ESPN Thematic Report on Challenges in long-term care

Croatia

2018

Paul Stubbs and Siniša Zrinščak
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Directorate-General for Employment, Social Affairs and Inclusion
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European Social Policy Network (ESPN)

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Summary

Croatia's long-term care (LTC) system is underdeveloped, with little or no co-ordination between the social welfare, health, and war veterans' systems; between national, county and municipal/city levels; or between state and non-state (not-for-profit and for-profit) providers. Whilst hard to assess properly, Croatia's overall spending on LTC, at approximately 0.4% of GDP, is one of the lowest in the EU. Those benefits which are available to cover LTC needs are fragmented, not available to all user groups, and often insufficient to meet basic needs. The burden of LTC still falls disproportionately on family members or on a growing informal care sector as part of the grey economy, with considerable scope for exploitation. Flexibility in employment to allow for care leave is uneven and varies from one user group to another.

Croatia has both a rapidly ageing population and increases in life expectancy not matched by increases in healthy life years. Demand for institutional care for older people already exceeds supply, with the more expensive private sector appearing more responsive to the shortfall than the statutory sector. Calculations of costs, both real economic costs and costs per beneficiary, appear not to exist. Although there has been greater focus on home care services in recent years, these have often been pilot programmes which, when integrated into mainstream services, experience significant reductions both in funding and in the number of beneficiaries. Demands for deinstitutionalisation, relevant for other client groups, have not been felt thus far in terms of LTC for older persons. Within the system as a whole, there is inadequate monitoring and inspection and few real quality standards. Assessment and case management systems are underdeveloped or non-existent as is multi-agency working.

Not only are key indicators not systematically calculated, but Croatia lacks a strategic approach to LTC which identifies short-, medium- and long-term priorities and sets out goals, responsibilities and, crucially, financing. Among the recommendations in this report, it is argued that community- and home-based services need to be expanded and equalised across regions. In addition, there is a need to ensure that innovative pilot programmes which demonstrate positive results are scaled up, integrated into the mainstream services, and funded adequately. Crucially, clearer regulation of pricing across state, non-state and for-profit services is needed.

An LTC crisis in Croatia is not far away, if not already upon us. LTC has to become the number one strategic priority across the health and social care sectors – with more resources devoted to it; the development of a continuum of care, improved assessment, case planning and case management; and timely and effective monitoring of quality standards. Empty rhetoric about 'subsidiarity' and 'family responsibility' can no longer be excuses for policy inaction.

1 Description of the main features of the country's long-term care system(s)

The long-term care (LTC) system is one of the least developed parts of the health and welfare system in Croatia. While the majority of services and benefits are administered through the social welfare system, some services and rights are provided by other systems with little co-ordination between them. The Ministry of Demography, Family, Youth and Social Policy is in charge of benefits and services provided through the welfare system, while the Ministry of Croatian Defenders is in charge of the LTC needs of war veterans. The healthcare needs of older people are provided through the healthcare system, which is also in charge of palliative care. Public homes for the elderly are owned by counties, though standards and rules of financing are set by the Ministry of Demography, Family, Youth and Social Policy. Counties, cities and municipalities can finance community care, which is significantly underdeveloped and fragmented. There is a growing private sector, particularly in institutional care for elderly and infirm persons, which reflects the general shortage of places in public homes for the elderly and especially for infirm or frail persons in need of healthcare, e.g. those who are terminally ill or who suffer from various mental illnesses. However, information on care provided in the private sector is very scarce, in particular in relation to fees and quality of services.

There is no information on how much is spent on LTC as a whole, as benefits and services are fragmented and accounted for as parts of the welfare/health/war veterans' systems. Available information suggests that Croatia spent only 0.4% of GDP on LTC in 2013, which is among the lowest in the EU, and much below the EU average of 1.6% of GDP.[1] The projected increase is also the lowest among the EU countries as Croatia will spend only 0.5% of GDP on LTC in 2060. Although there is no information on private spending, it is safe to conclude that LTC is financed mainly from the state budget.[2]

In terms of cash benefits, people can rely mainly on different social assistance benefits, including: guaranteed minimum income, which is the basic social assistance benefit; housing allowance; allowance for assistance and care; and personal disability benefit. For persons in need of LTC the most important are the allowance for assistance and care and personal disability benefit. The allowance for assistance and care can be claimed by a person who is unable to satisfy their basic needs without assistance in purchasing, preparing and eating food, in cleaning, in dressing, and in terms of personal hygiene. It is administered by Centres for Social Welfare (CSWs)[3] (deconcentrated statutory social work service agencies) and is based on an income and needs assessment. Personal disability benefit can be claimed by a person with a severe disability or serious long-term health condition, in order to ensure that their basic needs are met. It is also administered by CSWs and based on an income and needs assessment. The highest amount of personal disability benefit is set at 1,250 HRK monthly (approx. EUR 166) for a person without any income, while the allowance for assistance and care is set at only 500 HRK (EUR 66) monthly in full, or only 350 HRK (EUR 46) if accepted in part. According to the latest data there were 25,259 recipients of personal disability benefit in 2016, which represented a small rise from 23,740 persons in 2014; and there were 66,942 recipients of the allowance for assistance and care in 2016, which was lower than in 2014 (72,408

[1] European Commission (2015), The 2015 Ageing Report. Economic and budgetary projections for the 28 EU Member States (2013-2060). Luxembourg: Publication Office of the European Union.

[2] Živković, I., and Vajagić, M. (2014), Comments paper – Croatia. Peer Review on financing of long-term care. Slovenia 2014. Available at: http://ec.europa.eu/social/main.jsp?catId=1024&langId=en&newsId=2097&moreDocuments=yes&tableName=news

[3] Centres for Social Welfare (*Centri za socijalnu skrb*), formerly called Centres for Social Work, are public institutions responsible for co-ordinating social assistance benefits, social services and a range of statutory social work tasks. Currently, there are some 117 CSWs in Croatia, not including branch offices. They are deconcentrated units of central Government with founders' rights vested in the relevant Ministry.

recipients).[4] In terms of the age structure, 50.18% of recipients of the allowance for assistance and care were older than 65, and 13.58% of recipients of disability benefit were older than 65.[5]

Institutional care is mainly provided through elderly homes. At the end of 2016, there were 2 state homes for elderly and frail persons, 45 county homes, and 97 non-state homes owned by non-profit organisations, religious communities and other private legal entities.[6] Non-state homes offer residential care and are accredited by the Ministry but are not subsidised, unlike state and county homes. In terms of beneficiaries, 10,744 persons were in county homes at the end of 2016, 5,593 in other non-state homes, and only 169 persons in state homes. Thus 64% of places are provided by county homes. Among all beneficiaries, 19.6% were accommodated on the basis of CSW decisions at the end of 2015, which also means that the state is covering, fully or partially, fees for them.[7] It should be noted that this share is declining as it was 26% at the end of 2012.[8] There are no indications available as to why the share is declining – CSW staff make an assessment based on the income of users and family members, who may be asked to make co-payments. Over the period in question, the income criteria have not changed.

Though beneficiaries, except those whose stay is covered by CSWs, pay the price by themselves, the prices are set at a level below the full economic price, which means that state and county homes are subsidised by the state. While this is of course understandable, the methodology for calculating costs and beneficiaries' fees is not developed, despite many announcements that this would be done. In other non-state homes prices are much higher, which makes them unaffordable for most people. At the same time, private homes, where almost 34% of all users reside, are the only solution due to the shortage of places in county homes – particularly for very ill and frail persons.

One of the main processes in this field is that of deinstutionalisation, by which alternatives to institutions are developed, in particular by encouraging foster care, independent living with professional assistance, and return to biological families. However, this has been much more pronounced in relation to other client groups, including children and adults with disabilities, than in terms of the older population. At the same time, it must be noted that a significant proportion of adults with disabilities are, themselves, older persons, including many in institutions who have been there for a very long time. Hence, the process of deinstitutionalisation is, also, relevant in assessing LTC for older people. Up to the end of 2015, 951 beneficiaries had been moved from institutions to small flats/houses adapted to organised living.[9] The number of people in foster care rose from 704 in 2011 to 1,320 in 2015 for adults with physical or intellectual disabilities, and from 1,409 in 2011 to 1,581 for adults and elderly in 2015, while for adults with mental disabilities this rise was, understandably, much slower, i.e. from 862 in 2011 to 992 in 2015.[10] Foster care is also exposed to greater regulation in terms of facilities; quality standards; and a greater accent on education of foster careers, which

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[4] Data obtained from the Ministry of Demography, Family, Youth and Social Policy website: http://www.mspm.hr/pristup-informacijama/statisticka-izvjesca-1765/statisticka-izvjesca-za-2016-godinu/2290

[5] Social Welfare Strategy for Older People in the Republic of Croatia for the Period 2017-2020. Web: http://www.mspm.hr/UserDocsImages//Vijesti2017//Strategija%20socijalne%20skrbi%20za%20starije%20osobe%20u%20RH%20za%20razdoblje%20od%202017.-2020.%20g.pdf.

[6] Data obtained from the Ministry of Demography, Family, Youth and Social Policy website: http://www.mspm.hr/pristup-informacijama/statisticka-izvjesca-1765/statisticka-izvjesca-za-2016-godinu/22.

[7] Social Welfare Strategy for Older People in the Republic of Croatia for the Period 2017-2020. Web: http://www.mspm.hr/UserDocsImages//Vijesti2017//Strategija%20socijalne%20skrbi%20za%20starije%20osobe%20u%20RH%20za%20razdoblje%20od%202017.-2020.%20g.pdf.

[8] Social Welfare Strategy for Older People in the Republic of Croatia for the Period 2014-2016. Web: http://www.mspm.hr/djelokrug_aktivnosti/odrasle_osobe/starije_i_nemocne_osobe.

[9] Government of the Republic of Croatia (2017), National Strategy for Equal Opportunities for People with Disabilities from 2017 to 2020. Available at: https://narodne-novine.nn.hr/clanci/sluzbeni/2017_04_42_967.html.

[10] Buljevac, M., Milić Babić, M., and Leutar, Z. (2016), Respect of Rights for People with Disabilities in Foster Care and Family Homes. Zagreb: Disability Ombudsman Office.

aims to prevent prospective foster carers seeing fostering as merely an additional income source for some families.[11]

There is a great need for palliative care which has only recently started to be developed, as a part of the healthcare system. After the adoption of the first ever Strategy of Palliative Care in December 2013 some improvement has been be noticed, as there are now 10 mobile teams for palliative care at home, 22 hospital teams, 31 pain relief infirmaries, and so on. However, there is no information on whether any palliative care beds in hospitals are currently available whereas, according to a recent assessment, Croatia needs between 349 and 429 palliative care beds.[12]

Services are the least developed part of the generally underdeveloped LTC system. There are a few services available, but only a limited number of people in need of LTC can enjoy these services. Assistance at home is the most widespread service, which can be granted to vulnerable older people who are unable to provide food for themselves, or who need help with personal hygiene or any kind of psycho-social support. The service has existed, in some form, for many years. However, based on the income and needs assessment by the CSW, this service was provided to only 3,258 persons older than 65 at the end of 2015.[13] This was a significant drop in relation to two similar services organised at the end of the 2000s and beginning of 2010s by the then Ministry of Family, War Veterans and Inter-Generational Solidarity, as the number of beneficiaries was 15,550 in 2012. However, these services were organised outside the social welfare system, as projects in co-operation with local governments and not as legally prescribed rights, and with unclear criteria (in many cases political/clientelistic) varying according to the local communities with which the contracts were signed. The logical decision to incorporate this inside the welfare system resulted, however, in a significant drop in the number of beneficiaries, primarily for cost reasons during a period of austerity politics and fiscal consolidation. The Ministry is also financing a service called ‘hello help’, a button or bracelet linked to the telephone system that can be activated in the event of a fall, through 6 projects with a total of 1,507 beneficiaries. Counties and cities can finance other programmes, but we lack more precise data about their scope, number of beneficiaries and regional distribution. There is also assistance at home for people with disabilities, which also includes delivery of food and meals, shopping for other items, cleaning and ironing and help with personal hygiene. It is also means- and needs-tested. Only 1,300 persons were receiving this help at the end of 2015. People with disabilities can have help from personal assistants, which is assured for only 1,153 persons: although the age breakdown is not available, our sense is that this is primarily used for persons of active working age.

Underdevelopment of institutional, and in particular community, care means that the burden falls mainly on family members. The additional burden comes from the fact that, apart from maternity and parental leave, the system provides leave from work for carers only in the case of parents looking after children with disabilities or when there is a need for special care.[14] In the case of cash benefits described above, benefits are paid directly to cared-for-persons, while special child benefits for children with disabilities are paid to parents directly. While there are no data or research findings which can provide detailed information, it can be justifiably claimed that the shortage of services and rather

[11] Dobrotić, I. (2016), Development and difficulties of the eldercare system in Croatia. Društvena istraživanja, 25(1): 21-42.

[12] Republic of Croatia – Ministry of Health (2017), National Programme of Development of the Palliative Care in the Republic of Croatia 2017-2020, web: https://zdravlje.gov.hr/UserDocsImages/2017%20programi%20i%20projekti/NP%20RAZVOJA%20PALIJATIVNE%20SKRBI%20RH%202017-2020-%20usvojen%2018.10.2017..pdf

[13] Social Welfare Strategy for Older People in the Republic of Croatia for the Period 2017-2020. Web: http://www.mspm.hr/UserDocsImages//Vijesti2017//Strategija%20socijalne%20skrbi%20za%20starije%20osobe%20u%20RH%20za%20razdoblje%20od%202017.-2020.%20g.pdf

[14] Stubbs, P., and Zrinščak, S. (2016), ESPN Thematic Report on work-life balance measures for persons of working age with dependent relatives – Croatia.

inflexible leave schemes pose families with a stark choice "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 families".[15]

2 Analysis of the main long-term care challenges in the country and the way in which they are tackled

2.1 Main challenges

Analysis of the main LCT challenges is conditioned by a lack of data that can illustrate the main features of the existing system. In particular, this relates to data on quality of services provided, regional distribution and employees in the LTC system. This makes evidence-based policy nigh-on impossible.

There is a sharp contradiction between the fact that LTC is the least developed part of the welfare system and the increasing need for LTC, which traditionally was performed by the family. Profound challenges brought about by socio-demographic changes are still not met through any active social policy measures.[16] The recent UN report included Croatia in a group of countries with the highest projected drop in population by 2050 (Croatia is among 10 countries of the world with a drop of more than 15%).[17] Thus, the ageing of the population is the most striking socio-demographic trend. The old-age dependency ratio (population 65 and over relative to population 15-64) was 28.3 (the EU average was 28.8 in the same year) but according to projections this would rise to 32.3 in 2020, and 32.9 in 2030,[18] which would be above the EU average in the respective years. Recent intensive emigration is another factor here. Although detailed research is lacking, the fact is that among emigrants the majority are of prime working age, which means that older people are increasingly left alone without direct family help.[19] Finally, although the activity rates and employment rates of women are still much lower than of men, women are nowadays much more involved in education and more women get a university degree today than men: this will also affect the care of dependent family members, usually undertaken by women, in the future.

Though institutional care has a longer history, the number of available places is lower than the need for places. Taking altogether state and county homes for elderly, other homes and foster care, there are places for only 3.68% of those older than 65. In addition to long waiting lists, differences in price between state/county and private homes, and the lack of a clear methodology for calculating prices, there is an uneven regional distribution of available places. 9 out of 21 counties in Croatia have a below-average number of available places:[20] but there are no clear policy measures for overcoming this problem.

For people with disabilities and in need of LTC the main process, as stated above, is deinstitutionalisation, which contributed to the establishing of new services, particularly the provision of organised living in smaller flats and houses. This has not, on the whole,

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[15] Ibid., p. 17.

[16] Jedvaj, S., Štambuk, A., and Rusac, S. (2014), Demographic Ageing and Elderly Care in Croatia. Socijalne teme.; Dobritić, I., ibid.

[17] United Nations, Department of Economics and Social Affairs, Population Division (2017), *World Population Prospects: The 2017 Revision, Key Findings and Advance Tables. Working Paper* No. ESA/P/WP/248.

[18] Eurostat (2018) Population - Baseline projections: demographic balances and indicators. Available at: http://appsso.eurostat.ec.europa.eu/nui/submitViewTableAction.do.

[19] Župarić-Iljić, D. (2016), Emigration from the Republic of Croatia after the Accession to the European Union. Zagreb: Friedrich Ebert Stiftung. Web: http://www.fes-croatia.org/fileadmin/user_upload/FES_Iseljavanje_web.pdf.

[20] Social Welfare Strategy for Older People in the Republic of Croatia for the Period 2017-2020. Web: http://www.mspm.hr/UserDocsImages//Vijesti2017//Strategija%20socijalne%20skrbi%20za%20starije%20osobe%20u%20RH%20za%20razdoblje%20od%202017.-2020.%20g.pdf.

been extended to older people at risk. However, there are indications that deinstitutionalisation is coupled with a lowering of quality standards and available services in both institutional settings, which today have a smaller number of beneficiaries, and in new flats/houses. Thus, as community services are undeveloped, and as resources have to be invested in order to prepare people who have lived in institutions all their lives and who are incapable of taking care of themselves, deinstitutionalisation has brought very mixed results so far.[21] This is visible also in a shortage of personal assistants, in particular for helping children with disabilities to be involved in regular education. Only 40% of children up to 7 years old with severe disabilities are covered by any services, and these are mainly those which civil society organisations are offering.[22] Beside the fact that the number of available personal assistants is very low, the service continues to be offered as a project and not as a right, and is hence not sustainable, and only for 80 hours per month. The proportion of vulnerable older people receiving this service is extremely low. Similarly, and despite the fact that foster care is nowadays much more regulated than it was 10 years ago, research has shown that the rights of people in foster care are often denied, such as basic rights to personal income and the right to privacy.[23] The research showed that quality standards are not adequately regulated, and above all not implemented, and that there is a considerable lack of support from the social welfare system for foster care. As there is still only a limited number of available places in foster care, there is actually no opportunity to choose on the basis of what would be the best solution; and beneficiaries in particular do not have the opportunity to be involved in such decisions.

At the end of 2015 there were 72,054 persons who had filed their applications to be accommodated in county homes, among whom 25,992 were interested in immediate accommodation. As people can file their applications in different homes, and as there is no central register, the number of applications does not provide the real picture, but definitively there is a long waiting list. 78% of new places have been provided by non-state, mainly private, entities since 2003.[24]

A shortage of institutional and community services indicates that LTC is mainly preformed informally, by family and relatives. According to the EC 2015 Ageing Report the number of functionally dependent persons in Croatia was 274,000, of whom about 133,000 did not receive any kind of services/benefits.[25] In addition, even those who get cash benefits also have to rely on informal care to a great extent. We lack basic data or any kind of research insights on informal care and the challenges families and relatives face in such situations. As noted above, the possibilities for taking care leave are very limited. Only 3,742 persons got parent-carer status in 2016. For taking care of elderly and frail persons there are no specific leave schemes. Benefits are also set at a low level. As indicated by the latest Disability Ombudsperson's Report, the amount of personal disability benefit, as with all other welfare benefits, has not been changed in the last ten years. It is very probable that care is performed by other persons engaged by people in need or their families; however, this is left to the unregulated labour market. As there are no data available we lack a clear picture of the number of persons employed. Even in the formal sector, there are not enough data on persons employed, particularly in private elderly homes and for the assistance-at-home service. Though not adequately regulated,

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[21] Disability Ombudsman (2017), Activity Report 2016 – Summary. Available at: http://posi.hr/joomdocs/Sazetak-Izvjesca-o-radu-Pravobraniteljice-za-osobe-s-invaliditetom-za-20xx.pdf.

[22] Ibid.

[23] Buljevac, M., Milić Babić, M., and Leutar, Z. (2016), Respect of Rights for People with Disabilities in Foster Care and Family Homes. Zagreb: Disability Ombudsman Office.

[24] Dobrotić, I. (2016), Development and difficulties of the eldercare system in Croatia. Društvena istraživanja, 25(1): 21-42.

[25] European Commission (2015), *The 2015 Ageing Report. Economic and budgetary projections for the 28 EU Member States (2013-2060)*. Luxembourg: Publication Office of the European Union; Bađun, M. (2015), Informal long-term care for elderly and frail persons. *Institute for Public Finance Newsletter*, No. 100.

the assistance-at-home service offered employment to less employable women, and 1,045 persons were employed for offering assistance at home in 2012. However, as described above, the recent incorporation of this service inside the social welfare system resulted in a significant reduction in the number of beneficiaries and hence the number of people employed.

2.2 Reforms

The assessment of LTC challenges indicates not only that LTC is seriously underdeveloped in Croatia, but also that there are no relevant data and no clear measures for developing LTC in the future, in particular in relation to the balance between cash and in-kind services, quality standards, and employment. Thus it is almost impossible to give any kind of prediction as to how LTC needs will be met in future. This is also reflected in key policy documents quoted so far, such as the 'Social Welfare Strategy for Older People in the Republic of Croatia for the Period 2017-2020' or 'The National Strategy for Equal Opportunities for People with Disabilities from 2017 to 2020'. Such documents lack evidence and clear targets and measures, and remain consequently rather descriptive with very vague commitments. Even when some of the problems (and definitively not all of them) are rightly addressed, there are no clear indicators as to how to overcome them. In addition, it should be noted that such documents often refer to the 'subsidiarity' principle by which care should be performed primarily by people themselves and their families. However, subsidiarity involves measures and mechanisms which will enable families and local communities to take care of their frail members, so the mentioning of subsidiarity in such a context can be seen almost as an excuse for the limited intervention of the state.

2.3 Policy recommendations

In terms of policy recommendations, there is a clear need for more evidence in terms of statistics, indicators and research in order to plan for the future in an evidence-based way. Crucially, Croatia needs an LTC strategy, and above all a strategy that is clear in its objectives, priorities, goals, targets, responsible institutions, financing and is based on timely and appropriate monitoring and evaluation: the proliferation of strategies which simply gather dust[26] does not augur well here. More research is also needed into changing household and family forms and dynamics.

In terms of existing programmes, the right to a carer should be extended to other groups and not limited to children with disabilities. In addition, the balance between work and care should be improved for potential and actual carers, primarily through more flexibility in terms of care leave of varying duration. As stated in many of our other reports, the availability, quality and even geographical access to community-based services in the future is absolutely crucial. Without this, there is no possibility of a proper continuum of care and the current situation will continue, in which families have to choose between often inappropriate and expensive institutional care or simply risking the development of a patchwork of informal care resources, including the family's own. When pilot schemes are successful they should be scaled up and integrated into the statutory social protection system but not, as has happened in the case of home care for older people, in ways which lead to a significant reduction in both workers and beneficiaries. Community care services need to be not only sustainable but also regularly monitored and inspected to ensure consistent quality and not a kind of race to the bottom in terms of standards.

The calculation and regulation of prices for institutional care for older persons is an urgent priority. At the moment, the fact that state/county care is significantly cheaper

[26] Cf. Starc, N. (2007), 'Hundred strategies, one strategem – an inquiry into the Croatia aptitude to strategy production'. Web: http://bib.irb.hr/prikazi-rad?rad=316023 (accessed 22 March 2018). If anything, Croatia's compulsion to produce strategies which are never implemented has increased apace in the last decade.

but in short supply is fuelling the development of a largely under-regulated private sector. Crucially, co-ordination is needed between state and non-state actors and between healthcare and social welfare sectors, at national, regional and local levels. More inter-agency working, regulated through protocols, is clearly needed. In the longer term, reintegration of veterans with care needs into the broad social welfare and health sectors is required. LTC has to become the number one strategic priority across the health and social care sectors, with more resources devoted to it, the development of a continuum of care, improved assessment, case planning and case management, and timely and effective monitoring of quality standards. Innovative financing mechanisms, such as LTC insurance and social investment bonds, could also be options.

3 Analysis of the indicators available in the country for measuring long-term care

Indicators:

3.1 Ageing index and age coefficient (*Indeks staranje i koeficijent starosti*)

The ageing index is the percentage of the population aged 60 and over compared with those aged 0-19. An index of 40% or above indicates an ageing population.

The age coefficient is the percentage of the population aged 60 and over in the total population. A coefficient above 12% indicates an ageing population.

The source of both indicators is the Census of Population, Households and Dwellings (*Popis stanovništva, kućanstava i stanova*), issued by the Croatian Bureau of Statistics (*Državni zavod za statistiku Republike Hrvatske)*. A census is carried out every ten years. The last census was held in 2011 and the next census is planned for 2021. Data are available for every census from 1953 to 2011, and are disaggregated by gender and by region (county level).

Reports with full results in English and Croatian tend to be published 1.5 to 2 years after the census has been carried out.

See: https://www.dzs.hr/Hrv_Eng/publication/2012/SI-1468.pdf (accessed 20 February 2018).

3.2 Life expectancy at age 65, healthy life years, chronic morbidity and perceived health

Healthy life years (HLY) measures the number of remaining years that a person of a given age is meant to live without disability (and with moderate and severe activity limitation). The other indicators follow from this and calculate expected years without/with chronic morbidity and in very good-good/fair/bad-very bad perceived health.

Although data are derived from SILC, they are most usefully presented on the European Health and Life Expectancy Information System Database (http://www.eurohex.eu), with annual data from 1995 to 2014. Data for Croatia for HLY are available annually from 2010. The latest EHLEIS Country Report for Croatia was issued in October 2015 (http://www.eurohex.eu/pdf/CountryReports_Issue9/Croatia_Issue9.pdf, accessed 20 February 2018). A major problem with the data, of course, is that SILC surveys do not include those resident in institutional facilities of one kind or another, including nursing homes.

3.3 Total number of users of state, county and non-state homes for older persons and the infirm (*Broj korisnika domovi socijalne skrbi za starije osobe i teško bolesne odrasle osobe*)

These figures relate to homes which are integrated into the social care system, and can be found in the Annual Report on Homes and Users of Social Welfare (*Godisnje statističko izvješće o domovima i korisnicima socijalne skrbi*) produced by the Ministry of Demography, Family, Youth and Social Policy. The last report, available as an Excel file, was produced for 2016. The numbers are only disaggregated in terms of the source of payment and whether or not placement in the home was as a result of a decision by a CSW. They can be found on the Ministry's website although the search term makes it much more difficult than previously to access these. Currently, on the web site, annual reports from 2005 to 2016 can be downloaded. (Web: http://www.mspm.hr/dokumenti/10 - accessed 20 February 2018).

3.4 Gerontological and Public Health Indicators of Health Protection in Croatia and the City of Zagreb (*Gerontološko javnozdravstveni pokazatelji zaštite zdravlja starijih osoba u Hrvatskoj i Grada Zagrebu*)

This compendium, produced every three years, is a major source of information, including indicators, relating to the care of older people in Croatia (web: http://www.stampar.hr/sites/default/files/sluzbe/docs/2016/geron_ljetopis_2016_web.pdf - accessed 20 February 2018). Containing 846 Figures and 160 Tables over more than 1,300 pages, the document includes introductions, including a broad outline of the indicators used, in English and Croatian. Some data are derived from the census but others are based on annual administrative data and are usually presented from 2010 to 2015. In terms of LTC, some of the most useful indicators include:

1. hospitalisations and hospital days for the elderly aged >65, 2010-2015 (4.3)
2. leading causes of hospitalisation in the elderly by sex, 2010-2015 (4.6)
3. number of persons aged >65 experiencing difficulties in performing activities of daily living, 2011 (5.4 et seq.)
4. physical disability and impairments in persons aged >65, 2016 (6.1).

Sections 10 and 11, although based on small sample sizes, offer some quality indicators in relation to LTC, although the term is not used; rather the tables refer to 'quality indicators in healthcare and social welfare for the elderly' or 'gerontologic-public health analysis of selected old people's homes'.

3.5 Missing indicators

From this cursory overview, it should be clear that a number of potential indicators for assessing LTC are not readily available in Croatia, although they may be available through either unreleased administrative data and/or surveys. The most important of these include:

- number and structure of LTC beneficiaries
- number of home care hours received
- shortfall in services (by county)
- beneficiary satisfaction with services
- number and qualifications of paid staff working in LTC
- number of LTC beneficiaries subject to a care plan from a CSW
- expenditure on LTC per beneficiary
- extent of unmet need for LTC.

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