

**Insured but not protected:
mandatory health insurance in Croatia does not guarantee health care for all**

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An analysis published by WHO's European Regional Committee in 2018 -"Can people afford to pay for health care?"¹ - has provided a comprehensive overview of several healthcare systems in Europe, including Croatia. The whole series was conducted under WHO's drive to achieve Universal Health Coverage (UHC) and mainly spoke about financial protection from catastrophic and impoverishing healthcare costs. Considering these parameters, the study on Croatia concluded that, all in all, this is not the worst health care system in the region.

In fact, the study reports that direct expenditure for healthcare in Croatia is low, and the healthcare system is mainly public, organized to allow universal access and limit out-of-pocket costs. In short, the general direction of the healthcare system in Croatia corresponds, more or less, with the main UHC goals.

Unfortunately, practical experience with the same healthcare system shows that this might not be a complete picture: several sets of problems have arisen from commercialization of health care conducted over the past 30 or so years, even though out-of-pocket costs remain low compared to other countries. The problems encountered in Croatia can be taken as a warning of the consequences that can be brought along through a strictly coverage-oriented approach to organising health systems.

For a relatively long period of time, spanning from the end of WWI to the 1980s, health care in Yugoslavia (and thus Croatia), was based on a vision of primary health care similar to the one in the Declaration of Alma Ata, with strong emphasis on health care as a right. Even though the healthcare system then did not manage to fully fulfill the high standards set, there was, nevertheless, a clear intention and various attempts to build a publicly funded and publicly provided healthcare system based on needs, including mechanisms to ensure accountability to the community.

After the introduction of World Bank loans in the 1980s, however, this vision was replaced by attempts to have a system that is more 'cost-efficient', and less of a 'burden' for the national and federal budgets. The same discourse continued after the breakup of Yugoslavia, and what followed was a very successful campaign of re-framing health care as a commodity rather than a public good. One of the main results of this process has been the tying of health care to the state-funded, mandatory basic health insurance scheme, operated by the Croatian Health Insurance Fund (CHIF) that was initiated in 1993 through the Health Care Act and the Mandatory Health Insurance Act.

On paper, the mandatory basic insurance scheme guarantees the same level of health care for every citizen and some other population groups (e.g. non-nationals legally employed in Croatia). It is based on solidarity, which means that the health

¹Vončina, L. and Rubil, I. (2018) Can people afford to pay for health care: New evidence on financial protection in Croatia. Barcelona: WHO.
http://www.euro.who.int/_data/assets/pdf_file/0009/373581/Can-people-afford-to-pay-Croatia-WHO-FP-007-2.pdf?ua=1, accessed 8/9/2019

needs of people who are not able to contribute to CHIF's funds – for instance, because they are too young, unemployed or retired – are still addressed and financed from social contributions deducted from the salaries of the workers. Simply put, as Ministers of Health in Croatia like to underscore on public occasions, the national health insurance scheme is supposed to ensure that basic health care is accessible to everyone, independent of their financial status, and protects people from potential impoverishment due to high healthcare costs.

Despite the rosy picture outlined through legislation, the health insurance model has encountered several problems from the very first years of its implementation. One of the biggest problems is that the legally guaranteed level of health care is “basic”. Formally, basic should be equivalent to access to primary, secondary, and dental care, as well as access to medication and other essential medical products, but in practice it is closer to a benefits package, which can be re-defined – depending on “financial and other healthcare-related capacities”² - by the Ministry of Health, based on suggestions by CHIF and the Croatian Institute for Public Health. This means that patients who use only mandatory health insurance are left with co-payments for some medicines, hospital stay, and visits to their GPs. Even though these co-payments can seem low, they add up in cases of serious illness, and for people in need of more health care, they can pose a significant financial burden.

Additionally, health care procedures covered by basic insurance can be difficult to access due to geographic maldistribution of health facilities, bureaucratic obstacles, and waiting lists. In fact, even though (basic) healthcare is legally guaranteed to everybody (in determined categories), they still have to have a registered status with the CHIF. Occasionally, this has caused people not being able to avail of their basic health insurance for a period of time. For example, people graduating from university are often not informed that they need to register their change in status with CHIF within 30 days, so ever so often they are surprised to discover that they are formally not insured, and face a long administrative process to renew their health insurance.

A bigger problem has been caused by the introduction of 'complementary' health insurance schemes, which can be bought either from CHIF or private health insurance providers. At first sight, the cost of such complementary insurance does not seem too high. For instance, for approximately 10 euros a month, patients have their co-payments for hospital treatment, as well as for GP checkups and prescribed medication, covered. For a few euros more, a private complementary insurance policy can also cover the costs of medicines from CHIF's secondary medicines list, for which co-payments are more expensive. Finally, CHIF complementary insurance for some groups – including children and people older than 65 with monthly income below approximately 200 euros³ – is provided by the state.

Regardless of the 'bargain price', as many see it, and coverage of some groups from public funds, the introduction and subsequent changes in the price of complementary insurance schemes have been seen as problematic by patients' organisations and other NGOs. These groups have repeatedly warned that this way of providing health coverage negatively affects access and leaves specific groups of patients without the care that they need.

²Article 18, paragraph 3 of the Mandatory Health Insurance Act.

³ For comparison, the median monthly income in March 2019 was reported to be around 750 euros net.

One of the most vocal organisations in this regard has been the Pensioners' Union. For years now, they have been warning that due to the automatic annual adjustment of pensions, a significant number of elderly people are denied state-subsidized complementary health insurance, while at the same time they cannot afford to purchase a policy on their own. For example, when in 2018 pensions were increased by a little less than 10 euros, retirees with an initial pension of 195 euros exceeded the threshold for exercising their right to free complimentary insurance. The Pensioners' Union notes that because of this, "since 2012, approximately 260 thousand retirees have lost complementary insurance"⁴. That meant they either had to somehow arrange a monthly amount of money for a complementary insurance policy, or cover co-payments for prescriptions and checkups, which elderly people need significantly more than the average young, healthy, and employed person, out-of-pocket.

Since the price of some of the private complementary health insurance schemes is about the same amount of the pension increase, one might think that pensioners may still contract complementary insurance without any significant financial loss. However, lately it has been reported that some private health insurance providers refuse insurance policies to people older than 65, meaning that in reality this option may not even be available to pensioners.

Another recent example⁵ has shown that private health insurance companies are also quick to dismiss patients who use insurance 'too much'. The news of a man for whom an insurance company declined to extend complementary health insurance policy after he fell ill with a chronic disease, sparked a debate in 2018 both in the media and among political parties. The case also led to a formal explanation by the government, which, interestingly, mirrored almost exactly the one⁶ published by the insurance company. From their point of view (both the government's and the insurance company's, let us highlight that part once again), the case was overblown, since the insurance policy was not terminated, but simply not extended after the original contract expired, though it was made clear to the patient that this had happened because "he had too many health care needs".

The experience of limited access to complementary health insurance is not limited to pensioners and people with chronic illness, as a large number of workers also find themselves in a similar position. Given that complementary insurance is voluntary, many employers choose not to include it among the benefits they provide employees, leaving it for workers to cover complementary insurance policies at their own cost. Considering the overall disparity among income and life expenses in the country, it is safe to conclude that a large part of the working population chooses not to purchase complementary health insurance⁷.

⁴More details on the Pensioners Union website:

<https://www.suh.hr/index.php/30-naslovna/naslovna-stalno-na-vrhu/1682-desetak-tisuca-ostecenih-umir-ovljenika> (accessed 8/9/2019)

⁵<https://dnevnik.hr/vijesti/hrvatska/splicanin-ostao-bez-dopunskog-zdravstvenog-osiguranja-unige-jer-se-previsje-lijecio---526894.html> (accessed 8/9/2019)

⁶<https://vlada.gov.hr/UserDocsImages//2016/Sjednice/2018/10%20listopad/120%20sjednica%20VRH//120%20-%2023.3.pdf> (accessed 8/9/2019)

⁷According to WHO's study "Can people afford to pay for health care: New evidence on financial protection in Croatia", 64% of all population in the country is covered by complementary health insurance. However, the number of population groups whose health insurance is covered by the government accounts for one third of this percentage.

The experience with health insurance in Croatia corresponds almost exactly to what is described in other global literature on the topic, including Global Health Watch 4⁸. Linking access to health care and the ability to pay for it, directly or through an insurance policy leads to “inequality in access, market segmentation, cream-skimming, and exclusion of certain population groups (such as the poor, the sick, and the elderly)”. These groups are usually those that have the greatest need for health care, leading to a highly inequitable situation.

Having in place mechanisms for containing financial risk, as well as formal provisions for granting access to a set of basic health care procedures for everyone, may mask these consequences for a while. However, experience shows that this is not the same as guaranteeing universal health care. A Universal Health Care approach which considers health from a much wider angle than the financial one, would bring along positive changes in accessibility and quality of care for the people most in need of it, that is, for people who experience significant trouble accessing health care under the present UHC models. Continuing with the implementation of a coverage-oriented approach might do exactly the opposite thing, i.e. exclude more and more population groups from access to health care, while at the same time providing encouraging data about utilization of health care and insurance.

It is crucial for Croatia to recognize that the chosen approach to ensuring health care is incompatible with actually providing healthcare for everyone. Instead of continuing along the same path, where access to health care is tied to one’s insurance status, it would be encouraging to see the Ministry of Health shift away from the commercialized view of healthcare and commit to a rights-based approach, more similar to the one preceding the 1980s.

⁸Available from: <https://www.ghwatch.org/node/45484> (accessed 8/9/2019)