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THE CARE SECTOR IN CROATIA
CHALLENGES OF ORGANISING AND COLLECTIVE BARGAINING

INSTITUTE OF PUBLIC AFFAIRS

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Social Policy Programme

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1. Methodological preface

In preparation of this text, in spring 2024 the author performed desk research and conducted five interviews with two representatives from trade unions, two representatives from the employers' side, and one expert in the field. Each individual has extensive experience with the topic at hand and possesses in-depth knowledge of the issues.

2. General characteristics of the sector

Of 1,700 preschool education institutions in Croatia, only 5 are owned by the state. At the same time, the majority (around 1,300) are organised and financed by local and regional government units. There are also 355 private preschool institutions and 59 from religious communities. Together they provide services for 142,000 children, of which 130,000 are in a regular full-time programme. The preschool education sector employs 23,400 persons, of which 22,400 are women.

The care system in Croatia is composed of a combination of care benefits that are made with cash and in-kind payments. Older people with long-term care needs can use a mixture of different benefits and services. Two are cash benefits (the assistance and care allowance, and the personal disability allowance), while five benefits are in-kind services consisting of help at home (home assistance allowance and organised housing) or in residential settings, such as nursing homes, family homes and adult foster families.

Residential care is provided in nursing homes, family homes and adult foster families, and is called "accommodation" in Croatia. Accommodation combines lodging with help in activities of daily living (ADL) and Instrumental Activities of Daily Living (IADL). They can be provided by the state, counties or by private organisations, such as NGOs or religious communities. In addition, family homes and foster care families provide accommodation in private households for older people, combined with ADL and IADL. Family homes and foster homes are both considered non-institutional care in Croatia. About 3% of older Croatians receive a form of public residential care. In 48 public (45 county and 3 state) and around 100 private homes for the older population, there are 16,500 persons accommodated with around 3,600 employees (Ministarstvo pravosuđa i uprave, 2021). There are long waiting lists

for accommodation in these institutions, with the average waiting period being more than 15 years.

The healthcare needs of older people are served through the health system, including palliative care and home care at a primary care level. Chronic care beds are in wards for long-term treatment, palliative care, chronic mental disease, physical medicine and rehabilitation, while in special hospitals and resorts, chronic child diseases and chronic pulmonary diseases are treated.

In the social welfare system, there are around 2,300 people employed, of which 2,050 are women. More than 70% are professional workers, mostly social workers, lawyers, psychologists, defectologists, educational rehabilitators, social pedagogues and sociologists.

Spending on long-term care is significantly below the EU27 average. In 2019, long-term care was only 3.1% of health spending in Croatia and only 16.3% within the EU27 (EU Commission, 2021). Croatia has a high number of beds in rehabilitative and long-term care hospitals, but there has been little investment in community-based long-term care. It can be assessed that this sub-sector is overly regulated in detail by national legislation, which may weaken the incentive for collective bargaining.

3. Major problems and challenges in the sector

Croatia's care system is currently underdeveloped and faces several challenges. Primarily, the system is fragmented and there is little or no coordination between the social welfare, health, and educational systems. While the social welfare system and part of the institutions of care are under the Ministry of Labour, Pension System, Family and Social Policy, preschool institutions are under the Ministry of Science and Education, while capacities of care in hospitals are under the Ministry of Health. Furthermore, institutions in the care system are under national, county, and municipal/city ownership, with coordination gaps existing between various levels of government. Counties are mostly responsible for the operating costs of homes for older people and people with disabilities. Finally, another problem is that public and private (not-for-profit and for-profit) providers lack effective coordination.

Formal care is underdeveloped and mostly provided in institutional settings. The benefits available to cover care needs are fragmented, not available to

all user groups, and often insufficient to meet basic needs. The burden of care falls disproportionately on family members and a growing informal care sector as part of the grey economy, with considerable scope for exploitation. In 2022 close to 4% of older people over 65 years received the assistance and care allowance and around 1% received the disability allowance. Less than 1% received formal in-kind home assistance, as eligibility depends primarily on the support of family and friends.

Working in care is exhausting, demanding and relatively poorly paid. Therefore, it is not surprising that employees try to find jobs outside of the care system, where the working conditions are more favourable, and the income is higher. Thus, there is a serious labour shortage, which is particularly a grave problem in the conditions of population ageing and increased needs for care services, as well as an ageing workforce in the sector. Such lack of labour force in the sector is partially being alleviated by the arrival of foreign workers, but they are not that interested in working and staying in Croatia, where working conditions are unfavourable, and wages are lower than in Western European countries.

4. Characteristics of social dialogue organisations in the sector

4.1. Challenges of organising employees

According to *Zakon o reprezentativnosti udruga poslodavaca i sindikata* (The Act on Representativeness of employers' associations and trade unions. OG 93/14, 26/15) and the Guidelines for Negotiation of Collective Agreements that apply to employees in the state and public sector, in the procedure for recognition of representativeness of trade unions…, a representative trade union is a trade union that, at the level for which representativeness is being recognised, has a minimum 20% of members of the total number of unionised employees.

The largest trade union in preschool education is *Sindikat radnika u predškolskom odgoju i obrazovanju Hrvatske* — SRPOOH (Trade Union of Workers in Preschool Education of Croatia), which has more than 6,000 members, followed by *Sindikat obrazovanja, medija i kulture Hrvatske* — SOMK (Trade union of education, media and culture of Croatia), which has around 2,000 members.

For the health sector, the biggest employee organisation is *Hrvatski strukovni sindikat medicinskih sestara — medicinskih tehničara* — HSSMSMT (Croatian professional trade union of medical nurses and medical technicians) with almost 13,000 members. The trade union *Samostalni sindikat zdravstva i socijalne skrbi* — SSZSSH (Autonomous Trade Union of Healthcare and Social Welfare of Croatia) has 12,000 members in healthcare and social welfare in more than 150 trade union organisations throughout Croatia. Of the 12,000 members, around 2,300 are in social welfare, which is approximately 10% of all employees in this sub-sector. SSZSSH is followed by *Sindikat zdravstva Hrvatske* — SZH (Trade Union of Healthcare of Croatia), which has a few hundred members and is rarely representative. The biggest trade union in social welfare is *Sindikat zaposlenika u djelatnosti socijalne skrbi Hrvatske* — SZDSSH (Trade Union of Employees in Social Welfare Activities of Croatia). It has 4,000 members in different types of social welfare institutions from all parts of Croatia and it is representative in the field of social welfare. According to the Croatian Bureau of Statistics, in the sector of human health and social work activities, there are 109,000 employees, of which 85,000 are female. The health service employs around 85,300 (65,000 are female), while residential care activities employ 15,300 (13,100 are female) and social work activities without accommodation employ 8,800 (7,300 are female).

Challenges for all trade unions in the sector are related to the reduced interest in trade union membership and the weakening of collective bargaining. It is difficult to unequivocally state what could be the reasons for declining interest in trade unions in this sector. However, the decrease in interest in trade unions in this sector is significantly less pronounced than in other parts of the economy. Trade unions in Croatia as a whole, including the care sector, are quite fragmented and probably focused too much on short-term goals related to improving wages, and not on long-term goals such as improving working conditions, training and skills of employees, developing and accepting new technology, etc. At the same time, employees believe that trade unions do not protect their interests and do not provide adequate legal support. Furthermore, additional difficulties are related to achieving representativeness for collective bargaining and the conclusion of collective agreements (CA). Croatia is one of the few EU countries where medical doctors still do not have their own professional collective agreement. Croatian doctors have been seeking a professional collective agreement for years, but the government does not want to negotiate for it with the excuse that it will cause discomfort among other health and public service unions.

4.2. Good practices for organising employees

Trade unions in the public sector are considered to have had significant success with the recently signed Basic Collective Agreement for Public Servants and Employees in Public Services (OG 29/24). With it, the coefficient for calculating the salaries of employees and the amount of a jubilee award has been significantly increased.

The national government sets standards and defines salaries for teachers in public schools. In the preschool education sector, these salaries should also apply but unfortunately, the law is not always respected. The costs for these institutions are borne by local authorities. The workers from the kindergarten *Tratinčica* (Daisy) in the City of Koprivnica directly negotiated with the city's government and due to their lack of knowledge and low negotiation skills, the city did not treat them as equal interlocutors. Thus, their salaries were about 30% below those prescribed by law, and they did not have legal financial supplements for Christmas, Easter, and transportation costs. The workers enrolled in the Trade Union of Workers in Preschool Education of Croatia, and immediately after the first meeting with the representatives of the City, the relations and the negotiation process changed. The knowledge, expertise, and professional approach of the representative of the trade union led the City to a completely new approach in negotiations and soon led to the desired results. The workers' salaries increased, and they obtained the rights to all legal financial supplements. Of course, in a country where the laws are respected, this isn't a subject of negotiation at all as it is ensured by the regular institutions of the rule of law.

4.3. Characteristics of employer representation

The type of employer depends on the form of the subsector in the care system. For a preschool institution, employers are mostly cities represented by the mayor. There are both public and private healthcare providers. Private medical doctors who have contracts with the Croatian Health Insurance Fund mainly perform primary care and there is only one association in the private sector, *Udruga privatnih poslodavaca u zdravstvu* (The Association of Employers in Private Healthcare). Secondary and tertiary healthcare is performed by state-owned health institutions. Teaching hospitals, clinical hospital centres and state institutes of public health are state-owned, and health centres, polyclinics, general and special hospitals, institutions for

emergency medical aid, home care institutions, and county institutes of public health are county-owned. For state institutions in the care system, the Government is the employer, while for those founded by the county or the city, the employer is the regional or local government.

Organisations, both private and public, representing employers also include the Associations of Healthcare, Rehabilitation and Social Care by the Croatian Employers' Association. However, it is not active in collective bargaining. Furthermore, there is the Association of Towns and the Croatian Association of Counties, but — according to the interviewees — they do not participate in collective bargaining either because it is performed at the level of a particular town or county.

5. Collective bargaining and other forms of social dialogue in the sector – characteristics

As collective agreements for employees in preschool institutions are concluded at the level of local government, in some cases only SRPOOH is representative and signs the collective agreements. There are around 60 collective agreements in various cities around Croatia that cover more than 8,000 employees in preschool education, which is approximately 64% of all employees in this sub-sector. According to a statement from the interviews, the conditions of the collective agreement are mostly the result of wealth or unilateral political decisions of cities and municipalities, and much less pressure from trade unions and real negotiations. Thus, in addition to the examples of cities and municipalities that offer more than the legal minimum, numerous municipalities and cities sign collective agreements with the same national trade union organisations with rights lower than what is guaranteed by law, with the explanation that they do not have money and cannot afford to pay higher wages. A few years ago, protest demonstrations were held in which employees from preschool institutions from all over Croatia gathered in the capital, dissatisfied with their incomes being lower than prescribed. The then Minister of Education replied that he had sent a letter to all mayors that the law must be respected, yet there were neither real changes nor inspection supervision on that topic.

For employees in private sector healthcare, there is a sub-sectoral Collective Agreement for Employees in Private Sector Healthcare (OG 118/19). It was

signed in 2019 and remains in force. For public healthcare and welfare sector institutions for the care system founded by the state, the government is a signatory of collective agreements, primarily through the previously mentioned *Temeljni kolektivni ugovor za službenike i namještenike u javnim službama* (the Basic Collective Agreement for Public Servants and Employees in Public Services) (OG 29/24), and *Kolektivni ugovor za djelatnost socijalne skrbi* (the Collective agreement for social welfare), while for those owned by the counties, the employer is also the county, represented by the *zupan* (prefect). According to the conducted interviews, the level of employers' interest in entering collective bargaining is constantly diminishing as is the interest in the trade unions and collective negotiations, for the reasons given in section 4.1.

There is the National Health Council which deals mostly with current events related to clinical hospital centres, but also other issues in the field of healthcare. The National Health Council consists of nine prominent experts in certain medical professions who are appointed and dismissed by the Croatian Parliament, at the proposal of the Minister of Health. In their work, the members of the National Health Council propose and give expert opinions in the field of planning and development of all areas of healthcare, opinions on the appointment of Clinics within tertiary healthcare, as well as Clinical Hospitals and Clinical Hospital Centres.

5.1. Content analysis of collective agreements

According to the number of covered employees, the largest collective agreement is the Basic Collective Agreement for Public Servants and Employees in Public Services. It was signed by the Minister of Labour, Pension System, Family and Social Policy and 11 representative trade unions, including HSSMSMT, SZH, and SSZSSH. It is followed by the Collective Agreement for Employees in Private Sector Healthcare signed between the Association of Employees in the Private Sector and representative trade unions. The third largest is the Collective agreement for social welfare. There are only slight differences in all of them, almost everything is included in collective agreements, from working conditions to various monetary supplements and professional promotion. The mentioned collective agreements cover many things, but they generally do not cover wages and wage scale. Content analyses of these collective agreements show them to be mostly extensive with a tendency to recapitulate benefits and standards already regulated by the Labour Act or the Occupational Safety and Health Act, but not wages.

The system of setting wages and salaries is maybe a little bit complicated, so it is not easy to explain. Namely, the coefficients are determined by the regulation on job titles and the complexity of jobs in public service. The Basic Collective Agreement (BCA) defines the base for the calculation of wages and salaries. Exceptionally, if this is not defined by the BCA, the Government of the Republic of Croatia issues a special decision (as prescribed by the Law on the Base for Wages and Salaries in Public Services).

5.2. Other forms of social dialogue

In most care system institutions, there are works councils, but currently, they only partially facilitate communication and collaboration between employees and employers. In the context of care, works councils can play a vital role in advocating the needs of both care providers and recipients, ensuring fair working conditions, and promoting quality care standards through effective dialogue and negotiation.

5.3. Impact of European sectoral social dialogue

The impact of European sectoral social dialogue on social dialogue in the care sector in Croatia is relatively limited, with awareness of European dialogue and its results among social partners being inadequate. Dialogue at an EU level is not among the main interests of trade union members, with interviewed persons not believing it to have a significant impact on Croatian laws.

All three trade union confederations are members of ETUC. The Trade Union of Education, Media and Culture of Croatia is a member of EPSU while the Croatian Trade Union of Nurses and Medical Technicians (HSSMS-MT) is a member of Public Service International (PSI).

6. Conclusions and recommendations

Workers and the quality of jobs must be at the centre of all measures. In a customer-oriented service sector, such as the care system, workers are the most important and decisive prerequisite for the success and sustainability of any business. For successful business results, a high level of human capital is needed. It can be achieved only by the full respect of all employees, transparent decision making and on-time information on the accepted decisions. This relates also to wage transparency. Trade unions and works councils in

long-term care should not prevent but support the transformation of the workplace because stopping technological and organisational progress is certainly not beneficial to workers, particularly those who perform the simplest tasks.

The care system in Croatia experiences a serious shortage of labour force due to a poor image, low salaries and competition from other sectors. Employer branding primarily includes adequate remuneration, constant improvement of working conditions, clear presentation of all advantages of such work, high esteem of employees, possibility for their professional promotion and full respect of workers' organisations and their role. Successful employer branding can be an efficient mechanism for dealing with the problems of labour shortages and retaining the available labour force. Collective bargaining can be an important tool in creating more favourable working conditions, better remuneration and generating conditions that attract existing and new employees to the mentioned sector.

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> Trade Unions in preschool education sometimes have to send the Educational Inspection when the local authorities that are the founders of these institutions do not show the will and intention to solve the irregularities.

> I really do not see any reasons to be a trade union member. Unfortunately, trade union has very weak impact on the improvement of working condition in the care system, which are characterised by long working hours, strenuous jobs and low salary!

About the Author

Predrag Bejaković, PhD, took his doctorate at the Economics Faculty in Zagreb and worked full-time at the Institute of Public Finance, Zagreb. He has more than 30 years of professional experience, particularly in evaluations related to active labour market programmes, analysis of the labour market situation and trends, and social security programmes among others. He publishes in scientific and professional journals, and he is the author and co-author of a number of books from the areas of the economy, pension system, education (particularly VET and adult education), policy planning, public finance and labour economics. He has been a team leader and leading expert in various national and international projects (i.e. The study on the cost and benefits of vocational rehabilitation for persons with disabilities) and the Republic of Croatia in 2009 awarded him the annual prize for his contribution to social science. His main fields of interest are labour economics, health economics, pension system, public administration, industrial relations and education.