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Ante Malinar

The Health Care System in Croatia

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Content

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1. Country overview

Source: https://ontheworldmap.com/croatia (Accessed: December 23, 2022)

- Sub-Region: Central and Eastern Europe
- Capital: Zagreb
- Official Language: Croatian
- Population size: 3,899,000 (2021)
- Share of rural population: 1,642,337 (2021)
- GDP: US$ 67.84 billion (2021)
- Income group: High Income
- Gini Index: 28.9 (2019)

Source: World Bank 2022

- Previous entities and independence: No colonial period, at least not in the usual sense the colonies are defined. Croatia was part of the Austro-Hungarian empire (1868 – 1918), the Kingdom of Yugoslavia (1918 – 1941), and Socialist Yugoslavia (1945-1991) and achieved full political independence in 1991.

2. Selected health indicators

Indicator	Croatia	Global Average
Male life expectancy (2019)	75.5	70.8
Female life expectancy (2019)	81.6	75.9
Under-5 mortality rate (2020)	5 per 1,000 live births	37 per 1,000 live births
Maternal mortality rate (2017)	8 per 100,000 live births	211 per 100,000 live births
HIV prevalence (2021)	<0.1 % (15-49 age range)	0.7% (15-49 age range)
Tuberculosis prevalence (2020)	7 per 100,000 people	127 per 100,000 people

Source: World Health Organisation 2022

3. Legal Beginning of the System

Name and type of legal act	Workers Insurance Act
Date the law was passed	1922
Date of *de jure* implementation	1922
Brief summary of content	The main goal of the policy was to keep workers healthy by supporting sick workers, as well as providing healthcare for work related accidents. The law established three social health insurance schemes which each covered different professions and contracted their own healthcare providers (WHO 1999; Zrinščak 2007). Without SHI, access to healthcare was available to individuals who were able to pay. At the same time, Andrija Štampar, one of the co-founders of the World Health Organisation, inspired the development of a system promoting public health (WHO 1999; Zrinščak 2007).
Socio-political context of introduction	In 1918, the Austro-Hungarian empire collapsed, and Croatia joined the newly formed Kingdom of Serbs, Croats and Slovenes (renamed Kingdom of Yugoslavia) in 1929. Serbian elites had a dominating position in the new state and advocated for Serbian hegemony under the guise of Yugoslav unitarist ideology. Croatian politics at the time revolved around the questions of nation, statehood, and the opposition to the Serbian regime, which was led by the Croatian Peasant Party (not surprisingly, since the rural population constituted the numerical majority in Croatia at the time) (Banac 1984). The historical roots of Social Health Insurance in Croatia go back to the 19th century, when Croatia was part of the Austro-Hungarian empire. Austria introduced laws on work-related accident insurance in 1887 and sickness insurance in 1888, but these laws were applied only in Dalmatia (one part of Croatia under Austrian jurisdiction). In Croatia and Slavonia (two other parts of Croatia under Hungarian jurisdiction) the sickness insurance was introduced in 1891 and work-related accident insurance in 1907. The coverage was limited to the formally employed in individually specified companies which at the time consisted of very minor part of population (Zrinščak 2003; 2007). These Social Health Insurance (SHI) roots echoed through the development of the Croatian healthcare system.

4. Characteristics of the System at Introduction

a. Organisational structure

A more systemically organised healthcare system in which the state played a greater role, especially in terms of public health, was introduced in 1922, during the Kingdom of Serbs, Croats and Slovenes (later Kingdom of Yugoslavia) (Zrinščak 2003). Three SHI funds were organised by private organisations and each covered different professions (WHO 1999). Mineworkers were covered by The Brotherhood Treasury; government officials were covered by Mercur; other employees and workers were covered by the Central Office for Workers Insurance (WHO 1999). Although signed in 1922, it was not until 1937 when it began to be implemented and the SHI schemes only covered a minor part of population (Zrinščak 2007). These SHI funds contracted their own healthcare providers which also provided services to non-covered individuals who could afford it (WHO 1999). Besides SHI, another important characteristic of the healthcare system at the time was the development of the public health system under the auspices of Andrija Štampar. The goal was to introduce a range of public health services and educate the population about public health issues and prevention of disease e.g., hygiene (Džakula et al. 2014; Zrinščak 2007).

b. Provision

Indicator	Value
Number of physicians (1940), total	1780
Number of hospital beds in general hospitals (1940), total	6183
Number of hospital beds in general city hospitals (1940), total	571
Number of hospital beds in private general hospitals (1940), total	1120
Number of hospital beds in specialist clinical hospitals (1940), total	679
Number of hospital beds in mental hospitals (1940), total	2229
Number of hospital beds in sanatoriums (1940), total	1130

Source: Dugački & Regan 2016

c. Regulation

In the Kingdom of Yugoslavia, Ministarstvo narodnog zdravlja (Ministry of Public Health) was the central institution responsible for healthcare regulation which also had its regional administrative units named inspectorates (Ivičević 1993). These inspectorates supervised the activity of all healthcare institutions, appointed healthcare personnel, controlled the budget, and approved purchases (Ivičević 1993). In 1928, inspectorates and their authority were replaced by three new roles including: regional health officers (who assumed most of the responsibility of inspectorates), committees (which regulated hospitals), and healthcare institution managers (who appointed health staff) (Ivičević 1993).

5. Subsequent Historical Development of Public Policy on Health Care

a. Major reform I

Name and type of legal act	Social Insurance Act
Date the law was passed	1946
Date of *de jure* implementation	1946
Brief summary of content	Major policy goals included the expansion of healthcare financing, coverage, and benefit entitlements. To this end, compulsory SHI was introduced which was financed through state budget and payroll tax (WHO 1999). Alongside SHI, the tax-based system was financed through local, district, republic, and federal budgets. In 1948, SHI and state health service were merged, and were then financed by the state budget and payroll taxes. At first, SHI was organised at the local level, but soon it was centralised and managed on a federal level by the Institute for Social Insurance and later the Health Insurance Fund. Regulation of healthcare was under the jurisdiction of federal and republic Ministries of Health (Parmelee 1985). Healthcare provision was nationalised, although private practices were allowed to exist until 1950 (and again later for certain types of healthcare service such as dentistry). However, private practice was seldom used due to legal restrictions. In the following years the reforms in the healthcare system strived for the decentralisation of the system which culminated in 1974.
Population coverage	Throughout the years people covered by SHI steadily increased, and by 1959 half of the population was covered (e.g., workers and their dependants) (Parmelee 1985). Certain groups such as farmers were frequently disadvantaged e.g. part of farmer population was either not covered at all or had reduced scope of benefit entitlements (Parmelee 1985). However, by the early 1970s coverage had become practically universal (Rodwin and Šarić 1993; Parmelee 1985).

Type of benefits	In the early years of socialist Yugoslavia free healthcare was given to people suffering from specific diseases, "(e.g. acute infectious disease, tuberculosis, mental disorders) and those belonging to certain risk groups (e.g. the elderly, young children, expectant and nursing mothers)" (Parmelee, 1985: 720). By the early 1970s benefits became practically universal (Rodwin and Šarić 1993, Parmelee 1985).
Socio-political context of introduction	At the end of the Second World War, in 1945, the communist party led by Josip Broz Tito established a totalitarian state named the Federal People's Republic of Yugoslavia (renamed Socialist Federal Republic of Yugoslavia in 1963) and Croatia became one of its federal states. As in other communist states, private entrepreneurship and market economy did not exist. After Tito-Stalin split in 1948 socialist Yugoslavia started to create its own type of socialism – self-management socialism (Ramet 2002). Self-managed socialism strived for decentralisation in which workers could participate in the management of their enterprises. Similarly, public services such as healthcare, education, and social welfare went through the process of decentralisation and establishing self-management (Ramet 2002).

b. Major reform II

Name and type of legal act	The Constitution of 1974 (Ustav Socijalističke Federativne Republike Jugoslavije)
Date the law was passed	1974
Date of *de jure* implementation	1974
Brief summary of content	The main goal of the reform was to follow up and expand the previous processes of decentralisation in healthcare which started already in 1953, gained traction in the 1960s, and finally culminated in 1974. Yugoslavia developed a specific model of socialism which differentiated it from other (Soviet) communist nations – self-management socialism. By 1974, the system was heavily decentralised and multiple healthcare funds, called self-managing interest communities (Samoupravne interesne zajednice; SIZs), were organised on the municipal level. SIZs were formally managed by users and providers of healthcare services and were responsible for collection and pooling of payroll tax, and purchasing of healthcare services (Rodwin and Šarić 1993, Parmelee 1985). However, the communist party had a major influence on decisions made by SIZs. (Rodwin and Šarić 1993). Although contributions were a primary source of healthcare financing, some financing came from the republican/federal state government budget (cross subsidies paid to alleviate inequality between different republics pooled into special funds) and municipal budgets (mostly for agricultural workers) (Parmelee 1985).
Population coverage	Coverage was practically universal (Rodwin and Šarić 1993; Parmelee 1985). Healthcare was part of basic rights and citizens were obliged to subscribe to health insurance. Since 1969, minimum standards of healthcare had to be provided to all citizens (Vukmanović 1972).
Type of benefits	The benefits provided were practically universal with widespread informal payments (Rodwin and Šarić 1993; Parmelee 1985). Only 3% of out-of-pocket payments were formal co-payments introduced in the late 1980s (e.g., for drugs, cosmetic surgery, abortions) while a large majority were informal payments (Rodwin and Šarić 1993).
Socio-political context of introduction	Decentralisation and expansion of self-management culminated in the 1970s. SIZs were instituted in enterprises and public services as a response to growing social and economic problems which occurred in the mid-1960s such as high inflation, rising unemployment, and inequalities (Parmelee 1985). Despite the institution of SIZs, the central authorities and communist party still had a major influence in political, social and economic affairs. This kind of system was "mocked as SIZ ophrenia" (Ramet 2002, 9).

c. Major reform III

Name and type of legal act	Health Insurance Act, Healthcare Act
Date the law was passed	1993
Date of *de jure* implementation	1993
Brief summary of content	Major goals of the reform were to alleviate the deficiencies of the previous system, increase financial sustainability, contain costs, and create a healthcare system inspired by Western policies (Malinar 2022a). Although SHI was retained, it was centralised into one national healthcare fund: Croatian Institute for Health Insurance (CIHI) which was strictly controlled by the government, thus losing Bismarckian principles of decentralised multiple funds and corporatist governance. CIHI was a single payer of healthcare services and a main agency responsible for contracting healthcare providers and purchasing of their services (Malinar 2022a). In lieu of SHI, private insurance was also permitted (substitutive and supplementary) and formal co-payments started to play a greater role. In addition, healthcare was partly financed by the government and county budgets e.g. financing health care contributions to unemployed and public health programmes (Malinar 2022a). Furthermore, reforms enabled the private provision of healthcare and set the grounds for privatisation of primary care, as well as the possibility of some physicians to work both in public and private spheres.
Population coverage	Almost universal. Entitlements are based on contributions. Dependent family members are covered from contributions made by working family members. The state covers and pays for contributions of unemployed, pensioners, disabled, persons under the age of 18, and war veterans. (WHO 1999)
Available benefits	Practically universal. Comprehensive, negative list with only few services excluded such as cosmetic surgery. 10% co-payments on selected healthcare services such as visits to primary care, specialists, diagnostic tests, and drugs (exemptions for retired, war veterans, and people with disabilities)
Socio-political context of introduction	At the start of the 1990s, Croatia embarked on the transition from the communist regime toward democratisation, liberalisation, marketisation, and Croatian independence from socialist Yugoslavia under the leadership of a newly elected right-wing party Croatian Democratic Union (Milanović 2011; Dunatov 2010). The transition was followed by severe political and economic crises (high inflation and unemployment, severe decline of GDP) and a war from 1991-1995 following the proclamation of Croatian independence in 1991 (WB 1995; Stubbs and Zrinščak 2007; Ramet 2013). Healthcare reform debates were led by medical professionals and revolved around moving away from the communist system and creating a financially sustainable health care system inspired by policies found in the West (Malinar 2022a).

6. Description of Current Health Care System

a. Organisational structure

The 1993 reforms laid the foundation for the current health care system and the main organisational structure remains intact. Since the reforms, numerous incremental changes have been instituted and include changes in the benefit package (e.g., the extent of user fees, co-payments, and exemptions from co-payments), purchasing policy (e.g., introduction of DRGs in hospitals, mixed capitation, and fee for service in primary care), and regulation of primary care privatisation. Noteworthy changes include the abolishment of substitutive private insurance and introduction of voluntary complementary health insurance.

The system is still highly centralised with the Ministry of Health and CIHI acting as main regulatory agencies (see below). Nevertheless, some elements of decentralisation are observed. For instance, health centres (mostly primary care services) and secondary level hospitals are under county ownership.

b. Coverage

All citizens and residents have the right to healthcare through mandatory healthcare insurance (Džakula et al. 2021).

Percentage of population covered by social insurance schemes	Nearly universal
Percentage of population uncovered (under any scheme)	Negligible

c. Provision

Indicator	Value
Density of physician (per 10,000 inhabitants) in 2019	34.7
Density of nurses (per 10,000 inhabitants) in 2016	81.2
Density of public hospital beds (per 100,000 inhabitants)	555.8
Density of hospital beds in not-for-profit institutions (per 100,000 inhabitants) in 2020	3.5
Density of hospital beds in for-profit institutions (per 100,000 inhabitants) in 2020	7.1

Source: WHO 2022, Eurostat 2022

- *Importance of inpatient and outpatient sectors*

In 2019, Croatia spent 29.5% of its health expenditure on inpatient care and 37.9% on outpatient care. However, it is important to note that hospitals are major providers of both inpatient and outpatient care, amounting to 47.4% of the healthcare expenditure (in 2018) (Džakula et al. 2021).

- *Benefit package*

The service package offered by mandatory health insurance is very comprehensive and only excludes a few services, such as cosmetic surgery. Except for pharmaceuticals, there is no positive list of healthcare services in the benefit package (Džakula et al. 2021). However, most services are not fully covered and co-payments are necessary to access healthcare services e.g., primary care visits, certain drugs, medical procedures (Džakula et al. 2021). Certain groups within the population are exempt from co-payments e.g., people with disabilities, people who are poor etc. Moreover, co-payments can be avoided by purchasing complementary health insurance which is offered by CIHI, as well as private insurance companies (Vončina et al. 2010).

d. Financing)

Indicator	Value
Total expenditure for health as a % of GDP (2019)	7
Domestic General Government Health Expenditure (GGHE-D) as % Current Health Expenditure (CHE) (2019)	82
Domestic Private Health Expenditure (PVT-D) as % Current Health Expenditure (CHE) (2019)	18
Out-of-pocket (OOPS) as % of Current Health Expenditure (CHE) (2019)	11
Voluntary Prepayments as % of Current Health Expenditure (CHE) (2019)	4
External Health Expenditure (EXT) as % of Current Health Expenditure (CHE) (2019)	0

Source: World Health Organisation 2022

e. Regulation of dominant system

Primary regulatory agencies include the Ministry of Health, Ministry of Finance (supervising healthcare financing) and CIHI. Other regulations are delegated to the Croatian Agency for the Supervision of Financial Services (HANFA, see below), Agency for Medicinal Products and Devices (HALMED) (regulates pharmaceuticals) and Agency for Quality and Accreditation in Health Care and Social Welfare (health technology assessment, accreditation, and quality control of hospitals) (Džakula et al. 2014; 2021).

The Ministry of Health regulates the standards of healthcare services, training of healthcare professionals while food and environmental safety are regulated in cooperation with other ministries (Džakula et al. 2014). CIHI is the agency responsible for collection and pooling of funds, as well as contracting and financial and medical supervision (together with professional chambers) of public and private healthcare providers (Džakula et al. 2021). The Healthcare Insurance Act approved by the Croatian Parliament provides broad categories of healthcare benefits which are more clearly defined in the Plan and Programme of Health Care Measures. This plan is determined by the Ministry of Health and CIHI (Džakula et al. 2014; 2021). With the approval of the Ministry of Health, CIHI in cooperation with medical associations regulates the price of all healthcare services within the scope of mandatory health insurance (Džakula et al. 2021). Activities of CIHI are monitored by the Ministry of Health while the State Audit Office performs regular audits (Džakula et al. 2014).

7. Co-existing Systems

In Croatia, voluntary health insurance policies are available to supplement the mandatory health insurance. Supplementary health insurance is provided by private insurance companies, and it covers higher standard of care e.g., direct access to specialists, and better hospital accommodation (Malinar 2022a). Complementary health insurance covers co-payments for health services and drugs that require co-payments in the mandatory health insurance (Malinar 2022b). However, non-essential drugs are still subject to co-payments even if a person is insured through complementary insurance (Vončina et al. 2010). Complementary insurance is offered by CIHI- and private insurance companies and people are free to choose their insurer. The main difference is that CIHI's complementary insurance premium is community rated while private insurance companies usually charge age-dependent premiums (Džakula et al. 2021).

Both supplementary and complementary insurance offered by private insurance companies are regulated by the Croatian Agency for the Supervision of Financial Services (HANFA) and have to follow regulations regarding audits, technical reserves, solvency etc. (Džakula et al. 2021). On the other hand, complementary insurance offered by CIHI is exempt from these regulations which puts CIHI in a favourable market position (Bodiroga, Vukobrat 2013). the percentage of the population insured by complimentary insurance offered by private insurance companies is not known, but 76% of the population is insured by complementary insurance offered by CIHI, (Džakula et al. 2021). Certain groups within the population have their complementary insurance policy fully subsidised by the government (Džakula et al. 2021).

8. Role of global actors

Global actors are not directly involved in the financing, regulation, or provision of the healthcare system. However, global actors were involved in Croatian healthcare reforms. For instance, the World Bank financed multiple health projects and provided technical assistance and policy expertise by producing numerous analytical studies evaluating the healthcare system (Malinar 2022a; 2022b; forthcoming; Džakula et al. 2021). Besides supporting the early 1990s reforms, the World Health Organisation has primarily been involved in public health issues and gathering healthcare related data and statistics.

9. Additional Relevant Legal Acts

Republic of Croatia 2013a. Mandatory Health Insurance Act. Zagreb: Republic of Croatia

Republic of Croatia 2004. Patient Rights Protection Act. Zagreb: Republic of Croatia.

Republic of Croatia 2019a. Act on Data and Information in Health Care. Zagreb: Republic of Croatia

Republic of Croatia 2019c. Health Care Act. Zagreb: Republic of Croatia.

Republic of Croatia 2019b. Act on Quality of Health Care. Zagreb: Republic of Croatia.

Republic of Croatia 2020b. Voluntary Health Insurance Act. Zagreb: Republic of Croatia.

Republic of Croatia 2013b. Act on Pharmaceuticals. Zagreb: Republic of Croatia.

Republic of Croatia 2013c. Act on Medical Products. Zagreb: Republic of Croatia.

Republic of Croatia 2003. Act on Medical Profession. Zagreb: Republic of Croatia.

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