OECD Health Policy Studies

Improving Long-Term Care in Croatia

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Foreword

Croatia is ageing quickly: the share of the population aged 65 years and over is expected to grow from 21% in 2019 to 31% in 2050, remaining above the average for OECD countries. As people get older, they will need help with ongoing medical care, everyday activities such as washing and dressing, household activities such as cleaning and cooking, as well as with social activities such as going out for a walk. This help is part of what is commonly termed long-term care (LTC).

Croatia has traditionally placed a strong emphasis on family care, but with changing family characteristics, the long-term care framework needs to adapt. The Croatian legislation states that care to older people belongs to the family sphere first. Many older people who struggle to carry out everyday activities often find informal support in their spouses, children, friends, and neighbours. Unpaid, family care often comes with costs. Families and friends that provide support to dependent older individuals are more likely to experience declines in their physical health and their mental well-being and are more likely to drop out of the labour market or reduce working hours. Income levels of family carers decrease as a result. Furthermore, population ageing coupled with changing social norms and structures (e.g. household composition and female labour market participation) limit the pool of potential family carers available to older people today and in the coming years. Smaller, more geographically dispersed family structures will make this issue more acute as help from children could be more difficult to come by in the coming decades.

This report examines the provision of long-term care in Croatia. It analyses the care needs of the population and current gaps. It points to shortcomings of the system in terms of access to benefits and services, equitability, and affordability. The situation of family carers, their needs and support they receive are also described. The report proposes directions for reform to strengthen the formal component of the long-term care system, with the view that it should be developed to offer affordable alternatives to family care, and to improve direct support to family carers. Such policy options build on analysis of good practices from other EU and OECD countries.

This report brings together previous OECD work carried out in 2019-2021 for the Government of Croatia, with the support of the European Commission. Since the analysis was carried out, the Government of Croatia has also made some commitments to improve the situation. In 2022, the Government of Croatia modified the Social Welfare Act to include a benefit for family carers reflecting the analysis and recommendations outlined in this report. Additionally, the Operational Plan for the Development of Long-Term Care 2023-2027 of the Ministry of Health and the Ministry of Labour, Pension System, Family and Social Policy is currently being developed to improve the co-ordination of health and social services and investments in the development of non-institutional services are planned to enable older people to improve their quality of life and stay in their own home as long as possible. Finally, Croatia is planning an Ordinance on a unified methodology for assessing needs.

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Executive summary

The Croatian long-term care system is fragmented and public social support provides a lower coverage than in many other EU countries. Currently, Croatia does not have specific legislation on long-term care, nor a comprehensive system, but provides a range of social benefits and services for people with disability with different need assessments and eligibility criteria. These include two cash benefits (assistance and care allowance and personal disability allowance), as well as other in-kind services, namely home care services (home assistance allowance) and care in residential settings (nursing homes, family homes and foster families).

Overall, 5% of older people receive long-term care benefits at home, compared with 8% on average across 15 European countries with available data. At least 3% of older people lived in a residential care setting in Croatia in 2018, compared with an OECD average of around 4%. Even when considering LTC beds in hospitals, the overall rate of LTC beds remains lower than in most other EU countries. In contrast, about one-third of older people may have long-term care (LTC) needs, based on limitations in activity of daily living (ADL) and instrumental activities of daily living (IADL). This share is well above the EU average and there are large variations across the country.

The Croatian LTC system is underfunded. LTC expenditure is among the lowest in the EU as a share of GDP. In addition, benefits and services are based on strict eligibility criteria on income, limiting public support for home care and residential care. When those in need are entitled to public support, it covers only a fraction of the total costs, leaving individuals with high out-of-pocket expenditures, except in the case of institutional care. Those with moderate and severe needs at home are not sufficiently covered by public support and a large share of them risks living in poverty. Almost 30% of older Croatians are below the income poverty line, one of the highest rates among EU countries. Even though nearly two-thirds of older Croatians own their dwelling, options for selling assets to pay for long-term services are limited because only 5% of older people who live alone own their dwelling.

Family carers provide the bulk of care. According to a survey conducted by the OECD in Croatia in 2020, family carers are concentrated among women who provide support to their parents, in-laws, or spouses. Nearly 75% of carers are women and the mean age of carers is 62 years old. About 70% of carers do not work, of which close to 45% of carers are retired. An estimated half of carers live below the poverty line. Most carers provide help every day, and the rest mostly on a weekly basis: About 60% provide personal care, help with household chores and other types of (non-medical) care, amounting to a median of 45 hours of care per week. Caregiving takes a physical and mental toll on family carers. Family carers with care recipients who are not mobile or with advanced dementia have the heaviest burden.

Some avenues exist to strengthen LTC at home and in the community in Croatia:

- **Croatia should reform its social benefit framework to make it more coherent and less fragmented.** To make the ***social benefit framework more coherent and less fragmented***, Croatia should ensure a single entry-point for the provision of cash benefits and public services, based on one standardised need assessment. The current LTC provision generates inequalities across the country and leads to duplication. A gradation ladder of LTC needs with users of LTC

placed on the ladder into tiers depending on the severity of their condition and receiving higher or lower benefits accordingly could be introduced. There is scope for more co-ordination and greater opportunities for more efficient use of resources. The Zaželi programme overlaps with home assistance (in-kind) benefits, especially in the remote areas in Slavonian counties and in the islands. Having a standard, nation-wide need assessment and clarifying eligibility criteria for this programme would help expand home care provision nationwide by co-ordinating entitlements across the different benefits. Similarly, Croatia has little control over how public LTC home spending is used, because cash benefits represent the bulk of home help. Additional requirements for the benefits could be considered, or, alternatively, the use of vouchers to ensure a broader coverage for long-term care.

- **Croatia should explore options to promote other care options and could leverage on wealth to finance LTC**. To ***expand the offer and equity of the system***, Croatia needs to incentivise the supply of services while looking at financing options. The need assessment and the gradation ladder would ensure that residential care capacity is used by people with the most severe LTC needs, provided Croatia expands public support to home LTC for people with moderate LTC needs. Foster care and family homes have the potential to be an alternative to LTC facilities for care recipients with moderate-to-severe LTC needs and could be further promoted. For the benefit, there could be stricter asset-testing and less stringent criteria on income, which could help expanding the coverage and the generosity of the provision. Croatia could also consider using the primary residence for asset-testing but, as cashing the value of primary residence is often difficult, deferred payment options through home equity programmes could be considered in parallel.
- **Croatia should revise the carer status for people with disability to cover people over 65 or introduce a new cash benefit to support further the family carers who provide LTC.** The new cash benefit should compensate for the opportunity cost of family carers providing intense care, rather than offer a wage. In addition, the cash transfer should be combined with in-kind benefits (training and respite care). The amount of the cash benefit should be aligned with the current carer's status for people with disability (which does not cover people over 65), the minimum wage, and the poverty line, to ensure decent living conditions and fairness with other carers.

1 Croatia has a fast ageing and vulnerable population

This chapter contextualises the current and pressing challenges of the long-term care system in Croatia. It shows that the population is ageing fast and that long-term care needs are increasing. This chapter also discusses unmet needs.

This report uses data from SHARE Wave 6 (Börsch-Supan, 2020[1]) and 7 (Börsch-Supan, 2020[2]).[1]

In Croatia, the demand for long-term care (LTC) is set to increase, driven by population ageing. The household structure shows that most older people are living with, or close by, family members, reducing loneliness risks and indicating a potential supply of family carers. Older Croatians have one of the highest poverty rates among EU countries. Many do not have the income nor the wealth to pay for long-term care. In addition, the supply of health care received at home – which could help improve health in older ages and delay LTC needs – is already low and insufficient in Croatia, compared with most other EU countries.

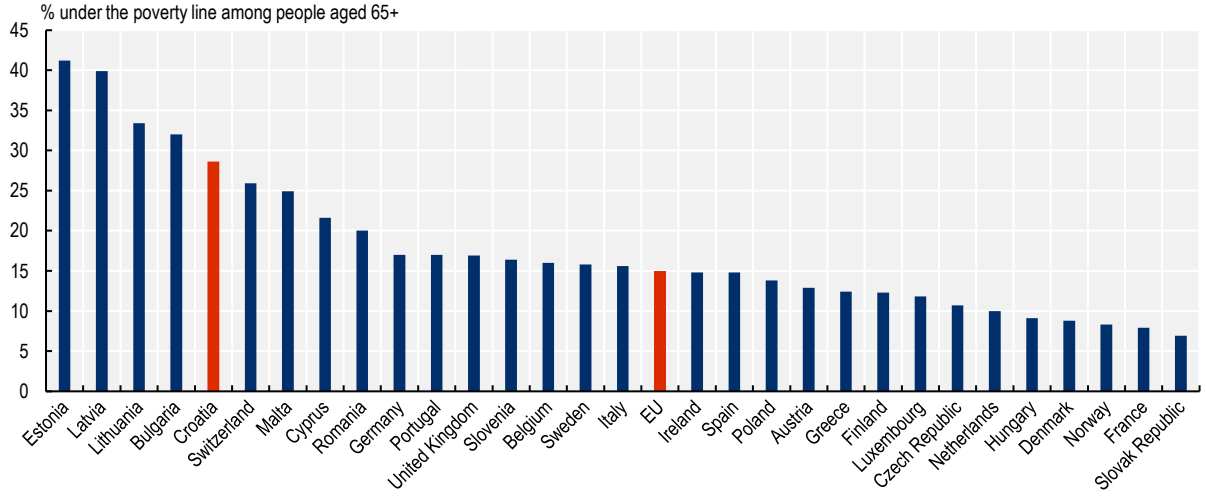
Setting the scene: An ageing population and vulnerable population

The Croatian population is ageing quickly. The share of older people will continue to rise strongly in the next 30 years. By 2050, 31% and 11% of the population will be aged respectively over 65 years old and over 80 years old. The share of Croatians aged over 65 will be especially high compared with other European countries: it will rank in seventh position behind Greece, Portugal, Italy, Lithuania, Spain, and Latvia.

Health problems and disabilities are common at older ages. Croatia has made major progress in health in the last decades, achieving gains in life expectancy that places Croatia on par with many other EU countries, although below the EU average. The gender gap in life expectancy is persisting and stark, with women living six years longer than men. Not all additional years of life are lived in good health. After age 65, in Croatia, more than 70% (or 12.5 years) of years of life was lived with some health problems and disabilities, a share that was much higher than the EU average of 50% (or 10 years) in 2017 (OECD/European Observatory on Health Systems and Policies, 2019[3]).

Many Croatians would not have the income nor the wealth to pay for long-term care. A sizeable share of older people would be at considerable risk of poverty if they had to make out-of-pocket payments towards the costs of LTC. Almost 30% of older Croatians were below the poverty line in 2017, one of the highest shares among EU countries (Figure 1.1). Despite a high ownership rate, most of older people living alone cannot cash their house to pay for LTC services. In Croatia, about 65% of older people report owning their primary residence, but only 5% of older people living alone own their dwelling, based on the Survey of Health, Ageing and Retirement in Europe (SHARE).

Figure 1.1. The poverty rate among older Croatians is fifth highest in EU



Note: The indicator is defined as the share of persons with an equivalised disposable income below the poverty line, which is set at 60 % of the national median equivalised disposable income (after social transfers). The EU average is weighted.
Source: Eurostat Database (data refer to 2017).

Most older Croatians live with family members, but 30% live alone. Over half of older people live with a partner or with a partner and other relatives who can potentially provide family care. Almost 20% of older people live with other people than their partner – for example, their children. The remaining 30% of older people live alone in Croatia, a rate similar to the EU average.

Data suggests that families play a strong support role for older people in Croatia. About 17% of low-income older people lived in overcrowded dwelling in 2017. In comparison, it was 10% across EU countries, suggesting that many older Croatians live with children and other relatives for economic and long-term care reason. In 2017, 60% of widows lived alone, although this did not necessarily mean that they lived far away from family members. About one-third of widows living alone had at least one child that lived less than 5 kilometres from them.

When turning to the geographic distribution of older people, Zagreb and its surroundings counts the largest number of older people. In 2017, over 814 000 people were aged 65 years and over, of which slightly more than 200 000 people were aged 80 years and over. In Zagreb, the capital, there were almost 150 000 people aged over 65 in 2017 and in the surroundings of Zagreb, Zagrebacka, about 57 000 people. In the second biggest city's province, Splitsko-dalmatinska, the number was about 85 000 people aged over 65. In contrast, in Licko-senjska, Pozesko-slavonska and Viroviticko-podravska, there were less than 15 000 people aged over 65.

However, the share of older people is slightly more concentrated in the southern coastal provinces: the share of older people is 25% in Licko-senjska and 24% in Sibensko-kninska. In comparison, the share of older people in Grad Zagreb is 19%. Overall, a sizeable share of older Croatians (38%) reported living in rural areas or villages.

As in all other EU countries, most older people are women. About 60% and 68% of people aged over 65 and 80 were women, respectively. While the shares among people aged 65 years and over were even across counties, those among people aged 80 years were less so. In Krapinsko-zagorska and Medimurska, the shares were at almost 75%, while they were only around 65% in Licko-senjska and Zadarska. Compared with men, older women are more likely to be lower educated, poor, to live alone and to be widowed.

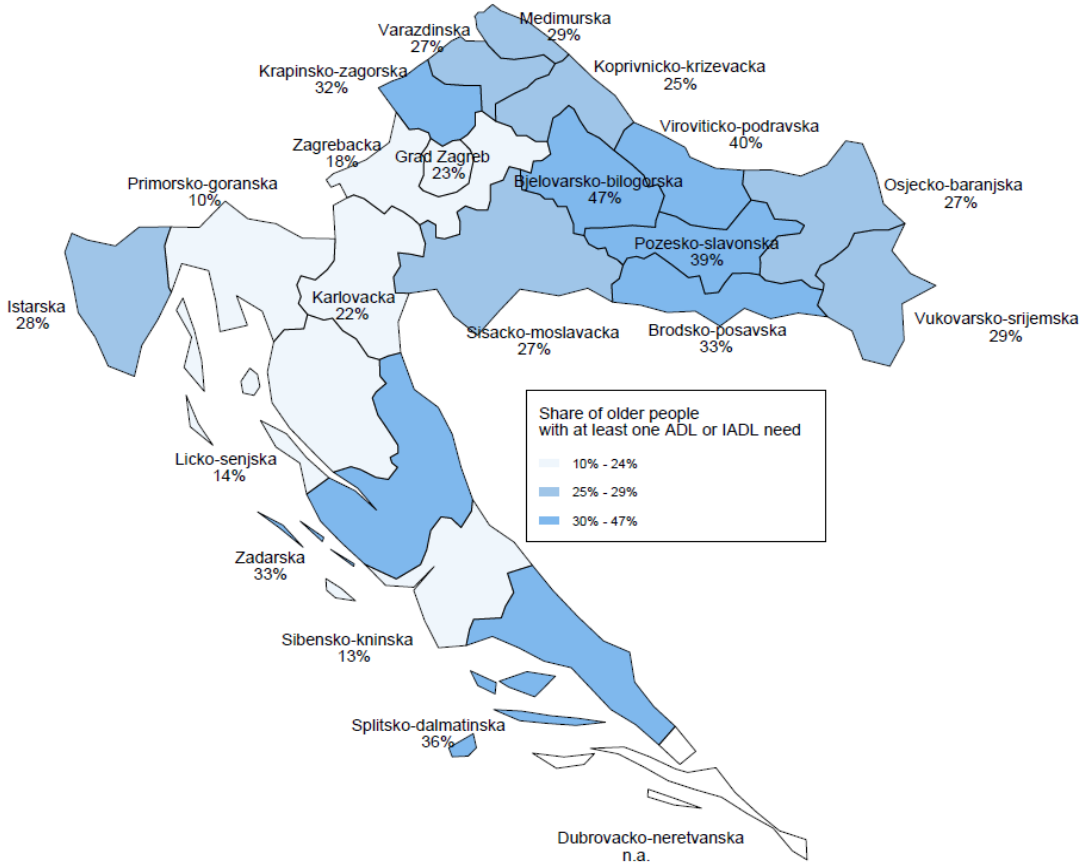
The demand for long-term care: A substantial share of older people has needs

While there is no single best measurement of LTC needs, nor an internationally consensus on "gold standard" to measure LTC needs, they are typically measured by assessing whether an individual requires help with basic activities of daily living (ADL), such as dressing or showering, and instrumental activities of daily living (IADL), such as preparing hot meals or managing money.

In Croatia, 18% of older people reported at least one limitation in ADL, 29% at least one IADL limitation and 32% at least one ADL or IADL limitation in 2017, according to the Survey of Health, Ageing and Retirement in Europe (SHARE). Overall, these rates are slightly higher than the EU average but are within the range of rates of Central and Eastern European countries.

The share of older people reporting limitations differs across counties, although small sample sizes limit interpretation. The share of older Croatians reporting at least one limitation ranged from under 20% to about 40% in 2017 (Figure 1.2). It was higher in the North-East of the country, while the rates were often lower in the West. Bjelovarsko-bilogorska, Brodsko-posavska and Splitsko-dalmatinska stood out as the counties with the most vulnerable older people among the 15 counties where data were available for the health, social and economic dimensions of LTC needs.

Figure 1.2. Share of older people with at least ADL or IADL limitations



Note: Small sample sizes – caution is required.
Source: Survey of Health, Ageing and Retirement in Europe (data refer to 2017).

In Croatia, LTC limitations increase with age and older women report limitations more often than men. Almost 40% of older women report at least one ADL or IADL limitation, compared with 23% for older men, and the gender gap is larger than the EU average of 10 percentage points. Limitations increase strongly with age especially for women. Two thirds of women aged over 80 years old reported at least one ADL or IADL limitation in the Croatian microdata sample, a share well above the EU average.

Differences in the prevalence of LTC limitations exist also between socio-economic groups, whether measured by education, income, home ownership and wealth. For instance, among the 20% poorest older Croatians the rate of LTC limitation is 40%, compared with 27% for the richest 20%, based on SHARE data on income and ALD/IADL. The social dimension also matters when looking at LTC limitations. Over 35% of older people living alone reported at least one ADL or IADL limitation, compared with 25% for those living with a spouse or a partner in 2017.

Because not all ADL and IADL limitations translate into LTC needs, cases of low, moderate, and severe limitations were defined to approximate the general level of severity of LTC needs. About 21% of older people with limitations in daily activities reported severe limitations, 33% reported moderate limitations and 46% reported low limitations in 2017.

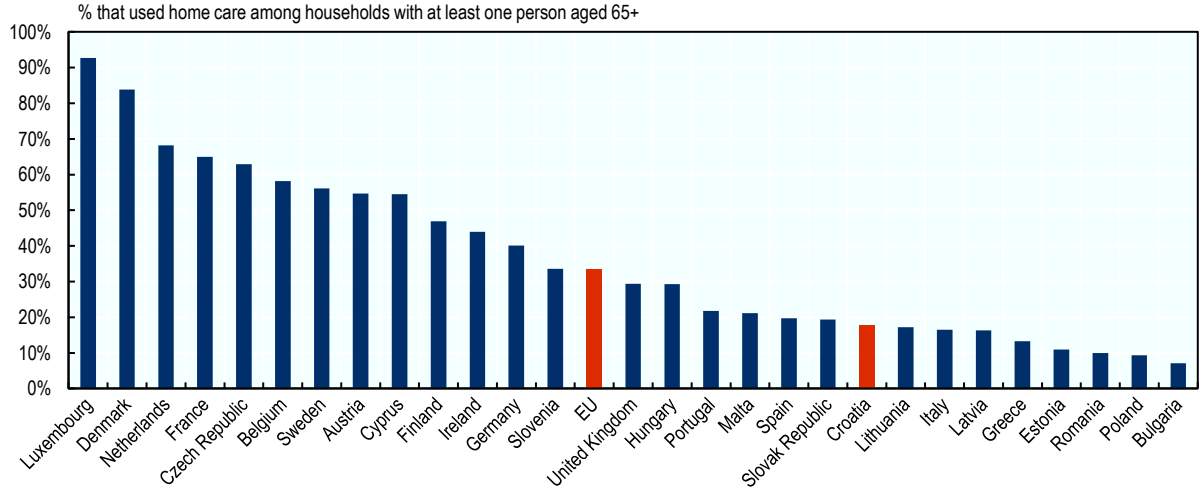
Low access to home health care for older people does not help preventing or delaying LTC needs

As health care needs and LTC needs are partly interlinked, health care provided at home can help prevent or delay LTC needs. Data from the European Union Statistics on Income and Living Conditions (EU-SILC) survey[2] indicate that the supply of health care received at home is already low and insufficient in Croatia, compared with most other EU countries.

In 2018, about 69 700 older Croatians received home assistance from nurses, technicians and physiotherapists, a rate of 86 per 1 000 older people. Older beneficiaries of home health care are frequently bed-ridden. About 44% of them are immobile, 31% suffer from severe mobility limitations and 5% are considered as near the end of life. The geographic variation is large, ranging from less than 20 per 1 000 older people in Dubrovačko-neretvanska, Virovitičko-podravska, Šibensko-kninska and Grad Zagreb to about two hundred or over in Ličko-senjska, Varaždinska, Istarska and Osječko-baranjska.

Compared with most other EU countries, access to home health care is low. Only 18% of households with an older person used formal home care in 2016 (Figure 1.3). This rate was well below the EU average of 34% and other countries such as Hungary (29%) and Slovenia (34%).

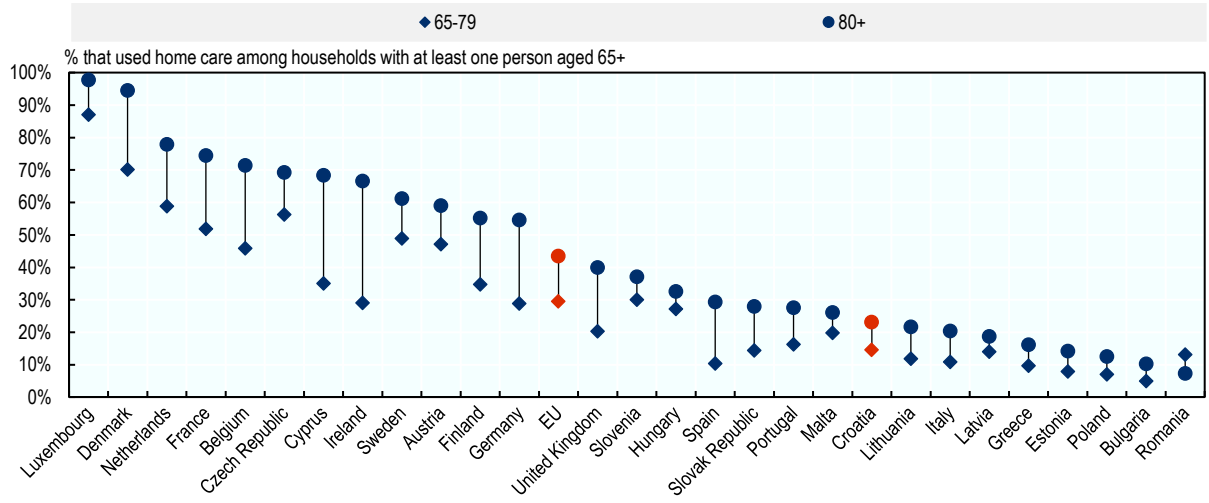
Figure 1.3. About 18% of households with older people used home health care in Croatia



Note: The EU average is weighted by sample weights.
Source: EU-SILC (data refer to 2016).

The rates of home care use suggest there may be gaps in the availability of home care use for those in need in Croatia. Home care use ranges from 15% among households with a respondent aged between 65 to 79 years old to 23% among households with a respondent aged over 80 years old (Figure 1.4). However, this increase of home care use is small in comparison to the strong association between LTC needs and ageing. In comparison, 19 other EU countries have a larger difference of home care use between the two age groups.

Figure 1.4. The increase of the rate of home health care use as people age is small in Croatia

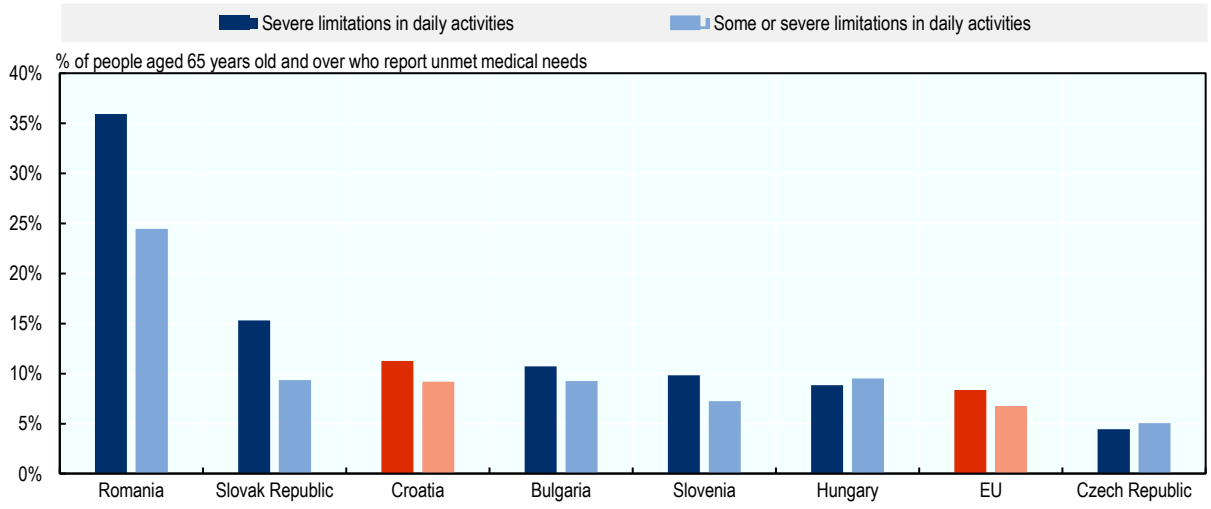


Note: The EU average is weighted by sample weights.
Source: EU-SILC (data refer to 2016).

Data on the rate of home care use by widowhood status seem to corroborate this suggestion. Being widowed is strongly associated with reporting LTC needs. Yet, the rate is only 16% for households with a married respondent and 18% for households with a widowed respondent in Croatia. In comparison, the average rates in the EU are respectively 25% and 40%. The gap in Croatia is smaller than in most other EU countries, suggesting again that the volume of home care use is lower across the board in Croatia.

Unmet medical needs among older people who report some or severe limitations in their daily activities is high. According to EU-SILC, about 7.3% of Croatians aged 65 years and over reported unmet medical needs in 2017, a level 1.6 times higher than for those aged 15 years old and over (3.1%) and much higher than the EU average of 3.6%. Unmet medical needs could have a knock-on effect on LTC needs, as chronic conditions are strongly associated with LTC needs. At 11%, the rate of unmet medical needs is even higher among those who report severe limitations in daily activities (Figure 1.5). The rate is similar in Slovenia, Hungary, and on par with the EU average.

Figure 1.5. Eleven percent of older Croatians with severe limitations in activities report unmet medical needs



Note: The EU average is weighted by sample weights.
Source: EU-SILC (data refer to 2017).

Distance to health care services and financial barriers are the main reasons for unmet medical needs among older people in Croatia. Among people reporting limitations, 50% of unmet medical needs are due to distance and over 20% are due to financial barriers in Croatia, although caution is needed because of small sample sizes. In comparison, most unmet medical needs across EU countries are first mainly due to financial barriers followed by waiting times.

2 The supply of formal long-term care is low and uneven in Croatia

This chapter discusses the long-term care system in Croatia. It presents the social benefit framework composed of cash and in-kind benefits that support older people at home and in long-term care facilities. It assesses the coverage of these benefits. It studies the eligibility criteria to understand their impact on the benefits' coverage. Finally, it discusses the generosity of the benefits, the affordability of long-term care and the estimated total long-term care expenditure.

Given growing long-term care (LTC) needs, higher than EU-average poverty rates and the low supply of health care at home, public support to formal LTC will continue to play a fundamental role in Croatia. The social sector is the main building block of such public support. However, the social sector faces challenges that hinder its capacity to meet the growing LTC needs. The social benefit framework comprises a series of benefits that lack harmonised eligibility criteria and have strict means-testing rules instead of a coherent and comprehensive system. As a result, there are many gaps in coverage and equity. In addition, the LTC system is underfunded: the social benefits are not generous, formal LTC is unaffordable for most people and the estimated LTC expenditure as a share of GDP is among the lowest of EU countries.

Public support for long-term care is fragmented and based on disability benefits

Croatia does not have a specific legislation on LTC. Instead, the division of roles and responsibilities in the legislation stems from historical legacies between the social and the health sectors. Responsibilities are shared between a range of public authorities, including the Ministry of Labour, Pension System, Family and Social Policy, the 136 Social Welfare Centres, the Ministry of Health, and the Croatian Health Insurance Fund. This split is accompanied by a vertical division of responsibility at different institutional levels (national and counties). In addition, many municipalities and NGOs provide day care and other LTC services, but the paucity of data limits the collection of information.

The Ministry of Labour, Pension System, Family and Social Policy oversees the legislation of social care, the network of social care entities and monitors the social welfare system. In 2020, the Ministry of Demographics, Family, Youth and Social Policy and the Ministry of Labour and Pension System merged into the Ministry of Labour, Pension System, Family and Social Policy.

The LTC public support comprises seven benefits that are in-cash or in-kind. Two are in-cash benefits – the assistance and care allowance and the personal disability allowance – and the others are in-kind services of help at home (the home assistance allowance and the organised housing[3]) or in residential settings, such as nursing home, family homes and foster families. These benefits and allowances are funded by the state with two exceptions. Counties are responsible for the operating costs of homes for older people and people with disability. They also developed their nursing homes that they fund entirely, although some sources of revenue can originate from the state.

The coverage of social benefits is low

The Croatian public support for older dependent people at home is mainly based on the two cash transfers oriented towards people with disability. These assistance and the disability allowances have different objectives. The assistance and care allowance aims to cover the care needs of people with disabilities, while the personal disability allowance intends to provide a basic income to people with disability for any daily life need, which can help to meet care needs but also other daily needs. Almost 4% of older people received the assistance and care allowance and 0.7% of older people the disability allowance in 2018. About 31 780 older people benefited from the assistance and care allowance – 45% of all beneficiaries of all ages – while about 5 660 older people received the personal disability allowance – 19% of all the recipients (Table 2.1).

Access to the LTC cash benefits is based on one standardised need assessment across the country, ensuring equitable access throughout the country. The Institute for Expertise, Vocational Rehabilitation and Employment of Persons with Disabilities performs the assessment. This institute was under the authority of the former Ministry of Labour and the Pension System and is now in the jurisdiction of the Ministry of Labour, Pension System, Family and Social Policy.

Both transfers are not very generous relative to the minimum wage: the personal disability allowance represents up to 40% of the minimum wage and the assistance and care allowance between 11% to 16% of the minimum wage. The assistance and care allowance can be provided fully or partially depending on the level of disability. Such cash transfers have the advantage of lower administrative and logistical costs and are quick to implement or modify. However, there is relatively little control over how the money is spent by beneficiaries.

Table 2.1. Number of recipients of benefits and services and rate per 1 000 older people

Benefits	Number of older people	Rate per 1 000 older people
Home assistance (in-kind)	3 940	Five per 1 000
Assistance and care	31 780	Thirty-nine per 1 000
Personal disability	5 660	Seven per 1 000
Accommodation	24 445	Thirty per 1 000
Home health care from nurses and physiotherapists	69 654	Eighty-six per 1 000

Note: Beneficiaries of foster care under age 65+ are included in the *Accommodation* category. Data refer to 2018.
Source: OECD Questionnaire on health and social care for older people, 2019-20 (Ministry of Demographic, Family, Youth and Social policy), GODIŠNJE STATISTIČKO IZVJEŠĆE O DOMOVIMA I KORISNICIMA SOCIJALNE SKRBI U REPUBLICI HRVATSKOJ U 2018. GODINI, GODIŠNJE STATISTIČKO IZVJEŠĆE O DRUGIM PRAVNIM OSOBAMA KOJE OBAVLJAJU DJELATNOST SOCIJALNE SKRBI I KORISNICIMA SOCIJALNE SKRBI U REPUBLICI HRVATSKOJ U 2018. GODINI.

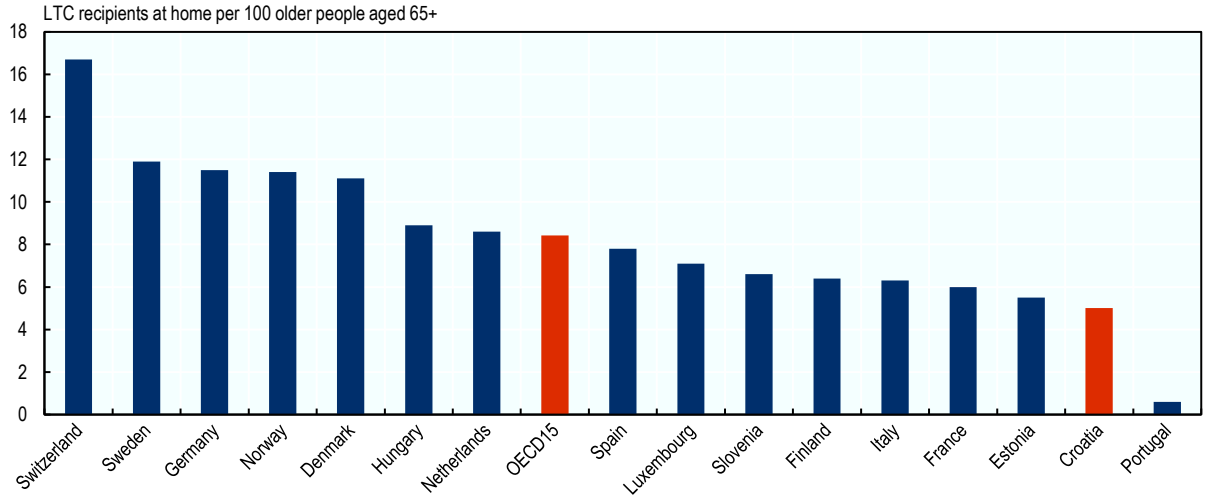
The age profile of the cash benefit recipients has evolved in recent years. There was a small drop of about 1 850 recipients of the assistance and care allowance between 2018 and 2016 entirely driven by a decrease of recipients aged 75 years and over. The number of beneficiaries aged 65-74 years old of the assistance and care allowance has increased over the same period. As for the disability allowance, the number of beneficiaries increased by about 3 640 recipients over the same period. The strongest increase is among the recipients aged 75 years and over. This increase is logical: the disability allowance was designed for adults with disability, before population ageing fastened, and now the pool of eligible people with severe disabilities is increasing with population ageing.

In-kind home assistance remains limited in coverage. Home assistance covers house chores, personal care, preparation of meals and other daily needs. About 0.5% of older people Croatians received in-kind home assistance in 2018. Contrary to the beneficiaries of the cash benefits, the number of beneficiaries increased among all age groups between 2016 and 2018. The services provided by the in-kind benefit were mostly related to housework (36%), food (25%), personal hygiene (12%) and other personalised daily needs (27%) in 2018. Over half of recipients were women, but an increasing number of men were receiving home assistance. The number of female recipients decreased, driven entirely by those aged 75 years and over, while the total number of recipients aged 65-74 increased over the period 2016-2018.

The rates of home assistance beneficiaries are well lower in all counties than the rates of the assistance and care allowance and they are much more uneven across counties. This uneven distribution reflects partly different eligibility criteria (see next section). The counties with most home assistance beneficiaries are Osječko baranjska, Sisačko moslavačka, Ličko senjska and Karlovačka.

Overall, the rate of LTC beneficiaries at home per 100 older people aged 65 years and over was five per 100 older people in Croatia, compared with eight on average across 15 European countries (Figure 2.1).

Figure 2.1. The rate of LTC recipients at home is lower in Croatia than across 15 European countries



Note: Data refer to 2017, except for the Netherlands and Slovenia (2016) and Croatia (2018). For Croatia, the home help recipients are those aged 65 years and over receiving the assistance and care allowance, the personal disability allowance, and the home assistance service. The number of beneficiaries is overestimated as people can be eligible for home assistance and one of the two cash benefits (the personal disability allowance of the assistance and care allowance).
Source: OECD Health Database 2020 and OECD Questionnaire on health and social care for older people, 2019-20 (Ministry of Demographic, Family, Youth and Social policy).

To partly offset the lack of home care services and to promote female employment, the Ministry of Labour and Pensions developed the Zaželi programme with associations and local authorities and the financial support of the European Social Fund. The programme hires women to work as home assistants of people with disability and older people in rural areas and islands where they are extremely hard to reach and where unemployment rates are higher than the Croatian average. The programme has two main objectives: reduce poverty among the most vulnerable people living in underprivileged areas and fill in a gap in the provision of home help. To be eligible, women must be unemployed and have only a primary or secondary education (up to high school degree). Women are guaranteed a full-time contract of up to 30 months at the minimum wage. Employed women receive a training up to a cost of HRK 7 000 per woman to increase their future employability and reduce the poverty risk (Christiaensen et al., 2019[4]). The choice of the type and area of the training is at the discretion of employed women. The duration of the training must be between 2 months and 6 months and can be taken up during or after the employment period (see Annex B for more information on training activities).

The European Social Fund has funded the programme since 2014 and invested more than HRK 1.8 billion in over 750 contracts with associations and local authorities (European Social Fund +, 2022[5]). In 2019, close to 4 000 people had been assisted through the programme. The counties that had received most funds by 2019 were Osjecko-baranjska, Sisacko-moslavacka and Grad Zagreb. Social Welfare Centres identify older people in need of LTC and ensure that those receiving help through the programme are not also similarly supported by other public or subsidised services. For instance, Sisačko moslavačka is one of the counties with the highest numbers of women employed in the Zaželi programme since December 2017, and only five older people received the home assistance benefit in 2018, compared with 354 in 2015. The decrease may be partly related to the Zaželi programme. Eligibility criteria are not defined in the Guidelines for Applicants; recipients are selected based on a joint decision of the applicant (municipality, NGO, etc.), the Social Welfare Centres and other partners of the applicant, if any.

In Croatia, residential care is provided in nursing homes, family homes and foster families. Specifically, residential care is named *accommodation* in Croatia. The main providers of residential care are care institutions. They are administered by the state, counties or by private organisations such as non-governmental organisations (NGOs) or religious communities. Family homes and foster care families also provide residential care in private households for older people. Family homes and foster care for older people are uncommon options for residential care in EU countries. Family homes also exist in France, Belgium, and Ireland, but they are not well-developed.

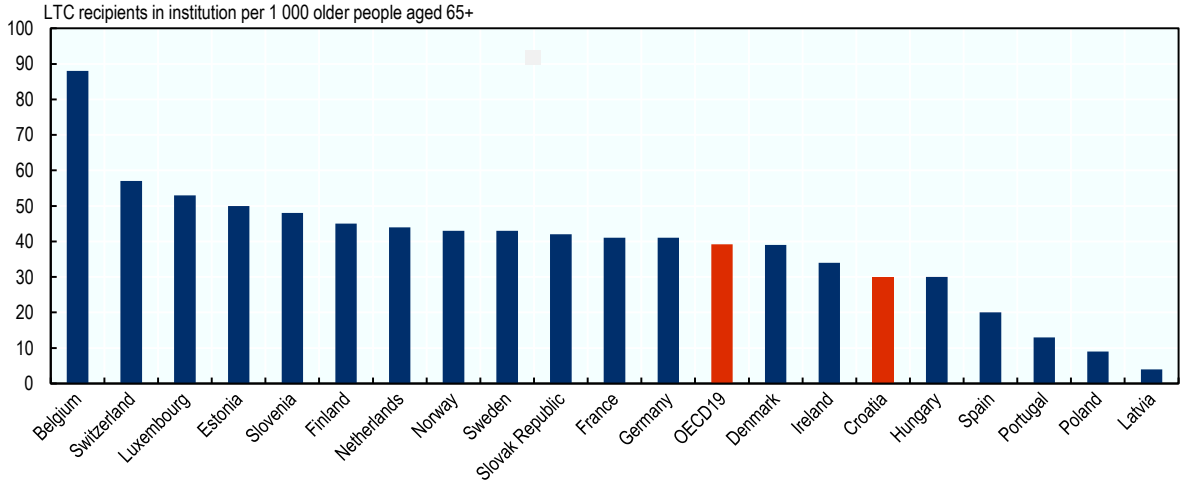
Over 24 400 older people (and children) stayed permanently in an *accommodation*, of which about 10 915 older people lived in a county nursing homes in 2018. Over 5 700 older people stayed in non-state non-county homes and family homes cared for about 5 500 users. Over 2 100 older people and children lived in foster families. In addition, state home for older people took care of 168 older people in 2018. Furthermore, state home for mentally ill people cared for 1 125 older people with a mental health diagnosis.

State and county nursing homes operate at full capacity, leaving no extra beds for interested users, including those eligible for public support. In 2018, the occupancy rate reached 93% and over 5 000 older people submitted a bed request that was not realised. Older people are particularly interested in county nursing homes because the price is much lower than the real market price (Bađun, 2017[6]). In comparison, close to 700 bed requests were not met in non-public nursing homes, although the occupancy rate was also slightly lower (86%).

The distribution of nursing home is highly uneven across Croatia: almost half of the nursing homes were concentrated in only three counties in 2015. The city of Zagreb counted 22% (35) of the nursing homes, Split-Dalmatia 11% (18) and the County of Zagreb (17). The remaining nursing homes (57%) were spread relatively evenly across the other 18 counties.

When turning to the coverage in residential care, EU comparisons suggest that the number of residents is low. Overall, at least 3% of older people lived in institutions in Croatia in 2018, compared with an OECD average of around 4% (Figure 2.2). Even though the share of people with LTC needs differs across countries, this rate likely indicates that Croatia has not developed residential care as much as other EU countries.

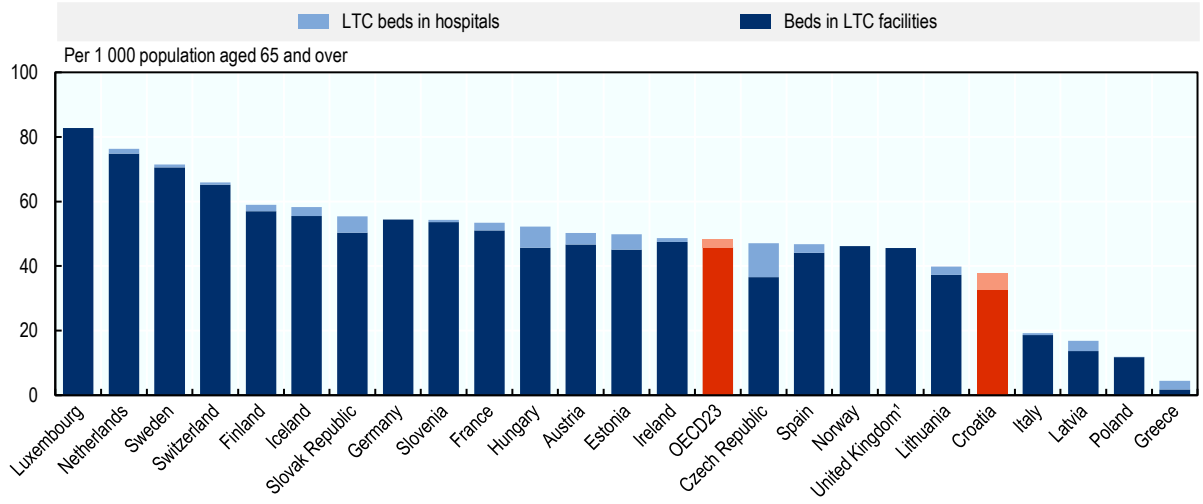
Figure 2.2. The rate of LTC recipients in institutions is lower in Croatia than across OECD countries



Note: Data refer to 2017 or latest year (2018 for Croatia). In Croatia, institutions entail all types of residential care, including foster homes (users aged 65+ but also children) and family homes.
Source: OECD Health Database 2020 and OECD Questionnaire on health and social care for older people, 2019-20 (Ministry of Demographic, Family, Youth and Social policy).

Even when factoring in LTC beds in hospitals, the overall rate of LTC beds (in residential care settings and hospitals) remains lower than in most other EU countries (Figure 2.3). Croatia had the third highest rate of long-term care beds in hospitals among EU countries, at 101 per 100 000 inhabitants in 2017. Long-term care beds in hospitals are for patients requiring long-term care due to chronic impairments and a reduced degree of independence in activities of daily living, including palliative care. They encompass beds for psychiatric and non-psychiatric curative (acute) care, from general hospitals, mental health hospitals and other specialised hospitals (Eurostat, 2019[7]).

Figure 2.3. The density of LTC beds is lower in Croatia than in most other OECD countries



Note: The three types of residential care are included for Croatia (nursing homes, foster homes (users aged 65+ but also children) and family homes). For foster families and family homes, data refer to the number of users and not the number of beds.1. The number of long-term care beds in hospitals is not available for the United Kingdom.
Source: OECD (2019[8]), *Health at a Glance 2019: OECD Indicators*, https://doi.org/10.1787/4dd50c09-en for all countries except Croatia, OECD Questionnaire on health and social care for older people, 2019-20 (Ministry of Demographic, Family, Youth and Social policy) for data on Croatian institutions and Eurostat Database for data on Croatian hospitals.

The low coverage is driven by eligibility criteria that limit coverage to those with low means

In Croatia, eligibility to long-term care support is asset-tested and income-tested. This applies to residential care and home care. Access to either depends on both income and asset-tests with a steep income-testing. For the assistance and care allowance, the income threshold of a single person represented 53% of the minimum wage and for the personal disability allowance, it was 40% in 2020, although not all incomes are considered. In addition, the amount of the personal disability allowance varies based on income, or in other words, the level of the personal disability allowance is income-tested. Asset-testing covers only non-primary residence in Croatia. In comparison, in other European countries and regions, the level of LTC benefits and schemes are mostly income-tested only (9 out of 21 EU countries or subareas) or both income-and asset-tested (8 out of 21 countries or subareas). The exact form of means-testing varies widely across EU and OECD countries.

Steeper asset testing and income testing apply for residential care and all beneficiaries should contribute to the total costs of their care, depending on their income. All beneficiaries of public support to residential care must contribute to the total costs of their care, the user share depending on their income. If the care recipients' income is insufficient, they are required to sell the primary residence if they live alone and the county and/or the state must pay the remaining.

Eligibility for formal in-kind home assistance depends primarily on the support of family and friends, contrary to many other EU countries, and is not based on a single standardised need assessment. This means that individuals with sufficient support from family caregivers will not be eligible for formal support and rely entirely on relatives to receive family care or pay for the formal care. In addition, access to public support for home care services is not based on a single need assessment that is standardised across the country. It varies across the territory, so it is likely that older people with the same level of LTC needs receive different home care public support depending on where they are assessed.

The overwhelming majority of family carers are not compensated for their unpaid care. A carers status exists but only about 500 people received it in 2018 because the eligibility criteria for the carer status were very restrictive. Caregiver status targeted mainly parent caregivers of children with disabilities and only a spouse or a partner under age 65 could be formally recognised by the state as a caregiver if the care recipient needed permanent support to maintain life. Note that after the timing of authoring the report, the Social Welfare Act was modified with improved support to family carers (see Box 2.1).

Box 2.1. The law passed in 2022 improves support to family carers of older people with the most complex needs

In 2022, the Social Welfare Act **NN 18/22** (https://www.zakon.hr/cms.htm?id=52195), **46/22** (https://www.zakon.hr/cms.htm?id=52192), **119/22** (https://www.zakon.hr/cms.htm?id=54052) made changes to social benefits and introduced under Section 11 modifications to the status of caregiver. The new eligibility criteria widen the pool of eligible family carers. One must be a parent or a household member who is physically and mentally able to provide care and who is sufficiently trained. The age limit of 65 years old was lifted. Caregivers are not eligible if the older person receives all-day day care or residential care.

The allowance for a caregiver is EUR 531 (HRK 4 000) per month, or EUR 597 (HRK 4 500) per month if the individual with severe disabilities cannot receive any support services in the community, or EUR 796 (HRK 6 000) if the person cares independently for two or more people with severe disabilities. The carer can take four weeks of compensated leave per year. The carer gains the rights to pension and compulsory health insurance and unemployment (Government of Croatia, 2022[9]). For reference, the gross minimum wage was increased to EUR 700 (HRK 5 274) per month in 2023. Compared with the previous caregiver allowance, it is much more generous and provides a good social protection.

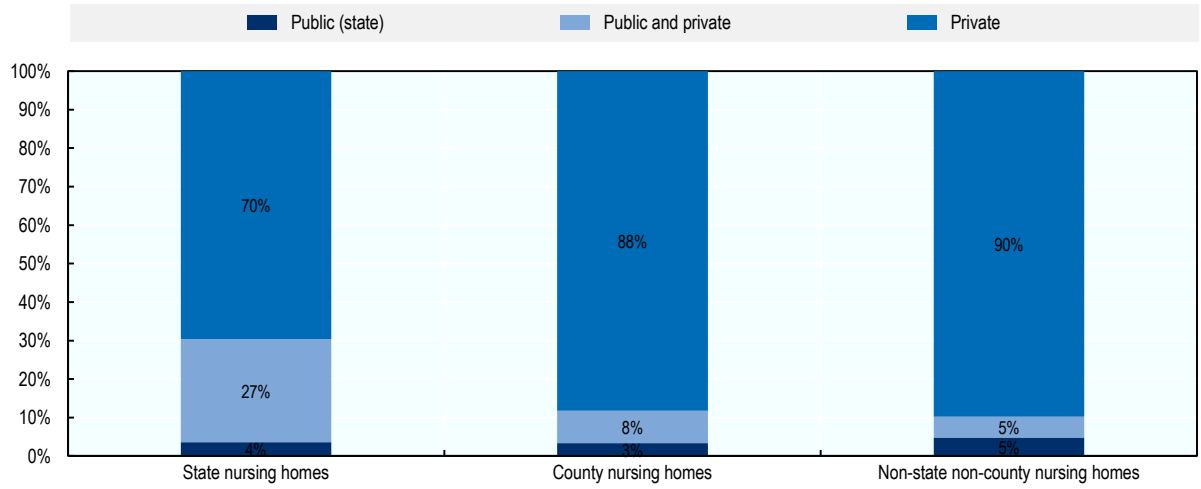
The system is underfunded: Estimated long-term care expenditure is among the lowest of EU countries

The state spent about HRK 317.615 million in 2018 on the three benefits for people with LTC needs at home. The assistance and care allowance represented the bulk of spending (HRK 203.939 million), followed by the personal disability allowance (HRK 87.426 million) and home assistance (HRK 26.250 million). The average estimated cost per home recipient aged over sixty-five is about HRK 9 500 per year. In addition, the state spent HRK 1.195 million on the caregiver allowance. About 4 500 people received it (about 4 100 people were parents of children with disability and about five hundred people were older people's caregivers).

While the level of charges (or prices) paid by *accommodations* users or by the state are not available, it is worth noting that most of the charges are born by users rather than the state (Figure 2.4). In comparison, in almost all EU countries with available data, user contributions are set either as a share of the care

recipient's income or as a share of the total costs of care. Public support for residential care does not depend on the user's means in only two countries: the Czech Republic and the Slovak Republic (Oliveira Hashiguchi and Llena-Nozal, 2020[10]). Croatia offers a small allowance for the personal needs of *accommodation* users of HRK 100 per month to make sure that the care recipient will have some money left after paying for the user contribution. Many other EU countries also aim to guarantee a small minimum income for residents of LTC facilities.

Figure 2.4. The share of private funding for charges (or prices) was 70% or over in the three types of nursing homes



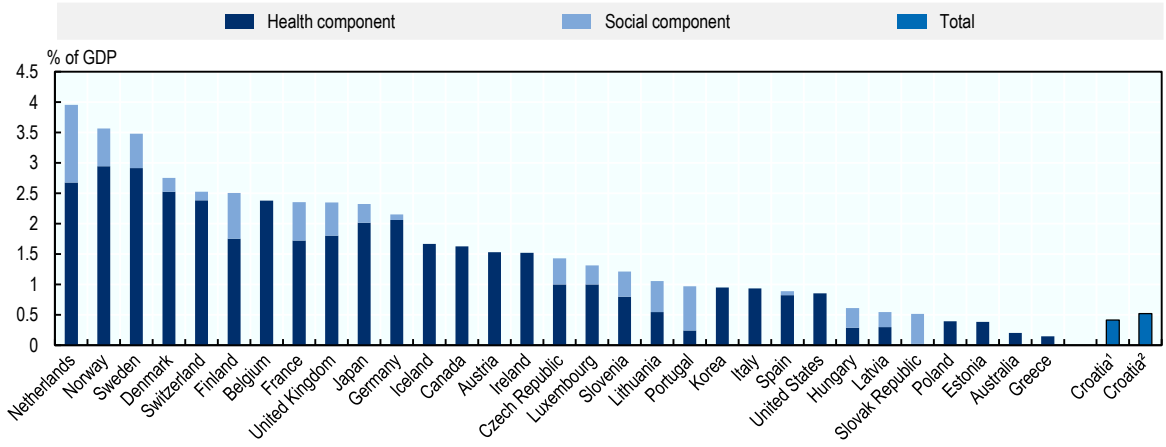
Source: GODIŠNJE STATISTIČKO IZVJEŠĆE O DOMOVIMA I KORISNICIMA SOCIJALNE SKRBI U REPUBLICI HRVATSKOJ U 2018. GODINI (data refer to 2018).

Funding of *accommodations* is very intricate. The state finances differently the state homes, the county nursing homes and the private providers. Because of the funding regulation between the state and the counties, it is possible to estimate expenditure of county nursing homes at about HRK 500 million. The counties were the first funders and if their funds are not sufficient to cover expenditure, the state covers the difference up to a specific limit. In 2018, the state spent HRK 164.550 million to finance county nursing homes.

With respect to health care expenditure, the Croatian health care system spent about HRK 520.9 million on long-term care in 2016. Hospitals spent HRK 367.2 million and providers of ambulatory health care HRK 153.6 million on long-term care, based on the SHA[4] classification.

Overall, known expenditure presented on LTC benefits and health care sums up to an estimated HRK 1.573 billion, or 0.41% of GDP in 2018 (Figure 2.5). When including the Zaželi programme, it reached 0.52% of GDP in 2018. In comparison, the European Commission estimated that Croatia spent on long-term care 0.9% of its GDP in 2016. The difference is at least partly related to out-of-pocket money and spending in other long-term care settings, such as day care centres.

Figure 2.5. Total LTC spending is lower in Croatia than in almost all other OECD countries



Note: Data refer to 2017 or the latest year for all countries except Croatia (2018). 1. Expenditure comprises spending on benefits and allowances and health care (hospitals and ambulatory health care), but not the Zaželi programme funded by the European Social Fund. 2. Expenditure also includes the Zaželi programme.
Source: OECD estimates for Croatia and OECD Health Statistics 2019 for the other countries.

Total LTC spending remains well lower than in most other OECD countries, even with the higher EU estimates for Croatia. In 2017, the average across OECD countries was 1.58%. Only four countries, including Poland and Estonia, reported LTC spending under 0.4%. The Slovak Republic spent about 0.52% of its GDP on long-term care and Hungary 0.61%.

Public social protection has limited impact on poverty risks associated with needing and paying for professional home assistance

While there is some data on LTC spending in Croatia, there is more limited understanding of how affordable LTC is for older people who need it, and whether public social protection is effective at reducing the risk of poverty associated with LTC needs. In the absence of sufficient data on the needs, income and assets of older Croatians making use of LTC services, this report generates estimates of the affordability of care by using models of the LTC benefits framework matching them to survey responses on LTC needs (Box 2.2) (Oliveira Hashiguchi and Llena-Nozal, 2020[10]).

Box 2.2. Methodology used to estimate affordability of formal LTC services

The approach used to estimate the affordability of out-of-pocket costs of formal LTC services follows three steps: (1) matching the Survey of Health, Ageing and Retirement in Europe (SHARE) responses to four stylised cases of LTC needs, (2), estimating total costs, public support, and out-of-pocket spending for each respondent, and (3), generating national-level indicators of the effectiveness of social protection for LTC in old age.

The stylised cases are based on specific activities described in number of hours of need for help with ADL, IADL, and social activities (see Oliveira Hashiguchi and Llena-Nozal (2020[10]) for more details on each case). These cases span various levels of care severity (low, moderate, and severe) and diverse ways in which these needs can be met (professional home care and institutional care). Four cases are used here, as summarised in Table 2.2 below.

Table 2.2. Stylised cases of LTC needs used in this chapter

#	Needs	How needs are met	Weekly costs of professional care in Croatia
1	Low	Around 6.5 hours of professional home care per week	HRK 239.07
2	Moderate	Around 22.5 hours of professional home care per week	HRK 827.55
3	Moderate	Around 10 hours of professional home care per week and 12.5 hours of family care provided by adult child	HRK 367.80 (for professional part; opportunity costs of family care not included)
4	Severe	Around 41.25 hours of professional home care per week	HRK 1 517.18
5	Severe	Around 41.25 hours of institutional care per week	HRK 669.23

Note: Detailed descriptions of the stylised cases are available in Cravo Oliveira Hashiguchi and Llena-Nozal (2020[10]), "The effectiveness of social protection for long-term care in old age", https://doi.org/10.1787/2592f06e-en.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire.

To determine how many older people in a population can be classified as having LTC needs as described in the stylised cases above, an internationally comparable source of data on these types of limitations is most appropriate. The SHARE provides such a source of data, with information on ADLs and IADLs. Limitations in ADL include difficulties in: (1) dressing, (2) walking across the room, (3) bathing/showering, (4) eating, (5) getting in/out of bed and (6) using the toilet. Limitations in IADL include difficulties (7) preparing a hot meal, (8) shopping groceries, (9) making telephone calls, (10) taking medications, (11) doing work around the house/garden, (12) managing money, (13) leaving the house independently and (14) doing personal laundry. SHARE waves 6 and 7 were used.

The matching methodology is based on a score of self-reported difficulties: reporting one to two limitations with ADL and IADL is considered equivalent to having low needs, reporting three to six is considered equivalent to having moderate needs, and reporting seven or more needs is considered equivalent to having severe needs. This matching method was selected based on a systematic set of tests to validate results.

The OECD worked with the Ministry of Demography, Family, Youth and Social Policy in 2019 to map assessment systems in use in Croatia to the stylised cases above. To do so, detailed descriptions of the abilities and limitations of the person in question, the services they require, and any other relevant assumptions, were given.

For each stylised case, older people may be eligible for different LTC benefits depending on the severity of their needs, their income and assets, and their family composition (see Table 2.3).

Table 2.3. Public LTC benefits, schemes and services for stylised cases used in this chapter

Stylised case #	Benefits, schemes, and services available
1	Older people with low needs are not eligible for LTC benefits in Croatia. If the older person's income is below 300-400% of the reference income, they will receive a subsidy for home assistance of HRK 119.54 per week.
2	Older people with moderate needs on low incomes (below 300-400% of the reference income) can receive a subsidy for home assistance of HRK 413.78 per week, if the older person has not sold property in the previous year and has no support from family members. People with moderate needs are also eligible for the Assistance and Care Allowance (HRK 420 per month), assuming the older person has a significant impairment.
3	Older people with moderate needs receiving in-kind support from an adult child are eligible for the Assistance and Care Allowance for HRK 420 per month.
4	Older people with severe needs earning below 300-400% of the reference income are eligible for a subsidy for home assistance of HRK 758.59 per week. In addition, they qualify for either the Assistance and Care Allowance or the Personal Disability Allowance. In this chapter, it is assumed that the older person receives the Personal Disability Allowance, which is set at HRK 1 500 minus income (except pension income).
5	Older people with severe needs and high assets can receive state support for accommodation if they have no support from family members. In this case, the State is entitled to claim a part or the whole value of this person's property after death or cessation of institutional care corresponding to the value of accommodation costs. Older people on low income will get a benefit based on the formula: Collective support = Total cost – (Income – 100) since they are entitled to keep HRK 100 per month of their income.

Note: Detailed descriptions of the stylised cases are available in Cravo Oliveira Hashiguchi and Llena-Nozal (2020[10]), "The effectiveness of social protection for long-term care in old age", https://doi.org/10.1787/2592f06e-en.
Source: OECD analyses based on the OECD Long-Term Care Social Protection questionnaire.

The following subsection discusses estimates that are based on a simulation of what the total costs of care, public support and out-of-pocket costs would be should older people access LTC. These are not estimates of the actual amounts in the real world, as they do not consider barriers to access nor individual preferences for using public LTC benefits, schemes, and services. In addition, the estimates rely on SHARE, which data on income and asset may be of limited quality (income and asset are difficult data to collect well in general).

The stylised cases confirm that the share of total costs of LTC covered by public support is limited. This is because most respondents with low and moderate needs have a combination of income and assets that would disqualify them from receiving public support, based on SHARE data for LTC needs, income and assets. Around 95% and 81% of those over sixty-five with low and moderate needs, respectively, do not qualify for any financial public support for home assistance. The other 5% of older people with low needs are eligible to receive public support in the amount of 50% of the total costs of care, while 12% of those with moderate needs would see only 13% of the total costs of home assistance be covered by public social protection, 7% with moderate needs would get at least 50% coverage. Around 84% of older people with moderate needs receiving a mix of professional and family home care, the family part from an adult child, would not receive any financial public support, while 16% would see 26% of the total costs of the professional part of their care covered by the public social protection system.

For those estimated to have severe needs, around 89% are eligible to receive public support covering 23% of the total costs of home assistance, while the remaining 11% would see 73% of the total costs covered by public support. Around 77% of older people with severe needs would receive no financial public support for the total costs of institutional care, while the remaining 23% would see, on average, 34% of the total costs of care covered (the range is 4% to 73%).

Estimates on out-of-pocket costs (the share of the costs that are left after accounting for public support) indicate that relying only formal LTC is typically unaffordable. On average across all older people with LTC needs eligible for public support, older people with low needs would need to spend 47% of their income to pay the out-of-pocket costs of home assistance. On average, older people with moderate and severe needs would need to devote all their income to pay the out-of-pocket costs of professional home care. In institutional care, older people with severe needs would need to devote on average 94% of their income to cover out-of-pocket costs.

These estimates on out-of-pocket costs show that older people must rely on (unpaid) family care to afford meeting their care needs. Older people receiving a mix of professional and family home care, on average, would pay 41% of their income to cover the out-of-pocket costs of care.

Estimates on poverty risks associated with LTC needs indicate that public support in Croatia may not be well-aligned with ageing-in-place policies. Stylised cases indicate that public support for institutional care completely reduces poverty risks associated with needing LTC in Croatia, however public support for home care for low, moderate, and severe needs does not bring relative income poverty levels back to pre-LTC levels.

To promote ageing-in-place, public social protection systems need to consider that older people who stay in their communities must cover basic living costs that they would not face if they were institutionalised. Consequently, even though public support for older people with severe LTC needs is higher for home care than for institutional care in Croatia, this may not be doing enough to prevent older people in the community from being at risk of poverty. Older people who are at risk of poverty cannot afford to make any out-of-pocket payments or they will be at an increased risk of poverty (especially if they are also asset poor and thus cannot deplete their assets to pay for care).

3 Family carers need additional support

This chapter details results of a novel and comprehensive survey on family carers in Croatia. It shows the profile of family carers in terms of demographics, socio-economic status, and care load. It also presents suggestions from focus group discussions on improving the current long-term care system, especially for family carer support.

In Croatia, as in many other EU countries, the bulk of care is provided by family carers, but little was known about them and their care situation. The OECD conducted a comprehensive survey under the guidance of the Ministry of Labour, Pension System, Family and Social Policy by designing and carrying out a questionnaire and focus group discussions in 2020. Field work was conducted between March and July 2020. To reach family carers, a complex procedure was undertaken, with questionnaires sent to health centres, which redistributed them to visiting nurses, who lent them to family carers. About 220 visiting nurses and 1 126 family carers completed the questionnaire on family care, care recipients and the care situations. The completion rate was 63% and 33% of all visiting nurses in Croatia replied. The answers are considered representative of family carers of care recipients who receive care from both visiting nurses and family carers. In addition, twenty-three visiting nurses and eleven family carers participated in focus groups. The selection of 34 participants provided a good county coverage (Grad Zagreb, Splitsko-dalmatinska, Osjecko-baranjska, Istarska, Brodsko-posavska, Vukovarsko-srijemska, Primorsko-goranska and Koprivnicko-križevacka). The methodology of the survey is explained further in Annex A.

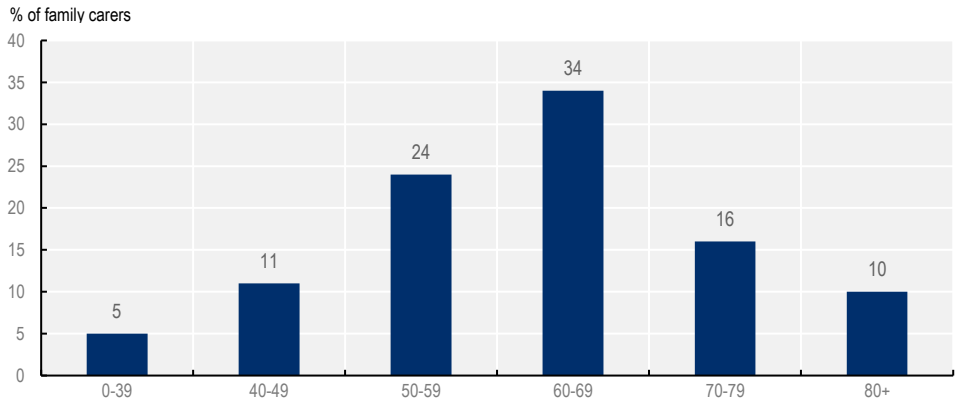
Family carers are mostly older women who are poor and feel fulfilled to provide a lot of (unpaid) care, but it takes a toll on them

Nearly 75% of the responding family carers are women and the mean age is 62 years old. Still, about 40% are aged under 60 years old (Figure 3.1). About 67% are married or in a partnership, 13% have never been married, 7% are divorced and 13% are widowed. The overwhelming majority of carers has children (77%) who are typically adult. About 15% of carers live alone, 40% live with someone else, 22% live with two other people and the rest (23%) live with three or more other people. Slightly over half of carers are children or children-in-law supporting their parents or their parents-in-law. About one-fourth of carers are spouse or partner. Discussions from focus groups underlined that neighbours and friends may also provide help, but it is usually limited to a few household activities, such as doing the groceries and preparing some meals.

In Slavonski Brod-Posavina, Bjelovar-Bilogora, Koprivnica-Križevci, Sisak-Moslavina, Virovitica-Podravina and Vukovar-Srijem, over half of carers are aged below 60 years old. At the contrary, carers aged 70 and over represent 30% or more of carers in Split-Dalmatia, Osijek-Baranja, City of Zagreb, Primorje-Gorski kotar, Istria, Varaždin and Krapina-Zagorje. These results are broadly consistent with previous research in Zagreb City, although the mean age was relatively younger (55 years old) (Štambuk, Rusac and Skokandić, 2019[11]).

While 46% of carers report a fair, good, or very good health, 55% of them report a chronic illness or a disability and 54% report being limited in their own daily activities to some extent because of a health problem.

Figure 3.1. About one-third of family carers are aged between 60 and 69 years old



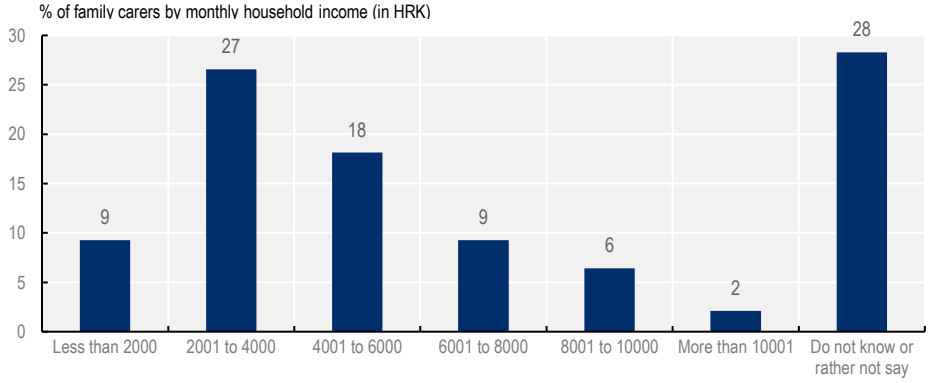
Source: OECD 2020 questionnaire to visiting nurses and carers in Croatia.

Family carers' education level is relatively low. Over one-fourth of carers completed a primary school education, over half hold a high school degree while only about one-fifth had a bachelor or a most advanced education degree. These results are aligned with previous research in Zagreb City, although the education degree was slightly higher on average (Štambuk, Rusac and Skokandić, 2019[11]).

Most carers are from lower-income households, but nearly half own their dwelling

When looking at carers willing to provide information on their household's income, over one-third of carers report a monthly household income under HRK 4 000, including for about 10% an income below HRK 2 000 (Figure 3.2). This is low in comparison to the minimum wage (HRK 3 750 in 2019). It is worth noting that 28% of carers indicate that they do not know or do not wish to provide information on their income.

Figure 3.2. Over one-third of carers report a monthly household income under HRK 4 000



Source: OECD 2020 questionnaire to visiting nurses and carers in Croatia.

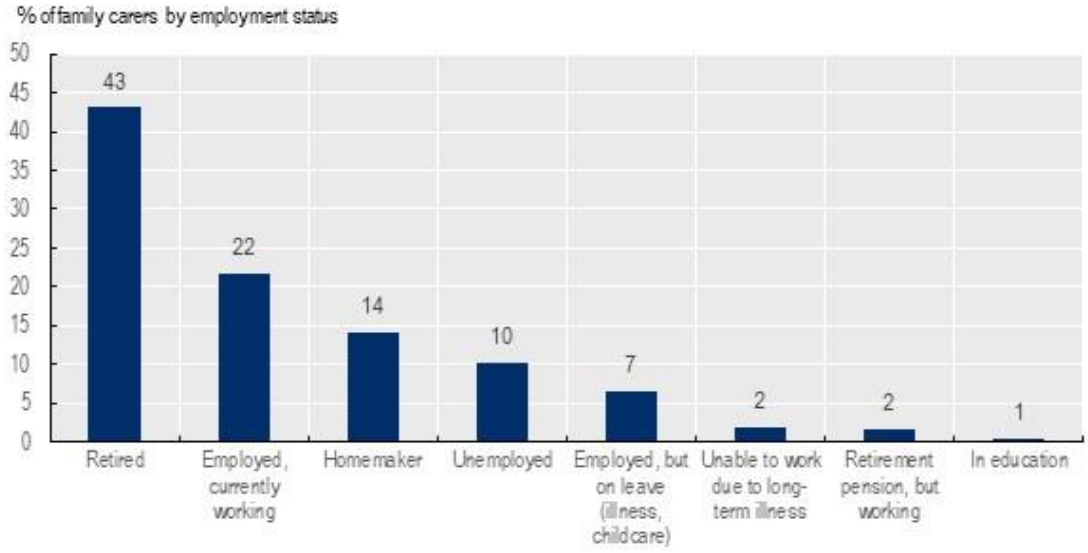
The following information on equivalised income is based on the midpoint of above ranges. The median estimated equivalised earning is HRK 2 887 and 20% of carers earn an estimated equivalised income below HRK 1 732. These represent respectively about 64% and 38% of the median equivalised net income (HRK 4 517 in 2019). In other words, almost half of carers live below the poverty line based on these estimates (following the EU definition of financial poverty, which sets the poverty line at 60% of the median income).

With respect to carers' assets, over 42% of carers who provided data own their dwelling without a mortgage, while 5% own it with loans. This is consistent with a previous study in Zagreb City (Štambuk, Rusac and Skokandić, 2019[11]).

Most carers do not work

Nearly 45% of carers are retired while 40% are still in the labour market (Figure 3.3). About 22% are employed and working, 7% are employed but on leave (illness, childcare), 10% are unemployed and 2% are retired but still working. In addition, 14% of carers are homemakers. The vast majority (91%) report working full-time and only 4% report having reduced working hours because of care giving. Among those unemployed, 4% report that they stopped working because of care giving.

Figure 3.3. Nearly 45% of carers are retired and about 40% are still in the labour market



Source: OECD 2020 questionnaire to visiting nurses and carers in Croatia.

Results from the focus groups are consistent in terms of labour force status, except that some indicate they left their job because of care giving. Evidence from the literature is more in line with the results from the focus groups if family care is intense. It shows that carers heavily involved in caregiving are more likely to withdraw from the labour force (Colombo et al., 2011[12]).

Findings on paid informal carers are limited, but migration within and out of Croatia plays a role

The findings on informal care paid under the table are limited but still insightful to draw a picture of the grey market. It can be estimated that about 10% of responding carers are paid carers informally hired and paid by families. This estimate may be conservative because it is likely that many paid informal carers did not wish to participate to a questionnaire prepared for the Government of Croatia.

This 10% estimated is based on data on care relationship and compensation. About 16% of carers report that they support non-relatives, and these carers could be neighbours but also paid informal carers working in the grey market. Among the non-relatives, 63% report that they receive a compensation for time spent caring (compared with 4% for the relatives). Few carers report the number of hours compensated (128 observations), but related information might be of interest. The median number of compensated hours of care is 21 hours and the average is 38 hours. The average is driven in part by a substantial (14%) share of carers that are compensated 24/7. Thus, one can calculate that a conservative estimate is 10% (16% X 63%).

Visiting nurses believe that paid informal carers are more common in wealthier counties. Within Eastern counties, in rural areas, informal carers are uncommon because family ties are stronger, and families tend to be poorer. In urban areas, younger generations often left their home to move to bigger towns in other counties so they cannot provide daily care and informal carers are more common.

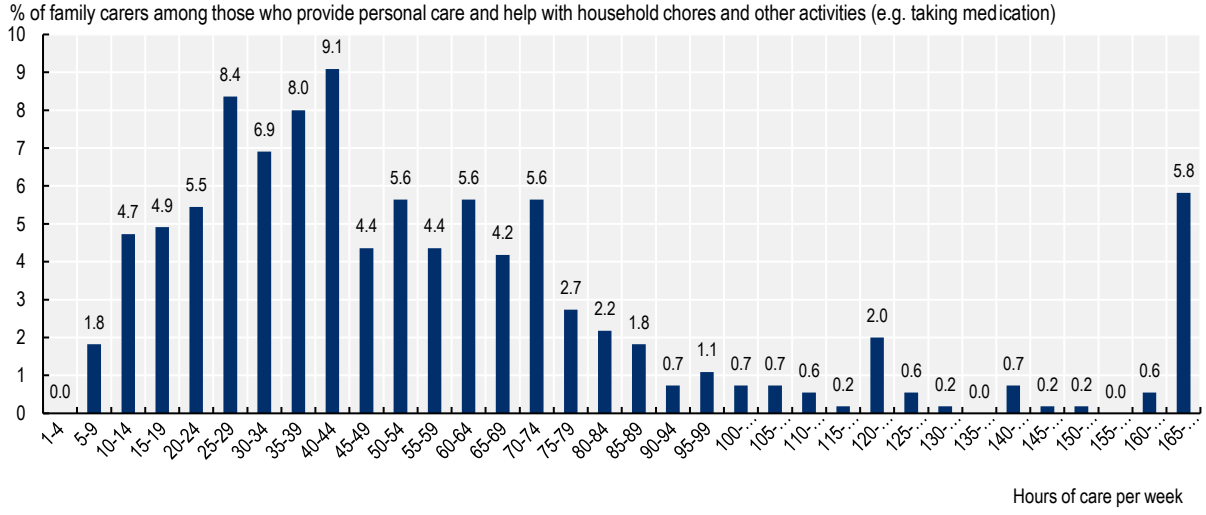
Focus groups indicated that migration from the poorest counties to neighbouring countries such as Austria and Italy and wealthier counties such as Istria depletes the local pool of paid informal carers in the poorest counties. In the North-Eastern counties, the paid informal carers prefer to work in Austria for the better working conditions. In North-Western counties, the picture is more nuanced. Even though paid informal carers from these counties emigrate to Italy where the pay is more than the double than in Croatia according to focus group participants, paid informal carers from Eastern counties move to North-Western to have higher wages. For example, the pay was about HRK 1500 for 15 days in Slavonski Brod in 2020 according to focus group participants. When the care recipient needs 24-hours care, two paid informal carers usually work in shift of 15 days, or else 12 hours/day. Focus group participants also reported that unpaid informal carers were paid around HRK 40 per hour in Zagreb City in 2020.

About three-quarters of carers provide personal care and help with household chores

About 75% of carers provide personal care and help with household chores, and 60% personal care, help with household chores and other types of support. The most common personal care is support in bathing or showering (69%), followed by support in dressing (62%), getting in and out of bed (50%), using the toilet (41%) and eating (37%). About one-fourth of carers provide these five types of support, suggesting that these carers look after care recipients completely reliant on support to live at home. Almost 90% of carers report helping with the groceries, 86% with cleaning the household, 75% with the laundry, 75% with the preparation of meals and 73% with the maintenance of the dwellings (e.g. gardening and or other maintenance chores). About 80% of carers provide other types of help, such as help with finances (70%), help with transport to leave the dwelling (70%), and help with medications (57%).

Caring takes more time than a ‘standard’ full-time job for 30% of all responding family carers. Among the 60% of carers reporting providing personal care, household chores and other types of support, the median number hours of care is about 45 hours per week and 6% provide care 24/7 (Figure 3.4). It may be possible that some carers could not allocate time spent on each type of support, overestimating the total number of hours of care.

Figure 3.4. Caring takes more time than a full-time job for half of the responding carers reporting personal care, household chores and other types of support



Note: These data are to be interpreted with caution as it may be possible that some carers could not allocate well time spent on each type of care or help, overestimating the total number of hours of care.
Source: OECD 2020 questionnaire to visiting nurses and carers in Croatia.

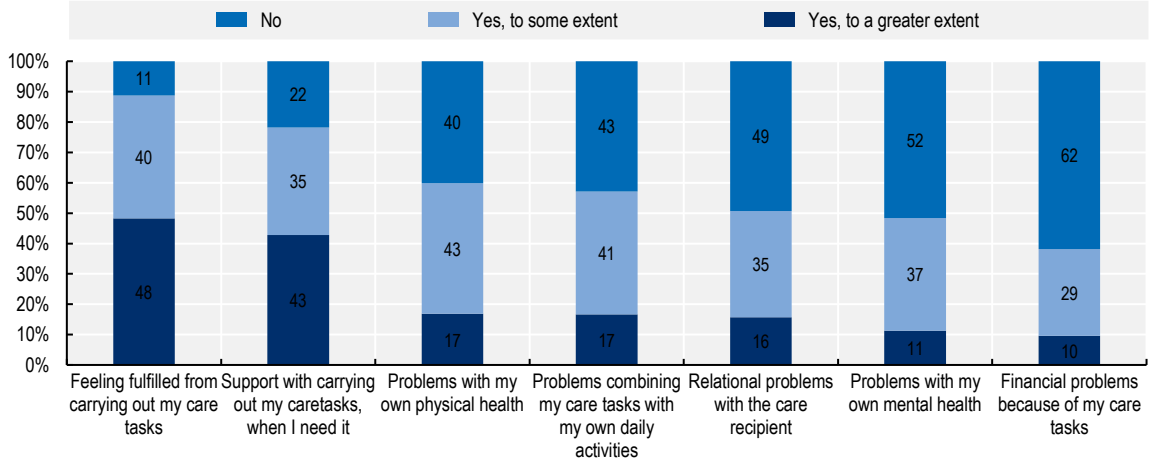
The number of hours of care is strongly associated with the frequency of care. Among those who care more than 10 hours per week, 85% care every day. Working family carers report a median of 35 hours of care, compared with 44 hours for non-working and non-retired family carers, and 50 hours of care for retired family carers. Caring may be so time-consuming that it can become difficult to juggle between care, work, and other activities.

About 90% of family carers (mostly women) with a job live in a household with at least one other adult and almost one-third live with a child aged below 18. In traditional households, these women would be expected to do the equivalent of three jobs: their paid job as an employee, the unpaid domestic work (e.g. cooking, cleaning) and the unpaid care work (older people and childcare). About 27% of carers who are employed report that they have problems to a great extent to juggle between care and their own daily activities, compared to 15% for retired carers.

Even if 90% of carers report fulfilled from care tasks, caring takes a toll

While about 90% report feeling fulfilled from carrying out care tasks and 78% report feeling supported, 60% report problems with their own physical health and 48% report problems with their own mental health. In addition, 57% of carers report problems to combine care tasks and their own daily activities and 38% report financial problems because of care tasks. About half of carers report relational problems with the care recipient (Figure 3.5).

Figure 3.5. Most carers feel fulfilled, but they also feel that care takes a toll on them



Source: OECD 2020 questionnaire to visiting nurses and carers in Croatia.

Focus group discussions highlight that those who bear the heaviest toll are family carers providing care 24/7 without the possibility to leave the care recipient for a few hours on a regular basis. The burden seems particularly difficult when the care recipient is bed-ridden and/or has advanced dementia. Focus group participants believe that nursing homes and foster care homes disregard bed requests of people with advanced dementia because of their dementia-related needs. Finding an appropriate substitute available for only a few hours on a punctual basis has also its array of challenges, so respite care is not guaranteed.

Preferred perceived options for improving care for the older people

Focus group participants highlighted training needs and financial support for family carers

According to participants of focus groups, family carers need more training to provide personal care and health care. For example, they commonly take care of wounds and pressure ulcers, and nurses train them "on-the-job," but not always sufficiently. In addition, nurses train family carers to turn people in bed, change diapers and bath people using as little strength as possible. Nurses deem training as key to enable family carers to provide nursing care when nurses are absent since visiting nurses usually come one or twice per month in the morning. According to them, family carers need to learn more about nursing care early on, because they visit too rarely to provide training at the time when health conditions deteriorate (it can occur very quickly). They also believe that family carers should know more about broader determinants of health (e.g. nutrition, physical activity).

Some focus group participants mention that some visiting nurses could become care co-ordinators and have this official responsibility. Croatia could learn from the example of Japan which created a new profession of LTC managers or from Germany. Such LTC managers or care co-ordinators require a license and a qualification exam to co-ordinate provision of health and social services care needs for older people. Care managers carry primary responsibility for ensuring co-ordination of care for older people with complex needs and are a first point of contact for such patients and their families (OECD, 2020[13]). In Germany, the community-based support for primary care (or AGnES) care model – nurses acting as case managers when visiting older people at home – provides specific training in case management. AGnES professionals can be qualified nurses or other assistants who have accumulated three years of professional experience; they receive training as a 'Medizinischen Fachangestellten' and an AGnES qualification. To work as case managers, they undertake an additional training module on communication and conflict management. AGnES nurses are also trained to deal with inter-professional and inter-sectoral collaboration (i.e. network and system management, co-ordination and control of aids, quality assurance in case management) and basics for taking a leadership role in care: assessing needs, monitoring and evaluating a patient (OECD, 2020[13]).

In addition, it may be worth training family carers to set boundaries, so that they feel less that their lives revolve only around care. Carers mention that older people can become more egocentric and impatient. Focus group discussions highlight that family carers providing care 24/7 should receive psychological support, because of the mental toll continuous care has on them.

Participants also agree that respite care, a cash benefit, and a carer status are essential support measures. Because it can be hard to find workers, they propose to introduce a new position of family carer for retired women, potentially those with a former professional background in nursing or childcare. These retired women could broaden the pool of competent workers willing to top up their pension with labour income.

Nursing homes are perceived as a last resort option

According to focus group participants, nursing homes tend to be seen as a last resort option in Croatia. It is the option when care recipients' care needs are so complex that carers do not know or cannot provide sufficient care or cannot afford to pay for home care. In areas where each generation tends to live in their own house, family carers are seen as more likely to be employed and to be looking after their children. The move to nursing homes may be seen as the only option available that is both within their budget and that matches their time constraints. Conversely, nursing homes are not even considered as a last resort option for poor families living in rural areas. In families where multiple generations live in the same household, poor families have enough "hands" to provide care, and, in any case, they cannot afford nursing homes.

According to participants' personal point of view, nursing homes have clear disadvantages. Beyond the lack of available and affordable places, inadequate quality was highlighted. Focus group discussions

highlighted the poor-quality food, lack of staff (the ratio of one nurse per twenty residents was quoted multiple times) and poor-quality care. Interviewees think that nursing homes often disregard bed requests of people with complex needs (e.g. those immobile, with advanced dementia). They believe that residents with complex needs are often put in bed, tied up to wheelchair, or medicated. Some interviewees witnessed such issues, while others heard of them.

At the same time, participants support the development of nursing homes, not only because of the long waiting lists but also because they do not think that the younger (female) generations will be ready to put someone else' needs first as much or will be able to. They believe that if quality improves, nursing homes would be a more attractive option. The main advantages of nursing homes mentioned were safety related to permanent supervision, socialisation, and group activities.

Quantitative data on the decision to provide family care confirms the qualitative findings. The most common combination is that family carers decide to care for the care recipient themselves and, at the same time, the care recipients decide that they do not to want to live in a nursing home. About 60% of carers report deciding to care for the older person, but in half of cases, the care recipients also decide that they do not want to live in an LTC facility. The results are similar across counties, except in Vukovar-Srijem and Osijek-Baranja, where the inability to pay for formal care is one of the main reasons to receive family care.

The focus group discussions nuance the picture on the decision of family carers to provide care. Participants report that many may help also out of social norms, especially in rural areas and especially if multiple generations live under the same roof. They believe that family carers may dare to go beyond social norms when their burden is very heavy, particularly when the care recipient is immobile and when it has advanced dementia.

Other types of care could be further developed

Other types of residential care – foster care and family homes – are better valued, but participants believe that the compensation for families make is unattractive when older people are immobile or with advanced dementia. Quality is considered higher: families are believed to have more time available to care as they can receive only up to four older people and standards are also higher (e.g. one older person per bedroom). Some believe that quality controls should be more frequent, notably because foster families provide care for financial reasons. In addition, they believe that foster families refuse people who are immobile or with dementia because the additional care is undervalued (the fee was between HRK 1 800 (about EUR 240) and HRK 2 400 (EUR 315) depending on the health condition of the older people).

With respect to care at home, participating visiting nurses propose to develop mobile teams to reach out to isolated people. The team could be composed of professionals who can provide health care and personal care. The idea behind is that mobile teams could visit more frequently each older person (visiting nurses tend to visit 1-2 times a month most older persons, while personal care needs are often daily needs). Croatia could implement the Buurtzorg model which originally started in the Netherlands and has been replicated in several countries. The model includes self-managed teams of nurses that are often composed of up to twelve nurses and support 50-60 patients at a time. The nurses provide a wide range of care; they also try to mobilise the client's social network and work closely with general practitioners and other community health care workers (OECD, 2020[13]). In addition, participating visiting nurses also suggest developing day-care centres where older people can spend days of half-days.

In addition, participating family carers underline that the applicants to the Zaželi programme should be screened for mental health issues. It seems that some grapple more with mental health issues when they start to provide care and they can refuse to visit severely ill patients (e.g. those with advanced dementia, epilepsy). There is a solid body of evidence that caregiving causes or worsens mental ill health symptoms such as depressive symptoms, particularly when caring for older people with dementia (del-Pino-Casado et al., 2019[14]; Rocard and Llena-Nozal, 2022[15]).

Focus group participants also discussed the tasks of health care professionals. Insights from these discussions are in Annex B.

4 Strengthening long-term care in Croatia

This chapter suggest policy avenues to strengthen public support to long-term care in Croatia. It offers a comprehensive strategy for improving home and community long-term care. The chapter pays particular attention to the most pressing priority for the Croatian government, namely, possible reforms to support further family carers, including with a cash benefit.

Croatia aims to improve home and community care for older people. The chapter provides expert recommendations seeking to inform the process for a reform of the Social Welfare Law, which was carried out in 2022. The first section outlines recommendations for improving home and community care. The second section develops in detail the possible first step of such strategy, advising to first focus on providing more support for family carers and specifying the considerations for a cash benefit for family carers.

A comprehensive range of options to improve home and community care

Developing formal care (and financial schemes) is key to support family carers to ensure that recipients and family carers make decisions without disregarding their personal preferences because of a lack of alternatives. To strengthen home care for older people, Croatia needs a broad package of reforms aiming to develop formal care in a financially sustainable manner while supporting family carers. The following subsections provide an overview of pathways to improve support for family carers and reform at-home care and foster and family homes.

While the following subsections do not cover institutional care provided in nursing homes, it is important to note that any comprehensive long-term care (LTC) system should include a well-developed component on care in nursing homes. Overall, at least 3% of older people live in institutions in Croatia, compared with an OECD average of around 4%. This rate may indicate that Croatia has not developed care in LTC facilities as much as other EU countries. The overall density of LTC beds (in nursing homes and hospitals) remains lower than in most other EU countries. In addition, state and county nursing homes operate at full capacity, leaving no extra beds for interested users – not even those eligible for public support.

Croatia could consider reviewing the price setting of nursing home stays and clarify the eligibility criteria for public support in state nursing homes and county nursing homes, especially given that the state covers part of the expenditure of county nursing homes in most counties. In theory, the Ministry establishes prices for nursing homes, but, in practice, prices are negotiated between the Ministry and the owners ("founder rights") of the decentralised nursing homes (Bađun, 2017[6]). In addition, an important share of the charges of nursing homes are born by users, rather than the state, including in public nursing homes. It could be valuable to monitor to what extent the most disadvantaged older people can access public nursing homes while funding them adequately.

To be effective in meeting LTC needs among older people, any LTC support should be adequately financed. Even though this project does not focus on funding schemes, the hurdles to estimate LTC expenditure presented in Chapter 2 suggest that LTC spending are not tracked and monitored adequately. In addition, the lack of comprehensive LTC spending estimates and the low supply of formal LTC provision suggest that the LTC system is underfunded.

A cash benefit for family carers and non-financial support are essential

Supporting family carers effectively is a key part of a successful strategy to address care needs among older people. It is beneficial for carers as caregiving takes a mental, physical, and financial toll. It is also beneficial for care recipients, because they often prefer to be cared by family and friends. And it is beneficial for public finances because it involves far less public expenditure for a given amount of care.

Most OECD countries have diverse ways to support carers, including a cash benefit and an array of non-financial support options. A cash benefit for family carers is a means to recognise and compensate carers. Since there is no cash benefit for family carers specifically designed for carers of older people with LTC needs in Croatia, the introduction of a new cash benefit targeted at family carers of older people could be considered. The existing carer's status is mostly used to help family carers of children with disability, even though family carers of older people are eligible under specific and strict conditions. It remains important that such cash benefit does not trap family carers into low-paid roles, nor incentivise family carers to provide care against their personal preferences due to a lack of adequate alternatives. The section "A new

cash benefit to family carers: Eligibility criteria, generosity, and regulation" provides the details on a possible new cash benefit.

Croatia should also consider introducing support services such as respite care, training, and counselling. They ensure quality of care and improve carers' wellbeing. Such services can be arranged for a low cost, including by leveraging on the voluntary sector or the visiting nurses, as in some other EU countries.

Leave from work to care for older dependent relatives also plays an important role in reconciling the work and family-life balance. In January 2019, the European Council published a Directive on work-life balance for parents and carers with the aim to increase the labour market participation of women and improve the take-up of family-related leave and flexible working arrangements. The Directive also provides opportunities for workers to be granted leave from a job to care for relatives. One concept introduced is the carer's leave for workers caring for relatives in need of care or support due to serious medical reasons. It is stated that carers should be able to take at least five working days per year. As for the other EU member states, Croatia should adopt laws, regulations, and administrative provisions necessary to comply with the directive. It would be timely to provide a new cash benefit to family carers while implementing the Directive to broaden the package of support.

Formal home LTC could be improved while introducing a cash benefit for family carers

This section presents key elements of possible reform avenues in Croatia, with a view to providing better alternatives to nursing homes, by enhancing the coverage and generosity of care provided at home and in foster care or family home.

Improving formal care is one efficient way to ensure that family carers decide to provide care because they want to. Family carers should not have to be forced to disregard their personal preferences because of a lack of adequate alternatives for their loved ones. Freedom of choice is particularly important for gender equality. Reducing the gender gap in caregiving requires good access to formal care and to financial support. As Croatia is a country with strong traditional family values, it is possible that female relatives will decide to provide care themselves unless their care recipients can access high-quality formal LTC. Providing alternatives to family care can contribute to reducing the gender gap.

Current cash benefits for care recipients could be combined in one cash benefit

The Croatian LTC system relies heavily on two cash benefits, the personal disability allowance and the assistance and care allowance. One avenue of change is to combine the two cash benefits into one unique cash benefit with several grades. For each grade, the eligibility and the level of the benefit could depend on a specified level of LTC need. The level of the benefit could be both income-tested and asset-tested. It could have stricter asset-testing and less stringent criteria on income than the current ones for the cash benefits, with a view to expanding the coverage of the provision. The need assessment should remain standardised across the country and could be adjusted to give more weight to limitations of daily activities (ADL and IADL). As in other EU countries, the levels of benefit should not differ by county.

The use of this cash benefit could be controlled to a certain extent. For instance, it could be provided by the Ministry in the form of vouchers as in France (*Chèque emploi service universel)*. A contract could be agreed between the paid carer and the care recipient, and this contract could be registered by Social Welfare Centres. As in France, social contributions (health, pension) could be paid by the state to incentivise the formalisation of the labour market. The voucher system would contribute to tackling poverty among vulnerable groups as well as their lack of social protection. Carers paid through vouchers could meet a set of eligibility criteria, in terms of health status and training. Low education requirements could be set to ensure the inclusion of current paid informal carers.

Asset-tests can help target limited public social protection budgets to older people who need it most. However, they can also act as a form of taxation on wealth and savings, thus having the potential to introduce distortions in saving behaviours (Oliveira Hashiguchi and Llena-Nozal, 2020[10]). Given a prevalent myopic behaviour in saving for LTC, the distortion effect may be small but is difficult to quantify

it. Eleven other EU countries and subnational areas have assets-tested institutional care benefits and schemes. Across these different benefits and schemes, there are a set of common features that assets-tests tend to have (Oliveira Hashiguchi and Llena-Nozal, 2020[10]). First, assets below a certain value are often excluded from assets-tests. However, these thresholds tend to be low compared to the national mean net wealth (e.g. equivalent to 2% of the national mean net wealth in England and Germany), and if public support is not effective below these asset thresholds, then care recipients may still end up using their assets to pay for care. Second, often only a share of all assets above the threshold are considered in assets-tests (although some countries and subnational areas do consider all assets). Third, assets-tests may include or exclude diverse types of assets. For instance, the care recipient's primary residence is often excluded from assets-tests when the older person or their dependents are living there (e.g. as in home care). Fourth, deferred payment agreements may be used to allow care recipients to postpone user contributions to their care. In such schemes, care recipients agree to use their assets (including their primary residence) to repay the public social protection system for any postponed user contributions. This happens if they sell their house (e.g. when moving to institutional care) or when they die.

Table 4.1. Treatment of assets in LTC benefits and schemes that apply assets-tests

Countries and subnational areas	Benefits and schemes	Setting	Simplified description of rule	Types of assets	Deferred payment?
Flanders (Belgium)	Allowance for the assistance of older people	Both	6% of assets	Primary residence excluded	No
England	Social care	Institution Home	No user contribution for assets below GBP 14 250, full contribution for assets above GBP 23 250	All Primary residence excluded	Yes Yes
Tallinn (Estonia)	Institutional care	Institution	Full user contribution if care recipient has assets	All	No
France	Allocation Personnalisée d'Autonomie Aide sociale à l'hébergement	Both Institution	100% of assets can be used for contributions None	Primary residence excluded All	No Yes
Germany	Assistance for care (Hilfe zur Pflege)	Both	EUR 5 000 excluded	All	No
Hungary	Homes for older people	Institution	Full user contribution if care recipient has assets; higher income allowance for care recipients that have assets	All	No
Lithuania	Institutional care	Institution	1% of assets over EUR 4 260[1]	All	No
Luxembourg	Complément accueil gérontologique	Institution	None	All	Yes
Netherlands	Wet langdurige zorg (Wlz) Wet Maatschappelijke Ondersteuning (Wmo)	Both	8% of assets over EUR 21 330	All	No
Slovenia	Municipality-subsidized care	Institution Home	100% of assets over EUR 2 500	All Primary residence excluded	No No
Spain	Ayuda al domicilio Prestación económica vinculada al servicio Antención Residencial	Home Home Institution	5% of assets	Primary residence excluded All All	No No No

1. Based on a value of EUR 355 per square meter for a property with twelve square meters. Countries and subnational areas are sorted top to bottom alphabetically by the name of the country.
Source: Adapted from (Oliveira Hashiguchi and Llena-Nozal, 2020[10]).

As in other countries, Croatia could consider more stringent asset-tests on the primary residence. For instance, the primary residence could be considered if no dependent lives in and if it is above a specific monetary value. Croatia could define a specific percentage of all assets (as in Flanders, Belgium, and Spain), or a specific percentage of assets from a certain threshold (such as in the Netherlands). An assessment of the distribution of assets and its median values could be used to determine such thresholds or percentage, using either tax data or the Household Finance and Consumption Survey (Kurnovac, 2020[16]).

At the same time, results from Chapter 1 showed that while about 65% of older people report owning their primary residence, only 5% of older people living alone own their dwelling. This limits the potential of stricter asset test on residence, even though it could still be considered.

One alternative is to cash the value of primary residence by developing deferred payment options. A French study estimated LTC affordability based on assets and concluded that a greater number of persons could finance LTC by using reverse mortgages. Of those without partner, 22% of dependent individuals could pay for LTC if they used all their savings except their home, while 49% of dependent individuals could pay for LTC if they took out reverse mortgages on their main residence. In contrast, only 6% of dependent individuals could pay for LTC out of their income alone. That being said, one-quarter would be able to finance less than 10% of their LTC expenses even when using assets (Bonnet, Juin and Laferrère, 2019[17]).

However, home equity programmes are typically not very developed in terms of housing market share and number of providers. Home equity programmes are still more products of last resort than well-thought purchases as part of a retirement planning or a health care plan. This is explained by several challenges on both the supply and the demand sides leading to an important regulation and the need for government-insurance programmes (Knaack, Miller and Stewart, 2020[18]). One policy option to stimulate the use of reverse mortgages would be for the public administration to act as lenders (Roberto Martinez-Lacoba, 2020[19]). A study of the potential for such products in Croatia suggests that a robust regulatory framework for reverse mortgages will be necessary as well as a strong role for the Croatian government (Marijana Badun, 2020[20]).

Two broad types of deferred payment exist through home equity programmes: the reverse mortgage loan and the home reversion. The main difference with regular mortgage is that the borrower does not need to make any repayments if she lives in the home. With respect to reverse mortgage, someone can borrow against the value of their home and receive funds as a lump sum, a fixed monthly payment, or a line of credit. The entire loan balance becomes due and payable when the borrower dies, moves away permanently, or sells the home. Then, the loan must be repaid by the heirs. They can reimburse the credit to the lender and keep the house or sell it. (Bonnet, Juin and Laferrère, 2019[17]). Contrary to private LTC insurance, reverse mortgages can be purchased at old age, regardless of borrower's health status. In the case of home reversion, the home is partially sold, and the person signs a lease-for-life agreement. Contrary to reverse mortgage loan, home reversion implies a transfer of ownership.

The first form of house equity programme has been available in France for two centuries ("le viager," a home reversion programme). Reverse mortgages were first available in the United Kingdom and have been existing in the United States since the 1960s. They were introduced in New Zealand and Canada in the 1980s. Other countries, like Spain, also have a home equity programme. In Canada and the United States, borrowers aged 62 years or older are eligible for reverse mortgages. In Spain, homeowners aged 65 and older are eligible for a reverse mortgage (Bridge et al., 2009[21]).

The type and degree of regulation varies across countries. The most stringent regulation is in the United States for the government-insured scheme (HECMs). The insurance guarantees that the borrower's debt will never exceed the property value and that borrowers will receive regular payments from the loan even if the property loses value or the lender becomes insolvent. They are only accessible via a provider approved by the Federal Housing Administration. More broadly, the Department of Housing and Urban

Development regulates reverse mortgages (Paying for senior care, 2020[22]; Bridge et al., 2009[21]). In the US, LTC facilities may be expensive, and most families rely on Medicaid to cover that cost. Eligibility criteria include asset test on the primary residence: one cannot own a home, but not live in. Therefore, a single person is required to sell their home to receive Medicaid support (this does not apply if a spouse remains at home). However, the decision has been carefully weighted because older people would not profit from the reverse mortgage is it were to move to an LTC facility within a brief period. In other words, this solution is attractive to borrowers only if the reverse mortgage can be used to pay for in-home care over a relatively long period (Paying for senior care, 2020[22]).

In the United Kingdom, reverse mortgages are regulated by the Financial Services Act, or the Consumer Credit Act and providers can self-regulate under the Mortgage Code or Safe Home Income Plan. The UK's Financial Services Authority also regulates most entities that are involved in reverse mortgages and promotes transparency to protect borrowers (Bridge et al., 2009[21]). In the United Kingdom the reverse mortgage market is still small, despite high homeownership rates among older people and high demand. This small market is concentrated in London, Southeast and Southwest, where house prices are high. However, there is a strong demand in other parts of the country where both real estate and non-real estate wealth are lower. Yet, the market is not developed as much in the other parts of the country. This is partly because of the risks faced by suppliers – providers need high house price growth to make profit on reverse mortgages. A study evaluated how much it would cost the government per scheme in each region to equate provider's expected profit return in every region to levels in the Southeast, one of the regions with the most developed market in reverse mortgage. The estimates indicate that the cost for the government would be large (Sharma, French and McKillop, 2020[23]).

In France, the financial public institution "Caisse des Dépôts et Consignations" launched in 2014 the "Certivia" fund to organise the purchase and management of home reversions by the older people aged over seventy. The borrowers sign the loan with the public fund, which is financed by the state (first envelop was EUR 120 million). The fund covers the cost of structural renovations and property taxes. The borrower is responsible for the other charges and housing taxes. In addition, an heir may acquire the property at the market price, after the death of the borrower. Estimates indicate that there are about 4 000 reverse mortgage loans sealed every year in France – a low number (Notre temps, 2015[24]).

The eligibility criteria of in-kind home care benefit could be standardised and improved

The eligibility for in-kind home care benefit does not currently rely on a nation-wide standardised needs assessment tool. As described in Chapter 2, local authorities are responsible for assessing the LTC needs and the level of home care benefit, so the need assessment varies by county. A standardised need assessment could be implemented to ensure equal eligibility to the benefit across Croatia. In addition, the eligibility and the level of in-kind benefit could continue to depend on LTC needs, income and assets, but there could be stricter asset-testing and less stringent income-testing, with a view to expanding the coverage and the generosity of the provision.

Foster care and family homes could be enhanced

Foster families and family homes are a well-regarded alternative to nursing homes for care recipients with moderate-to-severe LTC needs. In Chapter 3, focus groups discussions shed light on positive opinions on foster care; interviewees assume that foster families have more time for each older person than LTC workers in nursing homes and that quality standards are higher (e.g. one older person per bedroom), even though some believe that quality controls should still be more frequent.

As explained in Chapter 3, participants in focus groups believed that foster families did not accept older people when they were immobile or suffered from dementia because the fee did not cover enough the additional care (according to them, the fee is between HRK 1 800 (about EUR 240) and HRK 2 400 (EUR 315) depending on the health condition of older people). Incentives in the form of additional fees and

training could contribute to developing these alternatives. The current fee could be increased to compensate more generously those caring for older people with severe needs (e.g. mild-to-severe cognitive impairments, almost-bedridden or bedridden care recipients).

Foster families could be offered additional training when caring for older people with more severe LTC needs to ensure high-quality care. Training options could include medical care, such cleaning wounds and pressure ulcer, dementia training, end-of-life training, and a training on the management of their own well-being to avoid physical injuries and mental health issues, like anxiety.

It would also be advisable to develop foster care and family homes where LTC facilities are lacking most and where the pool of family carers tends to be reduced. In coastal counties, where tourism if an important source of revenues, foster care and family homes remain under-developed compared with other less-privileged counties.

While the OECD has not undertaken a thorough analysis on foster care and family homes in Croatia and in other OECD countries, it recommends exploring successful practices of child foster care in Croatian coastal counties and to consider developing active recruitment strategies, potentially through a public structure gathering all stakeholders, including not-for-profit organisations. A top up could also be considered for foster families in coastal counties to provide sufficient financial incentive.

In France, the state has tried to develop foster care for older people, with a limited success. A brief report suggested avenues of changes in 2008, among other initiatives. It highlighted major challenges, especially those related to recruitment, the under-valued image, and substitute recruitment (so that the carer can take leave). Among other recommendations, it suggested creating a supporting structure (such as a public umbrella structure to include not-for-profit organisations and the private sector), using vouchers ("Chèque emploi service universel") and speeding up the validation process. It also promoted the creation of a quality label for foster care (Rosso-Debord, 2008[25]).

Recommendations for children foster care in other countries can also provide some insights for foster care for older people in Croatia. In the United States, recruitment efforts are most likely to be successful if they focus on individuals with similar characteristics. Good recruitment practices also include hiring programme co-ordinators to lead community-based recruitment teams and assigning staff specifically to seek out family members. Agencies often partner with not-for-profit organisations to find foster caregivers (United States Joint Economic Committee, 2020[26]). Targeted recruitment has also gained momentum as a more effective strategy for recruiting foster families. Recruitment can be targeted towards specific professions, faith groups, ethnic groups, or geographic areas (Casey family programs, 2014[27]). In the United Kingdom, some local authorities join together to fund advertising campaigns, but with limited success (Baginsky, Gorin and Sands, 2017[28]). Research on foster care in children has shown that 'word of mouth' is one effective recruitment strategies, and many local authorities in charge of foster care regularly involve their existing foster carers in recruiting other carers (Baginsky, Gorin and Sands, 2017[28]). A set of evidence in other countries shows that 'word of mouth' is an important recruitment strategy (Randle et al., 2014[29]; Casey family programs, 2014[27]).

It is also important to develop strategies to keep foster families (Baginsky, Gorin and Sands, 2017[28]). Organised peer support and respite care are two efficient strategies to maintain the engagement of foster families (Casey family programs, 2014[27]).

A new cash benefit to family carers: Eligibility criteria, generosity, and regulation

The Ministry of Labour, Pension System, Family and Social Policy of Croatia indicated that a priority among LTC reforms is introducing a cash benefit targeted at family carers. Ideally, the cash transfer should come with a package of support for family carers providing intense care. – for instance, training and respite care should be included.

The OECD recommends that such benefit targets poor family carers who provide full-time care to older people with severe needs. The amount of the cash benefit should be aligned with those of the carer's status and the poverty line to ensure decent living conditions and some equality with other carers. The new cash benefit could aim to compensate for the opportunity cost for family carers providing intense care.

The design of such cash benefit could build on England's cash benefit, in the sense that eligibility criteria could be blind to family ties or a common residence. This would be different to Spanish and Portuguese cash benefits, where the cash benefit focusses on family members living with older people. While this new cash benefit would be primarily intended to support families, friends, and neighbours, it would also recognise the role played by paid informal carers privately hired by families. These carers in the grey area deserve decent living conditions and could also receive qualifying training at the end of the caring period.

This subsection details possible details of a cash benefit for carers, based on practices found in OECD countries (Rocard and Llena-Nozal, 2022[15]). At the same time, the OECD recommends piloting the introduction of a new cash benefit to carers in a minimum number of key counties (e.g. Zagreb, one on the coast and one in the North) and evaluating the introduction through a comparison with three other counties sharing similar characteristics. In a first phase, it would be important to consult stakeholders to collect their views on the potential challenges as well as their degree of preparedness. In parallel, Croatia should decide the evaluation criteria (the outcomes of interest) and the evaluation method. The OECD recommends planning a counterfactual impact evaluation. This would enable the Ministry to assess the changes that could be attributed to the implementation of the new cash benefit. In contrast to outcome monitoring, which only examines whether targets have been achieved, impact evaluation compares between what actually happened and what would have happened in the absence of the intervention. Even though randomised evaluation is the gold standard to evaluate policy impacts, it might be more feasible using a simpler method complemented with econometric tools to estimate the impact of the pilot test. The design of the cash benefit to family carers should be modified based on the results of the evaluation. After feedback of stakeholders and evaluation, the cash benefit could be implemented across counties in Croatia.

Target population and eligibility criteria

LTC needs of the care recipient

The objective is to select care recipients with severe LTC needs by using a standardised need assessment. Croatia has already developed a standardised need assessment that could be used, and some care recipients would have already been assessed because of their high LTC needs. Since 2017, a panel of experts has determined the type of disability and the degree of disability of older people claiming the assistance and care allowance and the personal disability benefit in Croatia. The panel of experts is chaired by a physician and is composed of at least one physician and one expert on disabilities who have a minimum of two years' experience each.

At the same time, Croatia could consider modifying the current need assessment to include more questions related to daily life limitations and focus less on specific diseases or disability. Needs assessment based on limitations are more inclusive than those based on reasons behind limitations (e.g. disease, impairments). It would be appropriate that a panel composed of medical and social experts, with knowledge of older people dependency and limitations, review and define further the indicators and thresholds used to evaluate the degree of disability. The level of disability should require over 40 hours of LTC and daily care, as detailed in the next section.

While there is no single internationally accepted and standardised definition of what constitutes LTC needs. standardised need assessments are in place in Austria, Belgium, Czech Republic, France, Germany, Latvia, Lithuania, Netherlands, Portugal, and Spain. For example, in Germany, the Health Insurance Medical Service or other appointed independent assessors use an instrument measuring ability in six domains (mobility, cognition and communication, behaviour patterns and psychological problems, self-reliance in personal care, self-reliance in taking medication, ability to structure life – e.g. arrange a daily routine). Furthermore, the instrument considers the ability to perform activities outside the house and manage the household (e.g. shopping, finance). For each criterion, a point value of self-reliance ranging between 0 (full self-reliance) and 3 (full dependence to assistance) is attributed. The domains have different weights, the highest weight being for the personal care domain and the lowest for the mobility domain. The total score is used to attribute a level of severity of impairment (from "one. minor impairments" to "five. most severe impairments"). It is worth noting that Germany recognises dementia as a condition that requires more support even if the person has no physical impairments.

Other characteristics of the care recipient

If a new cash benefit were introduced, a minimum age should also apply to the care recipient, as this is commonly the case in most OECD countries. A proposal is to use retirement age as the threshold. However, it would be valuable to have the recommendations of an expert in disability benefits in Croatia to ensure a certain consistency between this proposition of a new cash benefit and disability benefits for adults (aside from the personal disability benefit). The main advantage of such minimum age is to ensure that only family carers taking care of older people with LTC needs are eligible. However, LTC needs can start at an earlier age, especially in the Northern counties, where the health status tends to be poorer (see chapter 1).

As in many other EU countries, the cash benefit for family carers would be unrelated to the LTC benefits for the care recipients living at home. Care recipients could receive LTC cash benefits and in-kind home care (although in-kind LTC benefits are "care sighted": those with relatives able to help are not eligible for in-kind benefits).

Number of hours of care provided

The OECD recommends setting a minimum threshold on the number of hours of care to target those providing most care, hence those needing the most public support, building on England's example. The caregiver should provide care for at least 40 hours per week in total. In Croatia, family carers who work report a median of 35 hours of care, compared with 44 hours for non-working and non-retired family carers (about 35% of surveyed informal carers)[5] (see chapter on the profile of family caregivers). In England, the threshold is 35 hours per week.

The main advantage of this threshold is that it ensures a stricter coverage of the benefit to help those than need most help. At the same time, the principal disadvantage is that it excludes a share of carers who report struggling to combine care and other activities. As seen in the chapter on the profile of family carers, combining care and work can be challenging and leading to financial problems. The field survey carried out indicated that about 27% of carers who were employed reported that they had problems to a great extent to jungle between care and their own daily activities.

Characteristics of the family carers

Building on England's practice, it would not be necessary for the family carer to be a relative and would not have to live in the same household. Friends and neighbours could also be family carers (especially in rural areas) and this approach can contribute to formalising paid family carers working in the grey labour market. At the same time, this (absence of) eligibility criterion holds a contradiction, because the first target population is meant to be family members. The actual target population would have to be closely monitored in a pilot test to evaluate whether family members prevail and assess to what extent the cash benefit can

contribute to formalising the grey market. The field survey on informal carers found that an estimated 10% of carers were informally hired and paid by families (this is likely a conservative estimate).

Family carers should be at least aged sixteen or over and should be a resident of Croatia. The main advantage is that it ensures that citizens and some foreign-born are included, but it may trap some young Croatians or migrants in a form of low-paid work. Family carers should not be eligible for disability benefit (assistance and care allowance and the personal disability benefit) to make sure that they are fit to care. One challenge is the maximum age. The OECD suggests that while the family carer could be over retirement age, the person should not be receiving a pension benefit. An option whereby carers can combine pensions and a cash benefit may require a reduced cash benefit, depending on the amount of the pension.

Family carers should not be in full-time education or work so that they are available to provide care hours. While some countries allow for a combination of work and cash benefit, this solution has several drawbacks. It can make the benefit more intricate to be able to obviate a trap (not increasing working hours to keep the benefit[6]). In addition, work constraints the amount of time available for providing care and combining both can also lead to mental and physical health problems.

Amount of the cash benefit

The amount of the cash benefit should be aligned with the cash benefit of the carer's status and the net amount of minimum wage. The amount should be sufficiently generous to compensate the time spent caring. At the same time, it should remain lower than the net minimum wage and should not provide a financial disincentive to drop out of the labour market. This net amount of the benefit should not be lowered by taxes or social contributions opening rights to access public pension or health care. Instead, a covenant with the Social Welfare Centres could be implemented to cover at least pension rights and health insurance. This would be in alignment with the current carer's status for people with disability.

The introduction of such cash benefit might open the door to a professionalisation. It would allow relatives, friends, and neighbours to receive the cash benefit and social protection rights and might encourage others currently not doing so to start caring. It can also lead to the formalisation of the grey market of informal carers. As previously stated, the actual target population will have to be closely monitored in the pilot test to evaluate whether family members prevail and to which extent the cash benefit can contribute to formalising the grey market.

Type of regulation

The care recipient and the carer could sign a contract that could be registered by the Social Welfare Centres. The contract should state the tasks undertaken and provide information about the location of care and the caring hours. Defining a contract between the care recipient and the carer would enable Social Welfare Centres to monitor the care provision, but it would create additional administrative tasks for everyone (SWC, family carers and care recipients). It would be better for monitoring purposes to allow only one carer per person in need against compensation with the cash benefit. The cash benefit would be directly provided to the carer instead of relying on care recipients to transfer the money to ensure that the carers receive the money.

Finland is an interesting country example in the sense that municipalities directly hire family carers, and such an employment model could be considered by Croatia in the future. In Finland, the amount of the support depends on the intensity of the care needed. If the caregiver is unable to work due to LTC provision, the minimum amount is EUR 827 per month, and in the case of less intensive care provision, EUR 413 per month. This allowance is taxable, and it counts for pension rights (although at low level). Additional municipal services include, for example, help with washing, medical care, and meal deliveries. In addition, registered family carers are insured for accidents and are entitled for days off (three days off per month for intensive LTC provision). Municipalities may also offer temporary institutionalised care as a form of respite care for family carers. Since 2018, municipalities have provided coaching related to caring duties. There

are about 50 000 registered family carers, out of which approximately 60% are pensioners (Eurocarers, 2021[30]).

The care recipient and the carer would have to renew the contract regularly (e.g., every 2 years) to ensure regular means testing, such as in Spain and France. Because this contract is not a work contract, it does not need to entail a regulation of sick leave, nor the number of labour days and nor the maximum total amount of hours of care per week (the minimum being 40 hours per week). At the same time, in terms of annual leave it could be consistent with the carer's status (status njegovatelja) to include an entitlement of 30 days of leave.

With respect to monitoring, visiting nurses, workers hired by the Zazeli programme and other social workers should be able to monitor the impact of care provided by the family carers. In case of insufficient or inadequate care provision, they could fill a form to raise their concern to the Social Welfare Centres. Relatives should also be able to fill a form to report on maltreatment, neglect, or abuse. Social Welfare Centres would be in charge to follow-up and potentially terminate the contract. To control against fraud, circumstances could be checked at any time and fraud officers could also get information about the family carer from other government agencies and from a former employer or bank. Benefit fraud should be prosecuted, or the family carer asked to pay a penalty. If the family carer committed fraud, the cash benefit should be stopped and become unavailable in the future.

Training options for caregivers

As in Germany, a visiting nurse could visit the family carer at the older people's home to provide a short training on medical care acts (like cleaning wounds and managing pressure ulcer) and technical movements (e.g. shower someone, turn older people in bed). The visiting nurse could also teach about dementia if needed. While this training would enable carers to be more qualified, it would also mean that visiting nurses would see an increase of their workload, even though the results of the field survey indicated that many already trained family carers. Family carers should also be entitled to mental health care or counselling support to discuss how family care impacts their mental well-being.

A qualifying training option could be available at the end of the caring period to give the opportunity to carers to develop their education and increase the odds to find a position afterwards. This is particularly key as most carers are women who might have low career perspective before caring. Taking on care responsibilities full-time should not translate into the exclusion of the labour market for the rest of a working life. In addition, the former paid informal carers privately hired by families (whose labour status would be formalised) could also receive a qualifying training. This could help them improve their career perspective. However, such training would create additional expenditure.

Leave and respite care

Countries usually do not provide leave associated with the cash benefit, because the cash benefit is not meant to be the equivalent of a wage. However, a few countries set a fixed number of days of respite care. The OECD recommends setting respite care days for Croatia. An example could be the respite care in Slovak Republic, although the take-up is very low. In the Slovak Republic, municipalities provide respite care for a maximum of 30 days. Setting respite care at 30 days would also be consistent with carer's status (status njegovatelja), which allows to take up to four weeks per year of holidays. As in Germany, respite care could become available after having provided care for at least 6 months.

Alternatively, Croatia could provide in-kind respite care. At the same time, take-ups for in-kind respite care are typically low because of access and "logistic" difficulties: in-kind respite care may not be available and organising respite can be an organisational challenge.

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Annex A. Methodology of the field questionnaire and the focus groups

Under the Croatian Ministry of Labour, Pension System, Family and Social Policy guidance, the OECD designed the survey design and prepared the questionnaire, while the agency Kvaka conducted the survey on the field. The field work in Croatia took place between March and July 2020. The project is aligned with data privacy laws in the EU and in Croatia.

The OECD developed the sampling design, with the support of the Croatian Ministry of Labour, Pension System, Family and Social Policy. The sampling follows a two-stage procedure that has the advantages of: 1) providing a good coverage of the counties; 2) being simple enough to implement; and 3) making the sample representative of family carers and care recipients receiving visiting nurses' care.

In the first stage, the probability of selecting a nurse from a given county was calculated based on the percentage of Croatians aged 65 years old and over by county. In the second stage, in each county, nurses are selected under the constraints of maximising the number of different health centres within each county, while maintaining proportionality to the size of each health centre. The questionnaires were sent by mail to the health centres, which forwarded the questionnaires to visiting nurses.

In January, three working visiting nurses were randomly selected among visiting nurses working in Zagreb to provide feedback on the questionnaires. The three visiting nurses were excluded from the final sampling procedure and did not take part further in the survey.

Targeted sample size and response rates

The data collection follows a two-stage procedure to ensure an optimal response rate with a targeted sample size of two hundred nurses. In the first stage, three hundred questionnaires were sent to visiting nurses by mail on 9 March 2020, with 1 April 2020 as the deadline for completion (extended to 8 April if necessary). However, the COVID-19 outbreak slowed down the data collection as visiting nurses were not allowed to visit vulnerable populations or were heavily involved in the COVID-19 health efforts. On 1 April, only twenty completed questionnaires had been collected and a reminder was sent to prolong the deadline. As only sixty-seven questionnaires were received on 22 June, it was decided that the agency Kvaka would send an additional fifty questionnaires in June, with 31 July as the deadline. The selection of the additional visiting nurses considered the previous response rate in each county to maximise the country coverage.

When the data collection stopped, 220 questionnaires were collected, out of 350. The number of questionnaires was considered sufficient to make the sample representative of family carers of older people receiving care from both visiting nurses and family carers. The completion rate was good in terms of number of questionnaires collected (63%, out of 350) and in total 33% of visiting nurses completed the questionnaire in Croatia (see table below). However, no information was collected in four counties.

Table A A.1. Completion of the questionnaire by county

County	Number of visiting nurses in Croatia	Number of nurses who completed the questionnaire	% of nurses who completed the questionnaire
Sisak-Moslavina	12	9	75%
Vukovar- Srijem	23	16	70%
Šibenik-Knin	9	5	56%
City of Zagreb	76	41	54%
Varaždin	12	6	50%
Krapina-Zagorje	24	11	46%
Karlovac	22	9	41%
Osijek-Baranja	30	12	40%
Zadar	14	5	36%
Slavonski Brod-Posa..	37	13	35%
Split-Dalmatia	93	32	34%
Koprivnica-Križevci	22	7	32%
Istria	38	11	29%
Virovitica-Podravina	20	5	25%
Primorje-Gorski kotar	63	14	22%
County of Zagreb	105	20	19%
Bjelovar-Bilogora	24	3	13%
Dubrovnik-Neretva	13	0	0%
Lika-Senj	7	0	0%
Međimurje	7	0	0%
Požega-Slavonia	5	0	0%
Total	656	219	33%

Note: One observation was dropped because of the inability to match the ID with the county. The list of visiting nurses by county was provided by Croatian authorities.
Source: OECD 2020 questionnaire to visiting nurses and carers in Croatia.

Each questionnaire for visiting nurses was associated with six questionnaires on informal family carers, care recipients and the care situation. The quantitative analysis was performed on a much larger sample. Analysis was carried on a sample of 1 126 family carers (see table below).

Table A A.2. Number of observations by county

County	Number of observations	Percent
Bjelovar-Bilogora	17	1.51
City of Zagreb	194	17.23
County of Zagreb	108	9.59
Istria	59	5.24
Karlovac	50	4.44
Koprivnica-Križevci	37	3.29
Krapina-Zagorje	55	4.88
Osijek-Baranja	65	5.77
Primorje-Gorski kotar	62	5.51
Sisak-Moslavina	46	4.09
Slavonski Brod-Posavina	65	5.77
Split-Dalmatia	177	15.72
Varaždin	34	3.02
Virovitica-Podravina	29	2.58
Vukovar- Srijem	77	6.84
Zadar	25	2.22
Šibenik-Knin	26	2.31
Total	1,126	100

Source: OECD 2020 questionnaire to visiting nurses and carers in Croatia.

The questionnaire

The questionnaire booklet is composed of three parts:

- one questionnaire for visiting nurses, focusing on the tasks and type of care they provide.
- six questionnaires for visiting nurses, one per household, each one focusing on one care recipient.
- six questionnaires for family carer, one per household, each one to be filled by only one care recipient.

The first part for visiting nurses enquires on their caring activities, including the monitoring tasks and the medical tasks, the care co-ordination activities, the physical care activities, and the emotional and communication activities.

The second part for visiting nurses enquires on the care recipient socio-economic status (gender, marital status, income, children, wealth, accommodation), health status, functional health status (such as ADL or IADL limitations) and their public benefits.

The last part for family carer enquires on health and living conditions, care tasks performed, tenure, number of hours per week for the care tasks per week, their care relationship (relative, neighbour, friends etc.), their socio-economic status and the challenges that they meet. It also collects data on potential compensations received with a view to estimate the share of informal carers hired by families in the grey market.

The questionnaire was provided by mail to the visiting nurses, who completed their sections and shared the questionnaire with a family carer. For care recipients with more than one family carer, the family carer was the respondent.

- Process review

The OECD developed the questionnaire in late 2019 and early 2020, under the guidance of the Advisory Group (AG) of the project. The OECD presented a draft questionnaire to the AG in Zagreb on the 21st of November 2019 for feedback. Following AG's suggestions, the questionnaire was reviewed and validated for the pilot survey.

The agency Kvaka conducted a questionnaire with three nurses, in Zagreb on 20 January 2020, to receive feedback. The questionnaire was amended accordingly.

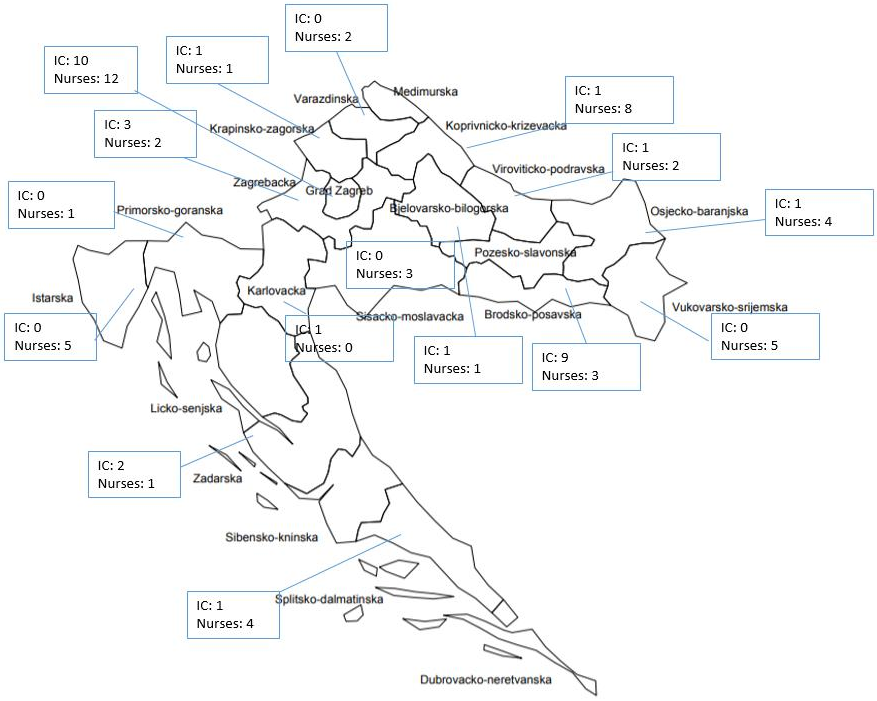
Methodology for the focus groups

Four focus groups and eleven in-depth phone interviews took place between September and October 2020 to provide an in-depth analysis about the provision of care and complement the answers of the questionnaire. The participants were selected in their counties among those who signalled their interest at the end of the questionnaire.

Targeted counties, selection of participants and length of focus groups

About thirty-one family carers and fifty-four visiting nurses were interested in participating in focus group discussions in Croatia (see figure).

Figure A A.1. About thirty-one family carer and fifty-four nurses were interested in participating to focus groups



Note: IC refers to family carers and nurses to visiting nurses.
Source: OECD 2020 questionnaire to visiting nurses and carers in Croatia.

Based on the number of older people, the number of older people with LTC need and the need to cover well the country, the counties targeted were Grad Zagreb, Splitsko-dalmatinska, Osjecko-baranjska, Istarska, Brodsko-posavska, Vukovarsko-srijemska, Primorsko-goranska, Koprivnicko-križevacka A total of 34 people were interviewed (see table).

Table A A.3. Selection of counties and groups

Focus group	Counties covered	Details
1 (16 September)	Zagreb	Six visiting nurses
2 (22 September-24)	Zagreb	interview by telephone. Six family carers
3 (18 September)	Koprivnicko-križevacka	Six visiting nurses
4 (22 September-24)	Brodsko-posavska	interview by telephone. Five family carers
5 (6 October)	Splitsko-dalmatinska, Primorsko-goranska, Istarska	Five visiting nurses (2 Split, 2 Pula, 1 Rijeka)
6 (1 October)	Osjecko-baranjska, Vukovarsko-Srijemska	Six visiting nurses (4 Osijek, one Županja, 1 Vinkovci)

Each focus group was composed of five or six participants. The focus groups were monitored by the moderator, Tamara Kraus from the company Kvaka. Individual responses were anonymised. The focus groups were held on Zoom due to COVID-19 pandemic. When participants did not know how to use Zoom or equivalent technologies, one-to-one in-depth interviews were conducted by telephone.

Topics covered

The three main topics that the focus groups covered were 1/ the profile of family carers, the 2/ caregiver monitoring and support and 3/ the most appropriate form of care.

The first part covers questions about family carers (directly or indirectly through visiting nurses). Questions enquire about the relationship to the care recipient, the employment status, the number of hours of care provided weekly, the balance between care, work and family responsibilities, and support. There are also questions about the reasons for providing care and challenges met (which ones, how do they deal with, who could solve them). The first part also includes a subsection on care recipient needs (what are the needs, whether they manage to meet the needs, what they bring most to care recipients).

The second part covers monitoring and support of family carers. Questions enquire whether and why they should be supervised, whether and to which extent family carers could be mentored. They also include questions about the support needed for family carers and the form that support should take.

The third part aims to understand the type of care that are preferred and why (nursing homes, carer status, home care, foster care). Questions enquire about advantages and disadvantages of each type of care, what works best and what should be developed to expand the preferred type of care.

Annex B. The profile of care recipients

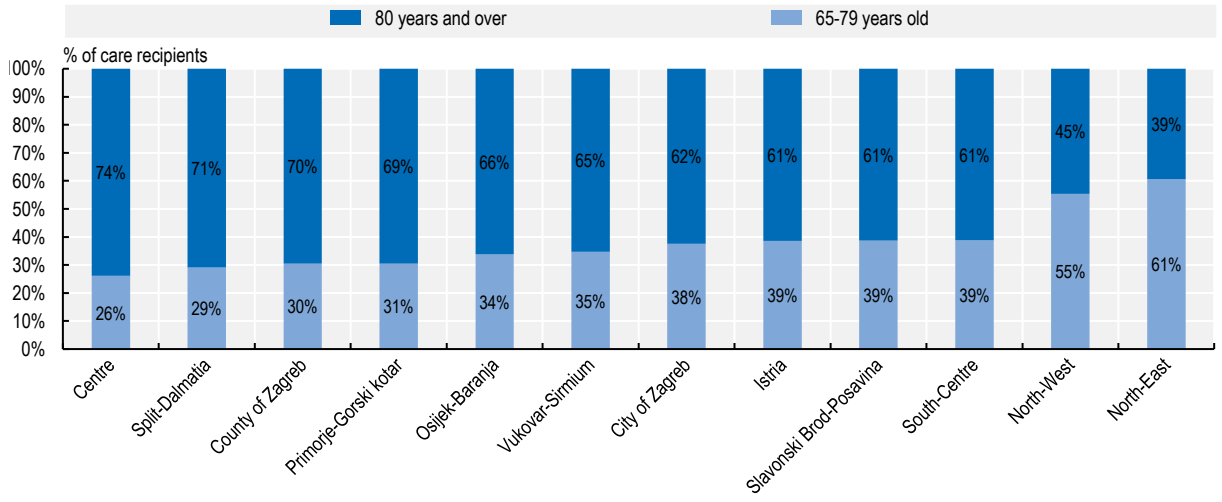
This Annex summarises (1) the results of the questionnaire on care recipients and (2) the findings of the focus groups on co-ordination with health care professionals. It describes the socio-economic situation, the LTC needs of care recipients and their access to aids. Then, it provides insights on the challenges faced in care co-ordination with health care professionals.

Two-thirds of care recipients are poor older women, living with others

Two-thirds of care recipients are women, of whom over two-thirds are aged eighty or over. About 83% have at least one child and among them 61% live with at least one of them. In other words, half of care recipients live with at least one of their children. About 15% of care recipients live alone, 40% live with someone else and 22% with two other people or more.

Care recipients aged between 65 and 79 are concentrated mostly in northern counties (Bjelovar-Bilogora, Koprivnica-Križevci, Sisak-Moslavina, Virovitica-Podravina, Varaždin and Krapina-Zagorje) (Figure A B.1). However, this does not mean that they are in better health than in other countries. The share of care recipients in poor or fair health and with chronic illness is similar in all counties. Rather, these results suggest that the older people living in the northern counties become in poor health earlier than in the rest of the country.

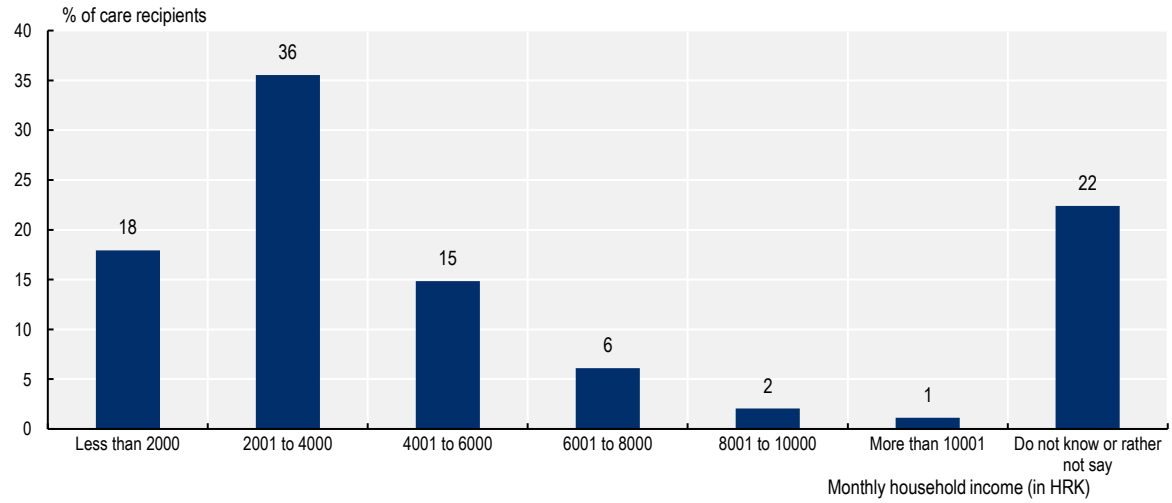
Figure A B.1. Care recipients aged under eighty are concentrated in the northern counties



Note: Counties were grouped together when there were too few observations (<59 observations). The North-East refers to Bjelovar-Bilogora, Koprivnica-Križevci, Sisak-Moslavina and Virovitica-Podravina. The North-West refers to Varaždin and Krapina-Zagorje. The Centre refers to Karlovac and Sisak-Moslavina. The South-Centre refers to Zadar and Šibenik-Knin.
Source: OECD 2020 questionnaire to visiting nurses and carers in Croatia (visiting nurses completed this section of the questionnaire).

Over half of household of care recipients make less than HRK 4 000 every month (Figure A B.2). In comparison, the monthly minimum wage was HRK 3 750 and the median equivalised net income was HRK 4 517 in 2019. Almost one-fifth have a household income of less than HRK 2000. However, it is worth noting that visiting nurses did not provide information on income for 22% of care recipients.

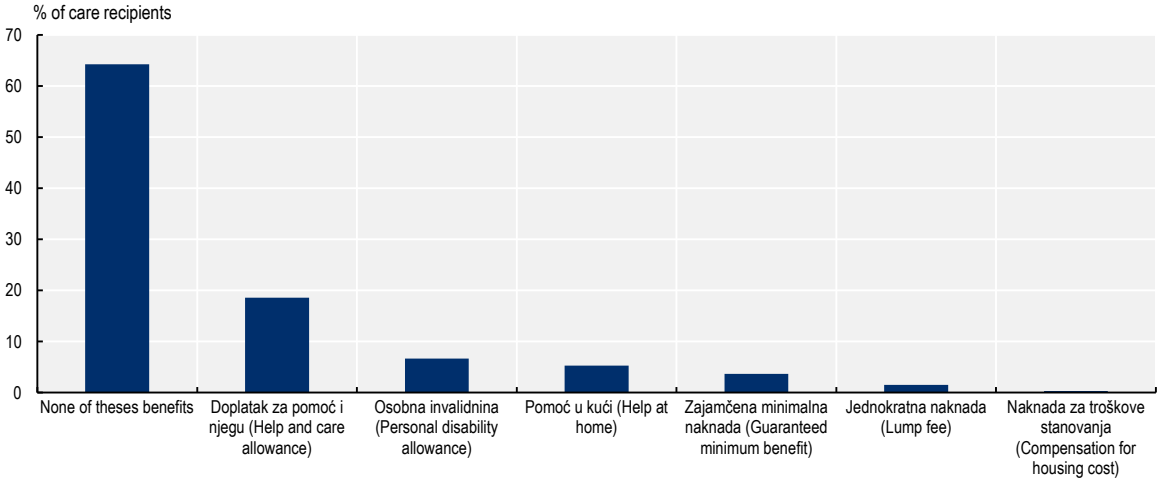
Figure A B.2. Over half of households earn less than HRK 4 000 every month



Source: OECD 2020 questionnaire to visiting nurses and carers in Croatia (visiting nurses completed this section of the questionnaire).

According to visiting nurses, about two-thirds of care recipients do not receive any of the six following benefits from social services: the help and care allowance, the personal disability allowance, the in-kind support at home, the guaranteed minimum benefit, the lump sum benefit and the compensation for housing costs (Figure A B.3). This suggests that there is room to increase the coverage of cash benefits.

Figure A B.3. About two-thirds of care recipients do not receive any of the six social benefits



Source: OECD 2020 questionnaire to visiting nurses and carers in Croatia (visiting nurses completed this section of the questionnaire).

According to visiting nurses, almost two-thirds of care recipients own their dwelling without mortgage, while 35% report living with relatives. Less than 2% of care recipients rent their apartment.

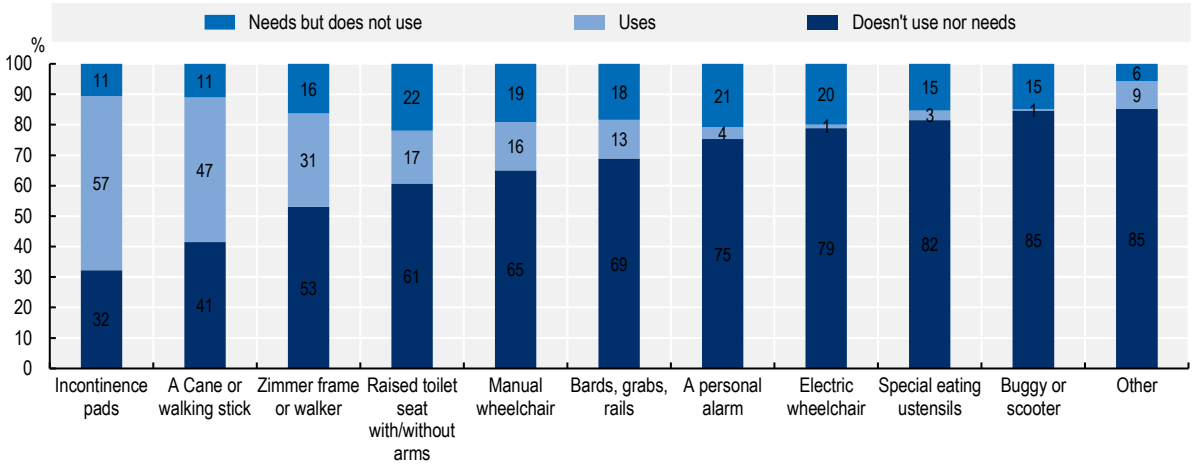
About 88% of care recipients need major support to perform at least one ADL or IADL. About 57% of care recipients need major support to perform at least one ADL and about one-fifth of care recipients are severely limited in the five ADLs. Visiting nurses believe that 64% of care recipients could not live alone, while 31% could live alone if they receive support and only 5% could live alone independently.

Access to aids is not regarded as an issue in general, but it may be complicated in specific cases

According to visiting nurses, only 16% of care recipients do not use aids that they need on average (Figure A B.4). The rate ranges from 1% for buggies and electric wheelchair to 21% for personal alarms. The most used aids are incontinence pads, cane or walking stick, followed by walkers, raised toilet seat and manual wheelchairs.

Focus groups participants believe that procedures could be simplified to obtain certain medical aids. For instance, family carers mention that they cannot access special anti-pressure ulcer pillow through HZZO – even diagnosis of fourth-degree pressure ulcer is not considered severe enough if it is not located on certain parts of the body. They also believe that free diapers should be automatically in the list of aids of HZZO when care recipients are over a certain age (e.g. 90 years old).

Figure A B.4. Only 16% of care recipients do not use aids that they need on average



Source: OECD 2020 questionnaire to visiting nurses and carers in Croatia (visiting nurses completed this section of the questionnaire).

Co-ordination with the health care professionals could improve according to the focus group discussions

The eleven family carers interviewed report issues related to co-ordination with home care professionals. According to them, visiting nurses and home healthcare workers come from about once a month to a few times a week if the care recipient is immobile or with dementia. However, when the care recipient is severely dependent, they think that formal care is insufficient. In addition, visiting nurses and home healthcare workers usually come only in the morning. This means that family carers must provide similar care in the afternoon and the evening.

Doctors decide on the frequency of home visits. Receiving more support depends on visiting nurses good will to co-ordinate with family doctors. Focus group participants also mention that doctors do not always consider visiting nurses' suggestions, even though they are more often in contact with care recipients.

Over two-thirds of visiting nurses report performing at least one care co-ordination tasks among their usual activities. About 73% of visiting nurses report that they refer patients to other health professionals, even though this is not their most frequent activity. Seventy-one percent of visiting nurses report developing, supervising, and co-ordinating care of patients in consultation with doctors, and 26% of them consider this activity as their most frequent care co-ordination task. More generally, about 74% of nurses report doing their most frequent care co-ordination task every day, 24% a few times a week, 1% once per week and 0.5% less often.

Focus group participants also point out that one single person could carry out care currently provided by visiting nurses, home healthcare and domestic care workers. More generally, they support the idea of some type of task-shifting to reduce care co-ordination workload.

Notes

[1] This report uses data from SHARE Waves 6 and 7: 10.6103/SHARE.w1.710 (http://dx.doi.org/10.6103/SHARE.w1.710), 10.6103/SHARE.w2.710 (http://dx.doi.org/10.6103/SHARE.w2.710), 10.6103/SHARE.w3.710 (http://dx.doi.org/10.6103/SHARE.w3.710), 10.6103/SHARE.w4.710 (http://dx.doi.org/10.6103/SHARE.w4.710), 10.6103/SHARE.w5.710 (http://dx.doi.org/10.6103/SHARE.w5.710), 10.6103/SHARE.w6.710 (http://dx.doi.org/10.6103/SHARE.w6.710), 10.6103/SHARE.w7.711 (http://dx.doi.org/10.6103/SHARE.w7.711), 10.6103/SHARE.w8cabeta.001 (http://dx.doi.org/10.6103/SHARE.w8cabeta.001), see (Börsch-Supan et al., 2013[32]) for methodological details. The SHARE data collection has been funded by the European Commission through FP5 (QLK6-CT-2001-00360), FP6 (SHARE-I3: RII-CT-2006-062193, COMPARE: CIT5-CT-2005-028857, SHARELIFE: CIT4-CT-2006-028812), FP7 (SHARE-PREP: GA N°211909, SHARE-LEAP: GA N°227822, SHARE M4: GA N°261982, DASISH: GA N°283646) and Horizon 2020 (SHARE-DEV3: GA N°676536, SHARE-COHESION: GA N°870628, SERISS: GA N°654221, SSHOC: GA N°823782) and by DG Employment, Social Affairs & Inclusion. Additional funding from the German Ministry of Education and Research, the Max Planck Society for the Advancement of Science, the U.S. National Institute on Aging (U01_AG09740-13S2, P01_AG005842, P01_AG08291, P30_AG12815, R21_AG025169, Y1-AG-4553-01, IAG_BSR06-11, OGHA_04-064, HHSN271201300071C) and from various national funding sources is gratefully acknowledged (see www.share-project.org).

[2] The European Union Statistics on Income and Living Conditions (EU-SILC) is a survey carried out every year since 2005 across all EU countries and other European countries (Iceland, Norway, Switzerland and candidate countries to the EU), under the coordination of Eurostat. Every year, an ad-hoc module complements the main questionnaire to provide a more in-depth picture of one dimension (for example, well-being, housing conditions, material deprivation, children's health, etc). The 2016 ad-hoc module focused on the access to various services, including health care services and formal home care.

[3] Organised housing service is not analysed in this report because of the very low number of recipients.

[4] System of Health Accounts. HC3 refers to long-term health care. Long-term health care comprises ongoing health and nursing care given to in-patients who need assistance on a continuing basis due to chronic impairments and a reduced degree of independence and activities of daily living (OECD/Eurostat/WHO, 2017[31]).

[5] Data are based on the distribution of weekly hours of care for family carers who provide personal care and help with household chores and other activities (e.g. taking medication). These data are to be interpreted with caution as it may be possible that some carers did not correctly allocate time spent on each type of care or help, overestimating the total number of hours.

[6] If benefit entitlements are fully withdrawn when earnings are above a certain moderate threshold, individuals will not be incentivised to work more than a limited number of hours.

OECD Health Policy Studies

Improving Long-Term Care in Croatia

The demand for help with daily activities – so-called long-term care – is set to increase in Croatia. The population is ageing at a faster rate than the EU average, and by 2050, about one-third of the population is projected to be aged 65 years and over. In addition, with one of the highest poverty rates among older people in EU countries, at 30%, most older people cannot afford long-term care without public support. However, the long-term care system is both fragmented, with multiple benefits and services across different providers, and underfunded with public expenditure among the lowest across EU countries. As a result, long-term care remains unaffordable for most people even after receiving public support, leading to gaps in access, inequities, and a strong reliance on relatives to provide the bulk of long-term care. This report suggests avenues to improve access and equity of long-term care and proposes policy recommendations to enhance the support for family carers.

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