Dignity first – priorities in reform of care services (Sweden, 26-27 September 2013)

Eldercare trends in Croatia[1]

Ivana Dobrotić
University of Zagreb, Faculty of Law, Department of Social Work

Iva Prpić
Ministry of Social Policy and Youth
Directorate for Adult Persons and Persons with Disabilities

The current situation and the recent trends in home care

The eldercare system in Croatia traditionally relied on publically provided residential services, while the other forms of care were of more marginal character. Since the late 1990s for-profit and non-profit providers have increasingly entered this area, and today they provide an important share of services. New residential homes started to be predominantly set up by non-state providers, e.g. 76.7% of new capacities founded since 2003 belongs to them (mainly to private providers, followed by religious communities and NGOs).[2] They become increasingly involved in home care provision as well. Besides the pluralisation of eldercare providers, the pluralisation of eldercare services also becomes an important trend and in the recent decade additional efforts have been directed towards the development of "alternative" forms of care such as adult foster care, family-type homes[3] and different community based services such as home care, day care centres, gerontology centres etc. (Dobrotić and Plasová 2013).

The "alternative" forms of eldercare, particularly different community-based services, gained on their importance and they become increasingly advocated as a more appropriate and cost-effective form of care (VRH 2003, 2007a, 2007b). As a result, in the last decade they widespread quite rapidly and become a prevalent type of eldercare provided under the social welfare system. Namely, according to the Ministry of Social Policy and Youth (MSPY) data, in 2011 the total eldercare capacities (residential and non-residential) amounted to 43,774 places, a capacity that covers 5.8% of persons aged 65 or over. Thereof, there were 17,536 elderly in residential care (40.1% of the total eldercare capacities, or the capacity that covers 2.3% of persons aged 65 or over), while the rest of 59.9% relates to different "alternative" forms of eldercare (adult foster care, family-type homes, home-care services, day-care centres etc.).

When it comes to the "alternative" forms of eldercare, according to the available data of the MSPY in 2011 there were 5,655 persons accommodated in adult foster care and family-type homes (this capacity covers 0.75% of persons aged 65 or over). The home-care services were provided to 5,083 beneficiaries: for 1,353

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[2] Despite this trend, the capacities by the state-owned, i.e. county-owned homes are still prevalent and they share in total residential capacities in Croatia amounted 62.5% in 2011 (MSPY 2012).

[3] Family-type homes are small housing units that can accommodate up to 20 persons.

beneficiaries through the Centres for home-care and nursing and for 3,730 beneficiaries through the non-institutional services provided by residential homes. Additional 15,500 elderly were covered by two contract-based programmes: "Home-care for the elderly" and "Day care and home-care for the elderly". Altogether, i.e. regardless the provision basis, the home care services covered around 2.8% of persons aged 65 or over. These programmes can be organised and provided by the local and regional self-government units, i.e. counties, cities and municipalities (LRSGU), religious communities, civil society organisations, legal entities or natural persons. It is important to mention here that the Croatian eldercare system has always relied on the subsidiarity principle, presuming a family responsibility as a primary one. Furthermore, a user's co-payment principle, i.e. the users' (or users' family members) obligation to contribute towards the costs of care according to their possibilities[4] was enacted in 1950s (Dobrotić and Plasová 2013).

As implied, the home care services in Croatia are provided on two different bases. On the one hand, *the right on home-care and nursing* can be exercised based on the decision of the centre for social welfare, in line with the provisions of the Social Welfare Act (Official Gazette 33/2012). It is a means-tested right (family income cannot exceed an amount of €200 per family member) that can be admitted only to those elderly in care need, who are not able to secure the needed care and help within their family. It cannot be provided to the elderly who have the contract of maintenance for life or contract of maintenance until death. The right on home-care and nursing consists of nutrition organisation, housekeeping, assistance with personal hygiene and other daily needs. It is founded from the public budget for those beneficiaries who meet the census criteria, while the others can still arrange the service provision if they pay for it from their own resources.

On the other hand, *the programmes "Home-care for the elderly" and "Day care and home-care for the elderly"* are implemented based on the contract between the MSPY and the LRSGU, where the subcontracting is primarily targeted towards the underdeveloped areas, areas with less developed services and high share of the elderly. These programmes are provided either by the LRSGU or by the other providers subcontracted by the LRSGU (e.g. civil society organisations or social welfare institutions). These services consist of the organisation of nutrition, performance of daily household chores, personal hygiene, provision of basic health care, psychosocial support and various socialisation activities, and are free of charge for the user. Although these programmes are notably directed towards the elderly with higher care needs, of lower socio-economic status, who live in single households and are without the possibilities to arrange a family-type care; there are no defined selection criteria to enter these programmes.

A depicted institutional fragmentation in home care resulted in problems with the transparency and equality of the system, as well as the problems related to the service quality, especially because there have been difficulties with quality control in contract-based programmes. The sustainability of the contract-based programmes is also not certain concerning what put users in precarious situation. Hence, the future reforms will have to tackle this parallelism, establishing a unique, financially sustainable system of elder care under which all the elderly will be entitled to the services under the same conditions.

Development of home care services in the last decade has been advocated also under the freedom of choice argument, as it allows to the elderly to decide on their own place and the way of living (VRH 2007b). According to the Social Welfare Act (Official Gazette 33/2012), a social assistance and social services should be realised based on the free choice principle and the user should be involved in its needs

[4] Today they participate in the service price according to their income and property.

assessment and the decision on the usage of needed services. Additionally, services provided in the social welfare system should be accommodated to the individual needs and circumstances, and the user should be actively involved in the whole process. Priority is given to the community-based services that should be available and affordable for all users. In spite of that, it should be noted that in practice these principles are not always achievable, notably due to the lack of services and regional differences in their availability, as well as the lack of information. Although there is no reliable data on waiting lists on eldercare services, the MSPY data on waiting lists for residential care speaks about the lack of present capacities. Namely, in 2011 there were 27,574 persons on the waiting lists for residential homes (MSPY 2012). Although this numbers must be read carefully as there is no central waiting list and usually one person applies in more than one facility, they ask for further intervention in this area, especially in non-residential forms of care. E.g. the focus groups with social workers in the City of Zagreb raised the issue of lack of home care services and actually showed how the elderly often do not have a possibility to freely choose their own place and the way of living as those who would prefer to stay in their homes and receive home care often apply for the place in residential facilities due to lack of home-based support in their living area (UISP 2010).

Further improvements are also needed when it comes to the individualisation of services and a person-centred approach. Namely, although the regulatory standards introduced in 2009 recognised the special care needs of e.g. persons with dementia diseases (Act no. 64/2009), existing studies indicate (e.g. Rusac et al. 2012) that there is still a lack of adequate services which are able to address their care needs in an appropriate way, as well as the needs of their carers (especially family members). Hence, the Swedish practice where the national guidelines for care of persons with dementia diseases were introduced could serve as an interesting source of good practice in this regard.

The use of technology in home care

The use of technology in home care is not gravest developed. In Croatia three residential homes for the elderly (in Rijeka, Pula and Zadar) provide the service “Halo help”, the so-called social alarm service (care-line), a remote assistance over the telephone with special alarm devices for the elderly. A similar service is also provided by the civil society organisation “Prisutnost”, active in the City of Zagreb and its surroundings. It provides a 24/7 alerting service and it is primary directed towards the elderly in single households, of lower socio-economic status, with health problems, or other persons not covered by care services. According to providers evaluations it is an important source of support for the elderly that assist them in everyday life, especially by providing them the feeling of security in the case of accidents. It is cost-effective, facilitates labour-market participation of family members and it prevents unnecessary institutionalisation.

The monitoring of the quality in the provision of services

When it comes to the quality monitoring, up to now solely the traditional approach has been followed, measuring the inputs such as staff to care-recipient ratios. To receive the permission to work, the providers of social services under the social welfare system were obliged to fulfil certain regulatory standards related to the minimal number of professionals and care environment (e.g. needed place and equipment to provide care). An inspectional supervision on expert work and law enforcement of service providers has been conducted by the Ministry.

However, the social welfare system has been going through the reform process, under the financial and expert assistance of the World Bank. One of the reform components has been related to the quality of social services and in order to standardise care practices the "Quality standards of social services in social welfare system" (MZSS 2010) were developed in 2008-2009. These standards describe the criteria of the quality social services and make an outset for the measurement of the quality of social services. That should allow for more transparent evaluation of service providers' quality and serve as a basis for their accreditation.

The quality standards encompass 15 general quality standards for all service providers and 10 additional standards for providers of residential care (5 for children and youth and 5 for adults). The general standards are related to: information availability, availability and appropriateness of services, integration and collaboration (up-keeping of social networks), evaluation and planning, decision-making and self-determination, privacy and confidentiality, security from exploitation, complaints, management, governance, provision of needed staff, work of volunteers and trainees, environment accessibility, conditions adopted to users` needs, and health, security and protection. Additional standards are related to the admission and dismissal procedure, relationship management towards the service users, autonomy and independence, health, nutrition and wellbeing, and restrictive measures. These standards are followed by the guidelines for their implementation and corresponding assessment indicators that are predominantly focused on the care process.

Still, these quality standards have not been implemented in eldercare yet. To make it possible, additional efforts will have to be directed towards their modification to accommodate them to the special needs in eldercare, where it is particularly important to consider different needs of individual user (e.g. persons with dementia diseases, in palliative care), as well as outcome indicators. Additionally, the current quality standards are predominantly directed towards residential care, so an additional consideration should be given to the particularities of the home care service provision.

The impact of policies and their sustainability

The recent trends in the Croatian eldercare system that has been reflected in higher capacities of the home care services contribute to larger service availability which allows an independent living in society and prevent unnecessary accommodation in residential facilities. Still, they did not manage to follow the growing demands for eldercare, what is reflected in long waiting lists for residential care, which is in some cases (as demonstrated earlier) the only possibility due to the absence of home care services in certain areas. It can be expected that these needs are going to be even higher as the population ageing is quite pronounced in Croatia who reached the share of 17.7% of population aged 65 and over (EU-28 average is 17.8; Sweden 18.8%; DZS 2013; Eurostat 2013). It is interesting to notice here that in spite of a similar share of elderly, the Swedish eldercare system provides services to a fairly higher share of elderly than Croatia (as stressed in the Host Country Paper their capacities cover 17.1% of the elderly population), what additionally speaks in favour of the need for new eldercare capacities in Croatia.

The lack of services put an additional burden on families and, respecting the fact that a dual earner-family is a prevalent norm in Croatia (Zrinščak 2008), that can cause a serious problems related to the labour market participation, especially if we take into the account the fact that recent studies conducted on the employed persons in Croatia (e.g. Dobrotić and Laklija 2009) show how the need to take care for dependant elderly is one of the most important determinants of the work-family

conflict, even more important than childcare. Moreover, the lack of services and regional differences in their availability do not ensure users to freely decide on the type of service, and services are not always accommodated to their specific needs. That asks for additional state intervention in this area where a special care needs of the elderly have to be respected (e.g. the elderly with dementia diseases, the growing needs for long-term care).

The available evaluations of home care programmes (Bouillet 2003; VRH 2007b) indicate how their development has a positive impact on the elderly and the society. Namely, the users of home care services reported how these programmes positively contribute to their quality of life as they provide them with a needed assistance in daily life and prevent their social exclusion. Additionally, they bring higher employment rates, as they employ new carers, particularly the persons with lower employability. E.g. in 2011 the contract-based home care programmes employed 1,045 persons in direct provision of services to the elderly, where 82% were women, mostly from the national priority groups for employment, such as young people without working experience (7%), long-term unemployed (46%) and unemployed above 50 years (18%) (VRH 2012). The evaluation also indicated a need for greater integration of home care services with healthcare (VRH 2007b), in order to enhance the service quality for the end user.

Additionally, the home care programmes are proved to be cost-effective (VRH 2007b). Thereof, in order to balance a quality and accessibility of care services with sustainable finances they are considered and advocated as a more appropriate form of care, which has to be prioritised in relation to the residential form of services. According to the Social Welfare Act (Official Gazette 33/2012) the social services should be primarily provided in users homes or local communities. The reliance on new technologies which are also shown to be cost-effective can additionally contribute towards the sustainability of the eldercare system, especially in the times of growing eldercare demands and scarce resources.

The consequences of the planned implementation of new quality standards can only be only presumed. Although they can enhance a care process, they also ask for more administrative work what can either lead to higher cost or less time left on direct provision of care related tasks.

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