ESPN Thematic Report on Inequalities in access to healthcare

Croatia

2018

Paul Stubbs and Siniša Zrinščak
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European Social Policy Network (ESPN)

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Summary / Highlights

Croatia has an insurance-based healthcare system but, as health insurance is readily extended to the non-working population, it is effectively a universalist system in terms of coverage. Mandatory health insurance is complemented by supplementary health insurance, available for EUR 9.30 a month, regardless of age or health status. Over 60% of the Croatian population has this additional insurance, thus avoiding co-payments for visits to a doctor and medicaments. Twice as many of those in the highest income quintile group as in the lowest quintile have additional insurance. In addition to contributions collected by the Croatian Health Insurance Fund (CHIF), the state also contributes directly on behalf of those exempt from payment. This is, however, at levels lower than prescribed in the rules, so that the system continues to run an extensive deficit, currently over EUR 1 billion. There is also private insurance, which allows additional rights, mainly realised through private health insurance. Measured as a percentage of GDP (7.3% in 2015) or in purchasing power standards (pps) per capita (EUR 1,245.04 in 2015), Croatia is in a group of EU Member States that spend least on healthcare.

Although rights to healthcare are comprehensive, in the context of financial shortages there is *de facto* rationing; also those medicines not included on the government's generic – so-called A – list are relatively expensive. While there is a recognition that waiting lists for some procedures are lengthy, information is not collected in a clear and transparent manner. The setting of monthly spending limits for hospitals serves to ration scarce resources, and those that can pay tend to turn to the private healthcare sector, which is rather small by EU standards. Medical staff are in short supply, mainly as a result of out-migration: four counties have a shortage of family doctors and there are reports of a national shortage of gynaecologists and paediatricians. The combination of a formal universal right of access to healthcare and shortfalls in financing the ever-escalating costs leads to informal rationing and a system in which *de facto* inequalities in access are significant.

Key groups whose access to healthcare may be limited include those on low income and with low education; Roma; women (particularly in relation to access to abortions); older people; and those living in rural or remote areas or on one of the Croatian islands. People on low incomes assess their health status as significantly worse than those from other income groups. Unmet need, although generally low, is more than 10 times higher in the lowest income quintile than in the highest, and 17.7% of those in the lowest income quintile report catastrophic health expenditure, compared to negligible rates among all other income groups. As far as Roma are concerned, they have a life expectancy some 10 years lower than the general population; around one person in five does not have health insurance for one reason or another; two thirds report problems in accessing essential medicines; and they face real problems in accessing antenatal care, with consequent negative effects on perinatal outcomes. Although Croatia has a relatively liberal abortion law, abortions can be costly and doctors may refuse to perform such operations for reasons of conscience: data from 2015 show that no abortions at all were performed in two general hospitals in Croatia. Older people also face the prospect of limited and declining healthy life years, along with higher levels of unmet health need and of waiting, compared to the population as a whole. Healthcare for those in rural areas has not been a policy priority and may have been adversely affected by functional reorganisation of hospitals. Those living on the Croatian islands, on the whole, have direct access only to basic healthcare and are reliant on sea or air transportation for more complex procedures.

Healthcare reforms are being implemented only slowly and unevenly; but in any case, they do not tackle key issues of inequalities in access to healthcare. Policies on healthcare need to go hand in hand with other social policies, particularly in relation to long-term care for older people. Income barriers to access could be addressed by increasing the income threshold for co-payments and/or capping co-payments for all those with serious or chronic health conditions. Healthcare for Roma needs to be part of

targeted area-based development interventions. A study of barriers to access to reproductive healthcare – especially abortions for women – is also needed, and regional inequalities and healthcare in remote areas, including the Croatian islands, need to be a reform priority. Crucially more policy-oriented research is needed on access to healthcare based on socio-economic status, ethnicity, gender, age, region and disability.

1 Description of the functioning of Croatia's healthcare system for access

The Croatian healthcare system is financed mainly through contributions and, as such, can be classified as a Bismarckian, insurance-based system. At the same time, the *de facto* extension of health insurance to the non-working population means that, to all intents and purposes, it functions in terms of coverage as a universalist system. The healthcare system operates at three levels: primary, secondary and tertiary. At the primary level, healthcare is mainly provided by family physicians who are private (about 70% of all primary physicians) or work as employees of the community health centres. In both cases, family physicians are contracted by the Croatian Health Insurance Fund (CHIF), and have to follow rules set by the CHIF. The secondary level includes hospital and treatment centres, while at the tertiary level healthcare is provided in clinics, clinical hospitals and clinical hospital centres. Hospitals and clinics are also publicly funded. Doctors employed by hospitals, clinics, clinical hospitals and clinical hospital centres can work privately in their free time; thus there is a kind of unregulated public-private mix, as there are no strict rules to ensure that these additional private engagements do not endanger the equal access of all patients in the public healthcare system. In addition, there are physicians who work exclusively in the private sector and a few private hospitals which work on market principles, or have contracts with private insurance providers.

Financing of the healthcare system is organised through the CHIF, which collects mandatory insurance payments. Employers contribute 15% of their employees' salaries or other income from employment, with an additional 0.5% as a special contribution to cover occupational injuries. Pensioners pay a contribution rate of 3% if their pension is above the average net wage (5,108 Croatian kuna (HRK) or EUR 681 in 2016). Low-income pensioners, insured family members (including children up to the age of 18 and students), the unemployed and other inactive persons are exempt from paying contributions, but have the same rights as those who do pay contributions. Alongside mandatory health insurance there is the possibility of opting in to additional health insurance provided by the CHIF and other private insurers, and/or private health insurance. Complementary insurance allows those insured not to pay user charges, while private insurance provides for an additional basket of rights, mainly realised in private health institutions.

As patients with only basic health insurance must make direct co-payment for every visit to a doctor or for any prescribed medicaments, additional health insurance is widespread: 1,623,799 persons paid for additional health insurance provided by CHIF in 2016.[1] There are no data on the number of persons who hold private insurance. The widespread use of additional health insurance is a result of its low cost (HRK 70 or EUR 9.30 per month) and lack of conditionality: everyone pays the same, regardless of age or health status. In 2014, some 62.6% of households had additional or private insurance; however, this varied considerably by income, with only 36.6% in the poorest quintile having such insurance, compared to 75.9% in the richest quintile.[2] Some 10% of CHIF income comes from the state budget, as a contribution for unemployed persons, additional contributions for pensioners and Croatian war veterans, and other persons exempt from paying contributions, in whole or in part. However, the payment is lower than it should be according to the rules – one of the causes of the deficit in the healthcare system.

[1] Croatian Health Insurance Fund (2017).

[2] Calculations by Ivica Rubil (The Institute of Economics, Zagreb) based on Household Budget Survey data provided by the Croatian Bureau of Statistics.

Croatia's spending on health is lower than in many peer countries, measured as a percentage of GDP and, crucially, in terms of health expenditure per capita. Health expenditure amounted to 7.37% of GDP in 2015, while measured per capita in purchasing power standards (pps) it amounted to EUR 1,245.04 and was, alongside Romania (EUR 865.05) and Bulgaria (EUR 1224.17), among the lowest in the EU Member States.[3] Spending on long-term care is also among the lowest, at 0.2% of GDP (see Stubbs and Zrinščak, 2018). A specific feature of the system is the high share of public expenditure compared to other countries. In 2015, compulsory insurance accounted for 74.39% and government spending for an additional 2.38% of current health expenditure. The share of voluntary insurance was 8.07% and out-of-pocket payments amounted to 15.16% of current health expenditure.[4]

In terms of **coverage**, the Croatian system is *de facto* universal, covering almost the entire population. Indeed, the number of insured people (4,298,008 in 2016) was higher than the estimated number of residents.[5] Formally, then, coverage is not a problem and non-coverage is a product of failing to register with the health insurance fund or, in the case of Roma detailed below, with problems in obtaining Croatian citizenship.[6]

Compulsory health insurance provides access to primary care (a general practitioner (GP) or family physician, paediatrician, gynaecologist, as well as dental care, obligatory vaccinations, and so on), visits to specialists and curative care in hospitals, as well as medicines. Access to hospitals is also secured through referral by a family physician. Rights are comprehensive and healthcare is formally accessible by all, regardless of health or socio-economic status. Co-payments for visits to doctors, for hospital stays and for medicines are covered by additional health insurance; but in any case, children under 18, disabled people, disabled war veterans and family members of deceased war veterans, as well as persons on low income (households with monthly income of below HRK 1,516/EUR 200), are exempt from charges. Co-payments range from HRK 10.00 (EUR 1.30) for a visit to a family physician to HRK 1,000 (EUR 130) for dental aids, or up to HRK 2,000 (EUR 266) for hospital treatment, irrespective of duration or type (physical or mental illness). Payments must be made up front, and there is no system of reimbursement. Croatia uses two lists of medicines: an A list, where co-payments are fixed; and a B list, where co-payments are the difference between the real cost of the medicine and the amount reimbursed by the CIHI, so that B list medicines can be prohibitively expensive. There is a list of treatments not covered by compulsory insurance, including medicine prescribed by private providers, cosmetic surgery or employment-related care.

Despite the universal coverage and generous package of services provided, there are many critical points in the functioning of the system. **Availability** of healthcare is an issue mainly due to long waiting lists. However, there are no publicly available data on the accessibility of healthcare services or on their geographical distribution. The Ministry of Health admits that there is a problem with waiting lists, and from time to time launches measures to reduce them; but there is no evaluation of the impact of these measures. Waiting lists are connected to poor financing of the healthcare system. Extensive rights mean that the system is in constant deficit, currently over HRK 8 billion

[3] EU-SILC 2016.

[4] EU-SILC 2016.

[5] There are three possible reasons for this. The first is connected with emigration, as many emigrants do not report their status and keep their insurance rights. Also, the difference between the insured people and the overall population is highest in the coastal areas and islands, which might indicate that these are foreign citizens who own apartments on the coast and have managed to obtain health insurance. Finally, a certain number of citizens of Bosnia and Herzegovina and Serbia may be registered as if they were living permanently in Croatia, even though they are not. See: 'We have more insured persons than citizens', *Večernji list*, 7 June 2016 (in Croatian), web: http://www.vecernji.hr/hrvatska/imamo-vise-zdravstvenih-osiguranika-od-stanovnika-1089961 (accessed 7 May 2018).

[6] Research from 2011 revealed that 82.5% of the Roma population had health insurance, compared to 97.4% of the population living in the nearby community (Zrinščak, 2014).

(more than EUR 1 billion), overwhelmingly incurred by hospitals.[7] Reforms are announced frequently but implemented rarely, so that the only way of reducing the deficit is to cut services, particularly the costlier ones, by setting monthly spending limits for hospitals, a *de facto* rationing of scarce resources. There are no transparent macro-level data on this to show trends across the country. Instead, our supposition is based on insider sources from a number of hospitals. Although data are lacking, those with more financial resources can opt to receive private care. One frequently mentioned reform concerns the functional integration of hospitals as a solution to the problem that some regions/counties in Croatia have a number of hospitals in close proximity to each other offering the same services; this results in unnecessarily high costs. Reforms along these lines have been slow to materialise and, in the absence of any publicly available documentation, lack any kind of transparency.

Another key issue in terms of **availability** concerns the shortage of qualified medical personnel, with Croatia experiencing high levels of out-migration of medical staff since it joined the EU on 1 July 2013. The Croatian Medical Chamber suggests that the average age of doctors is rising, with many family doctors continuing to work after retirement, although Croatia continues to have a lower rate of physicians aged 65 or above than other EU Member States.[8] There is a national shortage of gynaecologists and paediatricians, and a marked shortage of family physicians in 4 out of Croatia's 21 counties: Virovitica-Podravina, Bjelovar-Bilogora, Koprivnica-Križevci and Lika-Senj.[9] Information on nurses is lacking, but similar issues of emigration, together with poor working conditions and restrictions on employment after completing training, combine to create what may be an even greater shortage. In 2015, Croatia had 319.2 physicians per 100,000 inhabitants, a slight increase on figures for 2010; this placed it 19th out of the 28 EU Member States.[10]

Both **availability** and **affordability** of the system are reflected in its generally poor performance, which is also connected with poor preventive care and a high share of non-healthy lifestyles. Life expectancy is more than 3 years lower than the EU average;[11] standardised death rate due to cardiovascular diseases is very high, as is the infant mortality rate. Also, standardised mortality rates due to lung, breast and colon cancer are among the highest in the EU. The same is true for smoking and alcohol consumption.[12] The gap between the high and the low educated in terms of fruit and alcohol consumption is larger than the EU average.

There is no legal way to hasten one's access to public healthcare, particularly to services with long waiting lists. As noted, services can be accessed in the private sector, although we lack information on how much is spent on private health services (we surmise that there are significant socio-economic differences in this respect). A related issue concerns informal payments, whether in cash or in kind. Again, there are few data and the existing information paints a mixed picture. According to the latest Eurobarometer report, 45% of respondents in Croatia think that giving and taking bribes and the abuse of power for personal gain is widespread in the healthcare sector, while only 3% report having themselves given an extra payment or a valuable gift to a doctor or nurse.[13] In short, the

[7] https://www.jutarnji.hr/vijesti/hrvatska/zdravstvu-dodatnih-milijardu-kuna-za-dugove-bolnicama-proracun-ce-dodatno-smanjiti-vanjski-dug-a-jednom-ministarstvu-konacno-ide-vise-novca/6708108/ (accessed 8 May 2018).

[8] http://ec.europa.eu/eurostat/statistics-explained/images/3/37/Physicians%2C_by_age%2C_2015_%28%25%29_HLTH17.png (accessed 10 May 2018).

[9] https://www.hlk.hr/predstavljen-demografski-atlas-hrvatskog-lijecnistva-na-1-saboru-hrvatskog-lijecnistva.aspx (accessed 9 May 2018).

[10] http://ec.europa.eu/eurostat/statistics-explained/index.php/Healthcare_personnel_statistics_-_physicians (accessed 10 May 2018).

[11] EU-SILC 2016.

[12] See also OECD (2017).

[13] European Commission (2017); Williams and Horodnic (2018).

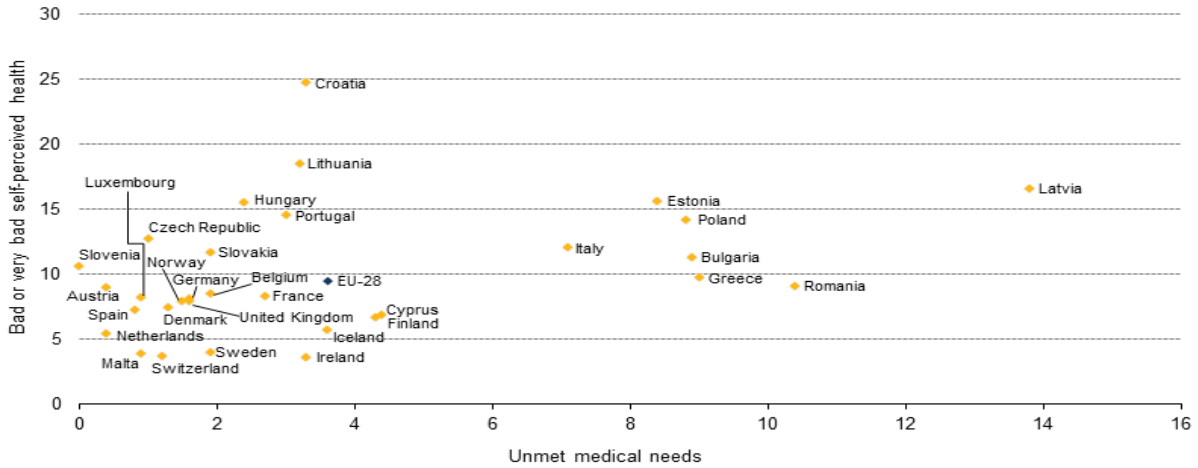
combination of formal universal rights to access to healthcare, combined with shortfalls in financing ever-escalating costs, leads to informal rationing and a system in which *de facto* inequalities in access are significant.

2 Analysis of the challenges in inequalities in access to healthcare in Croatia and the way they are tackled

The empirical evidence on the extent of inequalities in access to healthcare in Croatia is somewhat limited and often quite dated. Nevertheless, it is possible to trace, in broad terms, the key groups whose access may be limited and some of the reasons for this.

Class or **socio-economic status**, as measured by level of education and household income, appears to be important, not least in terms of self-reported health status. A study utilising a variety of data sets (Čipin and Šmolić, 2013) suggest that people in the highest income group were between 1.7 and 2.9 times more likely to consider themselves in good health than people in the highest income group. There is also a strong correlation between highest level of education achieved and positive self-assessment of health status. Croatia appears to be something of an outlier within the EU: it has very low overall reported unmet need for medical examination and extremely high self-assessment of bad or very bad health (see Figure 1). Some researchers have suggested that this paradox can be explained by the population's trust in healthcare institutions and workers, but its lack of trust in healthcare policies to make things better (Budak 2014). The reliability of the statistics also needs to be questioned. Although self-reported access to healthcare in Croatia is generally extremely good, there is considerable variation between income groups, with the OECD (using European Union Statistics on Income and Living Conditions (EU-SILC) data) reporting that unmet need for low-income groups was 5.2% in 2015 – more than six times the figure for high-income groups (under 0.8%) (OECD, 2017: 1 and 10-11). The 2016 EU-SILC data put the figures at 4.6% and 0.4% – an overall reduction, but a bigger differential between the highest and the lowest income quintiles. It is also worth noting that data from the European Health Interview Survey (EHIS) show a much higher level of unmet need than does EU-SILC.[14]

Figure 1: Self-perceived health status and self-reported unmet need for medical examination, 2013



Source: Eurostat (2015).

Although the overall prevalence of 'catastrophic health expenditure' (defined as household out-of-pocket spending exceeding 40% of total household spending net of

[14] Ivica Rubil and Luka Vončina, email correspondence.

subsistence needs) is low in Croatia compared to other EU Member States – 4.0% in 2014 – the lowest income quintile is over four times more likely to experience these, with 17.7% facing such payments in 2014 (Vončina and Rubil, cited in OECD, 2017: 12). This represented a significant decline from 25% or more in 2010 and 2011, during the period of economic crisis. The study also suggests that catastrophic out-of-pocket expenditure is overwhelmingly concentrated in the poorest quintile of the population; the figure is negligible for the second, third and fourth quintiles, although some 1.5% of households in the richest quintile also have such expenditure, reflecting their ability to pay for expensive medical treatment.

There is clearly a need for more research – revisiting surveys on access to healthcare and disaggregating the data by income group. One (now out-of-date) study used the European Quality of Life Survey (EQLS) data from 2003, broken down by income quartiles, to show that 26% of respondents in the lowest income quartile perceived the distance to the nearest medical facility to be a very serious problem (Šućur and Zrinščak, 2007). Given the salience of the finding that health inequalities appeared to be more marked in Croatia than elsewhere in the EU at that time, it is surprising that so few studies have been carried out since. Our general working hypothesis is that it is those segments of the population of Croatia at risk of poverty or social exclusion (27.9% of the population in 2016, according to Eurostat) who face the most significant problems in terms of accessing quality, timely and effective healthcare. There is no other income group facing similar problems. The lack of attention in research on access to healthcare for those on low income and with low socio-economic status is, in fact, matched by a significant level of policy indifference towards the same group.

Although they make up only a relatively small part of the Croatian population, members of the **Roma community** (estimated at 40,000, or around 1% of the population) face a number of significant issues in terms of access to health services – a complicated package involving poverty and exclusion, status, living conditions and geographical segregation, discrimination and prejudice, and culture and lifestyle. A recent report for the EU states that the average life expectancy of Roma in Croatia is, at 66.6 years, some 10 years lower than in the general population. Unlike some other countries in the region, and perhaps as a direct result of policy measures, the reported vaccination rate of Roma infants aged 0-6 years is high – 97%, compared to 99% within the general population (Matrix, 2014: 89). Data from the 2011 UNDP/World Bank/Roma survey comparing a sample of Roma with a non-Roma sample living nearby in similar circumstances,[15] show significant issues in relation to access to healthcare. Importantly, Roma have lower levels of coverage through health insurance: some 20% of Roma in the sample stated that they did not have health insurance or did not know if they had it (mainly a result of not having Croatian citizenship and of being unemployed). Roma also had less access to essential medicines: 66% of Roma stated that they could not afford prescription medicines, compared to 29% of the majority population nearby. In addition, Roma had a lower incidence of attending check-ups or screening. Deviating somewhat from the EU report, the UNDP study suggested that 15% of Roma children under 14 are not vaccinated, compared to 4% from non-Roma households nearby. The discrepancy is probably due to time-lag, with the UNDP survey carried out before policy commitments to raise the vaccination rate of infants in Roma settlements.

A retrospective study of antenatal services for Roma and non-Roma in the county of Virovitica-Podravina between 1991 and 2010 (Šegregur and Šegregur, 2017) found that Roma women visited gynaecologists less frequently than non-Roma – on average four times compared to six times during pregnancy – with 18.4% of Roma women, compared to only 2.2% of non-Roma, not seeing a gynaecologist at all. Although there were no home deliveries among the non-Roma women, 6.5% of Roma women had a home

[15] http://www.eurasia.undp.org/content/rbec/en/home/ourwork/sustainable-development/development-planning-and-inclusive-sustainable-growth/roma-in-central-and-southeast-europe/roma-data.html (accessed 9 May 2018).

delivery. There seems also to be a correlation between poor antenatal care and a higher incidence of perinatal complications.

Healthcare is one of the priority strategic policy areas in Croatia's Roma Inclusion Strategy for 2013-2020, which is currently being evaluated. This traces Roma's poor health to poor living conditions, as well as to problems in relation to access to health services, including medicines. In terms of health insurance, the strategy notes that Roma may sometimes not be registered as citizens and 'rarely exercise their right to health-care according to the Aliens Act' (Government of Croatia, 2012: 61). Based on limited evidence, the strategy tends to resort to 'culturalist' explanations for Roma ill-health in terms of addiction, noting tobacco and alcohol consumption, drugs and gambling. Perhaps to balance this, a section of the strategy addresses discrimination against Roma in the healthcare system, suggesting that more Roma healthcare workers could help to address the problem.

There is also too little information on **gender inequalities** in health, although the issue of **women's access to reproductive healthcare** has been noted as a matter of concern. Croatia's Law on Abortion, in force since 1978 and amended in 2009, emphasises a woman's right to choose; this is virtually an unconditional right up to 10 weeks following conception, and subsequently is subject to the approval of a medical commission. There are significant differences between hospitals and regions in terms of how they apply the law, however. Data from 2015 (Croatian Institute of Public Health, 2016: 279) show that there were no abortions performed at all in that year in two general hospitals in Croatia, most likely as a result of objections on grounds of conscience by senior medical staff, rather than lack of demand. The report of the Ombudsperson for Gender Equality for 2014 (2015) stated that of 30 medical institutions, 6 effectively refused to carry out abortions on grounds of conscience. Already, towards the end of 2014, the Ministry of Health indicated that hospitals where this was the case should make other arrangements for terminations of pregnancy to be carried out, and a number of hospitals brought in outside consultants to perform abortions. Although meant to be available on demand, abortions are not free in Croatia, and can cost up to HRK 3,000 (around EUR 400). Overall, access to abortions, in the context of mobilisation by the radical right to make Croatia's abortion laws more restrictive – and indeed to organise prayer vigils outside facilities where abortions are performed – has been described as a 'grey zone' in Croatia's healthcare system (Bijelić and Hodžić, 2014).

In the context of rapid demographic ageing and an unresponsive long-term care system, **older people** also face significant barriers in access to healthcare. In terms of healthy life years at age 65, Croatia fares considerably worse than the EU average, and the figures are deteriorating rather than improving. The latest EU-SILC data suggest that 4.3% of those aged 65 or over reported unmet need for healthcare in Croatia, compared to only 3.3% for the EU-28, and 0.9% of those of working age in Croatia.[16] Again, there are suggestions that the situation of older people in Croatia regarding unmet need, particularly as a result of waiting, as well as cost, is significantly worse when EHIS data are used.[17]

Finally, although there are hardly any data available on **regional inequalities** in healthcare access, there is considerable evidence that those in **rural areas**, those living on the **Croatian islands** and, to an extent, those living in the war-affected areas designated as **Areas of Special State Concern** face significant challenges in accessing some healthcare services. A recent survey of healthcare in rural and remote areas in eight countries (Rechel et al., 2016) suggests that the issue has not been a priority thus far in healthcare policy in Croatia; plans for 'functional reintegration' around four urban clinical centres have failed to address the appropriate allocation of tasks between

[16] EU-SILC 2016, downloaded 13 April 2018.

[17] Ivica Rubil and Luka Vončina, email correspondence.

different types of hospital, integration with other healthcare providers or intersectoral cooperation. In addition, with few exceptions, those living on the Croatian islands can access only rather basic healthcare without relying on sea or air transportation. The Croatian Health Strategy for 2006-2011 had a special focus on the Croatian islands,[18] although it is far from clear to what extent commitments made in that document have been met. Recent reports indicate that there are shortages of healthcare workers in rural areas and on the islands.[19]

Croatia has both a Strategic Plan for Human Resources in Healthcare 2015-2020, and a National Healthcare Strategy for 2012-2020. Although these address innovations – including the introduction of management information systems and the rolling out of e-health – there is little systematic attention paid to healthcare inequalities in terms of either outcomes or access. Reforms have stalled on many aspects, including the reorganisation of hospitals. Policy recommendations on tackling inequalities in access to healthcare need to go hand in hand with other social policies, of course, particularly those in relation to long-term care, and especially for older people. Income barriers to access could be addressed by increasing the income threshold for co-payments and/or capping co-payments for all those with serious or chronic health conditions. Healthcare for Roma needs to be part of targeted area-based development interventions. A study of barriers in access to reproductive healthcare for women is also needed – especially termination of pregnancy – and regional inequalities and healthcare in remote areas, including the Croatian islands, need to be a reform priority.

3 Discussion of the measurement of inequalities in access to healthcare in Croatia

Though access to healthcare is a public issue in Croatia (mainly on account of long waiting lists), inequality in healthcare is not perceived as important, and is consequently rarely discussed. Two main reasons can be singled out. First, there has been almost no research on different aspects of access to healthcare in terms of socio-economic status. Secondly, EU-SILC data on self-reported unmet need suggests an improvement in recent years, with the level of unmet need due to cost, distance or waiting lists standing at 1.7% in 2016, below the EU average of 2.5%. However, EHIS data suggest much higher levels of unmet need, particularly for older people, with levels higher than the EU average due to cost and waiting lists. The same is suggested by EQLS 2016 data.[20] Difficulties in access according to several questions (delayed visit to doctor or dentist due to cost, or delay in getting an appointment) are consistently higher in Croatia than in the EU on average. Moreover, differences between the highest and the lowest income quartiles are significantly greater than in the majority of EU countries. This all confirms the need for a range of diverse indicators on inequalities in access to healthcare, which could feed public debate and induce appropriate policy measures.

In addition, new data would be important. As some groups are particularly disadvantaged – like Roma, older people, people at risk of poverty and social exclusion, and persons with disabilities who need extensive care – qualitative and quantitative data on their position and barriers to access would be of great importance. Croatia is also regionally unevenly developed, and the rate of risk of poverty and social exclusion is disproportionally high in rural areas. As unequal access is very much connected with income, the lack of data on inequalities in access according to regional differences is a serious problem. This is of importance also as emigration (including by medical staff) is

[18] http://www.mppi.hr/userdocsimages/2007/vrh-252-09-otoci-zdravst.pdf (in Croatian) (accessed 10 May 2018).

[19] https://www.hlk.hr/predstavljen-demografski-atlas-hrvatskog-lijecnistva-na-1-saboru-hrvatskog-lijecnistva.aspx (accessed 9 May 2018).

[20] https://www.eurofound.europa.eu/data/european-quality-of-life-survey (accessed 10 May 2018).

higher from underdeveloped regions. Finally, there is a lack of data on socio-economic differences in death rates for different causes of death. Although morbidity rates are also connected with (un)healthy lifestyles, difficulties in obtaining access to healthcare may have an impact on survival rates for people from different income, age and identity groups.

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