early and to have a degree of free time, and resources, to devote to child care. At the same time, Croatia has an ageing population, with rising life expectancy not matched by an increase in the number of healthy life years, so that care of ageing and infirm parents is also becoming a significant issue, although this is a general trend within the EU as a whole (see Tables 1 and 2 for comparisons between Croatia and the EU-28). Croatia's labour market is rather rigid with relatively low rates of part-time and flexible work which can pose a problem for work-life balance.

Table 1: Healthy Life Years, Croatia and EU-28 2010-2013

[1] This section is based on Stubbs, P., S. Zrinščak and I. Vukorepa (2016) ESPN Country Profile, Croatia Section 2.1.4

	2010	2013
Croatia Female	60.4	60.4
EU-28 Female	62.6	61.5
Croatia Male	57.4	57.6
EU-28 Male	61.8	61.4

Table 2: Life Expectancy, Croatia and EU-28 2005-2014

	2005	2010	2013
Croatia Female	78.8	79.9	81.0
EU-28 Female	81.5	82.8	83.6
Croatia Male	71.7	73.7	74.7
EU-28 Male	75.4	76.9	78.1

Source: Eurostat http://ec.europa.eu/eurostat/data/database, Life expectancy by age and sex and Healthy life years

The gender dimension of long-term care and of caring is under-researched in Croatia. The overwhelming majority, some 78%, of those over 60 living alone are women, largely as a result of the fact that women live longer than men. At the same time, a World Bank report[2] notes that many widowed men remarry as a way of ensuring informal care in old age. Hence, although inter-generational care may be weakening in Croatia, gender-based spousal care, largely by women of men, remains strong. What is not clear is the extent to which women of working age look after dependent relatives. In addition, unlike some other European countries, there appears to be very little use of informal, semi-formal and formal caring undertaken by migrant women although, traditionally, in former Yugoslavia, there was a tradition of migrant workers moving from the poorer to the richer Republics, including female workers in the caring semi-professions[3].

Another important issue is regional differences, as well as differences in rural and urban areas. In general, urban areas are those in which more older people tend to live alone and also have fewer children. This is also the case for the more developed parts of Croatia, including Istria in the West bordering Slovenia, compared to Slavonia in the East of the country[4]. The importance of the Croatian diaspora in terms of long-term care and dependency is also worthy of more research. The largest wave of out-migration from Croatia occurred in the 1970s when large numbers of relatively young, largely unskilled or semi-skilled workers, moved as guest workers to a number of Western European countries, including Germany, Austria and Switzerland. A significant group of these workers has now reached, or is approaching, retirement age. Although evidence is sparse, if a significant number of this cohort decides to retire in Croatia, this will alter significantly the demand for long-term care. In addition, although evidence is largely anecdotal, it appears that the ageing parents of guest workers are among the main beneficiaries of private care facilities as it is their children who can afford the fees which are high in relation to the Croatian average wage[5].

[2] World Bank (2010) Long-term Care and Ageing – Bulgaria, Croatia, Latvia and Poland, http://siteresources.worldbank.org/ECAEXT/Resources/ECCU5_LTC_AAA_Case_Studies_Final_November2_2010.pdf (accessed 5 April 2016).

[3] Meznarić, S. (1986) *Bosanci (Bosnians)*, Belgrade: Filip Višnjić.

[4] Podgorelec, S. and S. Klempić (2007) 'Ageing and Informal Care of Older People in Croatia' (in Croatian) *Migracijske i etničke teme* 23(1): 111-134 web: http://hrcak.srce.hr/14476 (accessed 5 April 2016).

[5] Meznarić, S. and P. Stubbs (2012) 'The Social Impact of Emigration and Rural-Urban Migration in Central and Eastern Europe: final country report – Croatia', Cologne: GVG on behalf of European Commission DG Employment, Social Affairs and Inclusion.

A particular cause for concern is the fact that 24.2% of those over 65 live in single households. Also, the number of those who experience medical problems in everyday life is rising with age: in the youngest elderly group (65-74) the share is 38.4%, while in the oldest elderly group (85 years and more) this share rises to 67.9%. The share of permanently immobile persons is 10.7% in the oldest elderly group. Croatia has still not explicitly developed well-formulated long-term care policies relying, instead, on fragmented policies for children with disabilities, adults with disabilities and frail and vulnerable older people. In addition, responsibilities tend to be divided between the social welfare and the healthcare systems with little co-ordination between the two. As will become clear throughout this report, it tends to be the person with long-term care needs who is addressed by the system, albeit based on different categories, and rarely, if ever, that person's main carer or carers.

Institutional care for children and adults with disabilities is the responsibility of the central state, whereas institutional care for the elderly and infirm is devolved to the County level. There are also growing numbers of private providers, mainly NGOs for children with disabilities and private, for profit, providers for older people. Indeed, as a World Bank report recognised[6], the non-state sector of institutional care, in which beneficiary or other family contributions are higher, has been growing whereas the state (County) sector has largely stagnated. According to the latest available data Croatia had 274,000 functionally dependent persons in 2013, out of which 16,000 were in institutions for the elderly or similar types of institutional care, 17,000 received formal home care, and 108,000 different benefits. Thus, others (about 133,000) are dependent on informal care, and there is an estimation that many of those receiving benefits are at the same time dependent on informal care.[7] There are long waiting lists, particularly for public institutions, but we lack accurate data on this. Private institutions are more accessible in terms of places available, but not in terms of higher costs for accommodation and care. Many private old persons' homes are only accessible for those with access to significant resources, in particular those who have relatives working abroad. In public homes, if the person needs accommodation and care, but does not have enough income and/or property to cover costs, Centres for Social Welfare are entitled to place them in an adequate institution and to cover the difference in costs. Although a programme of home care and day care, mainly for vulnerable older people, originally introduced in a number of local authorities, has now been rolled out as a nationwide programme, the number of beneficiaries remains low in relation to overall needs. Although figures vary, long-term care expenditures as a proportion of GDP, estimated at between 0.1% and 0.4%, remain low by European standards[8]. Croatia's latest National Social Report mentioned only palliative care and funding for NGOs to deliver homecare services for older people in the section on long-term care[9].

1.2 Description of carers' leaves

The Croatian system provides for maternity leave (mandatory and additional) and parental leaves, with the possibility of right to work part-time. In addition, the Croatian system provides leave from work for carers **only** in the case of parents looking after children with disabilities or the need for special care, with a variety of leave entitlements existing for this group of carers after the expiry of statutory maternity and additional parental leave. There are three broad sets of rights here:

[6] World Bank (2010) op. cit.

[7] Bađun, M. (2015) Informal long-term care for elderly and infirm persons (in Croatian). *Institute for Public Finance Newsletter*, no. 100, December 2015.

[8] ASISP Report on Pensions, Health Care and Long-term Care (2014), page 33 and European Commission (2015) The 2015 Ageing Report: Economic and budgetary projections for the 28 Member States (2013-2060). Web: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf (accessed 15 February 2016).

[9] Republic of Croatia, Ministry of Social Policy and Youth (2015) National Social Report, pp. 19-20.

1.2.1 The time-limited right to work half-time.

This can be used by one employed (or self-employed) parent after statutory parental leave until a child reaches three years of age if, according to expert medical opinion, a child needs additional or intensive care. Decisions on entitlement are made by a medical commission established by the Croatian Health Insurance Institute (HZZO), based on a medical report from a General Practitioner and other documentation. Such a parent is entitled to salary paid by employer for the half-time work and to salary compensation paid by the HZZO. The salary compensation is paid at a flat rate of half the budget base[10], currently 1,663 HRK (approximately EUR 219) per month.

1.2.2 The right to extended full parental leave.

This can be used by one employed (or self-employed) parent providing that, before the start of this leave and throughout the duration of the leave, both parents are employed or self-employed. Single parents also have the right to this benefit provided they are employed. Right to the benefit ceases should a parent become unemployed. Extended parental leave is available in situations where a child has severe physical or mental incapacities or severe mental health issues. The right to extended parental leave can cover the period until a child is 8 years old. Eligibility is determined by a HZZO medical commission which can decide to grant the right for a shorter period, say for 6 or 12 months, subject to the possibility of renewal. The benefit is paid at a flat rate of 65% of the budget base, currently 2,100 HRK (approximately EUR 276) per month, providing the beneficiary has been in continuous paid employment for 12 months prior to the claim, or for a period of no less than 18 months in the 24 months prior to the claim. For those who cannot meet one of these conditions, providing they are employed at the time of the claim, payment is reduced to 50% of the budget base, currently 1,663 HRK (approximately EUR 219) per month.

1.2.3 The (unlimited) right to work half-time.

As with the second right above, this right can be used by one employed (or self-employed) parent providing that, before the start of this leave and throughout the duration of the leave, both parents are employed or self-employed. This right can be exercised in the case of children with severe physical or mental incapacities or severe mental health issues for the whole childhood, subject to a HZZO medical commission decision. Again, the commission can decide to award the right for a shorter period. In terms of remuneration, people receive half of their last month's net full-time salary, based on proof from the person's employer. For those who are self-employed the calculation is different, being 50% of the minimum base for paying health contributions, in force for at least six months prior to the claim. If the base is higher, the payment is 50% of this base. In effect, providing parents remain employed, this benefit covers adults with severe disabilities as there is, currently, no upper age limit at which childhood is deemed to end.

In each of the three cases above, the carer automatically receives health insurance as well as basic pension insurance. In addition, the carer may also have the right to other paid contributions subject to certain conditions.

It is also worthy of note that, regardless of disability, carers can extend parental leave to look after children for up to three years without monetary benefit. In all such cases, health insurance contributions are covered and the right to return to work after a period as carer remains.

In addition, the Croatian Labour Law contains provisions for short-term care leave to look after a family member who is ill. For a spouse, leave can be up to 15 working days and

[10] The budget base is a legal term which forms the basis of calculations and is set at an amount which can be changed by a decree or by secondary legislation (*pravilnik*) without needing to change the primary legislation.

for a child 20 working days. This leave is paid at 70% of salary, up to a maximum of 4430 HRK (approximately EUR 583 per month).

1.3 Description of carers' cash benefits

To the best of our knowledge, within the Croatian system, benefits are paid directly to the cared-for person, in this case an adult with disabilities but, of course, they can then be used to help with long-term care needs. In addition, special child benefits for children with disabilities are paid to parents directly. There are four broad sets of cash benefits or related benefits:

1.3.1 Disability benefit (*osobna invalidnina*)

This is paid to anyone who has severe disabilities or has suffered from a permanent deterioration of their health conditions. Under a revised system, eligibility is assessed by a Commission from the Agency for Professional Rehabilitation, under the Ministry of Labour, which then makes a recommendation to the Ministry of Social Policy and Youth. Although the benefit is not means-tested it is asset-tested insofar as persons who own a second flat or house in addition to their current residence and which could be sold or rented to provide income are not eligible. People who own business premises are also ineligible. The benefit can be paid to anyone over the age of 1 year old. Anyone who, according to the Social Welfare Act, is accommodated in a social welfare institution cannot receive the benefit. The amount of benefit is individually means-tested. Those with no income are eligible to a monthly allowance which is 250% of the base rate for recipients of guaranteed minimum income (Croatia's social assistance scheme of last resort), currently 1,250 HRK (or approximately EUR 164). Those who have an income are entitled to a benefit which is the difference between the base rate and their average income over the last three months, providing this is less than 1,250 HRK. For the purposes of the means-test, a number of sources of income are not counted as income, including: guaranteed minimum income benefit, housing allowance, child benefits, additional allowances for orthopaedic aids, and other benefits covered by relevant Family Law, not specified as such in the legislation.

1.3.2 Assistance and care allowance (*doplatak za pomoć i njega*).

This benefit can be paid to those who are unable to take care of their basic needs on their own, including buying and preparing food and basic personal hygiene. Again, persons are ineligible if they own a flat or house in addition to the one in which they live and which could be sold or rented, or if they own business premises. In addition, anyone who has signed a contract to enable themselves to receive lifetime care from another person is ineligible. Although the figures are not known, there has been widespread reporting of the practice of older people entering into such contracts with non-relatives whereby, in exchange for lifelong care by a live-in carer, the carer inherits the property when the owner dies. The benefit is also means-tested, and limited to those living alone whose average monthly income for the last three months does not exceed 250% of the base, currently 1,250 HRK (approximately EUR 164) or those in households where the average monthly income per household member does not exceed 1,000 HRK (approximately EUR 143). The level of benefit is relatively low, and may be at one of two levels, depending on the extent of the person's disability: it may be 100% of the base, namely 500 HRK (approximately EUR 71) or 75% of the base, currently 350 HRK (approximately EUR 46). Importantly, the benefit can be paid in addition to disability benefit. The full benefit, regardless of other income, is payable to anyone with severe disabilities, a severe permanent change in health status, and a blind, deaf or deaf-blind incapable of living an independent life. The reduced rate is paid, regardless of other income, to blind, deaf or deaf-blind persons capable of independent living, persons deprived of legal capacity and in the case of children whose parents work part-time in order to take care of children with severe disabilities. Although data is lacking, because there are no conditions attached to the benefit, as well as the low level of benefit, the scheme encourages informal care arrangements with persons paid in cash, as a kind of

informal or grey labour market, rather than payment to qualified carers who then pay tax and other contributions.

1.3.3 Child benefits (*dječji doplatak*)

Means-tested child benefits can be claimed by a child's parent(s), adoptive parent(s), grandparent(s) or any other person who is the primary caretaker. The amount varies according to income, with currently three income groups. In 2014, monthly benefits of HRK 199.56 (EUR 26) were paid for those with an income between HRK 1,119.53 (EUR 146) and HRK 1,663.00 (EUR 217); monthly benefits of HRK 249.45 (EUR 33) were paid for those with an income between HRK 543.14 (EUR 71) and HRK 1,119.53 (EUR 146); and monthly benefits of HRK 299.34 (EUR 39) were paid for those with a monthly income up to 543.14 (EUR 71). Importantly, children with health difficulties can receive benefits raised by 25%, with amounts varying according to which income band they are in, and children with severe health difficulties receive an allowance of 831.50 HRK (approximately EUR 109) regardless of income. Children with health difficulties can receive child benefits up to the age of 21, and children with severe health difficulties up to the age of 27. In the latter case, those who claimed this right before 1 January 2002 can receive this benefit with no upper age limit. Children who are in care in public institutions, or who are receiving education abroad, are not eligible for child benefits.

1.3.4 Tax allowances

For dependent children or any dependent person who is handicapped, the personal tax allowance is raised by 30% from 2,600 HRK (approximately EUR 342) to 3,380 HRK (approximately EUR 445). The dependent person's tax allowance is doubled to 5,200 HRK (approximately EUR 684) is the dependent person is severely handicapped, termed 100% disability within the Croatian Law, or has the right to assistance and care.

1.4 Description of carers' benefits in kind

Again, most benefits in kind in the Croatian system are rights for the dependent or cared-for person. However, they are included here because they help with long-term care in broad terms and, therefore, may be of indirect benefit to carers. Three broad forms of in-kind assistance are the most relevant.

1.4.1 Assistance in the home for people with disabilities (*usluga pomoć u kući*).

The basis for this can be found in the Law on Social Welfare and includes organised delivery of food or meals, shopping for food and other items, cleaning and ironing, and help with personal hygiene. Those eligible are those with physical or mental disabilities, mental health issues and those in temporary or permanent ill-health which means they require such assistance. Assessment is made by social workers from the Centre for Social Welfare. It is only available to those who do not receive any help from their own parents, spouse or children. It is also means-tested and limited to those whose monthly income, or the income of household members, is not more than 1,500 HRK (approximately EUR 197).

1.4.2 Assistance at home or day care for vulnerable older people

Although there have been commitments in the past to make it so, this is not an in-kind benefit which is available nationwide, rather it is based on contracts between the Ministry of Social Policy and Youth and individual municipalities. The right to day care is assessed by social workers and can include full-day (between 6-10 hours) or half-day placements (4-6 hours) and can be between 1 and 5 days a week. Again, the key criteria is to provide food, help with personal hygiene and provide psycho-social support. As such, the benefit is neither transparent nor nationally available, but is rather dependent on a local authority showing interest in hosting such a scheme with agreements made, again non-transparently, based on criteria which are far from clear and not, in any sense, based on need.

1.4.3 Respite care in public care institutions

There are provisions in the Law on Social Welfare for temporary or short-term institutional placement, targeted at children with developmental difficulties and adults with disabilities. The main criteria are the needs of the dependent person, with placement able to be for up to one year in the context of a rehabilitation plan. In addition, however, there is provision for respite care to enable carers of children with developmental difficulties to have a break. There are three lengths of respite care available. In general, respite care can be for up to 15 days in one year. However, where the carer takes a vacation, respite care can be for 30 days per year. In situations where a carer may be temporarily incapable of caring for a child with developmental difficulties or an adult with disabilities because of their own illness, respite care can be available for up to 60 days in a year.

2 Analysis of the effectiveness of work-life balance measures for working-age people with dependent relatives

2.1 Assessment of individual measures

2.1.1 Carers' leaves

There are no publically available figures on the number of carers who take advantage of any of the three forms of carers' leaves described above, nor is there any publically available information on trends in using these schemes over time. However, given that two of the three schemes relate to the possibility of half-time working, it is important to note that Croatia, currently, has one of the smallest proportions of part-time workers in the European Union. Eurostat figures show that in 2014, only around 5.3% of workers in Croatia worked part-time, compared to 19.6% in the EU-28, with only Slovakia and Bulgaria having lower rates[11]. Although early figures were calculated differently, the rate in Croatia appears to have fallen compared to both 2004 and 2009. In the absence of other information, then, we can conclude that, although the possibility of working half-time is, theoretically, offered to carers, the numbers able, in practice, to take advantage of this right is likely to be limited by the lack of a culture of part-time and flexible working within the Croatian labour market.

As noted above, two of the three care leave schemes are limited to those caring for children with disabilities and have what appear, at first site, rigid and artificial cut-off points at 3 and 8 years, respectively, dependent on the extent and nature of the disability. Assessment of the length of carer's leave appears to be entirely based on medicalised assessment of a child's functioning and not, at all, on the needs and circumstances of carers. Half-time working for three years appears to be a reasonable measure, allowing for continued engagement in the world of formal work whilst caring for a child with disabilities, and offers the likelihood of the carer being able to return to full-time work subsequently. However, total disengagement from the world of formal work for a period of eight years, as in the second scheme, seems unlikely to meet carers' needs for work-life balance, nor is it likely to be conducive to re-integration into the labour market at the end of this time. In addition, there appears to be no possibility of the carer leave being shared between both parents leading, we suggest, to the strong likelihood that those who take advantage of the scheme are overwhelmingly women, contributing even further to women's disadvantageous position in the labour market. The lack of flexibility to vary the amount of time devoted to formal work and to caring work is particularly worrying in the third scheme which is not time limited. As children with severe disabilities grow older, of course, their needs and functioning changes over time. In addition, as carer get older, their abilities and motivations to care may also change.

[11] Eurostat (2015) Employment, Statistics Explained, August, web: http://ec.europa.eu/eurostat/statistics-explained/index.php/Employment_statistics (accessed 17 February 2016).

These changes over time appear not to be addressed by the scheme. At the same time, it is the only scheme which treats care for a dependent child at home as similar to formal work, offering remuneration and contributions as if the carer was engaged in the formal labour market.

Crucially, as noted above, only one scheme, the third scheme, applies to care for an adult with disabilities providing this adult is the carer's child and has, indeed, had a disability from childhood. This means, in effect, that there are no extended leave schemes to support anyone caring for a partner, for a child who became disabled during adulthood, nor for their own parent or parents. In the absence of a culture of part-time working, then, it is highly likely in these circumstances that anyone wishing to care for a dependant relative other than a child, may have to withdraw completely from the world of formal work, with no prospects of reintegration into the labour market at a later date.

2.1.2 Carers' cash benefits

Strictly speaking, it is only the payments provided for those who take carers' leave to look after their children with disabilities, discussed above, which represent benefits paid directly to carers in Croatia. As noted above, the benefits which were discussed in the section on cash benefits, are benefits for those being cared for and **not** for their carers. This is, in many ways, their biggest flaw. One, partial exception, is child benefits which are paid, of course, to parents as carers, including the parents of children with disabilities, payable up to the age of 21 or 27, depending on the extent of disabilities or ill-health. Again, unfortunately, publically available statistics on the numbers of child benefit beneficiaries are not broken down according to the type or size of benefit, nor in terms of the age of the child, so that it is impossible to determine the number of claims relating to children with disabilities nor their trends over time. Trends in terms of the number of beneficiaries of two other cash benefits, disability benefit and assistance and care allowance, as well as those being supported through an in-kind benefit or service, namely assistance at home or day care, can be seen in Table 3 below. These trends are hard to interpret but are based on a combination of reforms and changing perceptions regarding the desirability and availability of different benefits.

Although the number of recipients of disability benefit has increased, this remains relatively low. At the same time, the numbers receiving assistance and care allowance has decreased. Those receiving support services, either assistance at home or day care has doubled between 2012 and 2014 but remains relatively small. It is likely to represent only a very small proportion of those who may need assistance. Crucially, as noted above, disability benefit, assistance and care allowance and child benefits are all means-tested and, although the level of eligibility is higher than for basic social assistance (Croatia's guaranteed minimum income scheme), the schemes are still limited to poor households. In contrast, of course, the fourth benefit noted, tax relief, benefits only those who are earning well above the minimum wage and tends to be regressive, with higher earners benefitting more.

Table 3: Beneficiaries of diverse schemes, 2012-2014

Year (end of the	2012	2013	2014
Disability benefit	21,059 (100)	22,362 (106)	23,740 (113)
Assistance and care	78,290 (100)	73,690 (94)	72,408 (92)
Assistance at home or	1,995 (100)	2,095 (105)	3,964 (199)

Source: Annual reports, Ministry of Social Policy and Youth

As we hinted at above, this distinction is likely to create what can be described as a 'dual' labour market of care. The poorest members of society receive small amounts of benefits which they may or may not pass on to relatives who care for them but which are likely to have very limited effects in terms of improving the well-being of either the cared-for or

the carer. The sums involved, we suggest, are far too low to be of more than marginal significance in terms of the choices made by either carers or the recipients. They are certainly too low to enable those in need of care to pay for quality care services within the formal labour market. Instead, they are likely to increase vulnerable people's dependence on unregulated, low quality, and even exploitative or predatory informal care services, including those provided in exchange for accommodation and the right to inheritance by non-relatives.

2.1.3 Carers' benefits in kind

Not unlike other aspects of Croatia's care regime, we can state clearly that there are very few resources devoted to carers as carers. It is notable that Croatia's anti-poverty strategy does not mention the term 'carer' at all[12]. In terms of in-kind benefits for those in need of care, we can also note that, compared to cash benefits, there appear to be very few services available and those that are either not rights enshrined in the system, as is the case with assistance at home or day care, or are rights enjoyed by a relatively small number of people. One of the few rights which is important for the well-being of both carers and cared for is the possibility of respite care within institutions. From annual statistical reports from the Ministry of Social Policy and Youth, respite care seems to be available primarily for children and, to an extent, adults with disabilities. There is, also, the possibility of receiving half-time and full-time day care. Although comparisons are difficult given the different way in which statistics are presented, we can see from Table 4 and 5 that numbers of children and adults able to take advantage of respite care or day-care in institutions is low and has not risen significantly between 2013 and 2014.

[12] Government of Croatia (2014) Strategy for Combating Poverty and Social Exclusion in the Republic of Croatia, 2014-2020.

Table 4: Respite and day care for children with disabilities, 2012-2014

Year (end of the period)	2013	2014
Respite care	228	290
Day care	n.k.	98
Half-Day Care	n.k.	597

Annual statistics, Ministry of Social Policy and Youth

Table 5: Respite and day care for adults with disabilities, 2012-2014

Year (end of the period)	2013	2014
Respite care	123	90
Day care	n.k.	222
Half-Day Care	n.k.	823

Annual statistics, Ministry of Social Policy and Youth

It is also important to note that a pilot scheme to provide personal assistants to persons with disabilities which both facilitated their possible reintegration into the world of work and, also, offered respite to relatives who may be their main carers, due to shortage of funds was never extended, as originally envisaged, as a nation-wide right enshrined in Law.

2.2 Assessment of overall package of measures and interactions between measures

In terms of the interaction between the different measures listed above, there appears to be little coherence and integration between a number of rather disparate and 'stand-alone' measures. Above all, notwithstanding a number of projects which have sought to introduce the concept, there is still no real system of 'case management' in Croatia with case managers such as social workers responsible for putting together a 'package' of care for those in need which, at the same time, would ease the burden on permanent carers. A general lack of close integration between social protection, personal social services, health care and employment services, noted in many of our earlier reports, takes on a particular significance in terms of the carers of those in need of long-term care. The linkage between care and employment for close relatives is, we suggest, extremely limited, to the detriment of the well-being of both carers and cared for. Carers have to make a stark choice, in the absence of a broader continuum of community-based care services, and in the absence of greater flexibility in terms of leave of absence from work and/or reduced working hours, between staying in the world of work and not caring for dependent relatives or leaving the world of work and caring full-time for dependent relatives.

In the absence of timely, accurate and fit-for-purpose statistics and research, it is hard to assess the gap in Croatia between the needs of carers and actual benefits and services which are available. As noted in many of our previous reports[13], Croatia has an extremely low activity rate; however, the 10 bps difference between activity rates for men and women is rather average. Croatia has the third lowest activity rates for both men and women in the 55-64 age group. LFS data shows that the percentage in Croatia who are "regularly taking care of relatives/friends aged 15 or over and in need of care is similar to the average for the EU-28: 59.3% of women (60.2% in the EU-28) and 40.7% of men (39.8% in the EU-28). In some contrast, the 2012 European Quality of Life survey showed that 14.5% of women and 8.5% of men reported that they were "involved in

[13] See, for example, Croatia Country Report, 2016.

caring for elderly or disabled relatives" every day, both being the highest rates in the EU-28. In addition, the figures are higher for both men and women drawn from the lowest income levels. Lack of flexibility in terms of work is revealed by statistics from the 20102 European Quality of Life survey which show that only 22.2% of women in Croatia say that they are "able to vary start and finish times", the second lowest in the EU-28, after Hungary[14].

2.3 Policy recommendations

Based on the evidence and analysis presented above, a number of policy recommendations to improve work-life balance for carers as well as the well-being of carers and their family members in Croatia can be listed. These are illustrative rather than comprehensive.

- Improving the evidence base - official statistics and research: there is a need for comprehensive, timely, and accurate data on all aspects of cash and in-kind benefits and services for carers and dependent relatives in Croatia. It is particularly important that numbers and trends are available for the number of beneficiaries of the various carer's leave entitlements discussed above. It is also important that such data should be disaggregated by gender, age and other categories. Beyond this, there is a need to support independent research which explores the current situation, and key challenges, facing carers and cared for in Croatia, addressing the gap between needs and provisions and examining which factors promote and which limit well-being. The issue of work-life balance and the challenges faced by those attempting to both care for dependent relatives and maintain at least one foot in formal employment should be a greater research priority.
- Rights of carers as carers: The category of 'carer' appears not to be present in terms of rights within Croatia Law. It would be important to explore whether the category should be introduced into, at the very least, labour law and social welfare law. Although the rights of parents of children and, to an extent, adults with disabilities, are recognised, there appears to be no recognition of the rights of carers of frail elderly persons, carers of partners nor, indeed carers of relatives or friends. At the very least, a debate is needed as to the implications of this and how to ensure a greater recognition of the rights of all carers in Croatia. Establishing a Carer's Charter which made rights clear could be a first step here. In addition, one possibility would be to extend the leave schemes discussed above to all carers of dependents regardless of the relationship between carer and cared-for.
- Greater flexibility for carers in terms of formal employment: At the moment, in Croatia, debates about 'flexibilisation' in the labour market tend to focus on the needs of employers and greater liberalisation rather than on the needs of carers. In effect, the same word flexibility can be used to describe potentially antagonistic requirements of, on the one hand, employers for more 'flexible' workers and, on the other hand, of employee-carers for more 'flexible' employment conditions. In general terms, carers need more flexibility both in terms of the reduction in working hours, beyond only the possibility of opting for half-time work, the length of leave, and the sharing of rights between partners, relatives, and so on. It could even be argued that the Croatian economy, as all dynamic economies, should be more open to flexible working, job sharing, and home working for all employees, not just those with caring obligations.
- Establishing a wider continuum of care services: Community-based alternatives to institutional care, whether in a social services or health care facility are needed to

[14] Synthesis report on work-life balance measures for persons of working age with dependent relatives, Statistical Annex.

avoid an over reliance, either, on informal care with no support and institutional care which may become long-term. Existing services including home care and support services, as well as respite care are needed. In addition, there is a need for a wider range of services which both prevent the need for institutional care and promote reintegration and return home.

- Case managers tasked with assessing needs and putting appropriate 'packages of care' in place: Whether in Centres for Social Welfare or in other settings, there is a need for carers and cared for to be able call on 'case managers' who should be able to assess initial needs, make regular follow up assessments, organising and implementing 'packages of care' which combine public and private resources, to maximise independence and quality of life of both cared-for and carers. There may be a case for a 'minimum' basket of care services to be enshrined in law to minimise, as far as possible, regional inequalities or urban-rural inequalities.
- Services for carers as carers: There is a clear need for more services to be targeted directly at the needs of carers, be these financial, physical and/or emotional. Central and local governments should consider offering grants to organisations of carers, and organisations offering support groups for carers.
- A clear and sustainable long-term care strategy: Croatia needs to develop a much clearer long-term care strategy. Incorporating all the elements noted above and, crucially, developing a strategy for sustainable funding including an appropriate balance of public (central, regional and local government) and private funding. The introduction of long-term care insurance, financed through social contributions, could also be considered. Informal care should also be costed and included in the expenditure system for long-term care as a whole.

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