European Social Charter | Charte Sociale Européenne

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EUROPEAN SOCIAL CHARTER

7th National Report on the implementation of the European Social Charter

submitted by

THE GOVERNMENT OF CROATIA

(Articles 11, 13 and 14 and for the period 01/01/2008 – 31/12/2011)

Report registered by the Secretariat on 1 October

CYCLE 2013

Ministry of Labour and Pension System

7th Report of the Republic of Croatia on the measures taken towards the implementation of the adopted provisions of the European Social Charter for the period between 1st January 2008 and 31st December 2011 (Article 11, 13 and 14)

June 2013

REPORT ON THE IMPLEMENTATION OF THE EUROPEAN SOCIAL CHARTER

The report submitted by the Republic of Croatia based on Article 21 of the European Social Charter, regarding the measures taken for the purpose of implementation of the adopted provisions of the European Social Charter, ,the instruments of ratification or approval of which were submitted on 26th February 2003, includes the period between 1st January 2008 and 31st December 2011 and refers to Articles 1 and 9 of the Charter and Article 1 of the Protocol. All terms used in this report which are of any gender importance, equally cover both male and female gender.

Pursuant to Article 23 of the Charter, the copies of this report were submitted to the:

- *Union of Autonomous Trade Unions of Croatia,*
- *Independent Trade Unions of Croatia,*
- *Croatian Trade Union Association,*
- *Association of Croatian Unions,*
- *Worker's Trade Union Association of Croatia,*
- *Croatian Employers' Association.*

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1. Legislation of the Republic of Croatia regarding Article 11 of the European Social Charter

The right to health care in the Republic of Croatia is regulated by the Constitution of the Republic of Croatia and by other legislative acts and secondary legislation. Article 56 of the Constitution prescribes that everyone is guaranteed the right to health care in accordance with the law. Constitutional provisions related to Article 11 of the European Social Charter that are the subject of this report, have not changed during the reporting period. Since the last report, the following regulations have been adopted and amended:

Acts:

1. Compulsory Health Insurance Act (Official Gazette, No. 150/08);
2. Amendments to the Compulsory Health Insurance Act (Official Gazette, No. 94/09, 153/09, 71/10, 139/10 and 49/11);
3. Act on the Amendments to the Voluntary Health Insurance Act (Official Gazette No. 150/08 and 71/10);
4. Health Care Act (Official Gazette , No. 150/08);
5. Amendments to the Health Care Act (Official Gazette , No. 155/09, 71/10, 139/10, 22/11, 84/11, 154/11 and 70/12);
6. Act on Artificial Insemination (Official Gazette, No. 88/09);
7. Act on Amendments to the Act on Artificial Insemination (Official Gazette, No. 137/09, 124/11 and 86/12);
8. Act on the Protection of the Population from Infectious Diseases (Official Gazette, No. 113/08 and 43/09);
9. Amendments to the Act on Medical Practice (Official Gazette , No. 117/08);
10. Amendments to the Medicinal Products Act (Official Gazette , No. 45/09 and 124/11);
11. Medicinal Products Act (Official Gazette, No. 67/08); ;
12. Amendments to the Medicinal Products Act (Official Gazette , No. 124/11);
13. Amendments to the Act on Taking and Transplanting Parts of the Human Body for the Purpose of Medical Treatment (Official Gazette, No. 45/09);
14. Act on Amendments to the Occupational Health and Safety Act (Official Gazette, No. 86/08 and 75/09);
15. Personal Identification Number Act (Official Gazette, No. 60/08);
16. Act on the Restriction of Usage of Tobacco Products (Official Gazette, No. 125/08);
17. Act on Amendments to the Act on the Restriction of Usage of Tobacco Products (Official Gazette , No. 119/09);
18. Act on Amendments to the Act on the Prevention of Narcotic Drug Abuse (Official Gazette, No. 149/09 and 84/11);
19. Act on Amendments to the Act on Official Statistics (Official Gazette, No. 59/12);
20. Personal Data Protection Act (consolidated text) (Official Gazette, No. 106/12)
21. Act on Amendments to the Occupational Health and Safety Insurance Act (Official Gazette, No. 67/08);
22. Act on the Termination of the Occupational Health and Safety Insurance Act (Official Gazette, No. 139/10).

Ordinances:

1. Ordinance on the conditions and means of exercising rights in the compulsory health insurance scheme (Official Gazette, No. 67/09, 116/09, 04/10, 13/10, 88/10, 131/10, 01/11, 16/11, 87/11 and 137/11);

2. Ordinance on amendments to the Ordinance on the conditions and means of exercising rights in the compulsory health insurance scheme (Official Gazette), No. 45/08);

3. Ordinance on amendments to the Ordinance on the method of registration and deregistration, and the acquisition of the status of an insured person in the compulsory health insurance system (Official Gazette, No. 33/08, 91/09, 04/10, 69/10, 01/11 and 48/11);

4. Ordinance on amendments to the Ordinance on the conditions and means of exercising rights in the compulsory health insurance scheme in connection with hospital treatment by means of medical rehabilitation and physical therapy at the patient's home (Official Gazette, No. 64/08, 91/09 and 118/09);

5. Ordinance on the conditions and method of the realisation of rights to orthopedic and other aids (Official Gazette, No. 17/09, 23/09, 53/09, 116/09, 04/10, 88/10, 110/10, 113/10, 01/11, 16/11 and 87/11);

6. Ordinance on the right to, requirements for and method of using health care in foreign countries (Official Gazette, No. 50/09, 118/09, 04/10, 13/10, 14/10, 01/11, 16/11, 31/11, 93/11 and 145/11);

7. Ordinance on the requirements for and the method of realisation of rights under the compulsory health insurance system to health care at home (Official Gazette , No. 88/10, 01/11, 16/11 and 87/11),

8. Ordinance on criteria for the classification of medications and on the prescription and issuing of prescription medicinal products (Official Gazette, No. 82/10);

9. Ordinance on standards and general rules of the right to health care under the compulsory health insurance system (Official Gazette, No. 79/11);

10. Ordinance on the right to, requirements for and method of using health care under the compulsory health insurance system in case of work-related accidents and occupational diseases (Official Gazette, No. 01/11 and 153/11);

11. Ordinance on the method and procedure of selecting occupational medicine specialists (Official Gazette, No. 48/11);

12. Ordinance on medical transport (Official Gazette, No. 123/09);

13. Ordinance on the method of examining deceased persons and determining the time and cause of death (Official Gazette, No. 46/11);

14. Ordinance on the form of the death certificate (Official Gazette, No. 46/11).

15. Ordinance on the implementation of the Act on Records in the Field of Health Care for primary and specialist health care ("Official Gazette , No. 4/95).

16. Ordinance on the implementation of the Act on Records in the Field of Health Care for stationary health care and monitoring of addiction (Official Gazette, No. 44/00).

17. Ordinance on the categorization of technical medical equipment of medical institutions (Official Gazette, No. 12/12).

Other:

1. Amendments to the plan and programme of health care measures under the compulsory health insurance system (Official Gazette, No. 156/08);
2. Basic Network of Medical Services (Official Gazette, No. 98/09, 14/10, 81/10, 64/11, 103/11,110/11 and 141/11);
3. Decision supplementing the Decision determining the basic list of medications of the Croatian Institute for Health Insurance ("Official Gazette, No. 16/08, 33/08, 68/08, 90/08 and 134/08);
4. Decision determining the basic list of medications of the Croatian Institute for Health Insurance ("Official Gazette , No. 27/09, 91/09, 97/09, 101/09 and 113/09, 69/10, 83/10, 131/10, 01/11, 54/11, 59/11 and 61/11);
5. Decision on determining the supplementary list of medications of the Croatian Institute for Health Insurance (Official Gazette, No. 69/10);
6. Corrigendum of the Decision on determining the supplementary list of medications of the Croatian Institute for Health Insurance (Official Gazette 83/10);
7. Decision amending the Decision on determining the supplementary list of medications of the Croatian Institute for Health Insurance (Official Gazette, No. 131/10, 01/11, 54/11 and 59/11);
8. Decision amending the Decision determining the list of particularly expensive medications determined by the Decision determining the basic list of medications of the Croatian Institute for Health Insurance (Official Gazette, No. 64/08, 90/08, 116/08, 02/09, 27/09, 59/09, 91/09, 113/09, 69/10, 131/10, 54/11 and 93/11);
9. Decision on the content and form of the document proving the status of insured persons of the Croatian Institute for Health Insurance (Official Gazette, No. 91/09, 113/09, 140/09, 04/10, 43/10 and 29/11);
10. Decision on the standards and general rules of the right to health care under compulsory health insurance in case of occupational injuries and occupational diseases with grounds for the conclusion of a contract (Official Gazette, No. 01/11, 06/11, 31/11, 78/11 and 153/11);
11. Decision on special standards and criteria for their implementation in the conduct of primary health care under the compulsory health insurance system ("Official Gazette , No. 50/10, 88/10 and 06/11);
12. Already indicated under 1 - Regulation on Amendments to the Food Act (Official Gazette, No. 155/08);
13. Implementation Programme of Vaccination for the current year (2008-2010).

2. Article 11 – RIGHT TO HEALTH CARE

With a view to ensuring the effective exercise of the right to protection of health, the Contracting Parties undertake, either directly or in co-operation with public or private organisations, to take appropriate measures designed:

1. to remove as far as possible the causes of ill-health;

2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;

3. to prevent as far as possible epidemic, endemic and other diseases.

2.1. Paragraph 1 – REMOVAL OF CAUSES OF ILL-HEALTH

Provoding universal access to health care

The Health Care Act (Official Gazette, No. 150/08, 155/09, 71/10, 139/10, 22/11 and 84/11) regulates the principles and measures of health care, the rights and obligations of persons who use health care, the designated competent authorities of social care for the health of the population, the contents and organisational forms of the provision of health services and the supervision of the provision of health services.

The organisation of health care needs to ensure conformity with the following principles:

- the comprehensiveness of health care, by including all citizens in the implementation of the appropriate measures of health care;
- the continuity of health care for citizens of all ages, through the comprehensive organisation of the implementation of health services,;
- the availability of health care through the distribution of medical institutions and companies that carry out health care services as well as health workers, who will enable equal conditions of health care for all citizens, especially in primary health care;
- a comprehensive approach to primary health care and a specialized approach through the organization and development of specialized clinical and public health accomplishments and knowledge, as well as through their application in practice;
- a specialized approach through the organization and development of specialized clinical and public health accomplishments and knowledge, as well as through their application in practice.

The accessibility of health care is achieved through a schedule of distribution of medical institutions and health workers in the Republic of Croatia which will enable equal health care conditions for all citizens, especially in primary health care.

The Health Care Plan, along with the previously acquired opinion of the Croatian National Institute of Public Health and competent chambers, is adopted by the Minister.

The Health Care Plan of the Republic of Croatia, for the purpose of implementation of health care in the unified health care system in the Republic of Croatia, determines the following:

- duties and objectives of health care;

- priority development areas;
- health requirements of the population of special interest for the Republic of Croatia;
- specific needs and possibilities for the realisation of health care in specific areas;
- implementing bodies and deadlines for achieving the Health Care Plan;
- bases for the development of health care by levels, including education and training of health care professionals, and the bases for the development of the health care system;
- standards for determining the network of the public health service, taking into account the availability of health care by area.

The implementation of this Plan, by using measures identified within the Plan and programme of health care measures under the compulsory health insurance system, includes primary, secondary and tertiary prevention measures, which are ensured by medical institutions, trading companies performing health care activities and health care professionals in a manner and under conditions stipulated by law, for the purpose of:

- protection and improvement of the health of the population;
- increasing life expectancy and reducing mortality;
- increasing the number of years of life without disease and/or disability;
- ensuring the highest possible levels of physical and mental health, along with care for improving the quality of life by protecting one's health and functional capacity.

Health care measures are taken on the basis of the plan and programme of health care measures, adopted by the Minister at the proposal of the instutites of public health according to the previously issued opinion of the competent chambers. Under the health care measures, a set of activities is implied, i.e. preventive, diagnostic, therapeutic and rehabilitational medical procedures in the implementation of particular levels of health care aimed at the attainment of objectives.

Health care measures for insured persons

The right of persons insured in the Croatian Institute for Health Insurance to health care is ensured through the implementation of health care measures, which are determined on the basis of the plan and programme of health care measures, adopted by the Minister of Health on the basis of a proposal of the Croatian Institute for Health Insurance and the Croatian National Institute of Public Health, pursuant to the previously issued opinion of the competent chambers and with regard to the allocated funds and available health care capacities.
Health care measures are the following:
1. protection from environmental factors harmful to health, including all measures for the preservation, advancement, monitoring and improvement of health and hygienic living and working conditions,
2. implementation of health education, awareness raising and promotion for the purpose of improving people's mental and physical abilities,
3. discovering and removing causes of diseases, i.e. prevention of diseases and injuries, as well as their consequences,
4. measures and activities for the prevention, timely detection and repression of infectious and chronic mass diseases,
5. health care measures regarding work and work environment (specific health care for workers),
6. treatment and rehabilitation of patients, physically and mentally impaired and injured

persons, as well as disabled persons,
7. special health care measures for persons over 65 years of age,
8. palliative care for the terminally ill and dying,
9. provision of comprehensive (preventive, therapeutic and rehabilitation) health care of children and young people,
10. ensuring comprehensive health care for women, specially regarding family planning, pregnancy, childbirth and maternity,
11. provision of medications and medical health care products,
12. post mortem examinations.

The strategic goals of the implementation of the Plan and Programme of Health Care Measures are the following:

- to increase the level of health of the entire population and reduce the prevalence of health risk factors by implementing health promotion programmes;
- reduce morbidity, mortality and disability from diseases, injuries and conditions to which preventive measures and effective health care can be applied;
- pay special attention to health conditions and health improvement measures of high-risk population groups.

According to the analysis of the health of the population, the primary objectives of the implementation of the Plan and Programme of Health Care Measures are the following:

- improvement of the health of the population;
- increasing life expectancy and reducing mortality;
- increasing the number of years of life without disease and/or disability;
- ensuring the highest possible levels of physical and mental health, along with care for improving the quality of life by protecting one's health and functional capacity.

On the basis of standards defined by the Health Care Plan of the Republic of Croatia, the basic network of medical services is determined for primary, secondary and tertiary levels of health care, as well as for the level of medical institutes.

The Basic Network of Medical Services is adopted by the Minister, upon previously obtaining an opinion from the Croatian National Institute of Public Health and competent chambers,.

The network of occupational medicine specialists who have concluded a contract with the Ministry of Health on the provision of health care services determines the required number of health care institutions and private-sector occupational medicine specialists.

According to the Health Care Act (Official Gazette, No. 150/08), the Basic Network of Medical Services is adopted by the Croatian Institute for Health Protection and Safety at Work, with the consent of the Minister. With the entry into force of the Act on Amendments to the Health Care Act (Official Gazette, No. 71/10) the Basic Network of Medical Services is adopted by the Minister, upon previously obtaining an opinion from the Croatian National Institute of Public Health and competent chambers,.
With the entry into force of the Act on Amendments to the Health Care Act (Official Gazette, No. 139/10) the network of occupational medicine specialists who have concluded a contract with the Ministry of Health on the provision of health care services is adopted by the Minister, upon previously obtaining an opinion from the Croatian National Institute of Public Health and competent chambers,
The Network of Telemedical Centres and the Emergency Medicine Network are adopted by the Minister at the proposal of the Croatian Institute for Telemedicine and the Croatian

Institute of Emergency Medicine.
The Basic Network of Medical Services determines the required number of medical institutions, companies, private-sector health workers, as well as the required number of primary health care teams, nurses, the number of specialist and consultative as well as specialised diagnostics health care teams for individual branches, the required number of physical therapists, the required number of beds for individual branches and types of hospitals, the required number of beds in in-patient clinics of community health centres, both for the territory of the Republic of Croatia and for the territories of local self-government units.
Standards for defining the network are: the total number of inhabitants of the Republic of Croatia, the total number of persons insured with the Croatian Institute for Health Insurance, demographic features of the population, the health condition and social structure of the population, the number of inhabitants in the catchment areas, characteristics of specific areas, availability of medical resources, the influence of the environment on the health of the population and economic potential.

According to the provisions of the Health Care Act and the Health Insurance Act, a network of county institutes of public health has been established, with the Croatian National Institute of Public Health as the umbrella institution responsible for their coordination. Public health services in the Republic of Croatia are provided by the Croatian National Institute of Public Health and institutes of public health in counties and the City of Zagreb, with respective hygiene and epidemiology branch offices for the area of one or more municipalities. The Croatian National Institute of Public Health coordinates and supervises the work of the network of local public health services.

The Croatian National Institute of Public Health (CNIPH) is a health institution in charge of providing health services, such as the epidemiology of quarantine and other infectious diseases and chronic widespread diseases, public health, public health education with the advancement of health and disease prevention, health ecology, microbiology, school medicine, mental health and prevention of addictions.

The Croatian National Institute of Public Health is a health care institution responsible per providing public health services, and, among other things, it carries out the following preventive tasks:

- plans, proposes and implements measures for the protection and promotion of the health of the population;
- protects and improves the health of the population by educational and other activities, as well as those related to health promotion;
- plans, proposes, coordinates and monitors specific health protection of children and youth, in particular in primary and secondary schools, and higher education establishments;
- monitors and analyses the situation in terms of epidemiology, proposes, organises and implements preventive and anti-epidemic measures;
- plans, supervises and evaluates the implementation of the compulsory immunisation programme;
- provides health education to the population about addiction diseases;
- collects information and keeps record in the field of addiction diseases (including tobacco, alcohol and psychoactive drugs);

- plans, proposes and implements measures for the preservation and improvement of mental health of the population;
- develops and proposes programmes and conducts research in the area of mental health protection and psychiatric protection for the purpose of monitoring, analyzing and assessing the mental health of the population.

Institutes of public health of the regional self-government units (20 county institutes and the City of Zagreb Institute of Public Health) carry out, amongst other things, the following tasks:

- provision of specific health protection of children and youth, in particular in primary and secondary schools, and faculties in their respective areas;
- collection, control and analysis statistical reports in the field of health, including those on addiction, for the Croatian National Institute of Public Health, at the level of units of regional self-government;
- continuous implementation of the measures of hygiene and epidemiology protection and carring out epidemiological analyses of the situation in the areas for which they are competent, along with the implementation, where necessary, of anti-epidemic measures and monitoring of the implementation of the complusory immunisation programmes.

Right to health care - a right under the compulsory health insurance scheme

The right to health care is a right acquired under the compulsory health insurance scheme, as is the right to financial compensation. The compulsory health insurance scheme is run by the Croatian Institute for Health Insurance (CIHI) and it is governed by the Compulsory Health Insurance Act (Official Gazette, No. 150/08). All persons under the compulsory health insurance scheme have the rights and obligations provided for by this scheme on the basis of the principles of reciprocity, solidarity and equality, in the manner and under the conditions laid down in the Compulsory Health Insurance Act. Within the rights acquired under the compulsory health insurance scheme, rights are ensured in the event of an employment injury or an occupational illness, which include measures for the implementation of specific health care for workers and diagnostic procedures in the case of suspected occupational illness, according to the Health Care Act (Official Gazette, No. 150/08) and special acts.
Persons with permanent residence in the Republic of Croatia and foreigners who have been approved permanent stay in the Republic of Croatia register for health insurance pursuant to the Compulsory Health Insurance Act, unless otherwise provided for by an international agreement on social security. Foreigners who have been approved temporary stay in the Republic of Croatia (after the expiration of three months of the date when their status is recognized) have the obligation to register for health insurance pursuant to the provisions of the Act on the Health Care of Foreigners in the Republic of Croatia, unless they have been provided with health care on some other ground.
Asylees and foreigners receiving subsidiary protection enjoy the rights provided by the compulsory health insurance scheme under the same conditions as persons insured under the compulsory health insurance scheme in the Republic of Croatia. Health care costs of these persons are financed from the State Budget, from the ministry competent for health care (Article 44 of the Asylum Act, Official Gazette, No. 79/07 and 88/10).

Registration for compulsory health insurance - the requirement for using health care services at the expense of the CIHI

An insured person of the CIHI exercises the right to health care at the expense of the CIHI if he or she has registered for compulsory health insurance and thus acquired the status of a person insured with the CIHI, pursuant to the provisions of the Ordinance on the procedure for registering, de-registering and gaining status of an insured person in the compulsory health insurance scheme and the amendments of the Ordinance (Official Gazette, No. 31/07, 56/07, 96/07, 130/07, 33/08, 91/09, 04/10, 69/10, 01/11 and 48/11). The status of an insured person is granted by the CIHI regional offices, on the basis of an application for registration for compulsory health insurance. These applications are filed with regional offices by a legal or natural person, within eight days of the day of occurrence or change of circumstances on the basis of which the status of an insured person is to be acquired. The application for compulsory health insurance may be filed with any CIHI regional office, and the status of an insured person is granted by the regional office on whose territory the person in respect of whom the application is filed has permanent residence, and, if the applicant is a foreigner, permanent or temporary stay.

The number and structure of CIHI insured persons in the period between 1st January 2008 and 31st December 2011

2008

According to the figures obtained from CIHI, in the period between January and December of 2008, 4,365,225 persons on average were entitled to health care and the number increased by 0.10% or 4,217 persons in comparison with the same period in 2007. A total of 1,582,261 active insured persons were registered, which is a 2.24% increase from the same period last year. In total, the number of employees increased by 34,738 persons, which points to the conclusion that the number of contribution payers is on the increase and the number of unemployed persons is decreasing.

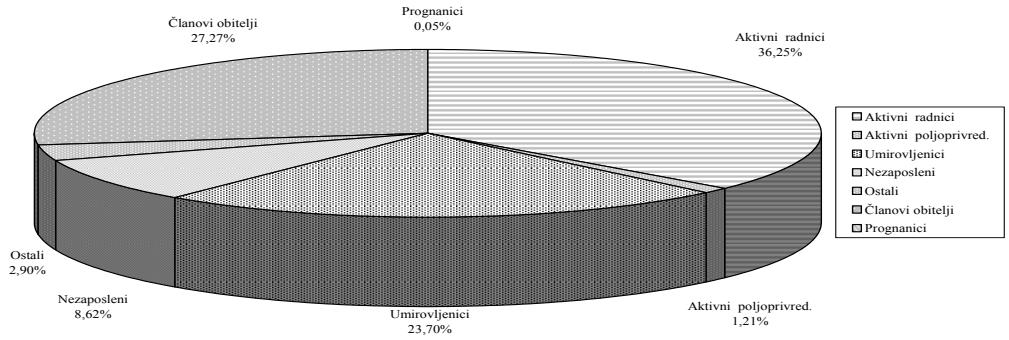
Of 1,582,261 active insured persons, there were 712,416 women or 45.03% and 869,845 men. 1,034,635 pensioners were registered and the number increased by 10,732 persons or 1.05%, while the number of members of other categories mostly fell in comparision with the last year, which is seen from the following review (Table 1, Chart 1).

Table 1 Insured persons

	Average number		Index	Share in %	
	I-XII 2007	**I-XII 2008**	**2008/2007**	**I-XII 2007**	**I-XII 2008**
- active workers	1,547,523	1,582,261	102.24	35.49	36.25
- active farmers	57,906	52,685	90.98	1.33	1.21
- pensioners	1,023,903	1,034,635	101.05	23.48	23.70
- unemployed people	388,286	376,447	96.95	8.90	8.62
- others	133,186	126,560	95.03	3.05	2.90
- family members	1,207,595	1,190,489	98.58	27.69	27.27
- displaced persons	2,609	2,148	82.33	0.06	0.05
Total:	**4,361,008**	**4,365,225**	**100.10**	**100.00**	**100.00**

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

Chart 1 Insured persons



CROATIAN	ENGLISH
Aktivni radnici	Active workers
Aktivni poljoprivred.	Active agricultural workers
Umirovljenici	Pensioners
Nezaposleni	The unemployed
Ostali	Others
Članovi obitelji	Family members
Prognanici	Displaced persons

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

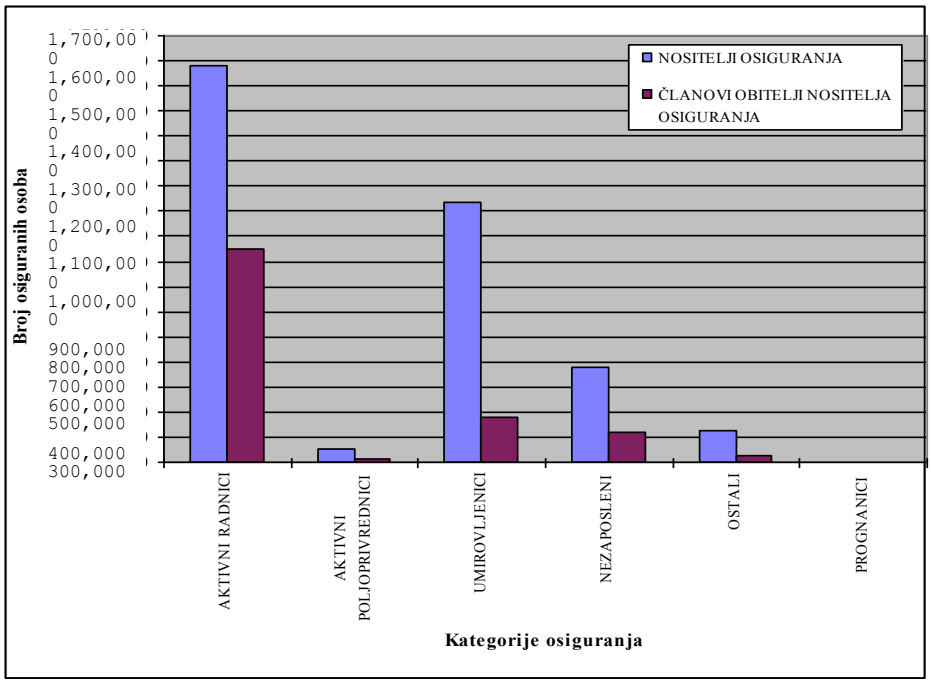
The structure of insured persons is such that active insured persons account for 36.25 % of the total number, pensioners 23.70 %, unemployed people 8.62%, family members 27.27 % and other categories (farmers, others, displaced persons) 4.16 %. Other insured persons are persons incapable of independent life and work, without means of support; Croatian Homeland War veterans, unless they have been provided with health care on some other ground; foreign pension holders who life in the Republic of Croatia and use health care services at the expense of foreign institutes of health insurance; persons who have been granted the status of disabled Homeland War veterans, war invalids and others. The structure of insured persons is such that family members account for 27.27% of the total number, which means that, along with 3,174,736 insurance holders, 1,190,489 family members have been registered. The ratio of insurance holders to their family members and structure can be seen in the following overview (Table 2 and Chart 2).

Table 2 Insured persons

	Average number in 2008		
	Insurance holders	**Insurance holders' family members**	**% of members with regard to insurance holders**
- active workers	1,582,261	849,038	53.66
- active farmers	52,685	16,398	31.12
- pensioners	1,034,635	177,858	17.19
- unemployed people	376,447	120,595	32.04
- others	126,560	26,600	21.02
- displaced persons	2,148	-	-
Total:	**3,174,736**	**1,190,489**	**37.50**

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social

Chart 2 Insured persons



CROATIAN	ENGLISH
Broj osiguranih osoba	Number of insured persons
NOSITELJI OSIGURANJA	INSURANCE HOLDERS
ČLANOVI OBITELJI NOSITELJA OSIGURANJA	FAMILY MEMBERS OF INSURANCE HOLDERS
AKTIVNI RADNICI	ACTIVE WORKERS
AKTIVNI POLJOPRIVREDNICI	ACTIVE AGRICULTURALWORKERS
UMIROVLJENICI	PENSIONERS
NEZAPOSLENI	THE UNEMPLOYED
OSTALI	OTHERS
PROGNANICI	DISPLACED PERSONS

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

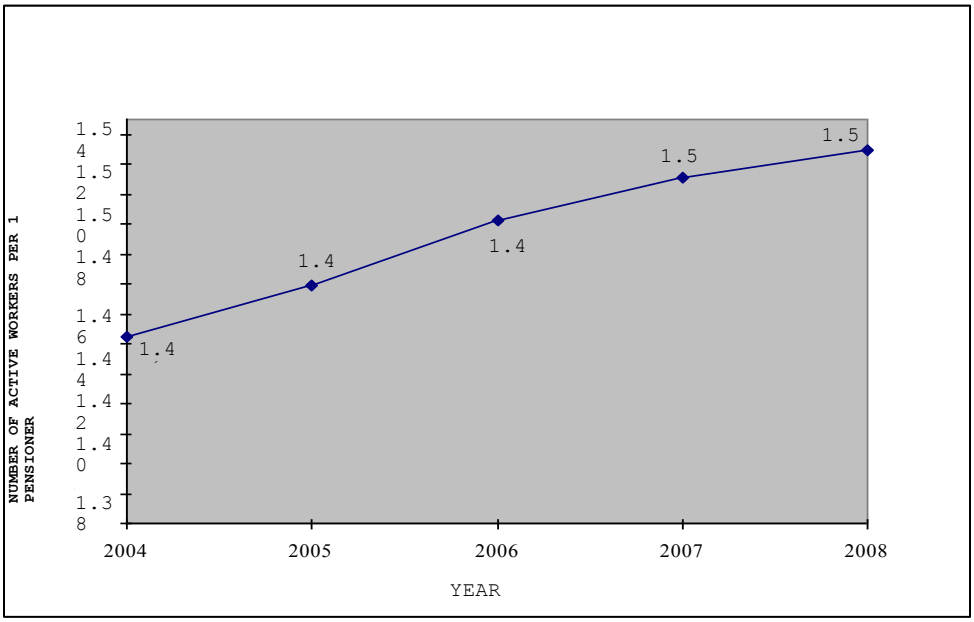
Along with 1,582,261 active insured persons, 849,038 family members are entitled to health care, which is 53.66 % of active insured persons. Along with 1,034,635 pensioners, 177,858 family members have been registered, and along with 376,447 unemployed insurance holders 120,595 family members have been registered. Furthermore, if the ratio of workers to pensioners is observed in the last several years, it can be concluded that the relation between these categories is becoming more favourable each year. In 2004, there were 1.40 people working for one pensioner and in 2008 there were 1.53 people working for one pensioner (Table 3 and Chart 3).

Table 3 Ratio of active workers to pensioners for the period 2004-2008

Year	Active workers	Pensioners	Number of active workers per pensioner
2004	1,412,445	1,005,342	1.40
2005	1,450,057	1,007,865	1.44
2006	1,505,547	1,015,823	1.48
2007	1,547,523	1,023,903	1.51
2008	1,582,261	1,034,635	1.53

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

Chart 3 Ratio of active workers to pensioners for the period 2004-2008



Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

2009

In the period between January and December 2009, 4,343,476 persons on average were registered at the CIHI and the number decreased by 0.50%, i.e. 21,749 persons in comparison to the same period in 2008, when 4,365,225 persons on average were registered. A total of 1,546,484 active insured persons were registered and the number increased by 2.26%, i.e. 35,777 persons in comparison with the period January - December 2008 (in 2008, an average of 1,582,261 active insured persons were registered). Out of 1,546,484 active insured persons, there were 699,947 women, i.e. 45.26% and 846,537 men. Furthermore, 1,030,736 pensioners have been registered and the number decreased by 3,899 persons, i.e. 0.38% in comparison with the previous year, when 1,034,635 pensioners were registered. The number of insured persons belonging to other categories (unemployed people, pensioner insurance holders on

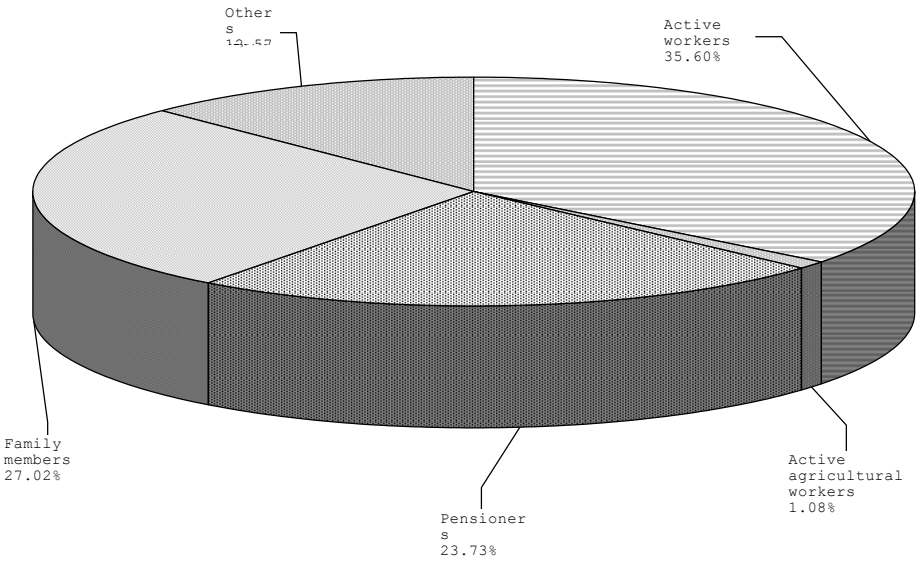
temporary stay abroad, students of secondary schools and students who are not insured as family members, persons incapable of independent life and others) increased by 8.03%, which is seen in the following overview (Table 4 and Chart 4).

Table 4 Insured persons

Insured persons	Average number		Index	Share %	
	I-XII 2008	I-XII 2009	2009/2008	2008	2009
- active workers	1,582,261	1,546,484	97.74	36.25	35.60
- active farmers	52,685	46,732	88.70	1.21	1.08
- pensioners	1,034,635	1,030,736	99.62	23.70	23.73
- family members	1,190,489	1,173,818	98.60	27.27	27.02
- others	505,155	545,706	108.03	11.57	12.57
Total:	**4,365,225**	**4,343,476**	**99.50**	**100.00**	**100.00**

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

Chart 4 Share of particular categories of insured persons in the total number of insured persons in the Republic of Croatia for I-XII 2009



Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

The structure of insured persons is such that active insured persons account for 35.60% of the total number, pensioners 23.73%, farmers 1.08%, family members 27.02% and other insured persons 12.57%. Of the average number of insured persons, 4,343,476, insurance holders account for 72.98% or 3,169,658 persons, while family members account for 27.02%, i.e. 1,173,818 persons. The ratio of insurance holders to their family members and structure is seen in the following overview (Table 5 and Chart 5).

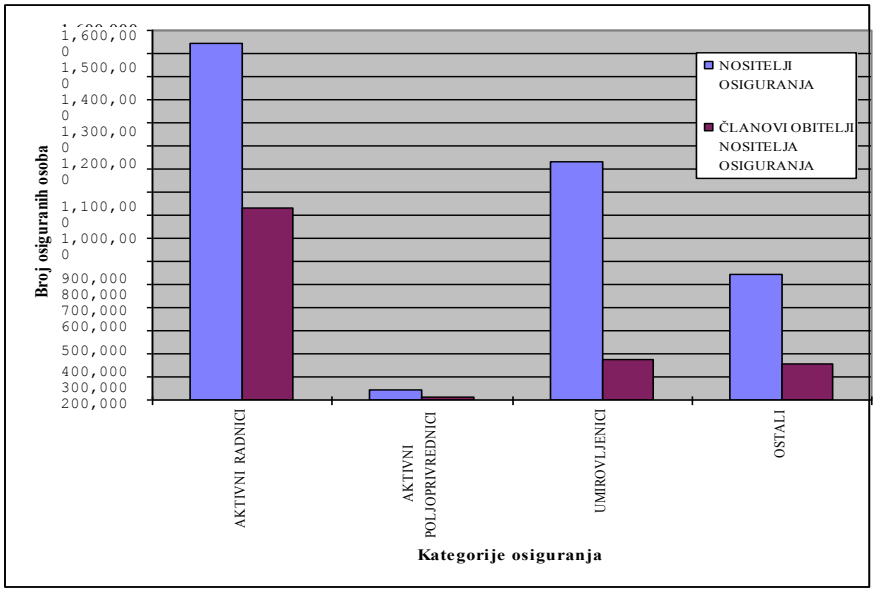
Table 5 Overview of insurance holders with family members by categories

	Average number - 2009		
	Insurance holders	Insurance holders' family members	% of family members out of

			insurance holders
- active workers	1,546,484	833,818	53.92
- active farmers	46,732	14,064	30.10
- pensioners	1,030,736	172,293	16.72
- others	545,706	153,643	28.15
Total:	**3,169,658**	**1,173,818**	**37.03**

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

Chart 5 Overview of insurance holders with family members by categories



Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

CROATIAN	ENGLISH
Broj osiguranih osoba	Number of insured persons
NOSITELJI OSIGURANJA	INSURANCE HOLDERS
ČLANOVI OBITELJI NOSITELJA OSIGURANJA	FAMILY MEMBERS OF INSURANCE HOLDERS
AKTIVNI RADNICI	ACTIVE WORKERS
AKTIVNI POLJOPRIVREDNICI	ACTIVE AGRICULTURALWORKERS
UMIROVLJENICI	PENSIONERS
NEZAPOSLENI	THE UNEMPLOYED
OSTALI	OTHERS
Kategorije osiguranja	Insurance categories

As visible from the previous table, along with 1,546,484 active insured persons, 833,818 family members have the right to health care, which is 53.92% of the total number of active insured persons. Of 1,030,736 pensioners, 172,293 family members have been registered. Furthermore, if the ratio of active insured persons - workers to pensioners is observed in the last several years, it can be concluded that the relation between these categories is becoming more favourable each year (Table 6 and Chart 6). In 2005, there were 1.44 employed persons

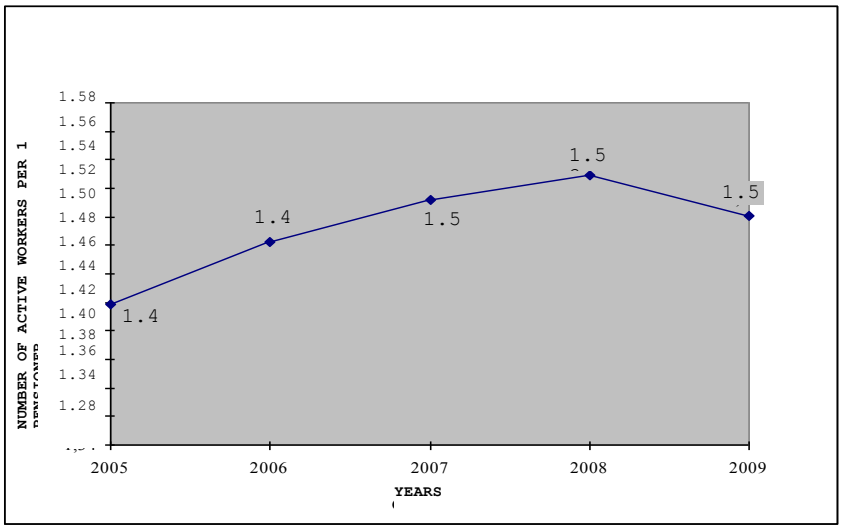
per one pensioner, while in 2009 there were 1.50 employed persons per one pensioner.

Table 6 Ratio of active workers to pensioners for the period 2005-2009

Year	Active workers	Pensioners	Number of active workers per pensioner
2005	1,450,057	1,007,865	1.44
2006	1,505,547	1,015,823	1.48
2007	1,547,523	1,023,903	1.51
2008	1,582,261	1,034,635	153
2009	1,546,484	1,030,736	1.50

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

Chart 6 Ratio of active workers to pensioners for the period 2005-2009



Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

2010

In the period between January and December of 2010, 4,348,014 persons in average were registered at the CIHI and the number increased by 0.10% or 4,538 persons in comparison with the same period of the previous year, when 4,343,476 insured persons on average were registered. A total of 1,493,148 active insured persons were registered and the number increased by 3.45% or 53,336 persons in comparison with the period January - December of 2009 (in 2009, an average of 1,546,484 active insured persons were registered). Of 1,493,148 active insured persons, there were 684,778 women or 45.86% and 808,370 men. Furthermore, 1,037,643 pensioners were registered and the number increased by 6,907 persons or 0.67% in comparison with the previous year, when 1,030,736 pensioners were registered. The number of farmers decreased by 13.02% and 40,647 farmers on average were registered in the observed period, while 46,732 farmers were registered in the same period of the previous year.

The number of insured persons belonging to other categories (unemployed people, pensioner

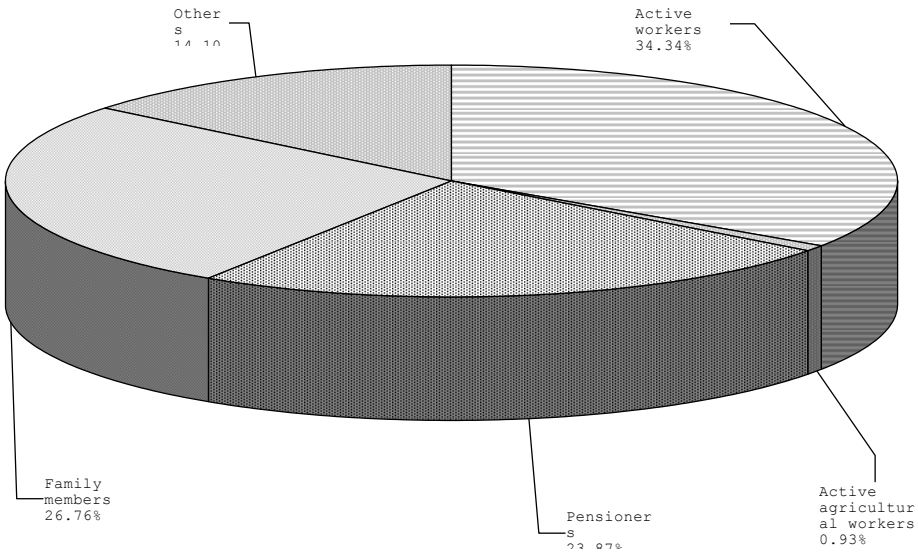
insurance holders on temporary stay abroad, students of secondary schools and students who are not insured as family members, persons incapable of independent life and others) has increased by 12.31%, which can be seen from the following overview (Table 7 and Chart 7):

Table 7 Share of particular categories of insured persons in the total number of insured persons in the Republic of Croatia for the period I-XII 2010

Insured persons	Average number		Index	Share %	
	I-XII 2009	I-XII 2010	2010/2009	2009	2010
- active workers	1,546,484	1,493,148	96.55	35.60	34.34
- active farmers	46,732	40,647	86.98	1.08	0.93
- pensioners	1,030,736	1,037,643	100.67	23.73	23.87
- family members	1,173,818	1,163,716	99.14	27.02	26.76
- others	545,706	612,860	112.31	12.57	14.10
Total:	**4,343,476**	**4,348,014**	**100.10**	**100.00**	**100.00**

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

Chart 7 Share of particular categories of insured persons in the total number of insured persons in the Republic of Croatia for the period I-XII 2010



Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

The structure of insured persons is such that active insured persons account for 34.34%, pensioners account for 23.87%, farmers account for 0.93%, family members account for 26.76% and other insured persons account for 14.10% of the total number. Of the average number of insured persons, 4,348,014 insurance holders account for 73.24%, i.e. 3,184,298 persons, while family members account for 26.76% or 1,163,716 persons.

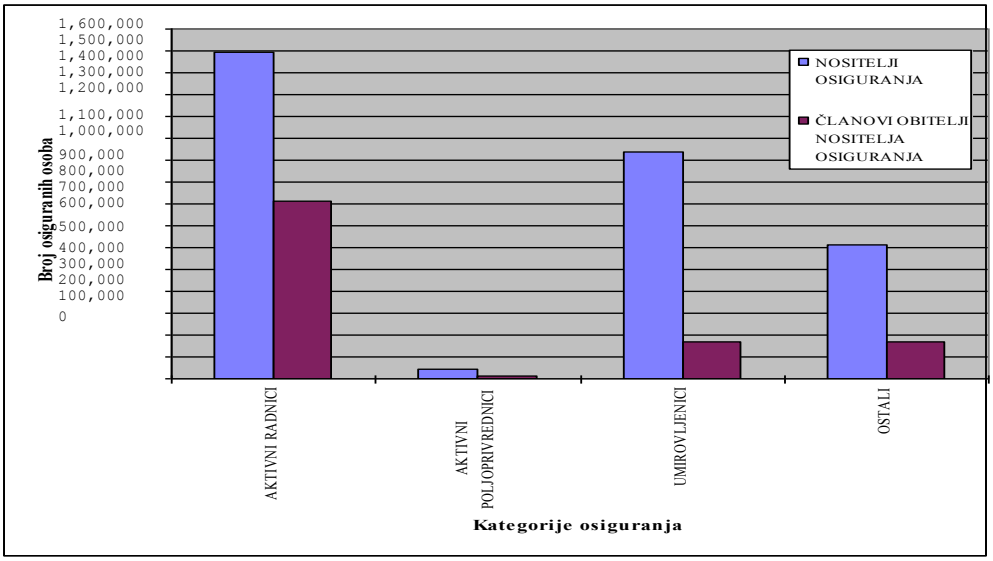
The ratio of insurance holders to their family members and structure is seen in the following overview (Table 8 and Chart 8).

Table 8 Overview of insurance holders with family members by categories

	Average number - 2010		
	Insurance holders	**Insurance holders' family members**	**% of family members with regard to insurance holders**
- active workers	1,493,148	811,772	54.37
- active farmers	40,647	12,086	29.73
- pensioners	1,037,643	169,309	16.32
- others	612,860	170,549	27.83
Total, Republic of Croatia:	**3,184,298**	**1,163,716**	**36.55**

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

Chart 8 Overview of insurance holders with family members by categories



CROATIAN	ENGLISH
Broj osiguranih osoba	Number of insured persons
NOSITELJI OSIGURANJA	INSURANCE HOLDERS
ČLANOVI OBITELJI NOSITELJA OSIGURANJA	FAMILY MEMBERS OF INSURANCE HOLDERS
AKTIVNI RADNICI	ACTIVE WORKERS
AKTIVNI POLJOPRIVREDNICI	ACTIVE AGRICULTURALWORKERS
UMIROVLJENICI	PENSIONERS
OSTALI	OTHERS
Kategorije osiguranja	Insurance categories

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

As visible from the previous table, along with 1,493,148 active insured persons, 811,772 family members have the right to health care, which accounts for 54.37% of the total number of active insured persons. Of 1,037,643 pensioners, 169,309 family members have been registered.

2011

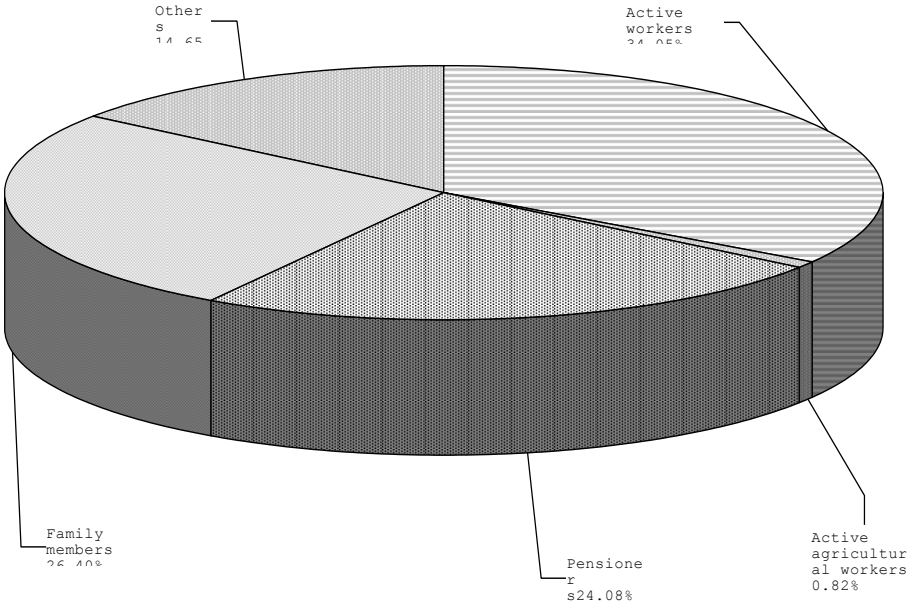
In the period between January and December 2011, 4,362,595 persons in average were registered at the CIHI, which is an increase by 0.34% or 14,581 persons in comparison with the same period of the previous year, when 4,348,014 insured persons on average were registered. 1,485,324 insured persons on average were registered and the number increased by 0.52% or 7,824 persons in comparison with the period January - December of 2010 (in 2010, an average of 1,493,148 active insured persons were registered). Of 1,485,324 active insured persons, there were 684,609 women or 46.09% and 800,715 men.
Furthermore, 1,050,460 pensioners were registered and the number increased by 12,817 persons or 1.24% in comparison with the previous year, when 1,037,643 pensioners were registered. The number of farmers decreased by 11.73% and 35,878 farmers on average were registered in the observed period, while 40,647 farmers were registered in the same period of the previous year. The number of insured persons belonging to other categories (unemployed people, pensioner insurance holders on temporary stay abroad, students of secondary schools and students who are not insured as family members, persons incapable of independent life and other) increased by 4.29%, which is seen in the following overview (Table 9 and Chart 9).

Table 9 Share of particular categories of insured persons in the total number of insured person in the Republic of Croatia for the period I - XII 2011

Insured persons	Average number		Index	Share %	
	I-XII 2010	I-XII 2011	2011/2010	2010	2011
- active workers	1,493,148	1,485,324	99.48	34.34	34.05
- active farmers	40,647	35,878	88.27	0.93	0.82
- pensioners	1,037,643	1,050,460	101.24	23.87	24.08
- family members	1,163,716	1,151,770	98.97	26.76	26.40
- others	612,860	639,163	104.29	14.10	14.65
Total, Republic of Croatia:	**4,348,014**	**4,362,595**	**100.34**	**100.00**	**100.00**

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

Chart 9 Share of particular categories of insured persons in the total number of insured person in the Republic of Croatia for the period I - XII 2011



Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

The structure of insured persons is such that active insured persons account for 34.05% of the total number, while pensioners account for 24.08%, farmers for 0.82%, family members for 26.40% and other insured persons for 14.65%. Of the average number of insured persons, 4,362,595, insurance holders account for 73.60%, i.e. 3,210,825 persons, while family members account for 26.40%, i.e.1,151,770 persons.

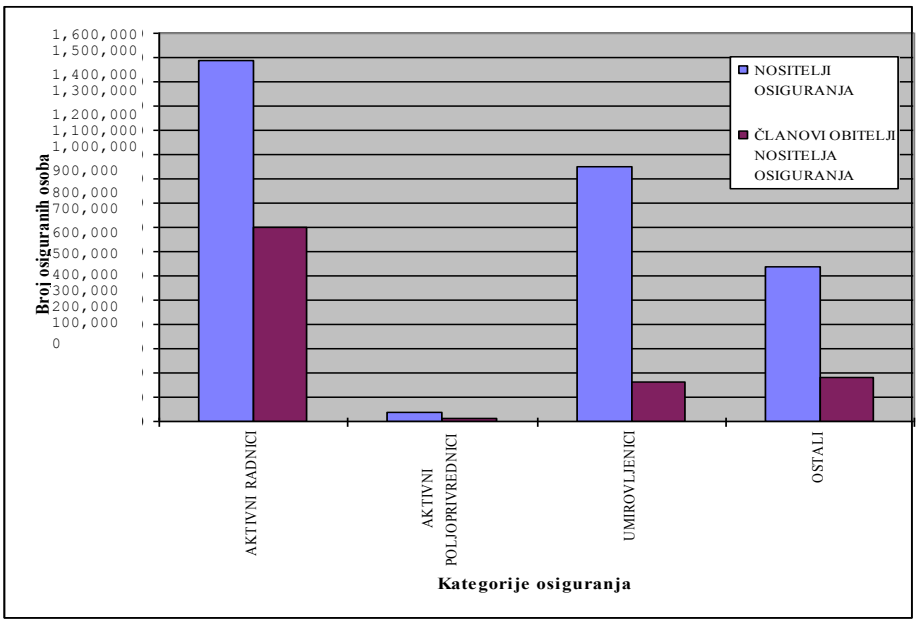
The ratio of insurance holders to their family members and structure is presented in the following overview (Table 10 and Chart 10).

Table 10 Ratio of insurance holders to their family members and structure

	Average number in 2011		
	insurance holders	**insurance holders' family members**	**% of family members with regard to insurance holders**
- active workers	1,485,324	797,919	53.72
- active farmers	35,878	10,381	28.93
- pensioners	1,050,460	164,443	15.65
- others	639,163	179,027	28.01
Total:	**3,210,825**	**1,151,770**	**35.87**

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

Chart 10 Ratio of insurance holders to their family members and structure



CROATIAN	ENGLISH
Broj osiguranih osoba	Number of insured persons
NOSITELJI OSIGURANJA	INSURANCE HOLDERS
ČLANOVI OBITELJI NOSITELJA OSIGURANJA	FAMILY MEMBERS OF INSURANCE HOLDERS
AKTIVNI RADNICI	ACTIVE WORKERS
AKTIVNI POLJOPRIVREDNICI	ACTIVE AGRICULTURALWORKERS
UMIROVLJENICI	PENSIONERS
OSTALI	OTHERS
Kategorije osiguranja	Insurance categories

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

Along with 1,485,324 active insured persons, 797,919 family members have the right to health care, which accounts for 53.72% of active insured persons. Along with 1,050,460 pensioners, 164,443 family members have been registered.

RIGHT TO HEALTH CARE

The manner of exercising the right to health care

As previously mentioned, an insured person exercises the right to health care under the compulsory health insurance scheme in the manner and under the conditions prescribed by the Compulsory Health Insurance Act, special regulations, inter-state treaties and the CIHI's general legal acts. Health care services can be used on the territory of the Republic of Croatia in health institutions and private health practitioners with whom the CIHI has entered into a contract on the provision of health care (CIHI contractors), and with natural or legal persons who are authorized for the production and retail sale of orthopaedic and other aids, in accordance with special regulations, with which the CIHI has entered into a contract on the

delivery of orthopaedic and other aids to insured persons in accordance with special regulations (contractual suppliers of aids). The right to use health care services abroad is exercised by persons insured with the CIHI under the conditions, to the extent and in the manner prescribed by general legal acts of the CIHI. When using health care services under the compulsory health insurance scheme, insured persons are obliged to participate in the coverage of a portion of the costs of health care services by paying the difference in the amount of 20% of the full price of the health care services received, and the amount cannot be smaller than a certain percentage of the budgetary base, indirectly or on the basis of an additional health insurance policy, taken out with the CIHI or an insurance company pursuant to the Voluntary Health Insurance Act.

According to the Voluntary Health Insurance Act and amendments to this Act (Official Gazette, No. 150/08 and 71/10), voluntary health insurance is divided into supplementary health insurance, additional and private health insurance.

Supplementary health insurance is an insurance used to cover a portion of the costs of health care services provided under the compulsory health insurance scheme. **Additional health insurance** provides for a higher standard of health care within the compulsory health insurance scheme and a more rights in comparison to those provided under the compulsory health insurance scheme. **Private health insurance** is used to provide health care to natural persons staying in the Republic of Croatia, who are not obliged to insure themselves pursuant to the Compulsory Health Insurance Act or the Act on the Health Care of Foreigners in the Republic of Croatia. Voluntary health insurance schemes are run by insurance companies licensed by the supervisory insurance authority and cannot begin to carry out activities regarding voluntary health insurance without the previously obtained approval of the minister competent for health matters (the Minister of Health).

Supplementary health insurance is also provided by the CIHI, which separates supplementary health insurance funds and compulsory health insurance funds. At the same time, supplementary health insurance is obtained on the basis of a contract on supplementary health insurance between policy holders and the insurer, i.e. the CIHI. Policy holders of supplementary health insurance are insured persons, i.e. legal or natural persons, state administration bodies or other bodies that have concluded a contract on supplementary health insurance for insured persons and committed to pay an insurance premium. Insured persons, i.e. natural persons who concluded or consented to the contract on supplementary health insurance, can only be persons with the status of insured persons within the compulsory health insurance scheme.

At the same time, the loss of compulsory health insurance coverage leads to the loss of supplementary health insurance coverage. With a general act, the CIHI determines the price of the supplementary health insurance premium with regard to the extent of coverage from the contract on supplementary health insurance, income census and the status of insured persons in the compulsory health insurance scheme.

For specific categories of insured persons, the premium for supplementary health insurance provided by the CIHI is financed from the State Budget. In this context, the following insured persons are covered (Table 11, p. 23):

1. insured disabled persons with 100% disability, i.e. physical impairment according to special regulations, persons with identified multiple disabilities, and persons with physical or mental impairments or mental illnesses, which prevent them from

independently carrying out activities suitable to their age, subject to the regulations on social welfare;
2. insured persons who are donors of human body parts for the purpose of treatment;
3. insured persons who are voluntary blood donors with more than 35 (men) and 25 (women) blood donations;
4. insured persons who are regular pupils and students over 18 years of age;
5. insured persons whose income per family member in the last calendar year does not exceed 45.59% of the budgetary basis (income census). The mentioned income icludes all income obtained by the family, based on revenues from non-self employment, income or profit from self-employment activities, income used to determine second property income and proprietary rights, capital, insurance and all other income obtained according to special regulations. If the insured person is a single person, his or her annual income in the previous calendar year should not exceed 58.31% of the budgetary basis.

However, it should be pointed out that the mentioned range of insured persons within the supplementary health insurance scheme was affirmed in the second amendment of the Voluntary Health Insurance Act, which entered into force on 18th June 2010. Until then, funds for the supplementary health insurance premium were allocated from the state budget for the following insured persons, next to the above mentioned:

- various categories of unemployed people with temporary or permanent residence in the Republic of Croatia, registered in the unemployment register of the Croatian Employment Service (for example, persons registered in the unemployment register of the Croatian Employment Service after the completion of education or interruption of education, termination of employment, Croatian Homeland War veterans etc.);
- insured persons who have been granted the status of Croatian war invalids according to the Act on the Rights of Croatian Homeland War Veterans and Their Family Members, as well as insured persons who have been granted the status of war invalids, military or civilian, according to the Military and Civilian War Invalids Protection Act;
- insured persons with disabilities and other persons granted the right to assistance and care in carrying out most or all life activities pursuant to special regulations, persons granted the right to personal disability benefits pursuant to special regulations, persons with at least 80% disability according to health insurance regulations or other special regulations, and other persons with physical or intellectual disabilities;
- insured persons - Croatian Homeland War Veterans with at least 30% disability.

The mentioned changes in the categories of insured persons with supplementary health insurance, for whom the funds for the supplementary health insured premium are allocated from the state budget, were effected according to the objectives and principles of the Economic Recovery Programme for the Republic of Croatia. Additional health insurance, i.e. the conditions and the manner of its implementation, are prescribed in the Ordinance on the conditions and manner of providing supplementary health insurance and amendments to the Ordinance (Official Gazette, No. 112/06 and 131/06). As previously mentioned, by concluding the contract on additional insurance with an insurance company licensed by the supervisory insurance authority pursuant to the Insurance Act, the insured person is able to secure a higher standard of health care within the compulsory health insurance scheme, and more rights in comparison to those those under the compulsory health insurance scheme. Additional insurance for a higher standard of health care within the compulsory health

insurance scheme includes:

1. health services above the standards of compulsory health care in certain fields at the level of primary health care, specialist and consultant health care and hospital care;
2. the use of higher number of health care services with respect to the number of health care services defined within the scope of health care rights and established standards and standard specifications of health care within the compulsory insurance scheme;
3. the possibility of choosing a physician, dentist, i.e. a medical doctor of the relevant specialization in health care institutions at the secondary and tertiary level of health care according to the contract between the insurer and the health care institution;
4. the stay of a family member or a custodian with the insured person in a hospital;
5. the use of aids and supplementations outside the standards of compulsory health insurance.

Also, additional insurance for more rights in comparison to those under the compulsory health insurance scheme includes:

1. coverage of the costs of health care services which are not covered by the funds for the compulsory health insurance scheme;
2. the payment of compensations above the amounts established with regard to rights within the compulsory health insurance scheme:
    - income benefits during temporary work disability, i.e. inability to work due to the use of health care;
    - financial compensation due to the inability of performance of activities on the basis of which other receipts are obtained and other incomes are achieved, according to the regulations on compulsory insurance contributions;
    - compensation of transport costs related to the use of health care within the compulsory health insurance scheme;
    - financial compensation during temporary inability to work after the expiry of the time-limit defined in the Compulsory Health Insurance Act.

Table 11 Overview of additional insurance policies taken out according to the categories of insured persons

no.	Description	2011	2012 (estimate)
1	Total number of insurance policies taken out	2,481,767	2,500,000
	(Amount of realised – estimated funds)	1,912,704,000	2,000,000,000
2	Total number of insured persons on 31 December 2011	4,362,595	-
3	Total number of insured persons who exercise the right to supplementary health insurance at the expense of the state budget	943,638	900,000
	(Amount of realised – estimated funds)	555,000,000	555,000,000
4	Number of valid insurance policies of supplementary health insurance on 31 December 2011	2,352,114	2,500,000
	(Amount of realised – estimated funds)	1,912,704,000	2,000,000,000
5	Number of valid insurance policies of supplementary health insurance at the expense of the state budget on 31 December 2011	906,572	900,000
	(Amount of realised – estimated funds)	555,000,000	555,000,000

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

Enquiry of the Committee

- *The committee requests that the following report contain data on the number of persons within the private insurance scheme.*

According to data submitted to the Ministry of Health by insurance companies, in the period between 1st January 2008 and 31st December 2011 there were 65 persons with private health insurance defined in the Article 7 of the Voluntary Health Insurance Act (Official Gazette, No. 150/08 and 71/10): "Private health care insurance is used to provide health care to natural persons staying in the Republic of Croatia, who are not obliged to ensure themselves pursuant to the Compulsory Health Insurance Act and the Act on the Health Care of Foreigners in the Republic of Croatia."

In exercising rights to health care, every person, according to the provisions of the Health Care Act and regulations on compulsory health insurance, has the right to:

1. equality in the entire process of the realization of health care;
2. free choice of doctor and dentist;
3. medical services of standardized quality and equal content;
4. first aid and emergency medical assistance when needed;

5. refuse treatment involving medical students and refuse any other interventions which would be performed by health workers who have not taken a professional exam are not auhorized for independent work;
6. refuse examinations and treatments, except in cases when this would endanger the lives of others, including the right to request in writing another doctor or dentist for reasons which do not have to be explained in length;
7. nutrition according to one's view of the world during stay in a health care institution;
8. perform religious rituals during the stay in a health care institution in an area envisaged for these matters;
9. be taken care of in a morgue in the case of death, following religious and other customs of reverence for the deceased.

When using health care services, the person exercises rights according to the Patients' Rights Protection Act (Official Gazette, No. 169/04).

The Plan and Programme of Health Care Measures under the Compulsory Health Insurance Scheme (Official Gazette, No. 126/06 and 156/08) determines health care measures. Through implementation of those measures, persons insured with the CIHI have the right to health care within the compulsory health insurance scheme. Subjects who are obliged to implement health care measures and the method of implementation are also determined.
According to the Plan and Programme of Specific Health Care Measures (Official Gazette, No. 07/122) specific health care measures are established and subjects (contractors and participants) are identified and are obliged to ensure and implement specific health care measures for workers. Objectives of the implementation of the Plan and Programme of Specific Health Care Measures for the Employed are the following: increase the level of health of the employed and reduce the prevalence of health risk factors through the implementation of the health promotion programme, reduce the morbidity, mortality and disability from diseases, injuries and conditions which can be acted upon by preventive measures and effective health care, implement special care services for the improvement of the health of employees in high-risk working environments.

Measures taken to improve the use of health care services by persons insured with the CIHI

In order to achieve further health improvement and higher quality of the health care system, in the period between 2008 and 2011, numerous novelties were introduced in health care organization and financing and in the range of rights of insured persons under the same health care programme. The range of health care services at the expense of the CIHI was extended, so that insured persons are not obliged to participate in the costs of health care services regarding artificial insemination (not only health care of women regarding pregnancy monitoring and delivery, which was previously the case). The above-mentioned was necessary for harmonization of the Compulsory Health Insurance Act and its amendments , (Official Gazette, No. 150/08, 94/09, 153/09, 71/10, 139/10 and 49/11) as well as the Act on Artificial Insemination and its amendments (Official Gazette, No. 88/09, 137/09, 124/11 and 86/12). Also, insured persons do not have an obligation to participate in the coverage of a portion of the costs of health care services related to the complete treatment of chronic psychiatric disorders (and not just hospital health care of chronic psychiatric patients, which was the case until the adoption of the amendments), considering the fact that these are disorders that, along with hospital care, require continuous and available specialist and consultant health care and primary health care, as well as health care at all levels, which

enables a longer remission period, prolonged working ability and a reduced need for hospitalization, which consequently leads to the reduction of costs regarding treatments of the above-mentioned diseases.

The mentioned participation in the coverage of a portion of the costs of health care services was extended to laboratory diagnostics at the level of primary health care, which enables a simpler and faster provision of this form of health care to insured persons (considering the fact that sampling for laboratory analysis is performed in the offices of attending physicians at the level of primary health care, and the material is transported in an adequate way in corresponding clinical biochemistry laboratories). Also, another change is related to the fact that medical examinations are no longer carried out by medical committees but by authorized physicians registered in the CIHI, for the purpose of achieving better operability and facilitating communication between the attending physicians at the level of primary health care and authorized physicians, as well as enabling better access to relevant medical documentation and the medical record of an insured person, simplification of the entire procedure and reduction of waiting times in the premises of the CIHI. As regards the implementation of the informatisation of the health care system, in line with which a *"smart card"* has been introduced, it enabled the CIHI to introduce a general act on the determination of the production costs of "smart cards" (given that the production and implementation costs are considerable). Also, for the purpose of improving the quality of health services and increasing accessibility in exercising rights to health care for persons insured with the CIHI, many activities have been undertaken for informatisation of the entire primary health care (implementation of *e-prescriptions* and *e-application* for compulsory health insurance, regular use of *e-referrals* for specialist and consultant health care) and, owing to network connection between the CIHI and contracting entities, the unhindered use, increased accessibility and improved quality in the provision of health care has been enabled for persons insured with the CIHI.

As part of the informatization of primary health care, the issuing of *e-prescriptions* begun in 2011. Namely, as part of the informatisation project, all activities within primary health care started with full application of implemented functionalities *e-Prescription* and *e-Referral*. Over 6000 contracting entities and 15000 health service providers are included in the informatization.

More than 300 experts indirectly participated in the implementation of informatisation. A support system for all subjects of informatization was established and it is at disposal for all subjects of informatization from 7 a.m. to 8 p.m. on weekdays and from 7 a.m. to 3 p.m. on Saturdays. The *e- waiting list*, a drug pricing module, drug reference module, medication-use control etc. were introduced in 2011. The development of a module which would include proposition analysis for insertion of new medicines in the List of medications covered by the CIHI's funds and other matters regarding the work of the CIHI's Medications Committee is underway. Also, it must be noted that in 2011 a List of Orthopaedic and Other Aids was compiled, simultaneously with the Ordinance on orthopaedic and other aids.

The new ordinance was made according to the List of Aids, which was professionally examined and proposed by a special expert committee on orthopaedic and other aids. The new Ordinance and the List helped terminate the process of improving the system of contracting and delivering aids, which includes a public call for proposals and a new model of contracting retail locations for the delivery of aids and an improvement of the aids advertising system, aids quality control and introducing responsibility not only for aids prescribers, but also for

subjects whose aids are on the List of Aids. There are more than 1800 types of aids with trademark names (as opposed to the previous approx. 600) and about 10000 different models of aids on the new List of Aids which consists of aids with trademark names (as opposed to the previous, which consists of aids with generic names). Although the new Ordinance on orthopaedic and other aids with the List of Orthopaedic and Other Aids was adopted on 14th December 2011 at the session of the Management Board, it entered into force in 2012 and was therefore not included in the period to which this report refers.

Protection of rights under the compulsory health insurance scheme

The protection of rights under the compulsory health insurance scheme is regulated by the provisions of the Compulsory Health Insurance Act and the Ordinance on the conditions and means of exercising rights in the compulsory health insurance scheme, and it was regulated in the same manner during report writing. As a rule, an insured person applies for the right to monetary benefit or other rights under the compulsory health insurance scheme to the competent regional or branch office of the CIHI, according to his or her permanent or temporary residence. The CIHI's regional or branch office must receive every written application for obtaining a compulsory health insurance right filed by an insured person. If the regional or branch office does not have jurisdiction for dealing with the application received, it must forward it to the regional or branch office with jurisdiction. In order to ensure the protection of insured persons' rights arising from compulsory health insurance, their applications are dealt with at two levels of jurisdiction. A first-instance decision on rights arising from compulsory health insurance is, as a rule, rendered by the competent regional office of the CIHI, according to the insured person's permanent or temporary residence. The insured person is entitled to lodge an appeal against the decision by the regional office. The appeal is lodged with the Directorate of the CIHI, within 15 days of the date when the decision was received. The appeal may be filed in person or sent by mail to the regional office of the CIHI which rendered the first instance decision. A decision rendered by the Directorate of the CIHI in appellate proceedings is final, and the insured person may file an administrative lawsuit against it before the Administrative Court of the Republic of Croatia.

Enquiry of the Committee

-The committee enquired whether persons who receive health care services under general health insurance schemes and are not registered with the employment service, have the right to medical assistance, when needed.

According to the provisions of the Health Care Act (Official Gazette, No. 150/08) and the regulations regarding the compulsory health insurance scheme, on the basis of the principle of the comprehensiveness of health care, all persons on the territory of the Republic of Croatia have the right to first aid and emergency medical assistance when needed. Also, pursuant to the provisions of the Compulsory Health Insurance Act and its amendments (Official Gazette, No. 150/08, 94/09, 153/09, 71/10, 139/10 and 49/11), persons with temporary or permanent residence in the Republic of Croatia who are incapable of independent life and work without means of support have the right to compulsory health insurance, pursuant to the decision adopted by a state administrative office competent for social welfare matters, unless they can be provided with compulsory health care on some other ground.
At the same time, the measures and procedure of determining incapability for independent life and work, as well as lack of means of support, will be determined by the minister competent for social welfare matters (the Minister of Social Policy and Youth), and the right to

compulsory health insurance based on the mentioned insurance basis is valid until the circumstances on the basis of which the right was obtained are changed.

What does the right to health care include

The right to health care under the compulsory health insurance scheme, as provided for by the Compulsory Health Insurance Act and the regulations adopted on the basis of that Act, includes:

1. primary health care;
2. specialist and consultant health care;
3. hospital health care;
4. the right to use medications;
5. the right to dental-prosthetic services and dental-prosthetic replacements;
6. the right to use orthopaedic and other aids;
7. the right to use health care abroad.

1. Primary health care

An insured person receives primary health care services from his or her attending primary health care physician, family (general) medicine practitioner, gynecologist, dentist or pediatrician selected according to the procedure laid down in the Ordinance on the procedure for exercising rights to a free choice of doctor and dentist on the primary health care system.

By way of exception, an insured person who temporarily stays outside the place of his or her permanent residence or temporary residence (e.g. while on a business trip, holidays) is, in the event of a trauma, acute inflammation or infectious disease, acute medical problem requiring therapeutic care or similar, entitled to receive primary health care services, with the exception of the right to a sick leave, from any primary health care doctor, who is a CIHI contractor, in the place where he or she is temporarily staying, to the same extent as from his or her attending physician.

Providing medical treatment to an insured person in his or her home

An insured person is entitled to receive medical treatment in his or her home, which may be provided in the form of:

- a house call in the event of an acute condition;
- medical treatment at home;
- provision of emergency medical services in the insured person's home.

Providing nursing care to an insured person in his or her home

An insured person is entitled to receive nursing care in his or her home if the following conditions are met:

- inability to walk or reduced mobility (persons who need assistance in order to move or use mobility aids);
- deterioration or complications of a chronic illness, under the condition that the attending primary health care physician at the same time provides medical

treatment to such a person in his or her home, and that he or she indicates the need for nursing care at home;
- temporary or permanent conditions making the patient unable to take care of himself of herself;
- after complex surgical procedures requiring wound bandaging and care, and care for types of stoma;
- for patients suffering from terminal stage diseases.

Medical care provided by health visitors

Professional assistance and care is provided to insured persons as a part of the health visiting programme:

- when it is necessary to monitor the condition of the mother and the child after childbirth;
-for health promotion and preservation purposes;
-to monitor and preserve the health of an insured person under increased risk of an illness.

Emergency medical assistance

An insured person is entitled to emergency medical care, which includes diagnostic and therapeutic services necessary to elminate the imminent danger to his or her life and health, without a referral sheet.

Emergency medical care is provided by medical institutions which have concluded a contract with the Croatian Institute for Health Insurance to carry out activities of emergency medicine, by emergency services of a hospital, or by the nearest physician.

Ambulance transportation

The right to transportation in an ambulance may be exercised by an insured person who:

- is unable to walk;
- has difficulty moving;
- is advised not to move on his or her own due to the nature of his or her illness.

At the same time, an insured person is entitled to use transportation in an ambulance to get to the nearest contracting entity of the CIHI which can provide the required health care, and the person exercises the right to use this transport on the basis of an order for medical transportation issued by the primary care physician who issued the referral sheet for the required health care. The necessity of medical transportation can also be identified by a physician in a contracting medical institution where the insured person is treated, a physician in a contracting medical institution carrying out activities of emergency medicine where the insured person is being treated or by an authorised physician of the CIHI, in accordance with the Compulsory Health Insurance Act and the Ordinance on the conditions and means of exercising rights in the compulsory health insurance scheme (Official Gazette, No. 67/09, 116/09, 04/10, 13/10, 88/10, 131/10, 01/11, 16/11, 87/11 i 137/11) and its amendments (Official Gazette, br. 45/08).

Llaboratory diagnostics at the primary health care level

The laboratory diagnostics at the primary health care level is provided on the basis of a referral issued by a chosen family (general) practitioner, printed out on a referral form for primary laboratory diagnostics or on the basis of an electronic referral, which is an electronic document in accordance with the Electronic Documents Act.

2. Specialist and consultant health care

An insured person is entitled to receive specialist and consultant health care at the nearest contracting health institution or from the nearest contracting private practitioner, according to the place of his or her permanent or temporary residence, which has entered into a contract with the CIHI, and on the basis of a referral sheet issued by the chosen primary care physician:

- family (general) medicine practitioner;
- pediatrician;
- gynecologist;
- dentist.

A specialist in school medicine, specialist in epidemiology or public health specialist decides on the need for a specialist examination and diagnostic or therapeutic procedure. Also, if a specialist of the contracting hospital decides, on the basis of the check-up that has been carried out, that there is a need for further specialist and consultation treatment with respect to the diagnosis on the referral sheet, an insured person has a right to specialist and consultative health care, which can be carried out in that contracting medical institution. This right can be exercised on the basis of referrals issued by the specialist who decided that there is a need for further treatment. If the required specialist and consultative health care cannot be carried out in that contracting medical institution, an insured person will use the same (specialist) referral sheet and go to another contracting medical institution which has a contract to carry out the required activity. An insured person exercises their right to specialist and consultative health care in a physical medicine and rehabilitation clinic, as well as the right to physical medicine and rehabilitation at home, in the manner and under the conditions stipulated by the general act of the CIHI. The contracting medical institution, or contracting private practitioner is obliged to immediately receive the person with a referral to use specialist and consultative health services, and no later than within 30 days of the date when the insured person first contacted them.

3. Health care provided in hospitals

An insured person can receive hospital health care in the contracting medical institutions for treatment of patients suffering from acute, subacute and chronic diseases, on the basis of a referral sheet for hospital treatment issued to the insured person by the chosen primary care physician or emergency medicine physician. Exceptionally, in the case of emergency medical assistance, the insured person can receive hospital health care without the referral sheet. Generally, the insured person receives hospital treatment at the nearest contracting hospital, by the place of domicile or residence, which according to the contract with the CIHI provides the health care needed. The referral is valid for 30 days after it has been issued, and in that period the insured person is obliged to contact the contracting medical institution to use the hospital health care. Hospital treatment of insured people suffering from chronic diseases is

carried out in contracting specialised hospitals for treatment of: mental illnesses, lung diseases, children suffering from permanent psychophysical disorders;hospitals for physical medicine and medical rehabilitation. The contracting medical institution is obliged to admit the referred insured person to hospital as soon as possible, and in cases of threat to life, immediately.

Medical rehabilitation at hospital

An insured person exercises their right to medical rehabilitation at a contracting hospital as a continuation of hospital treatment (initial rehabilitation) or on the basis of a referral sheet issued by a chosen physician (maintaining rehabilitation), for an illness, medical condition or consequences of an injury set out in the List of Illnesses, Medical Conditions and Consequences of Injuries for Which Medical Rehabilitation is Approved, identified in the Ordinance on the conditions and means of exercising rights in the compulsory health insurance scheme in connection with hospital treatment by means of medical rehabilitation and physical therapy at the patient's home. Medical rehabilitation services are received at the nearest specialist hospital providing medical rehabilitation services, according to the insured person's permanent or temporary residence, which was approved by the authorised CIHI physician.

The right to stay with the child whilst in hospital

A whole-day (24 hours a day) stay with the child

The right to whole-day (24 hours a day stay) is realised depending on the accommodation capacities of the hospital.
An insured person who can realise this right is:

- a mother of a child whose only source of nutrition is mother's milk, i.e. there is a need to breastfeed the child, which is confirmed by a chosen physician of the child or by a physician at the hospital where the child is treated;
- one of the parents of a child with development difficulties who is, pursuant to special regulations, holding a decision to this effect issued by the competent authority or a medical report by the competent expert evaluation body, and on the basis of a proposal made by a department physician of the contracting hospital where the child is being treated.

An insured person who realises their right to accommodation is not obliged to participate in health care costs, and the insured person who can, according to the Act on Compulsory Health Insurance, realise their right to salary compensation, is entitled to salary compensation for sick leave during this stay.

The right to day-time stay with the child

One of the parents is entitled to day-time stay with the child (not during the night), provided that:

- the child is under 5 years of age and
- that the child is hospitalised in a contracting medical institution for treatment of children suffering from acute illnesses;
- a parent of a child with development difficulties, holding a decision to this effect issued by the competent authority or a medical report by the competent

expert evaluation body, pursuant to special regulations, is entitled to day-time stay regardless of the age of the child.

This right is realised on the basis of a proposal made by the department physician of the contracting hospital where the child is being treated, based on the referral sheet issued by the chosen physician of the parents. An insured person who realises their right to accommodation is not obliged to participate in health care costs, and the insured person who can, according to the Act on Complusory Health Insurance, realise their right to salary compensation, is entitled to salary compensation for a sick leave during this stay.

The right to stay with the child at a specialist hospital providing medical rehabilitation services

On the basis of a proposal made by the chosen primary care physician on the basis of the opinion of a specialist, the medical committee of the CIHI regional office can, in exceptional cases, approve the stay of an insured person, i.e. one of the parents or a care-giver, with a child at a specialist hospital providing medical rehabilitation services, in the following cases:

1. when a specific "mother - child" training programme for parents or a person taking care of the child is being implemented, for children under the age of three;
2. when the presence of parents or caregivers is necessary for the conduct of a hospital rehabilitation treatment of children with special health needs is carried out.

Exceptionally, without the approval of the CIHI medical committee, the right to stay with a child, depending on the acommodation capacities of the specialist hospital providing medical rehabilitation services, can be exercised by:

1. an insured person - a mother of a child whose only source of nutrition is mother's milk, i.e. there is a need to breastfeed the child, which is confirmed by the chosen physician of the child or by the physician of the hospital where the child is treated;
2. an insured person - one of the parents of a child with developmental difficulties who is, pursuant to special regulations, holding a decision to this effect issued by the competent authority or a medical report by the competent expert evaluation body.

During the stay with the child, the parent is not obliged to participate in payment of the accommodation costs.

The right to stay with the child suffering from a malignant disease

An insured person - one of the parents of a child under the age of 18 suffering from a malignant disease who is staying at a contracting hospital's institution (clinical hospital centre, clinical hospital or clinic) where children suffering from malignant diseases are treated, has a right, based on the accommodation capacities of the contracting hospital, to stay with the child during his or her hospital treatment, on the basis of a referral sheet issued to the child for hospital treatment. The insured person who can excercise their right to accommodation is not obliged to participate in health care costs, and an insured person who can, in accordance with the Act on Compulsory Health Insurance, excercise their right to salary compensation, is

entitled to salary compensation for a sick leave during this stay. Also, it is necessary to mention that, according to amendments to the Ordinance on the conditions and means of exercising rights in the compulsory health insurance scheme from November 2011 (Official Gazette, No. 137/11), if there are no accommodation capacities in the contracting hospital, a parent of a child suffering from a malignant disease is entitled to compensation of accommodation costs in the amount up to the maximum amount per day of the daily allowance established by the Decision determining daily allowance for business trips and fees for users financed from state funds (Official Gazette, No. 55/04).

4. The right to use medications included in the CIHI's basic and supplementary lists of medicines

An insured person is entitled, under the health care rights from the compulsory health insurance, to use the medications determined by the Decision establishing the CIHI's Basic List of Medications (Basic List of Medications) (Official Gazette, No. 69/10) and Decision establishing the Supplementary List of Medicines of the CIHI (Supplementary List of Medicines) (Official Gazette, No. 69/10), in the manner and under condition stipulated by the Compulsory Health Insurance Act, the Ordinance on the conditions and means of exercising rights in the compulsory health insurance scheme and by other general acts of CIHI. The Basic Lists of Medications includes the most purposeful medications from the medical and economic point of view, for treating all illnesses, to which insured persons are entitled at full expense of the CIHI, if these medicines have been prescribed in the primary health care on the basis of defined medical indication. The Supplementary List of Medicines includes medicines whose price is higher than that of the medicines from the Basic List, and the CIHI covers the costs in the amount of the price of the equivalent medicine from the Basic List.

The medications included in the Supplementary List of Medications can be prescribed to an insured person or administered for medical treatment purposes if the insured person gives his or her consent, and on that occasion the insured person must be informed about their obligation to participate in the payment of the medication. Exceptionally, the insured person can be entitled to, on the basis of previous approval by the Medical Commision of the Directorate of the CIHI, a medication from the Basic List of Medications, or a medication from the Supplementary List of Medications, for which the insured person does not meet the prescribed medical indicators, under condition that the need for using this was suggested by the Medications Commission of the hospital where the insured person was receiving medical treatment, at the expense of the contracting hospital. Pursuant to the Voluntary Health Insurance Act, the CIHI can not provide coverage for price difference of medications included in the Supplementary List of Medications within the supplementary health insurance scheme.

5. and 6. The right to orthopaedic and other aids and dental aids

An insured person is entitled to aids at the expense of the CIHI, in accordance with the Compulsory Health Insurance Act, regulations passed on the basis of this Act, and under condition and in the manner stipulated by the Ordinance on the conditions and means of exercising the right to orthopaedic and other aids and by other general acts of the CIHI, if not prescribed differently by inter-state agreement. An insured person is entitled to aids included in the List of Aids, which is a constituent part of the Ordinance on the conditions and means of exercising the right to orthopaedic and other aids, and on the basis of medical indicators determined for each aid and on the basis of proper medical documentation. The aids are suggested and prescribed by a medical doctor of the relevant specialisation, chosen

general/family medicine practitioner, pediatrican or dentist, practitioner of a contracting medical institution or contracting private practice physician with whom the CIHI made a contract to provide health care.

If it is necessary to have the approval of the authorised physician of the CIHI or of the Medical Commision for Orthopaedic and Other Aids of the CIHI's Directorate in order to exercise one's right to aid, the contracting physician prescribes the aid on the proper form, which has to be delivered, together with medical documentation and detailed explanation of medical indication for the aid and also technical documentation, to the regional office of CIHI by the insured person in order to obtain approval.

Exceptionally, an insured person may, with the approval of the Medical Commission for Orthopaedic and Other Aids of the Directorate of the CIHI, exercise the right to aids included in the List of Aids, although there is no prescribed medical indication for them, if the use of that aid is, according to the proposal of the contracting physician, necessary for the treatment and rehabilitation of the insured person. Conditions that have to be meet to obtain particular types of aids, as stipulated in the List of Aids, are established and approved by authorised employee of CIHI. Another exception is that an insured person may, on the proposal of a medical specialist, exercise the right to an aid not included in the List of Aids, and this decision is made and approved by Medical Commision for Aids of the CIHI's Directorate.

On the basis of the verified "Certificate on the entitlement to an aid" the insured person exercises the right to an aid, a spare part or expendable supplies for this aid and repair of the aid by legal and natural persons - by supplier of aids, or other legal and natural persons who have a permit for the provision of retail medical supplies, and by contracting medical institutions or contracting private practitioners who take part in the provision of public health care services. The Ordinance on the conditions and means of exercising the right to orthopaedic and other aids, which entered into force on 1st May 2006, ceased to have effect on the day the "new" Ordinance on the conditions and means of exercising the right to orthopaedic and other aids entered into force (Official Gazette, No. 17/09), on 20 February 2009. This Ordinance was amended several times from the day it entered into force until 31st December 2011 (Official Gazette, No. 23/09, 53/09, 116/09, 4/10, 88/10, 110/10, 113/10, and 01/11), and these amendments have contributed to an easier and faster realisation of rights to aids by insured persons, better availability of indicated aids to the insured person and a more rational use of aids.

7. The right to use health care services abroad

The right to use health care services abroad can be realised by an insured person during work, professional training or education abroad, if:

1. the person is employed by a domestic or foreign employer headquartered in Croatia;
2. the person has been chosen or appointed to perform constant duties in specific state administration bodies, or local and regional self-government units;
3. the person is a member of a company administration;
4. the person does business and unified craft business, the person performs a professional activity in the form of a profession, and if a person does agricultural and forestry business;
5. the person stopped working because he or she was sent abroad, by a legal or natural

person, to undergo education, professional training or postgraduate study;
6. the person was sent abroad as a part of international technical-educational and cultural cooperation.

The right to use health care services abroad can also be realised by insured persons who:

1. are staying abroad for private business, including family members of these insured persons (spouse and children) who are staying abroad with them, or students studying abroad by their own choice;

2. are granted, by the CIHI, the right to be referred for medical treatment to a foreign health institution, under conditions stipulated by Ordinance on rights, conditions and modalities of use of health care abroad.

Business trip, work, professional training or education abroad

A business trip abroad is the insured person's stay abroad shorter than 30 days, ordered by his or her employer, regardless of reasons for the trip. When a worker is going on a business trip, his or employer is not obliged to obtain a certificate from the CIHI before the trip proving the worker's entitlement to use health care services abroad. By contrast, when a worker goes abroad to work or undergo professional training or education, his or her employer is obliged to file an application to the competent CIHI regional office and obtain a certificate showing that the worker is entitled to use health care services abroad. If no such certificate has been obtained, any expenses that may be incurred are to be covered by the employer. While on a business trip abroad and also during work, professional training or education, a person may only use health care services at the expense of the CIHI which can not be postponed until his or her return to the Republic of Croatia. The manner of using health care and the extent to which it can be used differs, based on whether there is an international agreement on social security with the countries where the health care is used, or not.

Stay abroad for private reasons

An insured person has a right to use health care services abroad under the condition that he or she has previously registered their stay abroad to the CIHI and that he or she has paid a special contribution for using health care services abroad at the CIHI regional office. Otherwise, the insured person is not entitled to receive health care services abroad at the expense of the CIHI. At the same time it should be pointed out that in 2011 the Decision on the basis and the rate of special contribution for the use of health care abroad by insured persons of the Croatian Institute for Health Insurance who are staying abroad for private reasons (Official Gazette, No. 91/11) was adopted and entered into force in August 2011, bringing advantages to the insured persons of the CIHI (cheaper stay, particularly for families consisting of spouses and children up to age of 26), depending on the length of the stay abroad and the number of insured persons staying abroad for private reasons. When an insured person stays abroad for private reasons, he or she is only entitled to use health care services at the expense of the CIHI in the case of emergency medical assistance required to eliminate the imminent threat to his or her life or health.

Referral for medical treatment abroad

An insured person may be granted the right to be referred for medical treatment to a foreign health institution, if such treatment can not be provided at CIHI's contracting health institution

in the Republic of Croatia, and can be successfully provided abroad.
A decision on the right to be referred for medical treatment to a foreign health institution is made in writing by the Directorate of the CIHI, in response to a written application filed by the insured person.

The scope of the right to health care

The right to health care under the compulsory health insurance scheme is provided under the same conditions for all persons insured with the CIHI. The CIHI provides complete coverage of health care expenses, to persons insured with the CIHI, in exercising their rights to health care under the compulsory health insurance scheme for:

1. complete health care for children up to 18 years of age and for children who are completely and permanently incapable of independent life and work (even after 18 years of age);
2. preventive and specific health care for pupils and university students;
3. health care for women in connection with pregnancy monitoring and childbirth, and health care in connection with medically assisted procreation, in accordance with the general act of the CIHI;
4. preventive and curative health care in connection with HIV infections and other infectious diseases for which there are legal provisions laying down measures to prevent their spread;
5. compulsory vaccination, immunoprophylaxis and chemoprophylaxis;
6. complete treatment of chronic psychiatric illnesses;
7. complete treatment of malignant diseases;
7. a complete treatment which is a consequence of an admitted accident at work or an occupational illness;
8. hemodialysis and peritoneal dialysis;
9. health care related to human organ removal or transplant for the purposes of treatment;
10. emergency medical care outside of hospital;
11. house calls and medical treatment at home;
12. health care provided by health visitors;
13. ambulance transportation for special categories of patients pursuant to a general legal act adopted by the minister responsible for health matters;
14. prescribed medicines from the CIHI's Basic List of Medicines;
15. nursing care in the patient's home;
16. laboratory diagnostics at a primary health care level.

Health care of foreigners

The conditions and methods of providing health care to foreigners in the Republic of Croatia are regulated by the Act on Health Care of Foreigners in the Republic of Croatia, which entered into force on 6th November 1997 and has not been changed since.

Provision of health care to foreigners

Foreigners receive health care services in the Republic of Croatia in the same manner and under the same conditions as Croatian citizens. Foreigners are entitled to health care to the

extent to which such care is provided to members of insured persons' families, pursuant to the regulations governing health insurance in the Republic of Croatia. A foreigner will personally cover health care costs in the Republic of Croatia if he or she does not have health insurance on another basis.

Health care of the following persons is financed from the state budget:

- foreigners who are entitled to health care on the basis of international agreements, unless otherwise specified in these agreements;
- persons with no nationality or persons under deportation orders whose extradition is not possible due to their extremely serious medical condition;
- foreigners staying in the Republic of Croatia following an invitation from Croatian state authorities;
- foreigners who have been granted refugee status and who are entitled to health care in the Republic of Croatia pursuant to special regulations;
- foreigners involved in procedures for granting the refugee status;
- minor foreigners found on the territory of the Republic of Croatia without parental supervision;
- foreigners suffering from cholera, plague, viral haemorrhagic infections, typhoid fever and diphtheria;
- foreigners who are obliged to personally pay for their health care costs pursuant to the Act on Health Care of Foreigners, but from whom it was not possible to recover the costs for the medical services offered.

Foreigners undergoing education or specialisation or participating in scientific research in the Republic of Croatia, as well as foreigners who have been approved permanent stay in the Republic of Croatia are obliged to obtain health insurance coverage pursuant to the health insurance legislation of the Republic of Croatia. Foreigners are entitled to receive emergency medical services. If a foreigner does not have the necessary document to prove that he or she is entitled to health care under health care regulations of the Republic of Croatia, or other special regulations or under an international agreement, a private health practitioner will charge the costs of providing emergency medical services to this foreigner.

If a health institution or private health practitioner is unable to collect payment for health care services rendered to a foreigner obliged to personally cover the costs of these services, they should take a written statement from such foreigner or his or her legal representative, in the case of a minor foreigner, which should contain the following information:

- name and surname of the foreigner;
- nationality of the foreigner;
- foreigner's permanent or temporary residence and his or her home address;
- number of the foreigner's travel document, the date when this document was issued and the name of the issuing authority;
- costs of health services rendered;
- payment mode and deadline, which should not be longer than 30 days.

If the foreigner fails to pay the costs of health services received within 30 days, the health institution or private practitioner will have these costs recovered from the state budget.

Enquiry of the Committee

- The Committee has requested that the following report contain updated data on the situation on waiting lists and the amount of waiting time in order to show progress achieved in relation to reducing waiting lists and waiting time.

The creation of waiting lists is a result of a combination of an exceptionally large number of patients who request health services daily and limited spatial capacities and capacities of staff in the health care system and also of the type and specific qualities of a medical institution and particular activity (in large institutions of tertiary health care, towards which a large number of patients is oriented, there are significantly longer waiting lists in comparison to those in smaller institutions). The development of waiting lists is determined by a number of factors such as location of the institution, contracting capacities (contracting number of beds, specialist and consultant health care, diagnostics, etc.), the scope of particular activities, number of health care practitioners, the amount and type of medical supplies etc., and especially by the number patients the institution takes care of, and the number of patients oriented towards the institution.

State of waiting lists (for procedures monitored by the Department for National Waiting Lists)

From the establishment of the Department for National Waiting Lists as a part of the Ministry of Health until December 2011, 19,548 patients were informed, by phone call and letter, about the possibility of undergoing a diagnostic examination or operation at another institution, and a total number of 10,588 patients was redirected.

Comparison of data - the average for the Republic of Croatia, October 2008/December 2011 (Table 64) - waiting lists for computer-assisted tomography CT (↓ 52.00%), heart ultrasound (↓ 69.93%), breast ultrasound (↓ 54.01%), hip replacement (↓ 51.00%), knee replacement (↓ 57.83%) were reduced; - waiting lists for magnetic resonance imaging (MRI) were extended (↑ 15.65%).

Table 12 Comparison of data – the average for the Republic of Croatia, October 2008/December 2011

Diagnostic/therapeutic procedure	Average waiting days - RH **2008 (October)**	Average waiting days - RH **2011 (December)**	Difference **December 2011 - October 2008 (%)**
MR	97	115	↑ 15.65
CT	75	36	↓ 52.00
Heart ultrasound	286	86	↓ 69.93
Breast ultrasound	137	63	↓ 54.01
Hip replacement	547	268	↓ 51.00
Knee replacement	600	253	↓ 57.83

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

A set of measures aiming at reducing waiting lists was prepared during the previous period and it includes: work reorganisation, supplementary education of health workers (since 2006 more than 2,200 specialisations for doctors of medicines, and more that 800 narrow

specialisations were approved), and acquisition of medical equipment: the Plan for Acquisition of Medical Equipment includes the acquisition of 177 new medical devices divided in 10 categories, of a total planned value of 827.5 million kuna.

The Ministry of Health will continue with the implementation of the *National Waiting List* project, in order to systematically deal with long-term waiting lists for particular health services, ensuring their provision within medically acceptable time limits. Activities on the reduction of waiting lists are directed towards ensuring that health care services are equally used, that all health care services are equally available to all health care users, and that waiting list in hospitals in the Republic of Croatia are managed more transparently. The same activities include proactive managment of waiting lists, solving the problem of multiple booking of patients for the same medical service, computer-based implementation of three types of waiting lists (fast, regular, control), integrated acquisition of embedded medical material, acquisition of ultrasonic and CT devices, and MR and CT services. The planned activities on reduction of long-term waiting lists include marketing activities aiming at promotion of less popular hospitals and less known experts in order to achieve equal distribution of hospital services, inclusion of patients' associations as well as connecting with the *E-booking* project. The project includes all hospitals, regardless of the situation on the waiting lists, in order to rationalize and increase efficiency of the hospital system and in order to improve connections between primary health care system and hospitals, which will further ensure equal quality and availability of health care.

Life expectancy in 2008, 2009, 2010 and 2011

According to data from the Central Bureau of Statistics, life expectancy at birth in Croatia in 2008 was 76.0 years for both sexes combined, 76.9 years for women and 72.4 years for men; in 2009 life expectancy at birth amounted to 76.3 years for both sexes combined, 79.6 years for women and 72.9 years for men; in 2010 it amounted to 76.6 years for both sexes combined, 79.6 for women and 73.5 years for men; in 2011 it amounted to 77.0 years for both sexes combined, 80.0 years for women and 73.9 years for men.

Table 13 Life expectancy at birth in Croatia during the period from 1991 to 2011

Year	both sexes	male	female
1991	70.99	66.05	76.21
1993	72.64	68.53	76.72
1995	73.29	69.30	77.21
1997	72.62	68.61	76.47
1999	72.83	68.92	76.55
2000	73.00	69.12	76.68
2001	74.65	71.03	78.17
2002	74.85	71.21	78.40
2003	74.73	71.17	78.23
2004	75.66	72.13	79.08
2005	75.44	71.13	78.92
2006	76.01	72.55	79.37
2007	75.89	72.40	79.32
2008	76.14	72.51	79.73
2009	76.43	73.03	79.75
2010	76.60	73.50	79.60
2011*	77.00	73.90	80.00

Source: Health for All - WHO database, World Health Organization, August 2012
*the Central Bureau of Statistics, 2012

Morbidity and mortality

Widespread chronic diseases are the greatest public health problem in the Republic of Croatia. When it comes to morbidity and mortality, predominant diseases are cardio-vascular diseases, followed by malignant diseases (with breast cancer in women and lung cancer in men being ranked first and colorectal cancer second), injuries, poisonings and respiratory system diseases.

During 2008 the most frequent groups of diseases treated in hospitals were neoplasms, diseases of the circulatory system, diseases of the digestive system, injuries, poisonings and some other consequences of external causes, and diseases of the genitourinary system. When it comes to hospital treatment, women outnumbered men (1.05:1). In 2008 women were most frequently hospitalised for neoplasms (14.2% - 42,077, of which malignant breast tumours were the most common). For men treated in hospitals in Croatia, the most common diseases were of the circulatory system (14.8% - 45,120, of which angina pectoris was the most common), then neoplasms (13.3% - 40,388, the most common being malignant tumours of the bronchi and lungs).

During 2009 the most frequent groups of diseases treated in hospitals were neoplasms, diseases of the circulatory system, diseases of the digestive system, diseases of the genitourinary system, and injuries, poisonings or some other consequences of external causes. When it comes to hospital treatment, women outnumbered men 1.03 to 1. In 2009 women were most frequently hospitalised for neoplasms (14.9% - 46,220, of which malignant breast tumours were the most common). For men treated in hospitals in Croatia, the most common diseases were of the circulatory system (14.9% - 44,867, of which angina pectoris was the most common), then neoplasms (14.4% - 43,409, the most common being malignant tumours

of the bronchi and lungs).

During 2010 the most frequent groups of diseases treated in hospitals were diseases of the circulatory system, neoplasms, diseases of the digestive system, diseases of the respiratory system, injuries, poisonings or some other consequences of external causes, and diseases of the genitourinary system. When it comes to hospital treatment, women outnumbered men 1.04 to 1. In 2010 women were most frequently hospitalised for neoplasms (13.9% - 40,619, of which malignant breast tumours were the most common). For men treated in hospitals in Croatia, the most common diseases were of the circulatory system (15.4% - 43,188, of which angina pectoris was the most common), then neoplasms (14.1% - 39.357, the most common being malignant tumours of the bronchi and lungs).

During 2011 the most frequent groups of diseases treated in hospitals were diseases of the circulatory system, neoplasms, diseases of the digestive system, injuries, poisonings or some other consequences of external causes, diseases of the respiratory system and diseases of the genitourinary system. When it comes to hospital treatment in Croatia, women outnumbered men 1.06 to 1. In 2011 women were most frequently hospitalised for neoplasms (13.7% - 41,805, of which malignant breast tumours were the most common). For men treated in hospitals in Croatia in 2011, the most common diseases were of the circulatory system (15.5% - 44,738, of which atrial fibrillation and atrial flutter were the most common).

According to the World Health Organisation, in many countries, the statistics on the causes of death is the most reliable source of health-related information for the assessment of the health situation. Mortality indicators are also used in the evaluation of achievement of strategic health goals in national health policies, as well as in the WHO Health Goals for the 21st century. The quality of mortality indicators depends on a series of requirements that must be complied with for the mortality statistics to be a reliable source of health information. In order to determine the basic cause of death, it is particularly important to properly fill out a death certificate. These forms are filled out by coroners, who can not enter the correct cause of death without co-operation with the physician who treated the person concerned before death and without medical documentation. Death diagnoses are coded in accordance with the International Classification of Diseases, the data are processed and categorised by various characteristics, which are, besides from the death diagnoses, also very imporant: age, sex, place of death, place of residence. As well as for the assessment of the health situation of the population, some of the mortality indicators are also used for the assessment of the performance of health services (e.g. the share of death from appendicitis and hernia, the share of post-mortem examinations, the share of post-mortem examinations carried out in hospitals), and some for the assessment of the quality of the overall mortality statistics, such as the share of unknown and insufficiently defined causes of death.

Deaths in Croatia from 2008 until 2011

The leading cause of death is the group of circulatory diseases, neoplasms, injuries and poisonings, respiratory diseases and digestive diseases. On average, 52,000 persons die annualy in Croatia, out of which three quarters die of circulatory diseases and neoplasms.

In the last five years, the share of unknown and insufficiently defined causes of death in the overall mortality was 1% (in 2010 it was 0.98%).

According to data from the Central Bureau of Statistics, in 2008 a total of 52,151 people who

had permanent or temporary residence in the territory of the Republic of Croatia died. In 2009 the number of people who died was 52,414.00, in 2010 it was 52,096, and in 2011 51,019. In the last three years mortality rate has been around 11.8/1,000 of the population (in 2011 11.6/1,000). Since 2009, there has been an increase in the share of women in total mortality rates. (Table 14).

Table 14 The number of deaths, mortality rate per 100,000 of the population and gender distribution in Croatia from 2008 until 2011

	2008	**2009**	**2010**	**2011**
Number of deaths	52,151	52,414	52,096	51,019
Mortality rate/100,000	1,175.24	1,183.41	1,179.23	1,158.79
% of men	50.3	49.7	49.3	49.4
% of women	49.7	50.3	50.7	50.6

Source: Documentation of the Central Bureau of Statistics

The leading cause of death is the group of circulatory diseases from which 50% of people die, thus, in 2008 the number of people who died from circulatory diseases was 26,235 (rate 591.2/100,000), in 2009 the number was 25,976 (rate 586.5/100,000), in 2010 a total od 25,631 people died from circulatory diseases (rate 580.2/100,000) and in 2011 24,841 people died from circulatory diseases (rate 564.2/100,000). When it comes to neoplasms, the second leading cause of death, in 2008 there were 13,280 deaths (rate 299.3/100,000 of the population), in 2009 the number of deaths was 13,496 (rate 304.7/100,000 of the population), in 2010 the number of people who died from neoplasms was 13,698 (rate 310.1/100,00) and in 2011 this number was 13,861 (rate 314.8/100,000). The third leading cause of death are injuries and poisonings, from which 3,034 people (rate 68.4/100,000) died in 2008; 2,986 in 2009 (rate 67.4/100,000); 2968 in 2010 (rate 67.2/100,000), and in 2011 the number of people who died from injuries and poisonings was 2,767 (rate 62.9/100,000). In the last four years, digestive diseases have been the fourth leading cause of death, from which 2,433 people died in 2008 (rate 54.8/100,000); 2,430 people in 2009 (rate 54.9/100,000); 2,459 in 2010 (rate 55.7/100,000) and 2,314 people in 2011 (rate 52.6/100,000). The fifth leading cause of death are respiratory diseases from which 2,249 people died in 2008 (rate 50.1/100,000); 2,263 people in 2009 (rate 51.1/100,000); 1,957 in 2010 (rate 44.3/100,000) and 2,052 people in 2011 (rate 46.6/100,000) (Table 15).

Table 15 The number of deaths, mortality rate per 100,000 of the population per groups of diseases in Croatia during the period from 2008 until 2011

Groups of diseases	2008		2009		2010		2011	
	Number	Rate/ 100,000	Number	Rate/ 100,000	Number	Rate/ 100,000	Number	Rate/ 100,000
Circulatory system diseases	26,235	591.22	25,976	586.5	25,631	580.18	24,841	564.2
Neoplasms	13,280	299.27	13,496	304.7	13,698	310.07	13,861	314.8
Injuries, poisonings and some other consequences of external causes	3,034	68.37	2,986	67.4	2,968	67.18	2,767	62.9
Digestive system diseases	2,433	54.83	2,430	54.9	2,459	55.66	2,314	52.6
Respiratory system diseases	2,249	50.68	2,263	51.1	1,957	44.30	2,052	46.6
Unknown and insufficiently defined causes of death	557	12.55	576	13.0	509	11.52	545	12.4

Source: Documentation of the Central Bureau of Statistics

The rank order of leading causes of death in men, by groups of diseases, was the same in the period from 2008 until 2011, which means that circulatory diseases ranked first, followed by neoplasms, injuries and poisonings were in the third position, digestive system diseases in the fourth position and respiratory diseases in the fifth. (Table 16)

Table 16 The structure of causes of death in men in Croatia, during the period from 2008 until 2011

Groups of diseases	2008	2009	2010	2011
	%	%	%	%
Circulatory system diseases	43.5	42.6	42.5	41.8
Neoplasms	29.4	30.0	30.6	31.7
Injuries, poisonings and some other consequences of external causes	7.7	7.3	7.2	6.8
Digestive system diseases	5.7	5.7	5.8	5.7
Respiratory system diseases	5.1	5.2	4.6	5.0
Other	8.6	9.3	9.3	9.0

Source: Documentation of the Central Bureau of Statistics

The rank order of leading causes of death in women, by groups of diseases, was the same during the period from 2008 until 2010, which means that circulatory diseases ranked first, followed by neoplasms, injuries and poisonings were in the third position and digestive system diseases in the fourth position. In 2009 and 2011 respiratory system diseases ranked fifth and in 2010 endocrine system diseases ranked fifth (Table 17).

Table 17 The structure of causes of death in women in Croatia, during the period from 2008 until 2011

Groups of diseases	2008	2009	2010	2011
	%	%	%	%
Circulatory system diseases	57.2	56.4	55.7	55.4
Neoplasms	21.4	21.5	22.1	22.8
Injuries, poisonings and some other consequences of external causes	3.9	4.2	4.3	4.1
Digestive system diseases	3.6	3.6	3.7	3.4
Respiratory system diseases	3.5	3.5	2.9	3.1
Endocrine system diseases	3.0	3.0	3.1	2.6
Other	7.4	7.8	8.2	8.6

Source: Documentation of the Central Bureau of Statistics

Maternal mortality

Maternal death rate has been at a very low lever for years and is limited to occasional cases. In 2008, three women died in Croatia due to complications during pregnancy, childbirth or puerperium (rate 6.86/100,000 live births). Of these three, only one died of causes directly related to childbirth (pulmonary embolism during puerperium, ICD-X, code 088,2), and the other two died of causes not directly related to childbirth, i.e. of diseases/conditions which occurred or were exacerbated during pregnancy, childbirth or puerperium (dilated cardiomyopathy and myocardial infarction). The maternal death rate due to direct obstetric causes was in 2008 in Croatia 2.28/100,000 live births, as opposed to the rate of 6.86/100,000 live births, which inluded deaths due to both obstetric and non-obstetric causes. These statistics show that there is a greater number of maternal deaths in Croatia which are not directly related to pregnancy or childbirth.

In 2009 six women died in Croatia due to complications during pregnancy, childbirth or puerperium (rate 13.46/100,000 live births). Of these six, two died of eclampsia, three of thromboembolism, and one of pulmonary embolism by amniotic fluid. From this data, it is evident that all of the six women in 2009 died of causes directly related to childbirth.

In 2010 four women died in Croatia due to complications during pregnancy, childbirth or puerperium (rate 9.22/100,000 live births). Of these four, two died of circulatory system diseases, one of thromboembolism and one of respiratory system disease. The maternal death rate due to direct obstetric causes was in 2010 in Croatia 2.31/100,000 live births, and of maternal deaths of all causes (both obstetric and non-obstetric) was 6.86/100,000 live births. These statistics show that there is a greater number of maternal deaths in Croatia which are not directly related to pregnancy or childbirth.

In 2011 four women died in Croatia due to complications during pregnancy, child birth or puerperium (rate 9.71/100,000 live births). None of the four women, who died due to complications during pregnancy, child birth or puerperium, died due to obstetric causes. Two of the women died during early pregnancy, one of acute idiopathic thrombocytopenic purpura and the other due to hereditary disorder of clotting factors. The other two women died during puerperium, one of cardiomyopathy and the other of epilepsy.

In order to reduce the risk of maternal death in Croatia, a number of measures are being

implemented within the health system for antenatal, partum and postpartum care, as prescribed by the Programme of Health Care Measures in Compulsory Health Insurance (Official Gazette, No.126/60), excerpt from the Programme for Health Health Protection of Women. This programme is being financed entirely by compulsory health insurance, which covers almost all citizens in the Republic of Croatia.

Infant mortality in 2008

In 2008, 195 infants died in Croatia, which represents a ratio of 4.5/1,000 live births (in 2007 this number was 234, i.e. 5.6/1,000). The largest number of newborns (0-27 days old) died in the first day of life or over the next few days of life (77.4% of newborns who died). A total of 61% infants died in the age between 0-6 days (119 infants), of which 32.8% died in the first 24 hours of their lives (64), and 28.2% between 1-6 days (55). Another 16.4% (32) died in the late neonatal period, whereas 34.4% (67) died between two months and 1 year of age.
The most frequent causes of death in infants were specific pathological conditions related to pregnancy or birth (with conditions in the perinatal period having a share of 57.0%) and congenital anomalies (30.8%), followed by symptoms, signs and abnormal clinical and laboratory findings not otherwise classified (3.1%), and three groups of diseases have the share of 2.1% - infectious and parasitic diseases; endocrine, nutritional and metabolic diseases; respiratory system diseases. All the other causes accounted for 3%. Of 195 infants who died in 2008, 123 or 63.1% died of ten leading causes of death. Of the leading causes, diseases arising as a result of gestation and immaturity are prominent, most frequently related to complications of the mother during pregnancy (inflammatory and other pathological changes of placenta). Of the other leading group of causes of infant mortality, i.e. congenital malformations, we can single out chromosomopathy (Edward and Patau syndromes), congenital diaphragmatic hernia and other congenital heart defects. The largest number of newborns (0-27 days old) died in the first day of life or over the next few days of life (77.4% of newborns who died).

Table 18 Infant mortality cause structure by ICD-10 disease groups in 2008

ICD-10 DISEASE GROUP		NUMBER	%	RANK
I.	Certain infectious and parasitic diseases	4	2.1	4/5
II.	Neoplasms	2	1.0	7
IV.	Endocrine, nutritional and metabolic diseases	4	2.1	4/5
VI.	Diseases of the circulatory system	1	0.5	8
X.	Diseases of the respiratory system	4	2.1	4/5
XVI.	Certain conditions originating in the perinatal period	111	57.0	1
XVII.	Congenital malformations, deformations and chromosomal abnormalities			
XVIII.	Symptoms, signs and abnormal clinical and laboratory findings not otherwise classified	6	3.1	3
XIX.	Injury, poisoning and certain other consequences of external causes	3	1.5	6
	TOTAL	**195**	**100**	

Source of data: Documentation of the Central Bureau of Statistics, 2009 (ISSN 1330-0350)

Perinatal mortality in 2008

Perinatal mortality in 2008, calculated according to the WHO methodology for international comparison, was 4.6/1,000 births. The European Union average was 6.0/1,000 births ≥ 1,000 grams birth weight, and the European Region average was 7.6/1,000 births. The perinatal mortality for all births (≥500 grams birth weight) was in 2008 in Croatia 7.0/1,000 births.

Infant mortality in 2009

In 2009, 235 infants died in Croatia, which represents a ratio of 5.7/1,000 live births (in 2008 this number was 195, or 4.5/1,000). The largest number of newborns (0-27 days old) died in the first day of life or over the next few days of life (81.3% of newborns who died).

A total of 60.4% infants died in the age between 0-6 days (142 infants), of which 36.6% died in the first 24 hours of their lives (86), and 23.8% between 1-6 days (56). Another 20.9% (49) died in the late neonatal period, whereas 18.7% (44) died between 2 months and 1 year of age. The most frequent causes of death in infants were specific pathological conditions related to pregnancy or birth (with conditions in the perinatal period having a share of 52.3%) and congenital anomalies (36.6%), followed by symptoms, signs and abnormal clinical and laboratory findings not otherwise classified (3.8%), and two groups of diseases have the share of 1.7% - circulatory and respiratory diseases. All the other causes accounted for 3.8%.

Of 235 infants who died in 2009, 136 or 57.9% died of ten leading causes of death. Of the leading causes, diseases arising as a result of gestation and immaturity are prominent, most frequently related to complications of the mother during pregnancy (inflammatory and other pathological changes of placenta). Of the other leading group of causes of infant mortality, i.e. congenital malformations, we can single out chromosomopathy (Edward and Patau syndromes) and congenital diaphragmatic hernia as the prominent ones.

Table 19 Infant mortality cause structure by ICD-10 disease groups in 2009

ICD-10 DISEASE GROUP		NUMBER	%	RANK
I.	Certain infectious and parasitic diseases	1	0.4	8
IV.	Endocrine, nutritional and metabolic diseases	3	1.3	6/7
VI.	Diseases of the nervous system	2	0.9	8
VI.	Diseases of the circulatory system	4	1.7	4/5
X.	Diseases of the respiratory system	4	1.7	4/5
XVI.	Certain conditions originating in the perinatal period	123	52.3	1
XVII.	Congenital malformations deformations and chromosomal abnormalities	86	36.6	2
XVIII.	Symptoms, signs and abnormal clinical and laboratory findings not otherwise classified	9	3.8	3
XIX.	Injury, poisoning and certain other consequences of external causes	3	1.3	6/7
	TOTAL	**235**	**100**	

Source of data: Documentation of the Central Bureau of Statistics, 2010 (ISSN 1330-0350)

Perinatal mortality in 2009

Perinatal mortality in 2009, calculated according to the WHO methodology for international comparison, was 4.4/1,000 births. The European Union average was 5.8/1,000 births ≥ 1,000 grams birth weight, and the European Region average was 7.7/1,000 births. The perinatal mortality for all births (≥500 grams birth weight) was in 2009 in Croatia 7.2/1,000 births.

Infant mortality in 2010

In 2010, 192 infants died in Croatia, which represents a ratio of 4.4/1,000 live births (in 2009 this number was 235, or 5.3/1,000). The largest number of newborns (0-27 days old) died in the first day of life or over the next few days of life (75.5% of newborns who died).
A total of 58.3% infants died in the age between 0-6 days (112 infants), of which 36.4% died in the first 24 hours of their lives (70), and 21.9% between 1-6 days (42). Another 17.2% (33) died in the late neonatal period, whereas 24.5% (47) died between 2 months and 1 year of age. The most frequent causes of death in infants were specific pathological conditions related to pregnancy or birth (with conditions in the perinatal period having a share of 58.9%) and congenital anomalies (29.7%), followed by symptoms, signs and abnormal clinical and laboratory findings not otherwise classified (4.2%), after that injuries, poisonings and certain other consequences of external causes (3.1%). All the other causes accounted for 4.1%.

Of 192 infants who died in 2010, 123 or 64.1% died of ten leading causes of death. Of the leading causes, diseases arising as a result of gestation and immaturity are prominent, most frequently related to complications of the mother during pregnancy. Of the other leading group of causes of infant mortality, i.e. congenital malformations, we can single out chromosomopathy (Down, Edward and Patau syndromes) and congenital diaphragmatic hernia as the prominent ones. The largest number of newborns (0-27 days old) died in the first day of life or over the next few days of life (75.5% of newborns who died).

Table 20 Infant mortality cause structure by ICD-10 disease groups in 2010

ICD-10 DISEASE GROUP		NUMBER	%	RANK
I.	Certain infectious and parasitic diseases	3	1.6	5
II.	Neoplasms	1	0.5	7/8
III.	Diseases of the blood and blood-forming organs and certain diseases involving the immune mechanism	2	1.0	6
IV.	Endocrine, nutritional and metabolic diseases	1	0.5	7/8
X.	Diseases of the respiratory system	1	0.5	7/8
XVI.	Certain conditions originating in the perinatal period	113	58.9	1
XVII.	Congenital malformations deformations and chromosomal abnormalities	57	29.7	2
XVIII.	Symptoms, signs and abnormal clinical and laboratory findings not otherwise classified	8	4.2	3
XIX.	Injury, poisoning and certain other consequences of external causes	6	3.1	4
	TOTAL	**192**	**100**	

Source of information:Documentation of the Central Bureau of Statistics, 2011 (ISSN 1330-0350)

Perinatal mortality in 2010

Perinatal mortality in 2010, calculated according to the WHO methodology for international comparison, was 4.7/1,000 births. The European Union average was 5.6/1,000 births ≥ 1,000 grams birth weight, and the European Region average was 7.4/1,000 births. The perinatal mortality for all births (≥500 grams birth weight) was in 2010 in Croatia 7.1/1,000 births.

Infant mortality in 2011

In 2011, 192 infants died in Croatia, which represents a ratio of 4.7/1,000 live births (in 2010 this number was 192 or 4.4/1,000).
The largest number of infants died in the early neonatal period (0-6 days old), during which

98 infants died, or 51.04% of all infants who died, most frequently as a consequence of immaturity and also as a consequence of the fact that the organism of an infant was not developed enough to live in the outside world due to preterm birth. The same number of infants died in the first 24 hours of their lives (48/192 or 25.0%) as in the age between 28-364 days of life (48), which shows how important is the availability of tertiary level neonatal care in the cases of preterm labour. A total number of 50 newborns or 26.04% died between 1-7 days of their lives and 46/192 or 23.96% of infants died during the neonatal period (7-27 days of life).
The most frequent causes of death in infants were specific pathological conditions related to pregnancy or birth (with conditions in the perinatal period having a share of 62.0%) and congenital anomalies (26.6%), followed by symptoms, signs and abnormal clinical and laboratory findings not otherwise classified (4.2%), after that injuries, poisonings and certain other consequences of external causes, infectious and parasitic diseases and respiratory system diseases (1.6%). All the other causes accounted for 2.6%.

Table 21 Infant mortality cause structure by ICD-10 disease groups in 2011

ICD-10 DISEASE GROUP		NUMBER	%	RANK
I.	Certain infectious and parasitic diseases	3	1.6	4
IV.	Endocrine, nutritional and metabolic diseases	2	1.04	5
VI.	Diseases of the nervous system	2	1.04	5
IX.	Diseases of the circulatory system	1	0.5	6
X.	Diseases of the respiratory system	3	1.6	4
XVI.	Certain conditions originating in the perinatal period	119	62.0	1
XVII.	Congenital malformations deformations and chromosomal abnormalities	51	26.6	2
XVIII.	Symptoms, signs and abnormal clinical and laboratory findings not otherwise classified	8	4.2	3
XIX.	Injury, poisoning and certain other consequences of external causes	3	1.6	4
	TOTAL	**192**	**100**	

Source of data: Documentation of the Central Bureau of Statistics, 2012 (ISSN 1330-0350)

Perinatal mortality in 2011

Perinatal mortality in 2011, calculated according to the WHO methodology for international comparison, was 3.5/1,000 births. The European Union average was 5.5/1,000 births ≥ 1,000 grams birth weight, and the European Region average was 7.5/1,000 births. The perinatal mortality for births ≥ 500 grams birth weight was in 2011 in Croatia 5.9/1,000 births, and when we take into account all births, regardless of the birth weight, the perinatal mortality was 6.3/1,000 births.

Approximate data for 2011

In 2011, in comparison with the previous year, there was a decrease by 5.0% in the number of live births, that is, 2 164 fewer children were born than in 2010. Out of the total number of 41 342 births in 2011, there were 41 197 live births and 145 stillbirths. Out of the total number of 41 197 live births, 21 177 or 51.4% were boys and 20 020 or 48.6% were girls. The birth rate (live births per 1 000 inhabitants) in 2011 was 9.4. In 2011, the number of deaths decreased in comparison with the previous year, that is, 1 077 persons died or 2.1% less than in the previous year. Out of the total number of deaths (51 019) in 2011, there were 25 185 or 49.4% of men and 25 834 or 50.6% of women. The death rate (deaths per 1 000 inhabitants) in 2011 was 11.6. The number of infant deaths in 2011 amounted to 192, that is, 0.38% of the total number of deaths. Out of the total number of infant deaths, 98 or 51.0% died during the first few days of life (0-6 days of age). The infant death rate (the number of infant deaths per 1 000 live births) in 2011 was

4.7, while in the previous year it was 4.4. The lowest infant death rate in 2011 was recorded in Požeško-slavonska County (1.4), and the highest one in Ličko-senjska County (8.3).
The natural increase rate in 2011 in the Republic of Croatia was negative and it amounted to -2.2 (-9 822 persons). The negative increase rate is also confirmed by the vital index (live births per 100 deaths), which was 80.7. The City of Zagreb had a positive natural increase rate, while a negative natural increase rate was recorded in all the other counties. The highest negative natural increase rate was recorded in Sisačko-moslavačka County (-1 081), with the vital index of 57.9. A positive natural increase rate was recorded in 101 towns/municipalities and in the City of Zagreb, a negative one in 445 towns/municipalities, while 9 towns/municipalities recorded a zero natural increase rate.

Croatia is a signatory of the Millennium Development Goals which, apart from containing measures to promote safe maternity, also emphasize the need for providing professional health care during labour and family planning measures aimed at pregnancy spacing and affecting the number of births during a lifetime. Given the fact that maternity protection is well-developed in Croatia (with 99% of births occurring in hospitals), these measures and indicators are no longer a priority in ensuring safe maternity, as are the measures of prevention, management and early detection of complications during pregnancy.
The primary objectives of the Croatian health system with regard to safe maternity and promotion of perinatal protection, according to the guidelines of the Commission for Perinatal Medicine of the MHSW and the Croatian Society for Perinatal Medicine, and in co-operation with the Croatian National Institute of Public Health, include:

1. regional organisation of perinatal care involving three levels of care for mothers and babies (ranging from the care for healthy pregnant women and healthy women who gave birth and their babies to the care for women with high-risk pregnancies, according to the level of risk);
2. development of specialist services, in particular neonatal services;
3. development of a perinatal information system to keep track of perinatal outcomes;
4. monitoring and evaluation of perinatal care at all levels;
5. inter-departmental co-operation in defining regulations promoting health protection rights of mothers and children;
6. implementation of the Millennium Development Goals dedicated to mothers and children.

99.9% of births occur in maternity wards, that is, with professional assistance, with low perinatal mortality rates. According to the WHO methodology, Croatia belongs to Eur-A countries with good health indicators and perinatal mortality of babies with more than 1000 grams of birth weight of <5‰.

Injuries

On the mortality scale in Croatia for 2011, injuries (ICD: Injuries, poisonings and other consequences of external causes; V01-Y98) are the third leading cause of deaths in Croatia, after circulatory diseases and neoplasms, with 2767 deaths and a share of 5.4% of all deaths. The number of deaths caused by injuries, according to age, oscillates, for both sexes in the last ten years, from 61 - 68/100 000, and no significant changes have been recorded. However, the number of deaths of women caused by injuries has slightly increased in that period. More men than women die of injuries. The average ratio of death rates for men and for women has been 2.1:1 in the last ten years. The importance of injuries as one of the leading

problems in the public health lies in the fact that injuries are the leading cause of death in children and young people. Regarding the indicator of premature mortality - the number of potentially lost years of life (1 - 75 years), injuries rank third (41 789), after neoplasms (98 688) and circulatory diseases (67 833). However, the greatest number of lost years of life per person occurs as a consequence of diseases.
Although injuries are the leading cause of death in children and young people, age-specific mortality rates for all diseases increase with age. The dynamics of changes in age-specific rates differs depending on the external cause. In 2011, the leading external causes of deaths from injuries were falls (36%), suicides (25%) and traffic accidents (18%). Most of the children and young persons (0 - 39 years of age) die in traffic accidents, middle-aged persons (40 - 64 years of age) die mostly due to suicides, while fall is the leading external cause of death in elderly persons (more that 65 years of age).

Among causes for hospital treatment, injuries ranked fourth in 2011 with 45 084 hospitalizations (inpatient unit), having a share of 7.6% and total rate of 1024/100 000. Falling is the leading cause of hospitalizations due to injuries, with a share of 41%, which means that every third hospitalization is for an injury caused by a fall. As regards elderly persons (more than 65 years of age) who are treated in hospital because of injuries, half of these hospitalizations are for injuries caused by a fall. Injuries caused by traffic accidents account for 23% of total number of hospitalizations due to injuries.

Prevention of injuries

In the *Plan and Programme of Health Care Measures under the Compulsory Health Insurance Scheme* (2006) injuries were classified as a priority health problem, and measures and procedures for their implementation were also indicated. In the *Plan for Public Health Development 2011 - 2015*, injuries were singled out as one of the leading problems of public health in Croatia. Among the goals, the need for development, implementation and evaluation of national injury prevention programmes for priority areas was indicated. The National Program of Road and Transport Safety has been implemented in Croatia since 1994. The implementation of the fifth continuation of the Program for the period 2011 - 2020 is in progress, and the main objective of this Program is the reduction of the number of deaths due to traffic accidents by 50%. The field of suicide prevention is described under mental health. The National Strategy for Protection of Mental Health is being implemented in Croatia, and the implementation of the National Suicide Prevention Programme for Children and Young People 2011 - 2013 is in progress. The *National Plan of Activities for the Rights and Interests of Children* 2006 - 2012 includes 124 measures aiming at the improvement of the quality of life of children in the Republic of Croatia and it includes prevention of injuries in children. In the section "Health", 5 measures refer to the development of the National Injury Prevention Programme for Children with clearly defined tasks for the local community, health services and educational system.

Diagnostics of infectious diseases is carried out by public health instutitions: "Dr Fran Mihaljević" Clinic for Infectious Diseases, clinical hospital centres, clinical hospitals and institutes of public health, as well as health institutions owned by the counties - isolation wards of general/county hospitals and institutes of public health in the counties/City of Zagreb. The institutions for treating tuberculosis are the following:

1. "Jordanovac" Pulmonary Disease Hospital, Zagreb;
2. Pulmonary Diseases and Tuberculosis Hospital, Klenovnik;

3. Specialist Pulmonary Diseases Hospital, Zagreb;
4. Specialist Hospital for Respiratory System Diseases of Children and Youth, Zagreb;
5. Polyclinic for Respiratory System Diseases, Zagreb;
6. internal medicine wards of general county hospitals, counties.

Sexually transmitted diseases

Protection from sexually transmitted diseases and their treatment in the Republic of Croatia is implemented at all levels of health protection. According to 2010 figures from the Service for the Epidemiology of Infectious Diseases of the Croatian National Institute of Public Health, the situation with regards to group of genital or sexually transmitted diseases is relatively favourable, as they had low and sporadic incidence: syphilis (18), gonorrhoea (20) and AIDS (22).

The institutions for treating AIDS are the following:

1. "Dr. Fran Mihaljević" Clinic for Infectious Diseases, Zagreb;
2. this clinic is also the Reference Centre of the Ministry of Health for AIDS. It needs to be mentioned that care and treatment of HIV positive patients is conducted at all levels of health care.

Institutions for mental health

The Psychosis Register of Croatia was established in 1961 at the Croatian National Institute of Public Health. In 2011, the group of mental illnesses and disorders ranked seventh on the list of the cause of hospitalisation in Croatia, with the share of 7.1%. However, when it comes to the number of hospital days, it is at the top of the list, with the share of 24.9% of the total number of hospital days. This actually means that every fourth day of hospital treatment was used for treating mental disorders. Schizophrenia is ranked high in the total number of hospital days used for treating mental disorders, with the share of 30.3%. The age-standardised rate of hospital incidence of schizophrenia has not shown any significant changes for years, and on average equals 0.26/1000 of the population above 15 years of age.

Psychiatric treatment in the Republic of Croatia is provided at the polyclinic and hospital health care level at the following health institutions:

1. Vrapče Psychiatric Hospital, Zagreb;
2. Sveti Ivan Psychiatric Hospital, Zagreb;
3. Ugljan Psychiatric Hospital, Ugljan;
4. Rab Psychiatric Hospital, Rab;
5. Lopača Psychiatric Hospital, Lopača;
6. "Dr Ivan Barbot" Neuropsychiatric Hospital, Popovača;
7. Psychiatric Hospital for Children and Youth, Zagreb;
8. psychiatric clinics at clinical hospital centres and clinical hospitals, Zagreb, Rijeka, Split and Osijek;
9. psychiatric wards in county general hospitals, counties;
10. Child Protection Polyclinic of the City of Zagreb, Zagreb;
11. "Sv. Rafael" Hospital, Strmac, Nova Gradiška.

After the competent court issues an order to institute the proceedings for mandatory referral of a mentally incompetent person who has committed an act with elements of a criminal offence to a psychiatric institution, the forensic documentation is forwarded to the members of the Commission for the selection of health institution for mandatory referral or transfer of persons with mental disorders, who have been declared mentally incompetent in criminal or misdemeanour proceedings, for his or her mandatory referral to a psychiatric institution within the meaning of Article 45a, paragraph 3 of the Act on the Protection of Persons with Mental Disorders.

Health protection of women

In 2010 a total of 1.534.621 women were covered by gynaecology care within the primary health care system. Of the total number of women who selected their primary health care gynaecologist, 631.660 or 41.1% actually consulted their gynaecologists. In 2010, in the area of health protection of women, a total of 219 teams worker under contracts with the Croatian Institute for Health Insurance, on the full time basis, and 21 teams on a part-time basis.
In comparison with the year 2008, the number of full-time teams working under contract decreased (by 8 teams). At the same time, the number of teams in private clinics not operating under contracts with CIHI increased by 5.

A special area of attention in the health protection of women is the care of pregnant women and women after childbirth. The number of examinations per pregnant woman varies significantly across counties, and in 2010 it ranged from 5 in the Vukovarsko-srijemska county to 12 in the Karlovačka County. The average at the level of the entire Croatia was 8.5 examinations carried out per pregnant woman, while in the previous year this number was 7. It is necessary to take into account the fact that a certain number of pregnant women, especially those with high-risk pregnancies, receive health care services at the specialist-consultation level and in hospitals. During the period between 2008 and 2010 there was an increase in the number of pathological conditions during pregnancy. During 2008, a pathological condition in pregnancy was found in 52.6% pregnant women, and in 2009 in 56.4% of pregnant women. During 2010, 57,975 pathological conditions in pregnancy were found, which is an increase by more than two times, when compared with 2009 (26,404). According to reports received from primary health care clinics providing health protection to women, the number of visits for family planning purposes has been constantly decreasing in the last three years. In 2010 the number of visits for family planning purposes and/or birth control purposes decreased by 0.4%, in comparison with the previous year. In 2009 there was a decrease by 20.3%, in comparison with 2008. Oral contraceptives were most frequently prescribed (75.5%), followed by intrauterine devices (12.9%).

In 2010, a total of 486,581 preventive examinations were carried out in the primary health care of women (the rate was 473.3/1,000 women of child-bearing age), which is an increase in comparison with the previous years (2009:416.4/1,000 2008:437.5/1,000). The number of preventive breast examinations carried out has been decreasing (rate: 71.1/1,000; 2009:108.2/1,000; 2008:121.1/1,000) which is probably a result of the implementation of the national breast cancer prevention programme. The number of smear tests (PAP smears) has also been decreasing (rate 397.4/1,000; 2009: 414.1/1,000 women of child-bearing age). Of the total number of breast examinations carried out in 2010, pathological findings were revealed in 5.4% cases, which was a decrease in comparison with the previous two years (6.0% and 5.8%). Of the total number of smear tests, pathological findings were revealed in 8.0% cases, which is also a decrease in comparison with the previous years. (9.2% and 9.4%).

The most frequent reasons for which women came to the gynaecologist and used services of the primary health protection of women in 2010 did not change in relation to the several preceding years. These were most frequently urinary and genital diseases with the share of 48.4%; factors affecting the health and contact with the health services (26.6%); pregnancy, childbirth and puerperium (9.1%); infectious and parasitic diseases (8.0%); and neoplasms (6.0%).

In 2011 a total of 1,472,336 women were covered by gynaecology care within the primary health care system. Of the total number of women who selected their primary health care gynaecologist, 543.352 or 36.9% actually consulted their gynaecologists. In 2011, in the field of health protection of women, a total of 214 teams worker under contracts with the Croatian Institute for Health Insurance on the full time basis, and 26 teams on a part-time basis. In comparison with the year 2010, the number of full-time teams working under contract decreased (by 5 teams). At the same time, the number of teams in private clinics not operating under contracts with CIHI increased by 4. A special area of attention in the health protection of women is the care of pregnant women and women after childbirth. The number of examinations per pregnant woman varies significantly across counties, and in 2011 it ranged from 6 in the Vukovarsko-srijemska County to 14 in the Bjelovarsko-bilogorska County. The average at the level of the entire Croatia was 9.2 examinations carried out per pregnant woman, while in the previous year this number was 8.5. It is necessary to take into account the fact that a certain number of pregnant women, especially those with high-risk pregnancies, receive health care services at the specialist-consultation level and in hospitals. During 2011, 62,115 pathological conditions in pregnancy were found, which is an increase by 7% in comparison with 2010.

According to reports received from primary health care clinics providing health protection to women (both those under contract with CIHI and those not under contract with CIHI), the number of visits for family planning purposes in 2011 decreased by 15.1%. Oral contraceptives were most frequently prescribed (81.8%), followed by intrauterine devices (10.2%).

In 2011, a total of 424,776 preventive examinations were carried out in the primary health care of women (the rate was 416.9/1,000 women of child-bearing age), which is a decrease in comparison with the previous year. The number of preventive breast examinations carried out decreased (rate 50.4/1,000; 2010:71.1/1,000) which is probably a result of the implementation of the national prevention programme for early detection of breast cancer. The number of smear tests (PAP smears) also decreased (rate: 333.5/1,000; 2010: 397.4/1,000 women of child-bearing age). Of the total number of breast examinations carried out in 2011, pathological findings were revealed in 10.6% cases, which was an increase in comparison with the previous year (5.4%). Of the total number of smear tests, pathological findings were revealed in 8.1% cases, which is very similar to the previous year (8.0%)

The most frequent reasons for which women came to the gynaecologist and used services of the primary health protection of women in 2011, did not change in relation to the several preceding years. These were most frequently urinary and genital diseases with the share of 48.3%; factors affecting the health and contact with the health services (26.0%); pregnancy, childbirth and puerperium (11.9%); neoplasms (6.1%) and infectious and parasitic diseases (4.7%). In comparison with the previous year, there was an increase in the number of examinations for pregnancy, childbirth and puerperium and a decrease in the number of

examinations for infectious diseases.

In 2011, 749 747 persons were treated in hospitals (in 2010 this number was 745,692, in 2009 it was 743,052, and in 2008 768,400), including stays in hospital for childbirth, abortion and hospital rehabilitation. The number of women treated was somewhat higher than the number of men (1.06:1).

The leading groups of diseases in the hospital treatment of women in 2008 were neoplasms (14.2% - most frequently malignant breast tumours), circulatory system diseases (12.3% - most frequently cerebral infarction), urinary and genital diseases (10.0% - most frequently polyp of female genital tract), diseases of the digestive system (7.1% - most frequently cholelithiasis) and diseases of the respiratory system (6.3% - most frequent diagnosis was chronic tonsil and adenoid disease), and other diseases and conditions (50.1%).

The leading groups of diseases in the hospital treatment of women in 2009 were neoplasms (14.9% - most frequently malignant breast tumours), circulatory system diseases (12.5% - most frequently cerebral infarction), urinary and genital diseases (10.2% - most frequently polyp of female genital tract), diseases of the digestive system (7.2% - most frequently cholelithiasis) and diseases of the respiratory system (6.4% - most frequent diagnosis was chronic tonsil and adenoid disease), and other diseases and conditions (48.8%).

The leading groups of diseases in the hospital treatment of women in 2010 were neoplasms (13.9% - most frequently malignant breast tumours), circulatory system diseases (13.1% - most frequently cerebral infarction), urinary and genital diseases (9.8% - most frequently polyp of female genital tract), diseases of the digestive system (7.4% - most frequently cholelithiasis) and diseases of the respiratory system (6.4% - most frequently pneumonia), and other diseases and conditions (49.4%).

The leading groups of diseases in the hospitalisation of women in 2011 were neoplasms (13.7% - most frequently malignant breast tumours), circulatory system diseases (12.9% - most frequently essential, primary hypertension), urinary and genital diseases (9.6% - most frequently polyp of corpus uteri), diseases of the digestive system (7.6% - most frequently cholelithiasis) and diseases of the respiratory system (6.4% - most frequently pneumonia, unspecified), and other diseases and conditions (49.8%).

Health care of infants and small children - preventive examinations and counselling

Health care of infants and small children is realised through two branches of the primary health care system: services for health care of children and general/family medicine, according to the free choice of the physician made by the insured person (parent).

Basic preventive health care of infants and small children consists of individual regular check-ups and follow-up examinations, examinations before vaccinations and counselling for parents in relation to the care and nutrition of the child. The standard number of preventive examinations planned by the Programme of Measures (Official Gazette, No. 126/06) is four examinations per infant and 4 examinations of a small child, with vaccination as prescribed by the Compulsory Vaccination Programme.

In 2008, of the total preventive visits of infants (206,228) in the primary health care system, 200,297 (97.1%) were preventive examinations (regular check-ups and/or examinations before

vaccination), and 5,931 (2.9%) were visits for counselling. Of the total preventive visits of small children (249,091) in the primary health care system, 216,683 (87.0%) were preventive examinations (regular check-ups and/or examinations before vaccination) and 32,408 (13.0%) were visits for counselling.

In 2009, of the total preventive visits of infants (221,739) in the primary health care system, 207,430 (93.5%) were preventive examinations (regular check-ups and/or examinations before vaccination), and 14,309 (6.5%) were visits for counselling. Of the total preventive visits of small children (269,126) in the primary health care system, 248,132 (92.2%) were preventive examinations (regular check-ups and/or examinations before vaccination), and 20,994 (7.8%) were visits for counselling.

In 2010, of total preventive visits by infants (196,032) in the primary health care system, 193,061 (98.5%) were preventive examinations (regular check-ups and/or examinations before vaccination) and 2,971 (1.5%) were visits for counselling. Of the total preventive visits by small children (252,658) in the primary health care system, 238,292 (94.3%) were preventive examinations (regular check-ups and/or examination before vaccination) and 14,366 (5.7%) were visits for counselling.

In 2011, of the total preventive visits of infants (170,299) in the primary health care system, 168,207 (98.8%) were preventive examinations (regular check-ups and/or examinations before vaccination), and 2,092 (1.2%) were visits for counselling. Of the total preventive visits of small children (314,386) in the primary health care system, 292,828 (93.1%) were preventive examinations (regular check-ups and/or examinations before vaccination) and 21,588 (6.9%) were visits for counselling.

Primary health care of infants and small children - 2008 indicators

Services for health care of children were provided by 252 teams. This care was provided for 364,997 insured persons, out of which 230,600 (63.2%) were pre-school children, while the rest of the insured persons were mostly children of school age. Health care provided by these services covered 79.6% of pre-school children (230,600 children), whereas other pre-school children (20.4% or 59,700 children), mostly living in rural areas and on islands, were cared for by family/general medicine services.
When it comes to the number of physicians and persons insured in the services for health care, one team was in charge of 1,472 insurees on average, of whom there were 930 children in the 0-6 age group. In 2008, a total of 468,954 preventive examinations of children younger that 7 years of age were carried out in the primary health care services, out of which there were 215,615 preventive examinations of infants or 4.5 visits per infant, and there were 253,339 preventive examinations of children in the 1-6 age group or 1.2 examinations per child. There were 4.5 preventive examinations per infant in the services for health care of infants and small children, whereas there were 4.4 preventive examinations in the general/family medicine services. There were no significant differences in the average number of preventive visits per infant between two services of primary health care for infants and small children - general/family medicine and services for health care of infants and small children. In both services, this number was below the standard determined by the Programme of Health Care Measures.
A total of 300,509 regular examinations were carried out in the overall primary health care (by services for health care of infants and small children and by general/family medicine services providing care to small children). In the group of infants who underwent regular

examinations, undernutrition was recorded in 1.8% cases, and overnutrition in 3.2% cases.
A total of 56.7% infants in the 0 - 2 months group were exclusively breastfed (51.3% in 2007), 15.8% (19.0% in 2007) were both breastfed and fed by breast milk substitutes, 12.3% were formula-fed (15.1% in 2007), and for 15.1% feeding history was unknown. In the group of infants older that three months of age, the share of exclusively breastfed infants fell to 41.4%, in the under 6 months group to 18.2%, and in the 6 - 11 months group, with the introduction of supplementary food, the use of substitutes for breast milk increased. A total od 74.8% of infants who underwent regular examinations were given prophylaxis against rickets (60.8% in 2007), and 9.7% were given prophylaxis against anaemia (10.4% in 2007). Signs of rickets were found in 0.4% of infants (0.4% in 2007). The most frequent developmental disorder found in infants during regular examinations was slowed psychomotor development, found in 3.2% of examined infants (2.6% in 2007). The shares of other disorders, such as phimosis (0.9%), congenital hip dislocation (0.5%), congenital heart defects (0.4%), other congenital anomalies (0.2%), cryptorchism (0.2%) and muscular and skeletal deformation were lower than 1%.

In the group of small children who underwent regular examinations, undernutrition was recorded in 1.5% cases (in 2007 in 1.4%), and overnutrition in 2.6% of children who underwent regular examinations (in 2007 in 2.3%). The most frequent pathological conditions found during regular examinations were carious teeth - in 9.6% of cases (9.9% in 2007), followed by dyslalia - 3.4% (3.1% in 2007); phimosis - 2.1% (2.0% in 2007), muscular and skeletal limb deformations - 1.8% (1.8% in 2007 as well), strabismus - 1.6% (1.5% in 2007).

According to the morbidity report, the number of recorded diseases and conditions up to 7 years of age was 978,077 (1,021,742 in 2007). The most frequent diseases were respiratory system diseases - 50.3% in 2008 (51.1% in 2007), then infectious and parasitic diseases - 9.4% in 2008 (9.0% in 2007), ear diseases - 6.2% in 2008 (6.4% in 2007), skin diseases and diseases of subcutaneous tissue - 5.4% in 2008 (5.3% in 2007), and symptoms, signs, and other clinical and laboratory findings - 3.8% in 2008 (3.5% in 2007).

Primary health care of infants and small children - 2009 indicators.
Services for health care of children were provided by 255 teams. This care was provided for 388,078 insured persons, out of which 249,745 (64.4%) were pre-school children, while the rest of the insured persons were mostly children of school age. Health care provided by these services covered 84.9% of pre-school children (249,745 children), whereas other pre-school children (15.1% or 44.408 children), mostly living in rural areas and on islands, were cared for by family/general medicine services.

When it comes to the number of physicians and persons insured in the services for health care, one team was, on average, in charge of 1,522 insurees, of whom there were 979 children in the 0 - 6 age group.

Primary health care of infants and small children - 2009 indicators

In 2009, a total of 490,865 preventive visits of children younger that 7 years of age were carried out in the primary health care services, out of which there were 221,739 preventive visits of infants or 4.4 examinations per infant, and there were 269,126 preventive visits of children in the 1 - 6 age group or 1.2 visits per child. Out of the total number of preventive examinations provided by the services for health care of infants and small children, there were on average 4.5 preventive examinations per infant, and in family/general medicine there were

4.1 preventive examinations

A total of 289,858 regular examinations of infants and small children were carried out at the primary health care level (both by the services for health care of infants and small children and by general/family medicine practitioners caring for small children). This number amounted to 300,509 or 3.6% in 2008. In the group of infants who underwent regular examinations, undernutrition was recorded in 1.7% cases and overnutrition in 3.0%. A total of 64.5% infants in the 0-2 months group were exclusively breastfed (56.7% in 2008), and 16.3% (15.8% in 2008) were both breastfed and fed by breast milk substitutes, 13.4% were formula-fed (12.3% in 2008), and for 5.8% feeding history was unknown. In the group of infants older than three months of age, the share of exclusively breastfed infants fell to 44.7%, in the under 6 months group the share of exclusively breastfed fell to 16.6%, and in the 6-11 months group, with the introduction of supplementary food, the use of substitutes for breast milk increased. A total of 80.35% of infants who underwent regular examinations were given prophylaxis against rickets (74.8% in 2008) and 10.3% were given prophylaxis against anaemia (9.7% in 2008). Signs of rickets were found in 0.6% of infants (0.4% in 2008).The most frequent development disorder found in infants during regular examinations was slowed psychomotor development, found in 2.8% of examined infants (3.2% in 2008). The shares of other disorders, such as phimosis (0.8%), congenital hip dislocation (0.6%), congenital heart defects (0.5%), other congenital anomalies (0.3%), cryptorchism and muscular and skeletal deformation (0.2%) were lower than 1%.

In the group of small children who underwent regular examinations, undernutrition was recorded in 1.5% cases (the same as in 2008) and overnutrition was recorded in 2.6% of small children who underwent regular examinations (the same as in 2008). The most frequent pathological conditions found during regular examinations were carious teeth - in 9.3% of cases (9.6% in 2008), followed by dyslalia - 3.3% (in 2008 it was 3.3% as well); phimosis - 2.1% (in 2008 it was 2.1% as well), muscular and skeletal limb deformations - 1.8% (in 2008 it was 1.8% as well), strabismus - 1.7% (1.6% in 2008).
According to the morbidity report, the number of recorded diseases and conditions up to 7 years of age was 999,941 (978,077 in 2008). The most frequent diseases were respiratory system diseases - 46,0% in 2009 (50,3% in 2008), then infectious and parasitic diseases - 9.6% in 2009 (9.4% in 2008), ear diseases - 6.2% in 2009 (in 2008 it was 6.2% as well), skin diseases and diseases of subcutaneous tissue - 5.4% in 2009 (in 2008 it was 5.4% as well), and symptoms, signs, and other clinical and laboratory findings - 4.6% in 2009 (3.8% in 2008).

Primary health care of infants and small children - 2010 indicators

Services for health care of children were provided by 254 teams. This care was provided for 393,776 insured persons, out of which 260,672 (66.2%) were pre-school children, while the rest of the insured persons were mostly children of school age. Health care provided by these services covered 88.6% of pre-school children (260,672 children), whereas other pre-school children (11.4% or 33,487 children), mostly living in rural areas and on islands, were cared for by family/general medicine services.

When it comes to the number of physicians and persons insured in the services for health care, one team was, on average, in charge of 1,550 insurees, of whom there were 1,026 children in the 0 - 6 age group.
In 2010, a total od 448,690 preventive visits of children younger that 7 years of age were

carried out in the primary health care services, out of which there were 196,032 preventive visits of infants or 4.1 visits per infant, and there were 252,658 preventive visits of children in the 1-6 age group or 1.1 visits per small child. Out of total preventive examinations carried out by the services for health care of infants and small children, there were on average 4.1 preventive examinations per infant, and in general/family medicine there were also 4.1 preventive examinations.
There were no significant differences in the average number of preventive examinations per infant between two services of primary health care for infants and small children - general/family medicine and services for health care of infants and small children. In both services, this number was below the standard determined by the Programme of health care measures.

A total of 269,023 regular examinations were carried out at the primary health care level (both by the services for the health care of infants and small children, and by general/family medicine practitioners caring for small children). This number amounted to 289,858 or 7.7% in 2009. In the group of infants who underwent regular examinations, undernutrition was recorded in 1.7% cases and overnutrition in 3.6%. A total of 66.3% of infants in the 0-2 months group were exclusively breastfed (64.5% in 2009), 15.5% were both breastfed and fed by breast milk substitutes (16.3% in 2009), 13.3% were formula-fed (13.4% in 2009), and for 5.0% feeding history was unknown. In the group of infants older than three months of age, the share of exclusively breastfed fell to 45.9%, in the under 6 months group the share of exclusively breastfed fell to 15.9%, and in the 6-11 months group, with the introduction of supplementary food, the use of substitutes for breast milk increased. A total of 81.6% of infants who underwent regular examinations were given prophylaxis against rickets (80.4% in 2009), and 11.1% were given prophylaxis against anaemia (10.3% in 2009). Signs of rickets were found in 0.1% infants (0.6% in 2009). The most frequent development disorder found in infants during regular examinations was slowed psychomotor development, found in 2.6% of examined infants (2.8% in 2009).
The shares of other disorders, such as phimosis (0.9%), congenital heart defects (0.5%), congenital hip dislocation (0.5%), other congenital anomalies (0.4%), muscular and skeletal deformations (0.3%) and cryptorchism (0.2%) were lower than 1%.
In the group of small children who underwent regular examinations, undernutrition was recorded in 1.4% cases (1.5% in 2009) and overnutrition was recorded in 2.5% of small children who underwent regular examinations (2.6% in 2009). The most frequent pathological conditions found during regular examinations were carious teeth - in 8.5% of cases (9.3% in 2009), followed by dyslalia - 3.4% (3.3% in 2009), phimosis - 2.3% (2.1% in 2009), muscular and skeletal limb deformations - 1.9% (1.8% in 2009), strabismus - 1.5% (1.7% in 2009). According to the morbidity report, the number of recorded diseases and conditions up to 7 years of age was 1,019,164 (999,941 in 2009). The most frequent diseases were respiratory system diseases with a share of 43.3% (46.0% in 2009), followed by infectious and parasitic diseases with 9.0% (9.6% in 2009), ear diseases - 6.0% (6.2% in 2009), skin diseases and diseases of subcutaneous tissue - 5.5% (5.4% in 2009), and symptoms, signs, and other clinical and laboratory findings with a share of 5.5% in 2010 (4.6% in 2009).

Primary health care of infants and small children - 2011 indicators

Health care of pre-school children

Health care of pre-school children was mostly realised through health care services for infants and pre-school children, as a part of primary health care system. It was provided by specialists in paediatrics (with privately owned services, or clinics leased from health centres) who have a contract to provide health care for children. A smaller part of

health care of children was realised through general/family medicine services (general medicine practitioners and specialists in general/family medicine), if, in accordance with the right to free choice of physician, a parent made this decision.

Preventive examinations and counselling for preserving and promoting health of children are a part of the compulsory Programme of Health Care Measures for Pre-School Children, completely financed by the compulsory health insurance.

In 2011, a total of 484,685 preventive visits of children younger than 7 years of age were carried out in primary health care services, out of which there were 170,299 preventive visits of infants or 4.6 examinations per infant and 314,386 preventive visits of children in the 1-6 age group, or 1.8 examinations per small child. There were 4.6 preventive visits per infant in the services for health care of infants and small children, whereas there were 5.1 preventive visits in the general/family medicine services.

In 2011, of the total preventive visits by infants (170,299) in the primary health care system, 168,207 (98.8%) were preventive examinations (regular examinations and/or examinations before vaccination), and 2,092 (1.2%) were visits for counselling. Of the total preventive visits of small children (314,386) in the primary health care system, 292,828 (93.1%) were preventive examinations (regular examinations and/or examinations before vaccination) and 21,558 (6.9%) were visits for counselling.

There were no significant differences in the average number of preventive visits per infant between two services of primary health care for infants and small children - general/family medicine and services for health care of infants and small children.

A total of 224,134 regular examinations were carried out in the overall primary health care (by services for health care of infants and small children and by general/family medicine services providing care to small children). This number amounted to 269,023 or 16.7% in 2010.

In the group of infants who underwent regular examinations, undernutrition was recorded in 1.8% cases and overnutrition in 3.7%. A total of 76.2% infants in the 0-2 months group were exclusively breastfed (66.3% in 2010), 14.1% (15.5% in 2010) were both breastfed and fed by breast milk substitutes and 13.5% (13.3% in 2010) were formula-fed. In the group of infants older than three months of age, the share of exclusively breastfed infants fell to 54.2%, in the 6-11 months group it fell to 14.8%, because with the introduction of supplementary food, the use of substitutes for breast milk increased. A total of 86.5% of infants who underwent regular examinations were given prophylaxis against rickets (81.6% in 2010) and 8.8% were given prophylaxis against anaemia (11.1% in 2010). Signs of rickets were found in 0.3% of infants (0.1% in 2010). The most frequent development disorder found in infants during regular examinations was slowed psychomotor development, found in 2.8% of examined infants (2.6% in 2010), followed by phimosis, which was found in 1.3% of examined infants. The shares of other disorders, such as congenital heart defects (0.6%), congenital hip dislocation (0.5%) and other congenital anomalies (0.4%) were lower than 1%. In the group of small children who underwent regular examinations, undernutrition was recorded in 1.7% cases (1.4% in 2010) and overnutrirtion in 2.3% (2.5% in 2010). The most frequent pathological conditions found during regular examinations were carious teeth - in 7.4% of cases (8.5% in 2010), followed by dyslalia - 3.2% (3.4% in 2010), phimosis - 2.4% (2.3% in 2010), muscular and skeletal limb deformation - 1.9% (1.9% in 2010 as well), strabismus - 1.5% (1.5% in 2010 as well).

Health care of children was provided, as a part of health care services for pre-school children, by 258 teams. This care was provided for 372,747 insured persons, out of which 257,976 (69.2%) were pre-school children, while the rest of the insured persons are mostly children of school age. Health care provided by these services covers 86.4% of pre-school children (257,976 children), whereas other pre-school children (13.6% or 40,760 children),

mostly living in rural areas and on islands, were cared for by general/family medicine services. When it comes to the number of physicians and persons insured in the services for health care, one team was, on average, in charge of 1,445 insurees, of whom there were 1000 children in the 0 - 6 age group.

According to the morbidity report, in the health care services of pre-school children the number of recorded diseases and conditions up to 7 years of age was 1,143,913 (1,019,164 in 2010). The most frequent diseases were respiratory system diseases - 36.1% (43.4% in 2010), then infectious and parasitic diseases - 9.4% (9.0% in 2010), symptoms, signs, and other clinical and laboratory findings - 7.1% (5.5% in 2010), ear diseases - 6.0% (6.0% in 2010 as well), skin diseases and diseases of subcutaneous tissue - 6.0% (5.5% in 2010).

Reasons for hospital treatment of pre-school children in 2008, 2009, 2010 and 2011

In 2008, hospital treatment was provided to 47,224 children in the 0 - 5 age group, most frequently for diseases belonging to the following groups: specific conditions in the perinatal period - 22.1% (most commonly for neonatal jaundice), respiratory system diseases - 21.6% (the most common diagnosis was chronic disease of tonsils and adenoids), infectious and parasitic diseases - 10.4% (most commonly for diarrhoea and gastroenteritis), and other - 45.9%.

In 2009. hospital treatment was provided to 45,921 children in the 0 - 5 age group, most frequently for diseases belonging to the following groups: specific conditions in the perinatal period - 21.3% (most commonly for neonatal jaundice), respiratory system diseases - 20.6% (the most common diagnosis was chronic disease of tonsils and adenoids), infectious and parasitic diseases - 8.3% (most commonly for diarrhoea and gastroenteritis) and other - 49.7%.

In 2010, hospital treatment was provided to 45,244 children in the 0 - 5 age group, most frequently for diseases belonging to the following groups: respiratory system diseases - 23.9% (the most common diagnosis was chronic disease of tonsils and adenoids), specific conditions in the perinatal period - 19.2% (most commonly for neonatal jaundice), infectious and parasitic diseases - 8.2% (most commonly for diarrhoea and gastroenteritis), and other - 48.7%.

In 2011, hospital treatment was provided to 45,239 children in the 0 - 5 age group, most frequently for diseases belonging to the following groups: respiratory system diseases - 24.5% (the most common diagnosis was chronic disease of tonsils and adenoids), specific conditions in the perinatal period - 18.7% (most commonly for neonatal jaundice), infectious and parasitic diseases - 8.6% (most commonly for diarrhoea and gastroenteritis), and other - 48.2%.

Preventive and specific health care of schoolchildren, young people and university students

The Croatian school medicine services have existed for decades. Since 1998 these services have been an integral part of county institutes of public health. Physicians who work in these services, after under-graduate studies at the School of Medicine, specialise in school medicine, which takes three years to complete (the new proposal is for a four-year course entitled "School and Adolescent Medicine"). Each physician and nurse is responsible for the preventive care of around 4,000 children, young people and full-time students. According to the Plan and Programme of Health Care Measures, parts of the obligatory programme include health education and counselling work.

In the primary health care, sick children of school age and university students are cared for by

general practitioners or family physicians, while preventive and specific health care is provided by school physicians operating within institutes of public health.
The activities of school medicine services within institutes of public health focus on the needs of children and young people and are implemented through regular and special programmes. While the health care services provided within general or family practices focus on the individual demands of sick insured person, both individual and mass approaches are used in preventive programmes. Methods include medical examination, screening, regular and other preventive examinations, along with the implementation of the compulsory vaccination programme, various types of counselling such as individual interviews and counselling for parents, pupils and teachers, as well as contemporary activities of health education and promotion, as an interactive method of learning, and working with parents and local communities.

According to the data of the CIHI, entire generations of children undergo examinations before enrolling in the first form of primary school (coverage of 100% and more). Before the commencement of the school year 2010/2011, 44,039 such examinations were carried out, 42,142 in the year before, 38,806 or 43,527 in the year before that. In line with the programme of regular examinations, during the school year 2010/2011 a total of 41,699 regular examinations were carried out in year five of primary school, which included 94% of the pupils, more than the average coverage during the previous years. In the eighth form of primary school, 47,058 (94%) of pupils were examined and attended career counselling. Although in the previous year, the number of examinations in the eight form of primary school was 45,455, with coverage of 94% as well, since 1998/1999 until this year there has been a slight increase in the number of these examinations. The number of pupils who underwent a regular examination during the first form of secondary school was 36,068 (71%), which was a little higher than in the previous years (in the school year 2009/2010, a total of 32,762 or 63% of pupils were given regular examinations). In the school year 2010/2011, 393,701 vaccinations were carried out in primary school and 40,608 in secondary school. Vaccination levels reached legal requirements (90%, and 95% for measles).

In the academic year 2010/2011, a total of 18,883 first year students underwent regular examination (24,890 in the previous year, 18,792 in 2008/2009, and 18,532 in the academic year 2005/2006). The greatest number of regular examinations was carried out in the largest Croatian cities: Zagreb (9,514), Osijek (2,083), Rijeka (2,059) and Split (1,503). Altogether 1,041 students were referred for follow-up examinations. Selective examinations were carried out on 1,731 students (1,888 in the previous year, 1,924 in 2008/2009, and 6,578 in 2005/2006). A total of 911 students contacted health services because of adapted programmes of physical and health education (1,058 in the previous year, 1,390 in 2008/2009, 1,150 in 2005/2006), and 6,191 students were examined before taking up residence in student halls of residence (this number has been stable for years - 6,360 in the previous year, 6,508 in 2008/2009, 6.922 in 2005/2006).

In 2010 in primary health care, a total of 1,292,602 diseases and conditions were found in patients in the 7 - 19 age group. The most common diseases were respiratory system diseases (524,461 diseases and conditions were found), infectious and parasitic diseases (99,570 diseases and conditions were found), skin diseases and diseases of subcutaneous tissue (94,828 diseases and conditions were found), and injuries, poisonings and some other consequences of external causes (83,985 diseases and conditions were found). In 2010, there were 32,905 hospitalisations of patients in the 10-19 age group, out of which injuries, poisonings and some other consequences of external causes were the most common reasons for hospitalisation (14.4%), followed by respiratory system diseases (14.3%).

Data for 2011 (school year 2011/2012)

Preventive and specific health care of schoolchildren is provided by school physicians as a part of public health care services. A total of 177 medical teams were employed in these services in the school year 2011/2012, which included 141 specialists in school medicine, 19 physicians undergoing specialisation and 17 general practitioners.
In accordance with the programme of regular examinations, in the school year 2011/2012 a total of 43,843 examinations of children were carried out before enrolling in the first form of primary school, and 37,570 examinations were carried out in the fifth form, that is, 86% of pupils were included.
In the eighth form of primary school, 90% of pupils were examined and attended career counselling (43,696 examinations). A total of 33,567 children or 64% of the entire generation underwent a regular examination in the year one of secondary school.
All of the children in the third form of primary school underwent a selective examination for visual impairment or impairment in color vision, and in year six 46,773 screenings for musculoskeletal disorders were carried out.
In school year 2011/2012, a total of 374,364 primary school pupils and 40,685 secondary school pupils were vaccinated (in the previous year there were 393,701 vaccinations in primary and 40,608 vaccinations in secondary school).
Specific parts of preventive health care programme for schoolchildren, to which special attention is directed, is health education and counselling. Counselling centres for children and young people at which children, parents and teachers can request help in solving the most common problems concerning growing up and health of children, are organised as a special form of counselling and the number of visits to counselling centres has significantly increased in comparison with 1998. In the school year 2011/2012 the number of visits in primary school was 118,409 (59,647 in 1998), and in secondary school the number was 38,516 (18,196 in 1998).

A total of 225,667 primary and 67,788 secondary school pupils was covered by some form of health education in the school year 2011/2012. Besides, 48,482 parents and teachers in primary and 4,789 in secondary schools participated in lectures, public discussions or workshops regarding health.

Preventive examinations for the adult population

During 2008, a total of 42,823 regular, periodic and follow-up examinations were carried out within general practice/family medicine on adults in the Republic of Croatia. In 2009 this number was 32,046 or 25% fewer than in 2008, and in 2010 this number amounted to 19,604 or 39% fewer than in 2009. During 2011, a total of 19,560 regular, periodic and follow-up examinations were carried out within general practice/family medicine on adults in the Republic of Croatia. This represents 0,2% fewer than in 2010 and even 95% fewer than in 1990. The low number of preventive examinations is an indication that general practice/family medicine lacks the mechanisms to finance preventive activities, and has become a passive health services, confirming and treating illnesses, but not significantly affecting positive changes in the health of the population, as laid down by law and according to its own declarations. From 2004, the CIHI's contracting physicians working in general/family medicine services, have been carrying out preventive examinations for the insured persons over the age of 50. Until the end of 2010, a total of 60,000 insured persons underwent a preventive examination and in that way the coverage of the target population (25%) was accomplished. Pathological conditions were found in 40% of the examined persons, and every fifth examined person was referred to further diagnostics and treatment.

Treating malignant diseases

Oncology patients are treated in clinical hospitals and in most of the general hospitals. The only specialist hospital for treating oncology patients is the Clinic for Tumours in Zagreb.

At the end of 2006, the National Programme for the Early Detection of Breast Cancer was launched, and at the end of 2007, the National Programme for Early Detection of Colon Cancer was also launched, and it has been continuously implemented during the reporting period.

The total number of newly diagnosed cases of invasive cancer (ICD codes C00-C97, not including skin cancer, C44) in 2009 was 21,199, of whom 11,483 were men and 9,716 women. The incidence rate was 477.7/100,000 (537.6/100,000 for men and 422.1/100,000 for women). The total number of newly diagnosed cases of invasive cancer (ICD codes C00-C97, not including skin cancer) in 2010 was 20,887, of whom 11,203 were men and 9,684 were women. The incidence rate was 472.8/100,000 (525.5/100,000 for men and 423.6/100,000 for women). The five most common sites for cancer in men, which cover 57% of new cases, are the trachea, bronchi and lungs (18%), the prostate gland (16%), the colon (9%), the rectum, rectosigmoid and anus (7%), and the bladder (7%). The five most common sites for cancer in women, which cover 53% of new cases, are the breasts (26%), the colon (8%), the trachea, bronchi and lungs (7%), the uterine body (7%), the ovaries, oviduct and adnexa of uterus (5%).

Rehabilitation

Hospitals for rheumatic diseases and rehabilitation

1. Thalassotherapy Crikvenica
2. Daruvarske Toplice (Daruvar Spa)
3. "Naftalan" Ivanić Grad
4. Krapinske toplice (Krapina Spa)
5. Lipik
6. "Biokovka" Makarska
7. Thalassotherapy Opatija
8. Stubičke Toplice (Stubice Spa)
9. Varaždinske Toplice (Varaždin Spa)
10. "Kalos" Vela Luka
11. Topusko
12. "Prim.dr.Martin Horvat" Orthopedic Hospital, Rovinj
13. Veli Lošinj Health Resort
14. Physical therapy and rehabilitation wards in 1 general hospital, 4 clinical hospital centres and 1 orthopedic hospital

Health care staff and associates

Health care staff in 2008

At the end of 2008, there were 70,990 permanent employees in the health system of the Republic of Croatia (70,431 in 2007). Of these, 52,954 were health staff and associates, 5,115 administrators and 12,921 technical staff.
Within the structure of the permanent health staff, the share of employees with secondary

qualifications is 37.7%, administrative and technical staff make up to 25.4% (26.0% in 2007), physicians 16.6%, health staff with junior college education 10.2%, stomatologists 4.6%, pharmacists 3.7%, other university degree staff (psychologists, speech therapists, social workers, special education teachers and others) 1.2% of the employed, and semi-skilled health workers 0.6%. A further 8,757 (7,682 in 2007) health staff and associates were employed on a temporary basis. In other words, on 31 December 2008 a total of 61,711 health staff and associates were employed on a permanent or temporary basis (compared with 59,863 in 2006).
The number of physicians per 100,000 inhabitants has increased in comparison with 1980 by almost one-third (from 167 to 266 in 2008), which is still less than the EU average (326/100,000).

Nurses represent almost a half of the total number of health care staff employed (46.7%). In the group of health care staff with secondary school and junior college education (33,995 employees), nurses and medical technicians make up 73% and the others are mostly health engineers and technicians. The number of nurses per 100,000 inhabitants was 522 in 2008. Out of 24,734 nurses, 15% have senior nursing qualifications. The number of nurses is also submitted, as a special indicator, to the WHO Health for All database, and the number of midwives is also specially monitored. The number of midwives in 2008 was 1,573. In 2008 there were 2.0 nurses or medical technicians employed per every physician in permanent employment.

Table 22 Total number of health workers employed in state and private medical institutions and in private practice (according to the type of employment and population per one health worker), in Croatia in 2008

Health workers	Permanent	Population per one health worker	Total	Population per health worker
Medical doctors	11,801	376	12,669	350
Stomatologists	3,261	1,361	3,484	1,274
Pharmacists	2,640	1,481	2,760	1,608
Other university degree staff	861	5,154	1004	4,420
Junior college education	7,214	615	8,491	523
Secondary school education	26,781	166	32,838	135
Semi-skilled	396	11,206	435	10,201
Total	**52,954**	**84**	**61,711**	***72***

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

Table 23 Total number of health staff employed in the primary health care system (general medicine, health care of women, health care of infants and small children) in Croatia in 2008

Medical doctors	**3,198**
Of whom specialists	1,676
Nurses - Junior college education	**172**
Nurses - Secondary school education	**3,027**

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

Table 24 Total number of health staff employed in school medicine services, in Croatia in 2008

Medical doctors	**170**
Of whom specialists	120
Nurses - Junior college education	**52**
Nurses - Secondary school education	**110**

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

Table 25 Total number of health staff employed in emergency assistance services, in Croatia in 2008

Medical doctors	**497**
Of whom specialists	29
Nurses - Junior college education	**36**
Nurses - Secondary school education	**898**

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

Table 26 Total number of health staff employed in occupational health services, in Croatia in 2008

Medical doctors	**183**
Of whom specialists	166
Nurses - Junior college education	**39**
Nurses - Secondary school education	**128**

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

Table 27 Total number of health staff employed in health visiting services, in Croatia in 2008

Nurses - Junior college education	**707**
Nurses - Secondary school education	**125**

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

Table 28 Total number of health staff employed in home care and rehabilitation services, in Croatia in 2008

Health staff - Junior college education	**327**
Health staff - Secondary school education	**1,891**

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

Table 29 Health institutions in Croatia* 31st December 2008

HEALTH INSTITUTIONS	NO. OF INSTITUTIONS
HEALTH CENTRE	**50**
CLINICAL TEACHING HOSPITAL	**3**
CLINICAL HOSPITAL	**4**
CLINIC	**7**
GENERAL HOSPITAL	**23**
SPECIAL HOSPITAL	**33**
HEALTH RESORT	**7**
PUBLIC HEALTH INSTITUTE	**22**
OTHER STATE INSTITUTES:	**3**
♦ INSTITUTE OF TRANSFUSIONAL MEDICINE	1
♦ OCCUPATIONAL HEALTH INSTITUTE	1
♦ TOXICOLOGY INSTITUTE	1
EMERGENCY CARE STATION	**4**
POLYCLINIC	**331**
INSTITUTION OF OCCUPATIONAL HEALTH	**13**
PHARMACY	**178**
COMPANY PROVIDING HEALTH SERVICES	**142**
Total	**820**

* Institutions regardless of the type of ownership

PHARMACIES	**1,133**
NURSING CARE AND REHABILITATION INSTITUTIONS	**155**
HOME CARE PRIVATE PRACTICE	**104**

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 20122

According to figures from the Croatian National Institute of Public Health, in 2008 there were 1,133 pharmacies, or 0,25 pharmacies/1,000 population. A total of 2,760 pharmacists were employed in state and private health institutions and private practice. There was an average of 1,608 population per one pharmacist.

Health care staff in 2009

At the end of 2009 there were 70,592 permanent staff employed in the health system of the Republic of Croatia (70,990 in 2008). Of these, 52,956 were health ***staff*** and associates, 5,081 administrators and 12,555 technical staff.
Within the structure of the permanent health staff, the share of employed who have secondary qualifications is 37.9%, administrative and technical staff make up 25.0% (25.4% in 2008), physicians 16.8%, health ***staff*** with junior college education 10.2%, dentists 4.6%, pharmacists 3.8%, other university degree staff (psychologists, speech therapists, social workers, special education teachers and others) 1.2% of the employed, and semi-skilled health workers 0.5%.
A further 9,238 (8,757 in 2008) health staff and associates were employed on temporary basis. In other words, on 31 December 2009 a total of 62,194 health ***staff*** and associates were employed on a permanent or temporary basis (compared with 61,711 in 2008).
The number of physicians per 100,000 population has increased in comparison with 1980 by almost one-third (from 167 to 266 in 2009), which is still less than the EU average (326/100,000). The EU-15 average in 2009 was 346/100,000, while the 12 newest members had an average of 271/100,000, according to data from 2009.
Nurses represent almost half of the total number of health care staff (45.7%).
In the group of health care staff with secondary school and junior college education (33,960 employees), nurses and medical technicians make up 71%, and the others are mostly health engineers and technicians.
The number of nurses per 100,000 population has risen from 354 in 1980 to 511 in 2009, which is still significantly less than the EU average (824/100,000 in 2009).
Of 24,201 nurses, 15% have senior nursing qualifications.
The number of nurses, as a special indicator, is submitted to the WHO Health for All database, and the number of midwives is also specially monitored. Since 1990, the number of midwives has been decreasing and it reached 1,476 in 2003, and after that it started increasing. In 2009 there were 2.0 nurses or medical technicians employed per every physician in permanent employment.

Table 30 Total number of health workers employed in state and private medical institutions and in private practice (according to the type of employment and population per one health work), in Croatia in 2009

Health workers	Permanent	Population per health worker	Total	Population per health worker
Medical doctors	11,847	375	12,771	347
Stomatologists	3,232	1,373	3,454	1,285
Pharmacists	2,673	1,660	2,853	1,555
Other university degree staff	857	5,178	1059	4,190
Junior college education	7,220	615	8,592	516
Secondary school education	26,740	166	33,021	134
Semi-skilled	387	11,466	444	9,994
Total	**52,956**	**84**	**62,194**	**71**

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

Table 31 Total number of health staff employed in the primary health care system (general medicine, health care of women, health care of infants and small children) in Croatia in 2009

Medical doctors	**3,201**
Of whom specialists	1,665
Nurses - Junior college education	**174**
Nurses - Secondary school education	**3,028**

Source of data: Documentation for the preparation of the seventh report on implementation of European social charter, Ministry of Health, June 2012

Table 32 Total number of health staff employed in school medicine services in Croatia in 2009

Doctors of medicine	**173**
Of whom specialists	**120**
Nurses - Junior college education	**53**
Nurses - Secondary school education	**112**

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

Table 33 Total number of health staff employed in emergency assistance services, in Croatia in 2009

Doctors of medicine	**514**
Of whom specialists	29
Nurses - Junior college education	**37**
Nurses - Secondary school education	**900**

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

Table 34 Total number of health staff employed in occupational health, in Croatia in 2009

Medical doctors	**188**
Of whom specialists	177
Nurses - Junior college education	**38**
Nurses - Secondary school education	**141**

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

Table 35 Total number of health staff employed in health visiting services in Croatia in 2009

Nurses - Junior college education	**714**
Nurses - Secondary school education	**120**

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

Table 36 Total number of health staff employed in home care and rehabilitation services, in Croatia in 2009

Health staff - Junior college education	**335**
Health staff - Secondary school education	**1,891**

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

Table 37 Health institutions in Croatia*, 31st December 2009

HEALTH INSTITUTIONS	NO. OF INSTITUTIONS
HEALTH CENTRE	**49**
CLINICAL TEACHING HOSPITAL	**4**
CLINICAL HOSPITAL	**3**
CLINIC	**7**
GENERAL HOSPITAL	**23**
SPECIAL HOSPITAL	**33**
HEALTH RESORT	**7**
PUBLIC HEALTH INSTITUTE	**22**
OTHER STATE INSTITUTES:	**5**
♦ INSTITUTE OF TRANSFUSIONAL MEDICINE	1
♦ INSTITUTE FOR HEALTH PROTECTION AND SAFETY AT WORK	1
♦ INSTITUTE OF TOXICOLOGY	1
♦ INSTITUTE OF MENTAL HEALTH	1
♦ INSTITUTE OF EMERGENCY MEDICINE	1
EMERGENCY CARE STATION	**4**
POLYCLINIC	**348**
INSTITUTION OF OCCUPATIONAL HEALTH	**13**
PHARMACY	**176**
COMPANY PROVIDING HEALTH SERVICES	**207**
TOTAL	**901**

* Institutions regardless of the type of ownership

PHARMACIES	**1,151**
NURSING CARE AND REHABILITATION INSTITUTIONS	**154**
HOME CARE PRIVATE PRACTICE	**105**

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

According to figures from the Croatian National Institute of Public Health, in 2008 there were 1,133 pharmacies. At the end of 2009 there were 1,151 pharmacies, or 0,25 pharmacies/1000 population. A total of 2,855 pharmacists (2,760 in 2008) were employed in state and private health institutions and in private practice. There was an average of 1,555 population per one pharmacist.

Health care staff in 2010

At the end of 2010 there were 72,207 permanent staff employed in the health system of the Republic of Croatia (70,592 in 2009). Of these, 54,873 were health staff and associates, 5,117

administrators and 12,217 technical staff.
Within the structure of the permanent health care staff, the share of employed who have secondary qualifications is 38.2%, administrative and technical staff make up 24.0% (25.0% in 2009), physicians 17.1%, health staff with junior college education 10.6%, stomatologists 4.3%, pharmacists 3.9%, other university degree staff (psychologists, speech therapists, social workers, special education teachers and others) 1.3% of the employed, and semi-skilled health workers 0.6%.
A further 8,270 health staff and associates were employed on a temporary basis (9,238 in 2009). In other words, on 31 December 2010 a total of 63,143 health staff and associates were employed on a permanent or temporary basis (62,194 in 2009).
The number of physicians per 100,000 population has increased in comparison with 1980 by almost one-third (from 167 to 266 in 2009), which is still less that the EU average (326/100,000). The EU-15 average in 2009 was 346/100,000, while the 12 newest members had an average of 271/100,000, according to data from 2009.
Nurses represent almost half of the total number of health care staff employed (45.5%).
In the group of health care staff with secondary school and junior college education (35,223 employees), nurses and medical technicians make up 71% and the others are mostly health engineers and technicians.
The number of nurses per 100,000 population has risen from 354 in 1980 to 511 in 2009, which is still significantly less than the EU average (824/100,000 in 2009).
Of 25,000 nurses, 16% have senior nursing qualifications.
The number of nurses, as a special indicator, is also submitted to the WHO Health for All database, and the number of midwives is also specially monitored. Since 1990, the number of midwives has been decreasing and it reached 1,476 in 2003, and after that it started increasing, and it reached 1,553 in 2010. In 2010, there were 2.0 nurses or medical technicians employed per each physician in permanent employment.

Table 38 Total number of health workers employed in state and private medical institutions and in private practice (according to the type of employment and population per one health worker), in Croatia in 2010

Health workers	Permanent	Population per health worker	Total	Population per health worker
Medical doctors	12,341	360	13,286	334
Stomatologists	3,121	1,422	3,331	1,332
Pharmacists	2,851	1,557	3,001	1,479
Other university degree staff	909	4,882	1079	4,113
Junior college education	7,646	581	9,051	490
Secondary school education	27,577	161	32,935	135
Semi-skilled	428	10,368	460	9,647
Total	**54,873**	**81**	**63,143**	**70**

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

Table 39 Total number of health staff employed in the primary health care system (general medicine, health care of women, health care of infants and small children), in Croatia in 2010

Medical doctors	**3,060**
Of whom specialists	1,694
Nurses - Junior college education	**129**
Nurses - Secondary school education	**2,873**

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

Table 40 Total number of health staff employed in school medicine services, in Croatia in 2010

Medical doctors	**184**
Of whom specialists	146
Nurses - Junior college education	**71**
Nurses - Secondary school education	**104**

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

Table 41 Total number of health staff employed in emergency assistance service, in Croatia in 2010

Medical doctors	**512**
Of whom specialists	33
Nurses - Junior college education	**41**
Nurses - Secondary school education	**916**

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

Table 42 Total number of health staff employed in occupational health services, in Croatia in 2010

Medical doctors	**180**
Of whom specialists	154
Nurses - Junior college education	**27**
Nurses - Secondary school education	**155**

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

Table 43 Total number of health staff employed in health visiting services, in Croatia in 2010

Nurses - Junior college education	**764**
Nurses - Secondary school education	**114**

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

Table 44 Total number of health staff employed in home care and rehabilitation services, in Croatia in 2010

Health staff - Junior college education	**343**
Health staff - Secondary school education	**1,815**

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

Table 45 Health institutions in Croatia*, 31st December 2010

HEALTH INSTITUTIONS	**NO. OF INSTITUTIONS**
HEALTH CENTRE	**49**
CLINICAL TEACHING HOSPITAL	**4**
CLINICAL HOSPITAL	**4**
CLINIC	**2**
GENERAL HOSPITAL	**22**
SPECIAL HOSPITAL	**33**
HEALTH RESORT	**6**
PUBLIC HEALTH INSTITUTE	**22**
OTHER STATE INSTITUTES:	**4**
♦ INSTITUTE OF TRANSFUSIONAL MEDICINE	1
♦ INSTITUTE FOR HEALTH PROTECTION AND SAFETY AT WORK	1
♦ INSTITUTE OF TOXICOLOGY	1
♦ INSTITUTE OF EMERGENCY MEDICINE	1
EMERGENCY CARE STATION	**4**
POLYCLINIC	**352**
INSTITUTION OF OCCUPATIONAL HEALTH	**12**
PHARMACY	**181**
COMPANY PROVIDING HEALTH SERVICES	**264**
Total	**959**

* Institutions regardless of the type of ownership

PHARMACIES **1,173**

NURSING CARE AND REHABILITATION INSTITUTIONS **157**

HOME CARE PRIVATE PRACTICES **99**

Source of data: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Ministry of Health, June 2012

According to figures from the Croatian National Institute of Public Health, in 2009 there were

1,151 pharmacies. At the end of 2010 there were 1,173 pharmacies, or 0.26 pharmacies/1000 population. A total of 3,001 pharmacists (2,855 in 2009) were employed in state and private health institutions and in private practice. There was an average of 1,479 population per one pharmacist.

Health care staff in 2011

At the end of 2011 there were 73,434 permanent staff employed in health system of the Republic of Croatia (72,207 in 2010). Of these, 55,837 were health staff and associates, 5,144 administrators and 12,453 technical staff. Within the structure of the permanent health care staff, the share of employed who have secondary qualifications is 38.1%, administrative and technical staff make up 23.6% (24.0% in 2010), physicians 17.2%, health staff with junior college education 10.6%, stomatologists 4.3%, pharmacists 4.1%, other university degree staff (psychologists, speech therapists, social workers, special education teachers and others) 1.3% of the employed, and semi-skilled health workers 0.5%.

A further 8,418 (8,270 in 2010) health staff and associates were employed on a temporary basis. In other words, on 31 December 2011 a total of 64,255 health staff and associates were employed on a permanent or temporary basis (compared with 63,143 in 2010).

The number of physicians per 100,000 population has increased in comparison to 1980 by almost one-third (from 167 to 281 in 2011), which is still less than the EU average (326/100,000). The EU-15 average in 2009 was 346/100,000, while the 12 newest members had an average of 271/100,000, according to data from 2009.

Nurses represent almost half of the total number of health care staff employed (45.6%). In the group of health care staff with secondary school and junior college education (35,823), nurses and medical technicians make up 71% (25,485), and the others are mostly health engineers and technicians.

The number of nurses per 100,000 population has risen from 354 in 1980 to 572 in 2011, which is still significantly less than the EU average (824/100,000 in 2009). Of 25,485 nurses, 16% have senior nursing qualifications.

The number of nurses is also, as a special indicator, submitted to the WHO European Health for All database, and the number of midwives is also specially monitored. Since 1990, the number of midwives has been decreasing, and it reached 1,476 in 2003, and after that it started increasing, and it reached 1,593 in 2011. In 2011, there were 2.0 nurses or medical technicians employed per each physician in permanent employment.

Table 46.
HEALTH WORKERS EMPLOYED IN STATE INSTITUTIONS AND IN PRIVATE PRACTICES (PERMANENT JOB AND TOTAL) AND POPULATION PER ONE HEALTH WORKER, CROATIA 2011

Health workers	Permanent	Population per one health worker	Total	Population per one health worker
Medical doctors	12.526	352	13.431	328
Doctors of dental med.	3.126	1.408	3.360	1.310
Pharmacists	2.972	1.481	3.117	1.413
Other university degree staff	986	4.465	1156	3.809
Junior college education	7.967	553	9.482	464
High school education	27.864	158	33.279	132
Semi-skilled	396	11.118	430	10.239
Total	**55.837**	**79**	**64.255**	**69**

Table 47. TOTAL NUMBER OF HEALTH WORKERS EMPLOYED IN PRIMARY HEALTH CARE (PHC) (GENERAL MEDICINE, HEALTH CARE FOR WOMEN, HEALTH CARE FOR BABIES AND SMALL CHILDREN) CROATIA 2011

Medical doctors	**3127**
Specialists	1764
Nurses – junior college education	**131**
Nurses – high school education	**2975**

Table 48. TOTAL NUMBER OF HEALTH WORKERS EMPLOYED IN THE FIELD OF SCHOOL MEDICINE IN CROATIA 2011

Medical doctors	**182**
Specialists	145
Nurses – junior college education	**76**
Nurses – high school education	**97**

Table 49. TOTAL NUMBER OF HEALTH WORKERS EMPLOYED IN THE FIELD OF EMERGENCY MEDICAL SERVICE IN CROATIA 2011

Medical doctors	**524**
Specialists	95
Nurses – junior college education	**55**
Nurses – high school education	**918**

Table 50. TOTAL NUMBER OF HEALTH WORKERS EMPLOYED IN THE FIELD OF OCCUPATIONAL MEDICINE IN CROATIA 2011

Medical doctors	**188**
Specialists	163
Nurses – junior college education	**27**
Nurses – high school education	**150**

Table 51. TOTAL NUMBER OF HEALTH WORKERS EMPLOYED IN THE FIELD OF HOUSE-CALL ACTIVITY IN CROATIA 2011

Nurses – junior college education	**774**
Nurses – high school education	**99**

Table 52. TOTAL NUMBER OF HEALTH WORKERS EMPLOYED IN THE FIELD OF DOMESTIC CARE AND REHABILITATION ACTIVITY IN CROATIA 2011

Health workers - junior college education	**351**
Health workers - high school education	**1817**

Table 53. HEALTH INSTITUTIONS IN CROATIA, DECEMBER 31, 2011

HEALTH INSTITUTIONS	NO. OF INSTITUTIONS
HEALTH CENTER	**49**
CLINICAL TEACHING HOSPITAL	**5**
CLINICAL HOSPITAL	**3**
CLINIC	**4**
GENERAL HOSPITAL	**22**

SPECIAL HOSPITAL	**33**	
HEALTH RESORT	**7**	
PUBLIC HEALTH INSTITUTE	**22**	
OTHER STATE INSTITUTES:	**4**	
♦ CROATIAN INSTITUTE FOR TRANSFUSION MEDICINE	1	
♦ INSTITUTE FOR HEALTH PROTECTION AND SAFETY AT WORK	1	
♦ INSTITUTE OF TOXICOLOGY AND ANTIDOPING	1	
♦ INSTITUTE FOR EMERGENCY MEDICINE	1	
♦ INSTITUTE FOR TELEMEDICINE	1	
EMERGENCY CARE STATION	**13**	
POLYCLINIC	**363**	
INSTITUTION OF OCCUPATIONAL HEALTH	**9**	
PHARMACY	**184**	
HEALTH COMPANY	**300**	
Total	**1.019**	
* Institutions regardless of the type of ownership		
PHARMACIES	**1.181**	
NURSING CARE AND REHABILITATION INSTITUTIONS		**167**
HOME CARE PRIVATE PRACTICE		**98**

According to the data of the Croatian National Institute of Public Health, in 2010 1.173 pharmacies have operated, and at the end of 2011 1.181, in other words 0,26 pharmacies/1000 inhabitant. The total of 2.972 the pharmacist (3.001 in 2010) have been employed in state and private medical institutions and private practice, while the average is 1.481 inhabitants on one pharmacist.

During 2008 and 2009 a total of 2.571 teams (2.571 medical doctors) worked in the activities of primary health care in its narrowest sense, which is made up of general/family medicine activities and the activity of babies and small children health care in the Republic of Croatia. In 2008 of the 2.571 doctors 1.447 were specialists (from them, 971 are specialists of general / family medicine, 253 specialists of paediatrics, 112 occupational doctors, 88 specialists of school medicine and 23 specialists of others specialities). Other health service providers constitute: 52 with junior college education, 2.528 with high school education.
During 2009 of a total of 2.571 medical doctors 1.494 were specialists (1.037 specialists of general / family medicine, 256 specialists of paediatrics, 100 occupational doctors, 83 specialists of school medicine and 18 specialists of others specialities). Other health service providers constitute: 49 with junior college education, 2.522 with high school education.
When compared to 2008, in 2009 there has been an increase in the number of medical specialists: the number of medical specialist in primary health care is overall higher for 3%, of which specialists of family medicine for 7%, paediatrics for 1%, occupational medicines lesser for 11%, school medicine lesser for 6% and others specialist lesser for 22%.
During 2010 a total of 2.540 teams (2.540 medical doctors) worked in the activities of primary health care in its narrowest sense. Of the 2.540 doctors 1.505 were specialists (1.072 specialists of general / family medicine, 255 specialist of paediatrics, 88 occupational doctor, 71 specialists of school medicine and 19 specialist of others specialities). Other health service providers constitute: 37 with junior college education, 2.498 with high school education. When compared to 2009, in 2010 there has been an increase in the number of medical specialists: the number of medical specialist in primary health care is overall larger by 0,7%, 3,4% of specialist of family, paediatrics less by 0,4%, occupational medicines less by 12%, school medicine less by 14% and

others specialists less by 5%. Health workers with junior college education are fewer by 24%, and the number of health service providers with high school education are lesser by 1% .
In 2011 a total of 2.545 teams worked on 2.552 locations (2.536 locations include full-time working hours, and 16 locations part of working hours) in the activities of primary health care in its narrowest sense. Of 2.545 doctors 1.534 were specialists of all specialities (of which, 1.095 were specialists of general/family medicine, 263 specialists of paediatrics, 84 occupational doctors, 70 specialists of school medicine and 22 specialists of others specialities). Other health service providers constitute: 43 with junior college education, 2.498 with high school education. When compared to 2010, in 2011 there has been an increase in the number of medical specialists: the number of medical specialists in primary health care is overall larger by 2%, of which the number of specialists of family medicine by 2%, paediatrics by 3%, occupational medicines less by 4,5%, school medicine less by 1,4%, and others specialist more for 16%. Health service providers with junior college education is up by16%, and the number of health service providers with high school education is the same.

In the activity of stomatological health care in 2008, a total of 1,824 teams worked, of which 1,659 stomatological, 74 specialists of child preventive stomatology and 91 other specialists. Teams without engagement with the Croatian Health Insurance Institute (CIHI) provided service in addition to the teams mentioned: out of 708 stomatological teams without engagement with the CIHI, 572 are stomatological, 23 specialists in child and preventive stomatology and 113 are of other specialities. During 2009, a total of 1,785 teams worked in this activity, of which 1,657 specialists of dental medicine, 62 specialists of child and preventive dental medicine and 66 other specialities. Alongside mentioned teams, teams without engagement with CIHI provided service: out of 650 teams of dental medicine without engagement with CIHI, 579 were specialists of dental medicine, 23 specialist of child and preventive dental medicine and 48 of other specialities. During 2010 a total of 1,748 teams worked, of which 1,617 teams of dental medicine, 52 specialist teams of child and preventive dental medicine and 79 teams of other specialities. Alongside the mentioned teams, teams without engagement with CIHI provided service, out of which 596 were teams of dental medicine, 13 specialised teams of child and preventive dental medicine and 49 teams of other specialities.

During 2010, a total of 1,748 teams worked, of which 1,617 teams of dental medicine, 52 specialist teams of child and preventive dental medicine and 79 other specialist teams. Alongside these teams worked another 658 teams of dental medicine without engagement with CIHI, 596 being teams of dental medicine, 13 specialist teams in child and preventive dental medicine and 49 teams of other specialities. In 2011 a total of 1,766 teams worked in the same field of activity, of wich 1,637 teams of dental medicine, 58 specialist teams in child and preventive dental medicine and 71 other specialist teams. These teams took care of about 3,844,955 insurees (around 1.2 % less than in 2010), from which 1,254,567 of the insurees have used health care (a reduction of 8.7% when compared to 2010). Alongside these teams, teams without engagement with CIHI have provided service: of 722 dental medicine teams without engagement with CIHI, 655 were teams of dental medicine, 19 were specialists teams of child and preventive dental medicine and 48 were teams of other specialities. 3,900,411 calls to contract (reduction of 5.4% when compared to 2010) and 772,344 calls to clinics without engagement with CIHI (increase of 10.2 % when compared to 2010) were recorded. Regardless of the contract with CIHI, 680,149 general medical examinations were performed (increase of 17.4% when compared to 2010). 1,845,400 teeth were filled (about 7.2% less than in 2010), and 556,384 teeth were taken out (decline of 4.9% when compared to 2010). In 2011, 242,566 prosthetic operations were performed (reduction of 3.7 % when compared to 2010) and 202,014 treatments of soft tissues

were performed (reduction of 44.1 % when compared to 2010).

Home health care is performed by registered and approved institutions for home nursing as a health activity on the primary level. According to the Health Care Act (Official Gazette 150/08), Article 82, institution for home health care carries out health care and the rehabilitation of patient as directed by a medical doctor. Institution can temporarily take care of patients in a stationary manner that require health care and rehabilitation. The established standard number of insurees for performing home health care were 3,500 insurees per one nurse. During 2008 145 senior nurses and 1,039 nurses with high school education worked in the activity of home nursing. According to the data on the number of insurees in primary health care, one nurse in the activity of home nursing is responsible for, on average, 3,759 insurees. During 2009, 128 senior nurses and 831 nurses with high school education have worked. According to the data on the number of insurees in primary health care, one nurse in the activity of home nursing is responsible for, on average, 4,663 insurees. According to the reports received for 2010, 107 senior nurses and 849 nurses with high school education worked in the activity of home nursing. According to the data on the number of insurees in primary health care, one nurse in the activity of home nursing is responsible for, on average, 4,718 insurees. In 2011, 140 senior nurses and 903 nurses with high school education worked in this activity. According to the data on the number of insurees in primary health care, one nurse in the activity of home nursing is responsible for, on average, 4,391 insurees. The recorded average number of house calls per nurse is 1,431 a year (reduction of 28% when compared to 2010).

The house-call protection is performed by senior nurses of house-call speciality based on the standard of 5,100 patients per one house call nurse, according to the Ordinance on standards and standard specifications of the right to health care from the basic health insurance (Official Gazette, No. 142/06). That number refers to the population count in the area of the competent medical centre/organisational unit of the County health center. During 2008, 775 senior nurses and 115 nurses with high school education worked in this activity. According to the data on the number of insurees in primary health care, one nurse is responsible for, on average, 5,001 insurees. During 2009 781 senior nurses (0.8% more when compared to 2008) and 136 nurses with high school education (an increase of 18.3% when compared to 2008) have worked. According to the data on the number of insurees in primary health care, one nurse is responsible for, on average, 4,877 insurees. During 2010, 838 senior nurses (7.3 % more when compared to 2009) and 123 nurses with high school education (a reduction of 9.6 % when compared to 2009) have worked. According to the data on the number of insurees in primary health care, one nurse is responsible for, on average, 4,693 insurees. In 2011, 844 senior nurses (0.7% more when compared to 2010) and 84 nurses with high school education (a decrease of 46.4% when compared to 2010 worked in the house-call activity) worked in the house-call activity. According to the data on the number of insurees in primary health care, one nurse is responsible for, on average, 4.935 insurees. The total number of house-call visits in 2011 has been 1,465,526, which is 3.6 % more than 2010.

Pursuant to Article 129 (2) (18) of the Police Act (Official Gazette, No. 129/00), the Minister of the Interior has issued the Ordinance on measures and the method of determining special mental and physical abilities of police officers of the Ministry of the Interior (Official Gazette, No. 54/06). This Ordinance regulates the measures and the method of determining special mental and physical abilities (health status) that the following must have:

1. candidates for appointment to the civil service, for the position of police officer,
2. training candidates fo the performance of the duties of police officer and
3. police officers.

In accordance with Article 2 of the mentioned Ordinance, health checks that lead to the assessment and the opinion about the health status, as a rule, are carried out by the Medical Centre of the Ministry of the Interior, and can be carried out by another medical institution with which the Ministry of the Interior concludes a contract about the performance of duties of specific health care.

The indicated Ordinance was brought,, based on the Police Act and does not apply to the specific health care of employees - police officers pursuant to the provisions of the Act on health care on which it refers to regarding need of delivering reports, but on the filling of requirements from the Police Act.

Therefore, further observations refer to the application of the mentioned Ordinance and the preventive measures of the health care of police officers that refers to educational activities and protection measures against infectious diseases in accordance with the epidemiological recommendations of the Public Health Institute as well as the activities from the programme of psychosocial employee protection of the Ministry of Interior.

Throughout the mentioned period, and taking into consideration the provisions of the Ordinance, for the purpose of admittance into employment of police officers, 181 police officers were medically examined in compliance with the measure categories of the police officers health status (A, B, C and D category). For the purposes of signing up for the adult secondary education program for the profession of a police officer, three tendering procedures has been carried out and according to conditions of the tender, 4238 applicants have been medically examined for the education for carrying out activities as a police officer.

46 police officers took the emergency supervision health checks at the proposal of a direct manager and/or chosen physician.

All police officers from 9 police administrations took the systematic supervision health checks in compliance with the measure categories of the police officers health status (A, B, C and D category).

For the purpose of preventive protections from infectious diseases, season vaccinations have been performed systematically (against the flu) and other infectious diseases like Hepatitis B. With the mentioned vaccinations all organisational units in the stationary accommodation are included, including police officers that are in contact with potentially infected persons. For the monitored period that number amounts to about 2500 police officers on average.

Also, it is important to mention that in the monitored period police officers were regularly educated about procedures of self-defence as well as to be of assistance to others in the framework of educational programmes of emergency aid and protection from infectious diseases, as part of regular education, as well as in specialist classes and annual plans of professional training in organisational units.
Furthermore, as one of the measures for the preservation of the police officers mental health, the Ministry systematically performs psychoeducative activities within index of stress, traumas, methods of confrontation and self-help, harmfulness of alcohol abuse and other forms of psychological aid through the counselling (individual and group). Also, a specific form of psychological aid is offered to police officers and other employees of the Ministries – psychological crisis interventions performed in situations indirect or direct participation in a

traumatic occurrence or other high stressful and emergency situation. About 120 police officers and other employees were included with such forms of work in the previous period.

Strict measures that prohibit smoking have been carried out in the Ministry of the Interior which all employees including police officers must follow. A systematical information about the harmfulness of tobacco products has been performed as part of implemented measures.

The right to health care of the employees and members of the armed forces of the Ministry of Defence of the Republic of Croatia is regulated by applicable civil and military legislation from the field of health care based on which the Ordinance on the procedure and authorities of in the process exercising the right on health care and rights to health insurance of the members of the armed forces was brought (Official Gazette, number 98/11). In the mentioned Regulation it is prescribed that the rights of the members of the armed forces of the Republic of Croatia from the compulsory health insurance fulfilled pursuant to the rules that regulate the system of obligatory health insurance in the Republic of Croatia, as well as the supplementary health insurance pursuant to the rules that the system of voluntary health insurance developed in the Republic of Croatia. Therefore, obligatorily and supplementary health insurance of the members of armed forces of the Republic of Croatia is performed by the Croatian Institute for health insurance (HZZO) and the data about the members of armed forces of the Republic of Croatia were presented in the total number and structure of insured persons which shall be submitted to the HZZO.

Health care for the members of the armed forces of the Republic of Croatia is ensured with the health capacities of the Armed forces on a primary level, which includes services of: general medicine, dental health care, hygienic-epidemiological health care and occupational medicines, and that on the secondary level, which includes: specialist-consultation health care and the service provision of hyperbaric oxygen therapy.
Health care on the primary, secondary and tertiary level and the level of health institutes that has not been ensured by the capacities of the Croatian Armed Forces to the members of the armed forces is ensured within the network of the public health service in the Republic of Croatia.

Health care of member of armed forces of Republic of Croatia is performed through the system of health aid as a part of a comprehensive aid system of the Croatian Armed Forces, and is provided in stationary and field conditions.

In stationary conditions health aid includes activities from the field of health care for the purpose of maintaining everyday life and work in military facilities in the area of the Republic of Croatia.
In field conditions health aid includes activities from the field of health care throughout performing tasks of the Croatian Armed Forces within and outside the area of the Republic of Croatia.
Organisational units of the Ministry of Defence and the Croatian Armed Forces competent for the activities of the health care system plan, organise, perform and monitor the implementation of measures of health care and perform activities from the field of health activities:

- monitoring the health status of the members of the armed forces of the Republic of Croatia and proposing the security measures and the advancement of their health;

- prevention, discovering and treatment of the disease;
- counselling, health education and the promotion of health for the purpose of its preservation and advancement;
- prevention, discovery and treatment of teeth and mouth diseases with rehabilitation;
- monitoring and the improvement of mental health;
- the epidemiological monitoring, prevention and suppression of the infectious and chronic mass diseases including addiction diseases;
- supply of medications and medical products;
- providing first medical aid, emergency responses and transport;
- health-statistical and other socially-medical activity;
- the health ecology;
- health care in field conditions;
- health care in peacekeeping operation, missions and other activities in foreign countries;
- health care in case of the appearance of an accidental situation in the territory of the Republic of Croatia;
- occupational medicine (preventive examinations);
- specialist-consilium health care;
- scientific research activity.

Health care of the members of the armed forces of the Republic of Croatia is performed by health care professionals:

Table 54 The number of health service providers in the Ministry of Defence and the Croatian Armed Forces in 2011

Medical doctors	**72**
Specialists	35
Doctors of dental medicine	23
Nurses – junior college education	**6**
Nurses – high school education	**140**

Source of data: Statement of the Ministry of Defence

Provision of health care for employees of the Croatian Armed Forces at the level of primary and secondary health care relies on partially on the civil health system so that the data e.g. about inoculations against infectious diseases of employees of the Croatian Armed Forces or the morbidity from infectious diseases will be presented in the complete report of the Public Health Institute in the Republic Of Croatia.

Based on the Ordinance on the medical fitness examination for military service (Official Gazette, No. 127/10, 29/12, 31/12 and 45/12) during 2011 a total of 7175 examinations of the members of armed forces of the Republic of Croatia has been performed in Military health center institutes.

4982 preventive examinations have been performed in the Institute of Aviation Medicine, specifically:

- 327 examinations for admission
- 168 examinations for education

- 1532 periodic examinations of active military personnel
- 1560 examines for the assignment to peacekeeping mission and operations
- 366 examinations of voluntary conscripts
- 754 examinations of military aircraft personnel
- 275 examinations of civil aircraft personnel.

2193 examinations have been performed in the Institute of Naval Medicine, specifically:

- 134 examinations for admission
- 15 examinations for education
- 695 periodic examinations of active military personnel
- 344 examinations with special working conditions
- 690 examinations for peacekeeping missions and operations
- 315 examinations of voluntary conscripts.

Operation of hospitals

Capacities and operations of hospitals in Croatia in 2008

In 2008 there were 77 hospital institutions and sanatoria in the Republic of Croatia. Of these, three were clinical hospital centres, 11 clinical hospital and clinics, 23 general hospitals and 26 special hospitals reporting on patient beds and 7 not reporting patient beds,1 health resort that reports patient beds and 6 not reporting patient beds. In addition, 10 general in-patient units and 6 maternity units outside hospitals operated in smaller towns.

The capacity filled in 2008 was 83.21% on an annual basis (87.67% in 1990). Clinics and clinical hospital had the fullest use of capacities (87.97 %), while specialist hospitals had the lowest rate (79.92%).

The turnover rate (the average number of days beds stand empty between patients) in general hospitals, in-patient units and maternity units outside hospitals was 1.56 in 2008, in clinical hospital centres, clinical hospitals and clinics 1.06, and in specialist hospitals 7.08 days.

Capacities and operations of hospitals in Croatia in 2009

In 2009 there were 77 hospital institutions and sanatoria in the Republic of Croatia. Of these, four were clinical hospital centres, 10 clinical hospital and clinics, 23 general hospitals and 26 special hospitals reporting on patient beds and 7 not reporting patient beds, 1 health resort that reports patient beds and 6 not reporting patient beds. In addition, 10 general in-patient units and 5 maternity units outside hospitals operated in smaller towns.

The capacity filled in 2009 was 82.43% on an annual basis (87.67% in 1990). Clinics and clinical hospital had the fullest use of capacities (88.55%), while specialist hospitals had the lowest rate (76.99%).

The turnover rate (the average number of days beds stand empty between patients) in general hospitals, in-patient units and maternity units outside hospitals was 2.00 in 2009, in clinical hospital centres, clinical hospitals and clinics 1.03, and in specialist hospitals 6.58 days.

Capacities and operation of hospitals in Croatia in 2010

The Croatian National Institute of Public Health started to implement the amended and modified Annual Report on the Work of Stationary Medical Institution in 2010. Every medical institutions, regardless of the type of ownership and regardless of the contract with HZZO, filled out the report. Data on the type of treatment (the treatment of acute patients and the treatment of subacute and chronic patients) that is performed according to the speciality where the treatment is carried out, and not according to the institution as it was the case up to 2010. The list and classification of specialities on acute and chronic is carried out in accordance with the HZZO code book, the Network of public health service and the Ordinance on the conditions for sorting out hospital medical institutions into categories.

In 2010 there were 69 hospital institutions and sanatoria in the Republic of Croatia. Of that, four were clinical hospital centres, 6 clinical hospital and clinics, 22 general hospitals, 26 special hospital and health resorts, 10 general in-patient units and 1 maternity units.

The capacity filled in 2010 was 77.24% on an annual basis (87.67% in 1990). Clinics and clinical hospital had the fullest use of capacities (79.50 %), specialist hospitals had the lowest rate (75.23 %), and for clinical centres, clinical hospitals and clinics it was 76.81%.

The turnover rate (the average number of days beds stand empty between patients) in general hospitals, in-patient units and maternity units outside hospitals was 2.23 in 2010, in clinical hospital centres, clinical hospitals and clinics 2.26, and in specialist hospitals 6.58 days.

Capacities and operations of hospitals in Croatia in 2011

In 2011 there were 70 hospital institutions and sanatoria in the Republic of Croatia. Of that, four were clinical hospital centres, 7 clinical hospitals and clinics, 22 general hospitals and 26 special hospitals and health resorts, 10 general in-patient units and 1 maternity units.

During 2011 the largest total annual utilization was that of clinical hospitals and clinics - 79.37%, then general hospitals, infirmaries and out-patient maternity hospitals - 72.76%, and finally that of teaching hospital centers, special hospitals and health resorts 70.26% .

The turnover rate (the average number of days beds stand empty between patients) in general hospitals, in-patient units and maternity units outside hospitals was 2.49, in clinical hospital centres, clinical hospitals and clinics 1.90 , and in specialist hospitals 11.15 days .

Total number of hospital beds in 2008

The total number of hospital beds in Croatia in 2008 was 5.47 per 1,000 population. The number of beds in the EU, after the accession of new members in 2004 was 5.91 per 1,000 population. Before these accessions, it was 5.84 per 1,000 population (2003), and the number of beds in new EU member states was 6.50 per 1,000 population (2004) (European HFA Database).

The number of hospital beds in Croatia decreased in the period 1990 - 2000 by about 24% (from a total of 35.251 in 1990 to 26.955 in 2000). This trend continued in 2001, so that there were 337 fewer beds in that year. A further reduction in the number of beds was recorded in 2008, when there were 70 fewer beds than in 2007.

The number of beds in all in-patient units per 1,000 population decreased from 7.4 in 1990 to

6.15 in 2001, and to 5.47 in 2008.

Total number of hospital beds in 2009

The total number of hospital beds in Croatia in 2009 was 5.40 per 1,000 population. The number of beds in the EU, after the accession of new members in 2004 was 5.91 per 1,000 population. Before accession, it was 5.84 per 1,000 population (2003) and the number of beds in new EU member states was 6.50 per 1,000 population (2004) (European HFA Database).

The number of hospital beds in Croatia decreased in the period 1990 - 2000 by about 24% (from a total of 35.251 in 1990 to 26.955 in 2000). This trend continued in 2001, so that there were 337 fewer beds in that year.

A further reduction in the number of beds was recorded in 2008, when there were 70 fewer beds than in 2007. In 2009 the number of beds was fewer for 315 in comparison to 2008.

The number of beds in all in-patient units per 1,000 population decreased from 7.4 in 1990 to 6.15 in 2001, and to 5.47 in 2008, and in 2009 it was 5.40.

Total number of hospital beds in 2010

The total number of hospital beds in Croatia in 2010 was 5.66 per 1,000 population. The number of beds in the EU, after the accession of new members in 2004 was 5.91 per 1,000 population. Before accession, it was 5.84 per 1,000 population (2003) and the number of beds in new EU member states was 6.50 per 1,000 population (2004) (European HFA Database).

The number of hospital beds in Croatia decreased in the period 1990 - 2000 by about 24% (from a total of 35.251 in 1990 to 26.955 in 2000). This trend continued in 2001, so that there were 337 fewer beds in that year.

A further reduction in the number of beds was recorded in 2008, when there were 70 fewer beds than in 2007. In 2009 the number of beds was fewer for 315 in comparison to 2008.

In 2010 an increase of the number of beds was recorded by 1050 in relation to 2009 (commencement of the implementation of the amended Annual Work Report of Stationary Medical Institution).

The number of beds in all in-patient units per 1,000 population decreased from 7.4 in 1990 to 6.15 in 2001, and to 5.47 in 2008, and in 2009 it was 5.40, and increased to 5.66 in 2010.

Total number of hospital beds in 2011

The number of beds in all in-patient units per 1,000 population in 2011 was 5.98. The number of beds in the EU, after the accession of new members in 2004 was 5.32 in 2009 per 1,000 population.

Acute beds in 2008

According to the type of beds per 1,000 population available in 2008, 3.63 were for acute cases (1.72 in general hospitals and 1.92 in clinics). The EU rate after the accession of new members in 2004 was 4.15 per 1,000 population. Before the accession of these members it was 4.00 beds per 1,000 population (2003) and the rate in new member countries was 5.15 beds per 1,000 population (2004) European HFA Database). The total reduction in hospital

beds in the period 1990-2000 shows that 37.6% took place in general hospitals and about 7.9% in clinics and clinical hospitals.
The trend continued in 2001, so that there were 115 fewer beds in comparison to 2000 in general hospitals and 77 fewer beds in clinics and clinical hospitals.

In 2008 a small increase of acute beds was recorded, so the total number of beds increased by 35 in comparison to 2007, in general hospitals the number increased by 84 beds, in clinics and clinical hospitals lesser by 49.

Acute beds in 2009

According to the type of beds per 1,000 population available in 2009, 3.60 were for acute cases (1.70 in general hospitals and 1.90 in clinics). The EU rate after the accession of new members in 2004 was 4.15 per 1,000 population. Before the accession of these members it was 4.00 beds per 1,000 population (2003) and the rate in new member countries was 5.15 beds per 1,000 population (2004) European HFA Database).The total reduction in hospital beds in the period 1990-2000 shows that 37.6% took place in general hospitals and about 7.9% in clinics and clinical hospitals.

The trend continued in 2001, so that there were 115 fewer beds in comparison to 2000 in general hospitals and 77 fewer beds in clinics and clinical hospitals.
In 2008 a small increase of acute beds was recorded, so there was 35 beds more in comparison to 2007, when there were 84 beds more in general hospitals, and 49 beds less in clinics and clinical hospitals.

In 2009 there were 89 beds less than in 2008, that is, 89.57 beds less in general hospitals, and 32 beds less in clinics and clinical hospitals.

Acute beds in 2010

According to the type of beds per 1,000 population available in 2010, 4.05 were for acute cases. The EU rate after the accession of new members in 2004 was 4.15 per 1,000 population. Before the accession of these members it was 4.00 beds per 1,000 population (2003) and the rate in new member countries was 5.15 beds per 1,000 population (2004) European HFA Database).
The total reduction in hospital beds in the period 1990 - 2000 shows that 37.6% took place in general hospitals and 7.9% in clinics and clinical hospitals.
The trend continued in 2001, so that there were 115 beds less in comparison to 2000 in general hospitals and 77 beds less in clinics and clinical hospitals.

In 2008 a small increase of acute beds was recorded, so there was 35 beds more in comparison to 2007, when there were 84 beds more in general hospitals, and 49 beds less in clinics and clinical hospitals.

In 2009 there were 89 beds less than in 2008 89, 57 fewer beds in general hospitals, and 32 fewer beds in clinics and clinical hospitals, in comparison to 2008.

From 2010 the amended Annual Work Report of Stationary Medical Institution started to apply, acute beds are noted according to the speciality where that treatment carried out, and not according to the institution as was the case in 2010. The list of specialities is carried out in accordance with the HZZO code book, the Network of public health service and the

Ordinance on the conditions for sorting out hospital medical institutions into categories.

The total number of acute beds in 2010 was 17 877, with 6936 in general hospitals, infirmaries and out-patient maternity hospitals, 9649 in clinical centres, clinical hospitals and clinics, and 1292 in special hospitals and health resorts .

Acute beds in 2011

According to the type of beds per 1,000 population available in 2011, 4.07 were for acute cases (4.05 in 2010), 1.65 (1.60 in 2010) were for general hospitals and 2.23 (2.22 in 2010) for clinical centers, clinical hospitals and clinics.
The total number of acute beds in 2009 after the accession of new members to the EU in 2004 was 3.57 per 1,000 population in 2009.

Chronic beds in 2008

In 2008 there were 1.84 beds per 1,000 population available for the treatment of chronic illnesses. The percentage reduction in the total number of chronic beds available in Croatia between 1990 and 2000 was 21.1%.
The trend continued in 2001, so that there were 145 available beds less in specialist hospitals in that year, compared to 2000.
A further reduction in the number of beds was recorded in 2008, when there were 105 beds less in specialist hospitals in comparison to 2007.

Chronic beds in 2009

In 2009 there were 1.80 beds per 1,000 population available for the treatment of chronic illnesses. The percentage reduction in the total number of chronic beds available in Croatia between 1990 and 2000 was 21.1%.
The trend continued in 2001, so that there were 145 available beds less in specialist hospitals in that year, compared to 2000.
A further reduction in the number of beds was recorded in 2008, when there were 105 beds less in specialist hospitals in comparison to 2007, and in 2009 there were 226 beds less.

Chronic beds in 2010

In 2010 there were 1.62 beds per 1,000 population available for the treatment of chronic illnesses. The percentage reduction in the total number of chronic beds available in Croatia between 1990 and 2000 was 21.1%.
The trend continued in 2001, so that there were 145 available beds less in specialist hospitals in that year, compared to 2000.
A further reduction in the number of beds was recorded in 2008, when there were 105 beds less in specialist hospitals in comparison to 2007, and in 2009 there were 226 beds less.

Since the beginning of the impementation of amendments to the Annual Work Report of Stationary Medical Institution in 2010, chronic beds are recorded according to the specialty within which the treatment is carried out, and not according to the institution, as was the case in 2010. The list of specialities is prepared in accordance with the HZZO code book, the Network of Public Health Services and the Ordinance on the conditions for the categorisation of hospital medical institutions.

The total number of chronic beds in 2010 was 7140, 113 in general hospitals, infirmaries and out-patient maternity hospitals, 140 in clinical centres, clinical hospitals and clinics, and 6887 in special hospitals and health resorts.

Subacute and chronic beds in 2011

In 2011 there were 1.92 beds per 1,000 population available for the treatment of chronic illnesses (1,62 in 2010). The total number of chronic beds in 2011 was 8212, 113 in general hospitals, infirmaries and out-patient maternity hospitals, 140 in clinical centres, clinical hospitals and clinics and 7959 in special hospitals and health resorts.

Table 40. Hospital operations indicators, Croatia 2008

	Total	*Total acute patients*	*GHs, IPUs MHs*	*CHCs, CHs & clinics*	*Chronic patients*
CROATIA					
1. Number of beds	24282	16088	7616	8472	8194
2. **Number of beds per 1,000 population**	5.47	3.63	1.72	1.91	1.84
3. Number of doctors	5132	4696	1945	2751	436
4. No. of beds per doctor	4.7	3.4	3.9	3.1	18.8
4. No. of discharged patients	768400	683622	331499	352123	84778
5. No. of days of hospital treatment	7374576	4984483	2264157	2720326	2390093
6. Average length of treatment	9.60	7.29	6.83	7.73	28.19
7. Annual occupancy of beds	304	310	297	321	292
8. % usage of beds	83.21	84.88	81.45	87.97	79.92
9. No. of patients per bed	31.64	42.49	43.53	41.56	10.35
10. Turnover rate	1.94	1.30	1.56	1.06	7.08

Source of data: Croatian National Institute of Public Health, Croatian Health-Statistical Yearbook for 2008

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Table 41. Hospital operations indicators, Croatia 2009

	Total	*Total acute patients*	*GHs, IPUs, MHs*	*CHCs, CHs and clinics*	*Chronic patients*
CROATIA					
1. Number of beds	23967	15999	75559	8440	7968
2. Number of beds per 1,000 population	**5.40**	**3.60**	**1.70**	**1.90**	**1.80**
3. Number of doctors	5205	4778	1960	2818	427
4. No. of beds per doctor	4.6	3.3	3.9	3.0	18.7
5. No. of discharged patients	743052	659665	317339	342326	83387
6. No. of days of hospital treatment	7210881	4851841	2124053	2727788	2359040
7. Average length of treatment	9.70	7.36	6.69	7.97	28.29
8. Annual occupancy of beds	301	303	281	323	296
9. % usage of beds	82.43	83.08	76.99	88.55	81.11
10. No. of patients per bed	31.00	41.23	41.98	40.56	10.47
Turnover rate	2.07	1.50	2.00	1.03	6.58

Source of data: Croatian National Institute of Public Health, Croatian Health-Statistical Yearbook for 2009

Table 42 Hospital operations indicators, Croatia 2010

		Total	Acute patient treatment	Subacute and chronic patient treatment	General hosp. infirmaries, and outpatient maternity wards	Clin. teach. hosp., clin. hospitals and clinics	Special hospitals and natural spas
		1 (2+3) (4+5+6)	2	3	4	5	6
HRVATSKA - Croatia							
1.	No. of beds	25.017	17.877	7.140	7.049	9.789	8.179
2.	No. of beds per 1,000 pop.	5.66	4.05	1.62	1.60	2.22	1.85
3.	No. of doctors	5,582	5.185	397	2.035	3.050	497
4.	No. of beds per doctor	4.48	3.45	17.98	3.46	3.21	16.46
5.	No. of patients discharged	745.692	679.283	66.409	285.630	367.118	92.944
6.	No. of bed days	7.053.292	4.906.170	2.147.122	1.935.595	2.744.313	2.373.384
7.	Average length of treatment	9.46	7.22	32.33	6.78	7.48	25.54
8.	Annual bed occupancy	282	274	301	275	280	290
9.	Bed utilization (%)	77.24	75.19	82.39	75.23	76.81	79.50
10.	No. of patients per bed	29.81	38.00	9.30	40.52	37.50	11.36
11.	Turnover interval	2.79	2.38	6.91	2.23	2.26	6,58

Source of data: Croatian National Institute of Public Health, Croatian Health-Statistical Yearbook for 2010

Table 58. Hospital operations indicators, Croatia 2011

	Total	Acute patient treatment	Subacute and chronic patient treatment	General hosp. infirmaries, and outpatient maternity wards	Clin. teach. hosp., clin. hospitals and clinics	Special hospitals and natural spas
	1 (2+3) (4+5+6)	2	3	4	5	6
CROATIA						
1. *No. of beds*	25.671	17.459	8.212	7.094	9.589	8.988
2. *No. of beds per ,1000 pop*	5.98	4.07	1.91	1.65	2.23	2.09
3. *No. of doctors*	5.758	5.415	343	2.059	3.163	536
4. *No. of beds per doctor*	4.46	3.22	23.94	3.45	3.03	16.77
5. *No. of patients discharged*	749.747	681.748	67.999	282.970	379.244	87.533
6. *No. of bed days*	6.966.783	4.885.332	2.081.451	1.883.936	2.777.941	2.304.906
7. *Average length of treatment*	9.29	7.17	30.61	6.66	7.32	26.33
8. *Annual bed occupancy*	271	280	253	266	290	256
9. *Bed utilization (%)*	74.35	76.66	69.44	72.76	79.37	70.26
10. *No. of patients per bed*	29.21	39.05	8.28	39.89	39.55	9.74
11. *Turnover interval*	3.21	2.18	13.47	2.49	1.90	11.15

2.2. Paragraph 2. - CONSULTATIVE AND EDUCATIONAL INSTITUTIONS

Consultative work

Consultative work takes place in a mandatory separate and made known time for consultations in the duration of at least 3 hour each week, for the purpose of helping and solving the basic problems with which children, adolescents, their parents, guardians and teachers encounter: adjustment to school, school failure, behaviour disorders, development issues and maturations, chronic disturbances of health, family planning, abuses of psychoactive drugs and other forms of dependences, problems of mental health etc.

Consultation for the purpose of preservations and advancements of health and a healthier way of living
Working with pupils and students in solving most common health and psychosocial problems and focussing towards the acceptance of healthier habits and attitudes.

Consultations with professors and skilled specialists of the school
Carried out as part of every systematic and other preventive examination for the purpose of observing and health monitoring all students.

Working with parents
Consultative work with parents for the purpose of solvings current problems regarding school, behaviour and maturation and relationships in the family.

Consultation about the preservation and advancement of reproductive health
Consultative work with young people and students about relationships among genders, acquisition of responsible sex behaviour and the use of contraception.

Consultation about the preservation and advancement of mental health
Consultative work with young people and students about the most common problems of mental health (the stress, depression, anxiety, self-confidence, self-esteem and other).

Active care of children, young people and students with chronic disturbances of health
The monitoring of pupils and students that suffers from chronic disturbances of health in relation to the medical condition and abilities and necessary measures of health care in the upbringing and getting an education as well as the performance monitoring of mastering the education programme.

Taking care of children, young people and students with health risks
Detection and identification of children and young people with health risks and behaviour disturbances (excessive bodyweight, inclination to addictive behaviour - consummation of alcohol, experimenting with psychoactive drugs, inclination to promiscuous behaviour, escaping from home, avoiding class, juvenile delinquency and other).. The individual consultative and health-educational work, cooperation with administrative and technical school services, with the families of the children, adolescents or students and the Centres for Social Work.

Taking care of students with disability in psychological or physical development
The registrations and records of student that are grouped by professional commissions of the health care and education system or welfare because of their handicap in psychological or physical development. For all children integrated into regular schools or the attendants of special schools constant cooperations with administrative and technical services of school is necessary for the purpose of monitoring their health status and abilities and success of mastering the planned educational programme.

Counselling centres for children and young people in which children, parents and professors can request the help for the solving of most common problems concerning growing up and the health of children, have been organised as a special form of work and the number of visits to the counselling centre constantly increases. Specific parts of the programme of preventive student health care, specifically health education and consultative work are given special attention. Counselling centres for children and young people in which children, parents and professors can request the help by the solving of most common problems concerning growing

up and the health of children, have been organised as a special form of labour and the number of visits to the counselling centre is constantly increasing. In primary school visits to the counselling centre have increased from 59,647 in 1998, up to 132,077 in the 2004/2005 school year, 127,124 in the previous year and somewhat fewer in the 2011/2012 school year (118,409). In secondary school visits to the counselling centre have moved from 18,196 up to 38,516 in the 2011/2012 school year. The indicated shows that precisely such a form of work is required and that it was lacking in the system. In the counselling centres for children and young people under the Departments for School Medicine, children in the primary school and their parents mostly asked for help because of the problems caused by chronic diseases (48%), learning problems (23%), problems of mental health (14%), risky behaviour (8%) and problems of reproductive health (7%). At high-school students besides chronic diseases (43%), problems and requirements for advice because of reproductive health and sexually transmitted infections (22%), learning problems (12%), mental health (12%) and risky behaviour (11%) are more often represented.

Besides the regular activities of counselling centres, from 2000 the founding of specific counselling centres for the reproductive health of adolescents the as part of service of school medicine is being supported (activities indicated in the strategic documents such as the National program for youth-related activities. In the town of Zagreb, the City Office for Work, Health Care, Social Welfare and War Veterans supports the Counselling Centre for Reproductive Health within the Institute for Public Health in Zagreb, the Department for School Medicine. The City of Rijeka supports the "Open Youth Centre" in the Institute for Public Health of the Primorsko-Goranska County, Department for School Medicine, whereas in the town of Split, several specific counselling centres were organised as part of the Institute for Public Health and currently operate on a voluntary basis.

In the regular plan and programme of primary and secondary schools, health education contents exist in the subjects of Science, Biology and Physical Education. According to their annual programme, school medicine services carry out part of their activities as activities of health education, complementary with the existing curriculum.

Health education and the promotion of health

According to the annual work programme, health education and the promotion the health is performed as a separate activity and/or integrated with general medical examinations and vaccinations.

Activities of health education with students

Primary school I-IV form
Personal hygiene in the preservation of health
Importance of proper nutrition and its impact on growth and development
Socially unacceptably and violent behaviour and ill-treatment
Primary school V-VI form
Psychological and somatic changes in puberty, menstruations
Dependences (smoking, alcohol and psychoactive drugs)
Primary school VII-VIII form
Protection from HIV/AIDS and other sexually transmitted diseases
Healthy maturation and growing up
Secondary school I-III form
Family planning, abortion, methods of contraception, marriage, family, children
Responsible sexual behaviour, sexually transmitted infections

Self-defence and caring for your own health
Students
Individual and teamwork in accordance with requirements and indications
Methods of health-educational work:
Health education is, in general, carried out at school, and methods are lectures, debate, workshop, interview, working in small groups, public discussions, education of peers, participation in media programmes.

Enquiry of the Committee

- *The Comittee has requested that general data about the implementation of the National textbook standard be submitted with the following report, and especially about how thoroughly they have been revised and what was undertaken to ensure biased and discriminating statements do not appear in other educational materials. The Comittee also requests detailed information about the educational reform on sexual and reproductive health, which has been started in the last several year (pursuant to the reply of the Government to the complaints).*

1) National Textbook Standard

All textbooks and corresponding additional teaching tools that are used in primary and secondary schools have positive expert opinion given by expert committees about the compatibility with the national and concerned curriculum and the Textbook Standard.

According to art. 4 Paragraph 2 of the Act on Textbooks for Primary and Secondary School (Official Gazette, No. 27/10 and 55/11), textbooks, additional and auxiliary teaching tools with its contents not may be contrary to the Constitution of the Republic of Croatia and proclaimed principles of democratic order that especially refers to the protection of the human rights of minorities, fundamental freedoms and rights of man and citizen as well as gender equality.

The textbook standard Official Gazette, No. 07/07) regulates ethical requirements as well. Positive expert opinion is given only to textbooks and corresponding additional teaching tools that have been fully harmonised with them. The ethical requirements of the Textbook Standard are based on truth, confidentiality and objectivity of the textbook contents, ordinary laws of man, principles of democracy, rules of law and on patriotism. Hence the textbook:

1. points to ethical issues, accomplishments and consequences of a scientific and technological development;
2. supports, fosters and promotes the principles of sustainable development;
3. preserves the Croatian national identity;
4. reflects the richness of diversities of the Croatian society, enables knowledge a acquisition on equalities of individuals and social groups and promotes the right to diversity;
5. supports gender equality in an appropriate method by using both gender nouns, especially in the mention of titles and interests, not impairing, at the same time, the communication level and the simplicity of the Croatian language, as well as preparing both genders for active and equal participation in all areas;

6. objectively and authentically presents cultures, religions and civilizations and ethnic and religious groups;
7. promotes the familiarisation and appreciation of ethnic minority values in the Republic of Croatia and other nations in Europe and the world.

The preparation of a new Textbook Standard has started, and its draft includes the following provisions:

- textbooks shall be oriented towards promoting core values which results from the commitment of Croatias education policy for the comprehensive personal development of students, for the preservation and development of the national, spiritual and material natural heritages of the Republic of Croatia and for the European coexistence;

- ethical requirements shall be based, apart from on human rights, on children's rights as well;
- textbooks shall support gender equality in an appropriate manner using it in an equal ratio by illustrating characters of both sexes.

All textbooks are harmonised with the mentioned requirements, regardless of them expressing those requirements directly in them (social and humanistic subjects) or indirectly (natural science, technical and other subjects).

Besides textbooks and additional teaching tools, auxiliary teaching tools can be used in schools and based on the approval of Education and Teacher Training Agency and the Agency for Vocational Education and Training and Adult Education. Article 4 Paragraph 2 of the Act on textbooks is also applied to them.

2) Educational reform on sexual and reproductive education

The Education and Teacher Training Agency has established a Commission for the preparation of the curriculum of health education that has 14 members as follows:
- consultants of the Agency constitute 9 member seats;
- outside experts constitute 5 member seats.

4 subject units/modules of the curriculums of health education have been proposed, specifically:

- to live healthy;
- sex/gender equality and responsible sexual behaviour;
- preventions of dependences;
- prevention of violent behaviour.

Implementation includes:

- elaboration of teaching units;
- preparation of the plan for professional training of teacher/educator for which the designated competent authority will be the Education and Teacher Training Agency with its external associates;

- the making of a curriculum of health education (Ministry Of Science, education and sport);
- implementations of the curriculum in schools.

Health education for students

314,342 students of primary and 77,204 students of secondary schools have been included in some form of health education in the school year 2004/2005, 305,236 students of primary and 89.498 students of secondary schools were included in 2005/2006, 257,222 students of primary and 77,407 students of secondary schools were included in 2010/2011 school year, and 225,667 students of primary and 67,788 students of secondary schools were included in the school year 2011/2012. The total of 18,414 students in 2010/2011 have also been included into health education (20,189 students in 2009/2010, 16,059 students in 2008/2009, 14,888 students in 2005/2006), specifically lectures, public discussions or some form of teamwork.

Health education for parents

Participation in parental meetings. Participation of a physician at parental meetings in the 1st, 4th or 5th and 8th form of primary school nad in the 1st form of secondary school, as well as in connection with problems of maturation and vocation choice, is obligatory.

Health education for school workers

Work on the professional training of educators for the purpose of improving the solving of specific health issues. Obligatory Participation in the Teacher's Council is obligatory once a year. Apart from that, 75,431 parents and professors in primary and 10,122 in secondary schools have participated in lectures, public discussions or workshops regarding health.
In school year 2011/2012, 48,482 parents and professors in primary and 4.789 in secondary school participated in lectures, public discussions or workshops regarding health (58,205 in primary and 4,310 in secondary schools in the previous year).

Enquiry of the Committee

- The Committee requested detailed information on trends in drug use as part of the next report.

According to the results of the European-based research of the European School Survey Project on Alcohol and Other Drugs (ESPAD) for 2011 (data for 2007 enclosed) Croatia is not an exception, with regard to smoking and drug use among young people of 15 - 16 years of age, from other European countries involved in the research, while with regard to drinking habits,it was among the countries with the highest prevalence.
The usage of cannabis is in the European average (18% (18%) of the examinees have tried cannabis in their life in Croatia, 17% (19%) on average in all countries) while the use of other drugs is much shorter than in other countries (5% (4%) would try any drug apart from cannabis in their life in Croatia, 6% (7%) in other countries).
According to the previous period (ESPAD research was conducted in 1995, 1999, 2003 and

2007), in 2011 smoking frequency increased among pupils. The proportion of students who smoked on a daily basis (at least one cigarette a day in the last 30 days) increased, from 26% of boys in 1995 to 29% in 2007 and 31% in 2011, while the percentage of girls increased from 19% in 1995 to 26% in 2007 and 27% in 2011. Heavy episodic drinking (having 6 or more drinks in a month) is also increasing. In 1995, 13% of boys and 4% of girls in the first grade of secondary school had 6 or more drinks on one occasion during the same period, while in 2007 the number of boys was three times higher (39%) and the number of girls was four times higher (16) and in 2012, 30% of boys and 18% of girls has 6 or more drinks. In the period from 1995 to 2011 a sharp rise, and than stagnation and even reduction of marijuana use was registered. In 1995, 12% of boys and 5% of girls experimented with marijuana. The percentage of boys doubled (24%) and the percentage of girls tripled (17%). In 2007, the number of students experimenting with marijuana decreased in relation to data from 2003 and 20% of boys and 15% of girls experimented with marijuana and in 2011 the percentage for boys was 18% and for girls 17%..

With regards to experimenting itself, it is evident that there is no large oscillations in age groups through the year. Boys experiment slightly earlier than girls and the prevalences of experimenting among boys is somewhat higher from 11 and 13 years of age. By the age of fifteenth the difference between genders is lost and an equal share of girls and boys have smoked cigarettes.
According to the results of the Health Behaviour in School-aged Children from 2010, risky behaviour in Croatian children and adolescents points to the stagnation of spreads of experimentings with cigarettes and alcohol as well as the reduction of experimenting with marijuana. 21% of boys and 19% of girls smoke every day at the age of 15, and at the same age 30% of boys and 9% of girls drinks beer at least once a week. 16% of boys and 11% of girls took marijuana at least once at the age of 15.

Special measures that are taken for the health-care of addicted persons

Monitoring system of dependency problems as a separate medical-social phenomenon was founded in the Croatian Institute for public health in the early eighties. From total data on morbidity and mortality on the national level, the data on persons treated because of the misuse of psychoactive drugs have been separated and the Croatian Registry of Treated Psychoactive Drug Abusers has been gradually built, that is maintained by the Service for school and adolescent medicine and prevention of dependence of the Croatian Institute for public health. System of treatment is based according to the applicable National strategy of prevention of drug abuse in the network of out-patient and hospital treatment. Spread of experimenting in adolescent population, characteristics and progress of risky behaviour are monitored by participating in international research (ESPAD and HBSC) that is co-ordinated by the Croatian Institute for public health.

Table 59.

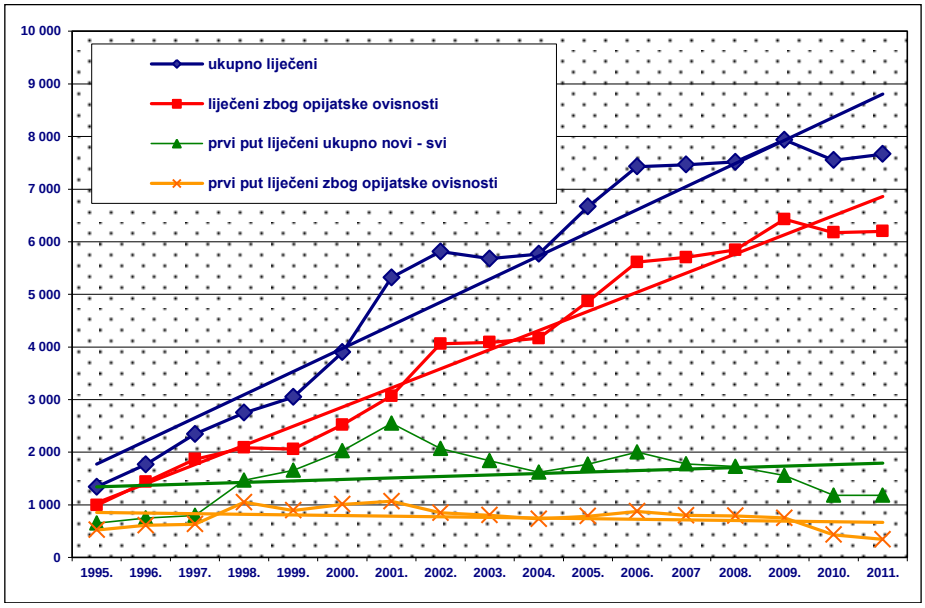
Year	Number of treated persons	Treated because of opiates	Number of persons treated for the first time	Proportion (%) of the ones treated for the first time	Opiates treated for the first time	Proportion (%) of opiates treated for the first time from all new
2008	7.506	5.846	1.700	22,7	769	45,2
2009	7.733	6.251	1.463	18,9	667	45,6
2010	7.550	6.175	1.161	15,6	430	36,4
2011	7.665	6.198	1.151	15,0	343	29,8

Source of data: Documentation for the preparation of the seventh report on implementation of European Social Charter, Croatian National Institute Of Public Health, December 2012.

During 2010 7.550 persons were under treatment, of which 1.161 persons were under treatment for the first time (15,6%). As compared to 2009 the total number of recovering drug addicts is smaller for 2,4%. During 2010 6.175 the persons were under treatment due to the misuse and/or dependences on opiates, of which 430 were under treatment for the first time (7,0%). For the first time since the beginning of treated consumers and addicted persons monitoring, the number of the new opiate addicts is so small. The number of new heroin addicts has persisted on around 500 persons for several years now.

During 2011, 7.665 persons have been registered in medical institutions of the Republic of Croatia, treated for the dependence on psychoactive drugs, of which 1.151 persons were under treatment for the first time (15,0%). As compared to 2010 the total number of recovering drug addicts is larger for 1,5%. Because of the misuse of opiates 6.198 persons were under treatment during 2011, of which 343 were treated for the first time (5,5%). For the first time since the beginning of treated consumers and addicted persons monitoring, the number of the new opiate addicts is so small And the total amongst new complaints for treatment is a smaller portion of opiates (29,8%), while the non-opiate addicts amount to 70,2%. With monitoring in the Register it is obvious that the impact of the prevention system and the out-patient treatment of addicts succeeds in keeping addicted persons in the treatment.

Chart 11.



Source of data: Documentation for the preparation of the seventh report on implementation of European Social Charter, Croatian National Institute Of Public Health, December 2012.

Table 60.

Year of treatment	Average age		
	Men	Women	General
2005.	28,4	28,1	28,3
2006.	29,0	28,7	28,9
2007.	29,8	29,2	29,7
2008.	30,1	29,5	30,0
2009.	31,2	30,5	31,1
2010.	31,8	30,6	31,6
2011.	**32,4**	**31,1**	**32,2**

Source of data: Documentation for the preparation of the seventh report on implementation of European Social Charter, Croatian National Institute Of Public Health, December 2012.

The addict population in the Republic of Croatia is becoming more and more older, and the average age of treated persons (men and women) show an upward trend. Considering that we record treated persons because of the misuse and/or dependences on all psychoactive drugs, the year span is also very large. From 2005 onwards the increase in the average age of both woman and men is recorded so is 2011 majority of treated is older than 31. Women were 31,1 years old on average and in the last seven years they are three years older. Men were 32,4 years old on average and in the last 7 years they are 4 years older.
According to the data of the European Monitoring Centre for Drugs and Drug Addiction, the average age of admittance to the outpatient treatment due to the use of opiates in European countries is 33 years of age. For them around 8 years pass from the first use up to first contact with the treatment.
According to the data on the number of overall treated persons on a 100.000 population of the age span of 15-64 years based on counties, Istarska County has the most recorded (542,5), follow by Zadarska County with the rate of 493,7. City of Zagreb (435,6), Šibensko-Kninska County (344,4), Primorsko-Goranska County (340,8), Dubrovačko-Neretvanska County (330,3) and Splitsko-Dalmatinska County (305,5).
According to the Health Care Act (Official Gazette, no. 121/03) and the Act on Amendments to the Act on the Prevention of Narcotic Drug Abuse (Official Gazette, no. 149/09 and 84/11) the system for the prevention of dependences and the out-patient treatment addicts has become part of the system of the Croatian National Institute of Public Health. By then county centres for the prevention of dependences have become integral parts of the county Public Health Institutes. They integrate, in its organisation and work outlines, the activities of the health care system, social protection and educational system for the purpose of implementing constant monitoring, education, psychotherapy, family therapy, prevention of HIV infection and hepatitis, as well as help in the solving of other life problems of addicts and their families, like providing help to occasional drug consumers and their families.

The treatment of addicts is primarily carried out organizably within the health system of the country, and particular measures of rehabilitation can be carried out outside the health system (non-governmental organisations, social institutions and within the prison system). Method of treatment implementations is based on the treatment approach identical to other chronic uninfectious diseases. Prescribing medications, the everyday stock count and treatment results are performed at the level of primary health care, and the total treatment is a result of cooperations between polyclinical-specialist and hospital service when necessary. The treatment is planned and performed according to the needs of the individual and is changed

according to the condition of the disease.

The coordinated Croatian model is expertly applied in medical treatment which is well known and recognised under that name in international professional circles. Model supposes constant cooperation of the specialised out-patient prevention centres and the out-patient treatment of addicts as well as doctors of primary health care that is teams of family medicine in carrying out treatments of addicts. With this the wide availability of treatment through the system primary health care along with the simultaneous insurance of professional guidance from the part of the specialist, the integrated comprehensive care about the addicts is enabled, destigmatization and normalisation of treatments, decentralisation and deghettoization of addicts and low programme costs.

For mentioned activities of the prevention of dependences and treatment of addicts in the system of health care financial resources are ensured, according to Drug Abuse Prevention Act in the state budget, out of budgets from the regional and local governments, the Croatian Institute for Health Insurance and from other sources (gaming revenue). All addicted persons under treatment in the system of health care are entitled to basic health insurance and all rights which result from it.

Information on all the measures that are undertaken for the purpose of the protection of reproductive health of all persons, and specially adolescents.

Measure health care that aim to ensure general access to health care are regulated with the Health Care Act and represent:

- protection from environmental factors harmful for health, including preservation measures, advancement, monitoring and improving health and hygienic living and working conditions of a human being;
- implementation of the health education, education and promoting health with the purpose to improve mental and physical abilities of a person;
- discovering and removing causes of diseases, i.e. prevention of diseases and injuries, as well as their consequences;
- special measures of health care of the population older than 65 years;
- insuring a comprehensive (preventive, therapeutic and rehabilitative) health care for children and young people and a method of regular control of children, their vaccinations and treatment on the primary level, that is at the level of Institute for Public Health;
- insuring a comprehensive (preventive, therapeutic and rehabilitative of protection of women in relation to family planning, pregnancy, birth and maternity, as well as disease
- specific health protection of workers includes preventive examinations for the purpose of determining working ability, monitoring of the workers health status, cooperation about informing, professional training, education in the activity of occupational medicine, work hygiene and work organisation.

Health care of persons over the age of 65

In the activity of general/family medicine in 2008 2.867.253 identified diseases and conditions have been recorded at the age from 65 and over, in 2009 3.178.798, in 2010 3.245.287 and in 2011 4.027.349 which amounts to 32,8% of total recorded diseases and conditions of all age groups. The most frequent groups of identified diseases and conditions in

older persons in the observed period are: diseases of the circulatory system (with the ratio of about 22%), diseases of the muscular-bone system and the connective tissue (around 12%) and diseases of the respiratory system (around 8%).

At the age of 65 and over in 2008 10.514 (10.230 in 2009) preventive and 3.257 (2.000 in 2009) general medical examinations have been recorded. In 2010 only 4.398 preventive and 1.117 general medical examinations have been recorded, and in 2011 6.269 preventive and 1.119 general medical examinations have been recorded.

The ration of hospitalised at the age of 65 and over amounts to about 35% the total people treated in the hospitals of Croatia. In 2008 213.240 hospitalizations have been recorded of persons over the age of 65 (rate of 307,5/1.000), in 2009 213.187 hospitalizations have been recorded (rate of 279,4 /1.000) and in 2010 203.744 hospitalizations of persons over the age of 65 (rate of 267,3/1.000). The leading groups of diseases that cause hospitalizations of elderly people are: diseases of the circulatory system (rate around 75/1000), tumors (around 50/1000), diseases of the digestive system (around 25/1000), diseases of the eye and its adnexa (around 20/1000) injuries, poisonings and other effects of external causes (around 17/1000).

Of the total number of hospitalised people over the age of 65 more than 100.000 hospitalizations of women are recorded annually (109.328 in 2010) and around 90.000 hospitalizations of men (94.416 in 2010), which is a result of a higher number of women in the elderly population. However, rate of the hospitalization of women older than 65 year is 235/1.000 (in 2009 it was 244/1.000; in 2008 266/1.000), and men over the age of 65 317/1.000 (in 2009 the rat was 335/1.000 and in 2008 375/1.000). During 2011 number of treated patients at the age of 65 years and over in hospitals in Croatia (without hospital rehabilitation) is 211.557 (or 35,7% of a total number of treated). The leading groups of diseases that cause hospitalizations of at the age of 65 years and over are: diseases of the circulatory system (52.469), tumors (34.186), eye diseases (19.257), diseases of the digestive system (18.495) and injuries, poisonings and some other effects of external causes (13.953). Hospitals in Croatia takes care of more women than men over the age of 65 (1,16:1).

Counselling and diagnostic services

a) for schools;

Preventive and specific health care of school children is carried out by general/family practitioners and school medicine specialists, within the activities of the Public Health Institute.

In the school year 2010/2011, 257,022 primary-school and 77,407 secondary-school students have been included in some form of health education (in the school year 2009/2010, 273,797 primary-school and 77,396 secondary-school students were included). In 2010/2011, a total of 18,414 students were included in health education (whereas in 2009/2010 there were 20,189, , in 2008/2009 there were 16,059 and in 2005/2006 there were 14,888 of them) through lectures, public discussions or some form of teamwork. In addition, 75,431 parents and professors in primary schools and 10,122 of them in secondary schools have attended lectures, public discussions or workshops on the subject of health.

b) for other groups.

The employed

On 31st December 2010, there were 1,432,454 active insured persons in Croatia, which represents 38.2% of the working-age population from 15 to 65 years of age, that is, 82% of the active population. Preventive care within the activity of occupational medicine, which has been included into compulsory health insurance since 2008, is provided for the employed, which has resulted in an increase in the number of occupational medicine teams preventive examinations of the employed, which no longer depend only on the willingness of the employer and the activities of the occupational health and safety inspection. According to reports related to the activity of occupational medicine, in 2010, 173 teams worked full hours and 13 teams worked partial hours. In 2010, each team cared for an average of 8,318 employees (8,794 in 2008). Given that the teams were unevenly distributed, the number of employees receiving care ranged from 4,403 in Primorsko-goranska County to as much as 20,282 in the Međimurska County.

A total of 403,231 examinations were carried out in Croatia in 2010 (an increase of 12.7% in comparison to the previous year). 79% (2009:71%; 2008:64%; 2007: 59%) of the total number of preventive examinations were preventive examinations of the employed, out of which 51.3% were examinations of male and 48.7% were examinations of female employees. The rate of preventive examinations is the highest in the last five years, amounting to 281.5 to 1,000 employees (2009: 174.0/1,000; 2008: 167.6/1,000; 2007: 145.7/1,000; 2006: 148.5/1,000). The rate of periodic examinations (examinations at high-risk workplaces) also increased in comparison to the previous years, amounting to 113.1 per 1,000 employees (2009:88.9/1,000; 2008: 86.0/1,000; 2007: 67.0/1,000; 2006: 69.5/1,000).

In the beginning 2011, there were more changes in the health care of the employed. Treatment of employment injuries and occupational diseases was again provided by general/family practitioners, whereas the Croatian Institute for Health Insurance entered into contracts with occupational medicine specialists, thus making them competent for carrying out preventive activities in the working-age population. According to reports related to the activity of occupational medicine, in 2011, there were 182 full-time teams and 12 part-time teams (9 teams more in comparison to 2010).

185 occupational medicine specialists, 6 other specialists and 24 general practitioners have worked in this activity.

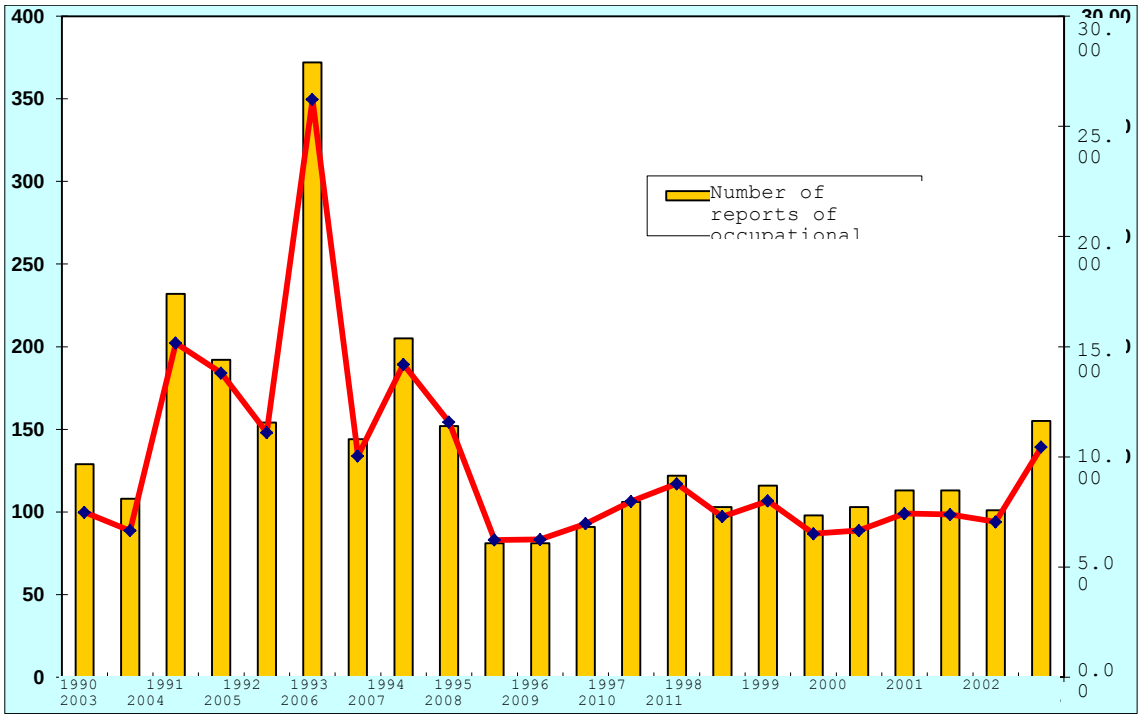
According to data of the Croatian Institute for Health Insurance in Croatia, there were 1,485,324 active insured persons. Each occupational medicine team has cared for an average of 7,900 employees (2010: 7,980; 2009: 8,794 employees).

In 2011, a total of 402,396 examinations have been carried out in the Croatia, which represents a slight decrease in comparison to the previous year (2010: 403,231). 71% (2010:79%; 2009: 71%; 2008: 64%, 2007: 59%) of the total number of preventive examinations were preventive examinations of the employed, out of which 58.7% were examinations of male and 41.3% were examinations of female employees. The rate of preventive examinations is decreasing and has amounted to 191.5 per 1,000 employees (2010: 281.5; 2009: 174.0/1,000). The rate of periodic examinations has also decreased in comparison to the previous year, amounting to 110.3 per 1,000 employees (2010: 113.1/1,000).

A total of 3,395 occupational diseases was reported in the period from 1990 to 2011. The total

morbidity rate for 2011 was 10.4/100,000 active insured persons, which is an increase in comparison to 2010. (7.1/100,000). For the observed period from 1990 to 2011, it ranged between a minimum of 6.2 (in 1999) to a maximum of 26.2 (in 1995). The most frequent reported occupational diseases in Croatia are: pneumoconiosis (29%), hearing damage caused by the harmful effects of noise (18%), damage caused by vibration (14%), infectious diseases (12%) and skin diseases (9%). Occupational diseases are mostly caused by long-term exposure to damaging effects, however, data for 2009 and 2010 raise concern and indicate insufficient implementation of prevention measures. Namely, occupational diseases in these two years were predominantly diagnosed in employees which had been exposed to damaging effects at the workplace for 11-15 years (42.6 %), followed by those with a relatively short exposure period of up to 6 years or 6 -10 years (17.8%), most of whom is were employed in the processing industry (58.,3%) which indicates insufficient implementation of protection measures at the workplace and insufficient training regarding occupational safety. Employees with an exposure of 21 and more years (10.9%) have ranked third.

Chart 12 Number of reports of occupational diseases and morbidity rates per 100,000 active insured persons from 1990 to 2011



Data source: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Croatian National Institute of Public Health, November 2012

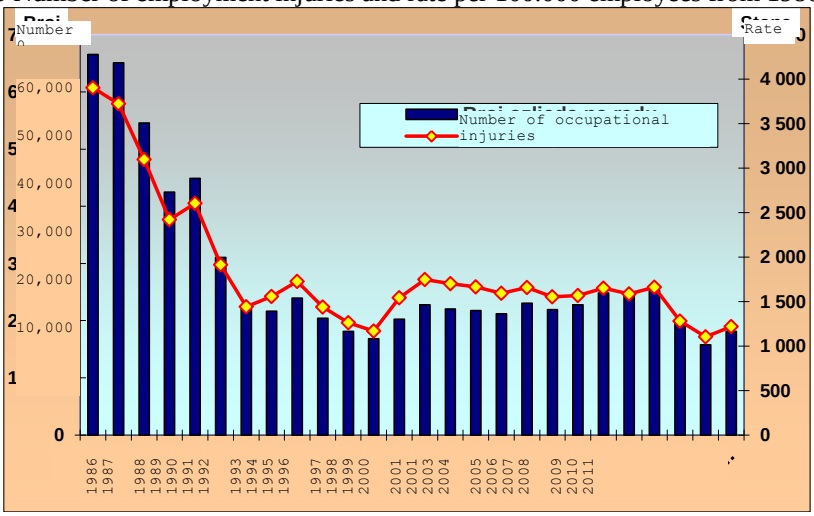
Less than 20,000 employment injuries are recorded in Croatia every year, which means that 10-17 out of 1,000 employes are injured every year. These rates have remained more or less constant over the last ten years. According to these values, Croatia is ranked among countries with a low rate of reported employment injuries.

In 2010, there was a total of 15,791 reports of employment injuries, which in relation to the previous year showed a decrease of 19.3%. The highest specific rates with regard to activity (only injuries at the workplace) have been recorded in the following activities: water supply, wastewater treatment, waste management, environmental improvement (1,651.67/100,000), the processing industry (1,450.31/100,000) and construction (1,160.99/100,000). In 2010 there have been 38 occupational deaths, which is the same number as the previous year. 35 employees died at the workplace (92.1%), while 3 died on the way to/from work(7.9%). Total rate of fatalities amounted to 2.65, which is an increase in comparison to the previous year (2.46), but also a considerable decrease in comparison to 2008 (5.26/100,000). With regard to fatalities resulting from injuries sustained exclusively in the workplace and the number of employees, the average rate was also higher, amounting to 2.44 (2009: 2.07/100,000). As in the previous years, the most dangerous activity with the greatest number of fatalities was the construction industry, followed by agriculture, forestry, fishery and the processing industry.

A total of 18,116 reports of employment injuries was received in 2011, which is 14.7% more than in the previous year. As in the previous years, most injuries occured at the workplace (81.1%), while 18.9% of them occurred on the way to or from work. The total rate of employment injuries amounted to 1,219.67/100,000, while the rate of injuries which occurred exclusively in the workplace amounted to 988.81/100,000. Both rates are higher in comparison to 2010 (1,102.37/100,000 or 832.36/100,000). The highest specific rates with regard to activity (only injuries at the workplace) have been recorded in the following activities: water supply, wastewater treatment, waste management, environmental improvement (2,043.72/100,000), agriculture, forestry and fishery (1,919.72/100,000), and construction (1,733.42/100,000).

In 2011 there have been 46 occupational deaths, which is eight persons more than the previous year. 38 employees died at the workplace (82.6%), while 6 died on the way to/from work(17.4%). The total rate of fatalities amounted to 3.09/100,000, which is an increase in comparison to the previous year. With regard to fatalities resulting from injuries sustained exclusively in the workplace, the average rate was even higher, amounting to 2.56/100,000. As in the previous years, the most dangerous activity in 2011 with the greatest number of fatalities sustained at the workplace was the construction industry (17.03/100,000), followed by agriculture, forestry and fishery (9.03/100,000) and the processing industry (4.49/100,000).

Chart 13 Number of employment injuries and rate per 100.000 employees from 1986 to 2011



Data source: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Croatian National Institute of Public Health, November 2012

On 29th December 2008, the Government of the Republic of Croatia adopted the National Programme of Occupational Health and Safety Protection for the period from 2009 to 2013. The strategic objective resulting from this Programme is to provide conditions for a "healthy workplace", safe work and to prevent the damaging of health. By achieving this objective, the Republic of Croatia accepts the EU Strategy on Safety and Health at Work 2007 – 2012. Application of the National Programme will contribute to the solving of numerous problems in the field of protection of health and safety at work, such as inadequate education, non-harmonisation and inconsistent application of regulations, absence of research projects, and, most importantly, neglect of injury and occupational disease prevention measures.

Measures undertaken to promote health education

The basic aim of health policy is not only to extend life expectancy, but also improve the quality of life. Apart from the further improvement and development of the health services, this includes efforts to promote healthy lifestyles, reduction or elimination of preventable health risks, and improvement of the quality of life of the chronically ill and disabled.
The Department for Health Promotion of the Croatian National Institute of Public Health has been operating since 1999. The idea of promotion of health assumes the improvement of health and the creation of potential for good health before health problems or threats to health occur. Health promotion is defined as a process which enables people to improve their health and enables them to control it.
The tasks of the Department are the following:

- to propose, promote and participate in organising and implementing programmes to promote health;
- to publicise the necessary recommendations and promote a healthy way of life (non-smoking, healthy eating habits, regular physical exercise, responsible sexual behaviour, strengthening the ability of individuals to overcome crises, etc.) through health education and training and the public media, to draw up appropriate expert proposals and/or educational and promotional materials;
- to provide expert assistance and support for programmes to change health-threatening habits;
- to promote the creation of the conditions to simplify leading a healthy lifestyle and make it more attractive than other options;
- to pay particular attention to promoting the creation of a social environment which supports the adoption of a healthy way of life, including the appropriate legislative aspects;
- to improve co-operation with other sectors (education, the food industry, agriculture, etc.) in the field of health promotion; monitoring and evaluation of individual programmes.

Many projects are being implemented by various organisations, which are financed from the state budget or from international sources. Education of health personnel and partners in health promotion activities is currently underway, which had begun earlier as part of certain projects.

Query of the Committee

- The Committee has requested that the subsequent report contain examples of activities carried out the for the purpose of health promotion, including projects organised by other organisations and financed from the state budget.

Presentation of a part of the activities of the Croatian Red Cross and the Youth Sports

Games non-governmental organisation in the field of addiction prevention

From 2008 to 2011, the Croatian Red Cross systematically implemented activities of exchange of syringes and needles used by hard drug addicts (the project is also known as the Needle Exchange Project – NEP or NX). The Programme was implemented in Zagreb, Zadar, Nova Gradiška and Krapina. In these cities, the Programme is implemented in accordance with the drug abuse harm reduction policy adopted by the Ministry of Health and the Office for Combating Drug Abuse of the Government of the Republic of Croatia (an integral part of the National Strategy on Combating Drug Abuse in the Republic of Croatia 2006–2012). The Programme is also implemented in other areas of the Republic of Croatia by the HELP, TERRA, LET and Institut non-governmental organisations. The primary objective of such Programmes is to reduce the risk of spreading blood-transmitted diseases – AIDS and Hepatitis B and C - among addicts to heavy drugs injected intravenously, which represent one of the main risk groups for spreading these deadly diseases.
The Croatian Red Cross carries out primary prevention of addictions through the education and counselling of children, adolescents and parents on all forms of risk behaviour. Efforts are undertaken to inform parents about the problem of addiction in youth and symptoms of risk behaviour, for the purpose of early recognition of problems and strengthening of the role of parents and families in addiction prevention and treatment. Public discussions, lectures and workshops on the subject of addiction are also organised in children's day care facilities, primary and secondary schools, counselling centres and associations of recovering alcoholics. This raises the awareness of the local community of the existence of the problem and the level of education regarding addiction-related issues, as well as focuses the attention of parents, teachers, students and especially persons with this problem and their family members on communication and the development of social skills and healthy lifestyles. Some of the subjects covered are: "How to effectively communicate with your child", "How to develop self-awareness and self-confidence in the child", "How to say NO", "How to encourage the responsible behaviour of children" and "How to protect children from addiction", in order to improve the knowledge and skills of parents necessary for better interaction within the family, more efficient fulfilment of educational roles and the development of cooperation of schools and families in preventive action. 41 lectures have been held during 2008, attended by a total of 794 persons. In 2009, 53 lectures have been held, attended by a total of 788 persons. During 2010, 42 lectures attended by 616 persons have been held as part of the Programme. The activities of counselling centres and associations of recovering alcoholics, as well as systematic prevention activities, considerably contribute to the mitigation and/or solving of the problem of drug and alcohol addiction in the local community. The associations of the CRC continously advertise and promote the programme through the local press, radio and television programmes).
The project entitled "Bistra YOUTH SPORTS GAMES 2010" represents the fourteenth Youth Sports Games which took place from June to mid-September 2010, in which 51 350 children and young people participated and socialized through competing in ten sports. Since the Games were taking place during the summer holidays, when young people are not in school, this was a chance for them to socialize, participate in sports activities, learn about a healthy lifestyle and habits, and in this way avoid all forms of addiction and misbehaviour. All activities were carried out under the "Live life without drugs because drugs take lives" slogan. The objective for 2010 was improving the quality of activities on local levels, modifying the follow-up activities to cover the whole year and further gradual internationalization of the programme. 15 to 20 volunteers have participated in each county, which amounts to 420 persons plus members of the related organisation and county coordinators, which amounts to a total of 462 persons. 47 003 young people have participated

in 2009, while in 2010 their number has risen to 51 350. The value and importance of the programme has been recognised by prominent national and international institutions and individuals. Thus, the Games are sponsored by the International Olympic Committee, and supported by FIFA, UEFA, FIBA, ITF, FA and numerous other institutions. The organisation has permanent employees, which, during the year, look for sponsors, donors and others which recognise the importance of the Games and invest in them to support the welfare of children. The Games are planned to cover the entire region and the Youth Sports Games organisation hopes that they will become an international project in the near future. Apart from promoting a healthy lifestyle and sports, the Games improve the quality of life of children and young people and develop positive social values, which has proven to be the most efficient prevention of all forms of addiction and deviant behaviour. Sports and recreation not only affects regular physical development of youth, but also the intellectual, aesthetic and moral education of the entire society. The Project is implemented in accordance with the National Strategy for Combating Narcotic Drug Abuse in the Republic of Croatia 2006-2012, the Action Plan for Combating Narcotic Drug Abuse 2009-2012, the National Strategy for Creating a Stimulating Environment for the Development of Civil Society and the Operative Plan of the National Strategy for Creating a Stimulating Environment for the Development of Civil Society 2006 - 2011.
CSOs continue to play a significant role in public-health programmes and other forms of health care. In order to strenghten cooperation with civil society and raise the level of awareness, the Ministry of Health finances programmes and projects of non-governmental organisations which contribute to the prevention of chronic illnesses, improvement and health protection of the diseased, prevention of infectious diseases, prevention of dental diseases and improvement of dental health, promoting patient rights, improvement and protection of the health of children and young people affected with malignant diseases, improvement of mental health protection, as well as, for example, cooperation programmes for the implementation of the National Strategy on Combating Drug Abuse, prevention of HIV infection etc. The funds allocated for all these programmes amounted 15,634,057.47 HRK in 2008, 16,764,396.00 HRK in 2009, 13,918,157.32 HRK in 2010 and 12,831,000.00 HRK in 2011.

2.3. Paragraph 3 - PREVENTION OF DISEASES

Prevention of infectious diseases

Pursuant to the Act on Protecting the Population from Infectious Diseases (Official Gazette, No. 79/07) the prevention and suppression of infectious diseases is of interest to the Republic of Croatia. General and special measures are undertaken for the prevention and suppression of infectious diseases. If an endemic disease or a disease on an epidemic scale occurs, anti-epidemic measures are implemented by the hygiene and epidemiology branches of the institutes of public health of the counties or the City of Zagreb, and in the case of an epidemic affecting two or more counties, anti-epidemic measures are implemented upon the proposal of the Reference Centre for the Epidemiology of Infectious Diseases of the Croatian National Institute of Public Health.
Epidemiological services in Croatia are responsible for emergency anti-epidemic interventions in each case of disease or suspicion of a disease with great epidemic potential. Most urgent intervention by epidemiological services is also needed in the event of disease (or death) clusters, i.e. epidemics.
Anti-epidemic medical interventions include: epidemiological investigation in the field, detection of new cases of disease, diagnostics of the disease and epidemic diagnostics accompanied by necessary microbiological confirmation of the disease, contacting ill people

in the field, diagnostics of the disease or diagnostic tests used to identify carriers of the diseases, chemoprophylaxis by medicines or anti-epidemic vaccination, implementation of measures involving isolation, quarantine and anti-epidemic disinfection, anti-epidemic pest and insect control, supervision of contacts, ill people and carriers, collective medical treatments, and other anti-epidemic measures, specific for each of the infections diseases listed in the Act on Protecting the Population from Infections Diseases (88 diseases), and for each epidemics or death cluster. Another task of epidemiological services is to intervene in the case of unknown diseases, biological attacks and in extraordinary situations, such as natural disasters, toxic and radioactive incidents and other situations increasing the risk of infectious diseases. To be able to carry out their tasks, epidemiological services must closely co-operate with microbiological services, from which they request diagnostic tests on human and other samples, to establish sources and transmission channels of diseases and to cut these channels by special epidemiological measures and procedures. Close co-operation is required not only with microbiological (public health laboratories), but also with environmental public health laboratories.

In most of their activities involving supervision of infectious diseases, epidemiological services intervene in the field and work as emergency medical services, for which it is necessary to have in place a special epidemiological IT system at the national level, an early warning system with an epidemiologist available 24 hours, 7 days a week. In addition, services on the whole territory of Croatia should be organised in such a way that their work is co-ordinated at the national level.

Since infectious diseases know no borders, the Croatian epidemiological services are linked with the European WHO Office in Copenhagen, through their early warning system (IHR WHO). They actively participate in anti-epidemic activities at European level and will soon join the European Early Warning and Response System (EWRS). The Service for the Epidemiology of Infectious Diseases of the CNIPH manages and co-ordinates all epidemiological IT systems (individual reporting of infectious diseases, early warning, 24/7 duty rotas, reporting vaccination side-effects, monitoring the implementation of the Compulsory Vaccination Programme in Croatia, global early warning system for epidemics – IHR, and WHO and EU disease reporting systems).

The activities of the epidemiological services enabling their emergency anti-epidemic response consist of preventive and other activities which are a basic precondition for protecting the population from infectious diseases. On the one hand, they reduce chances of disease outbreaks, while on the other they enable an insight to be gained into the epidemiological situation and prompt intervention. The scope of these activities will be presented below in terms of levels of epidemiological health care in the country.

Organisation of epidemiological services in Croatia and activities relating to monitoring infectious diseases

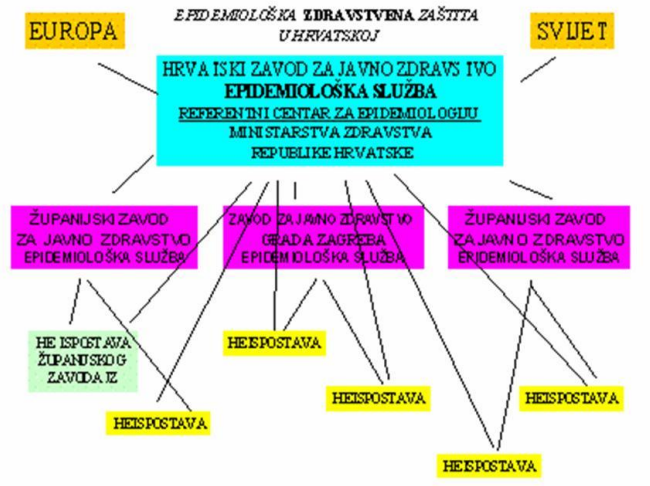
The organisation of epidemiological services is subject to the fact that it is an emergency medical service, which due to the nature of its focus (infectious diseases which threaten the entire population of the country and indeed other countries), must be centrally, i.e. nationally co-ordinated.

The Service for the Epidemiology of Infectious Diseases of the Croatian National Institute of Public Health carries out the co-ordinating and consultative functions of the work of the entire service. According to epidemiological precautionary measures and the requirements of the profession (which are at the same time the requirements of the International Health Regulations), the Service is of necessity organised as a pyramid structure on three levels:

The Service for Epidemiology and Microbiology is part of the Institute of Public Health. The

Service operates at all three levels of health care (according to the Health Care Act) and forms a network throughout Croatia. The Health Care Act requires the Croatian National Institute of Public Health to include epidemiology, microbiology and health ecology within its services. Epidemiological services are united under the Act and are not divided between infectious and non-infectious diseases. Due to the scope and means of work at the national level, the task of epidemiology within the CNIPH is divided between the Service for the Epidemiology of Infectious Diseases and the Service for the Epidemiology of Chronic Widespread Diseases.

Chart 14 System of epidemiological health care, i.e. national system for monitoring infectious diseases in Croatia



CROATIAN	ENGLISH
Epidemiološka zdravstvena zaštita u Hrvatskoj	Epidemiological health care in Croatia
Hrvatski zavod za javno zdravstvo	Croatian National Institute of Public Health
Epidemiološka služba	Epidemiological service
Referentni centar za epidemiologiju MZSS-a RH	Reference Centre for Epidemiology, Ministry of Health of the Republic of Croatia
Županijski zavod za javno zdravstvo – Epidemiološka služba	County Institute of Public Health – Epidemiological Service
Zavod za javno zdravstvo Grada Zagreba	City of Zagreb Institute of Public Health
HE ispostava Županijskog zavoda za javno zdravstvo	HE Unit, County Institute of Public Health
Obiteljski liječnik, liječnik u bolnici i dr.	Family practitioner, hospital doctor etc.

Data source: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Croatian National Institute of Public Health, June 2012

The first level (primary health care) comprises HE units (Hygiene and Epidemiology Units), belonging to county institutes of public health (113 teams, i.e. one epidemiological team comprising a specialist epidemiologist, a graduate sanitary engineer and a computer expert, per 40,000 population), as a component of the primary health care system. In organisational terms, they are part of county institutes of public health. Hygiene and epidemiology services at the first level are epidemiological intervention services in cases of infectious and non-infectious diseases, and also cover ecological tasks mandatory at the primary health care level. HE units receive notifications of infectious diseases in their area and intervene promptly in the field, carry out preventive and anti-epidemic measures, monitor infectious and non-infectious diseases in their area, monitor the environment (water supply, sanitation, preventive disinfection and pest control, etc.), inspect buildings (restaurants, hotels, homes and other places, according to the Act on Protecting the Population from Infectious Diseases), and carry out health education and training for employees involved in work which may lead to the spreading of infectious diseases. HE units distribute vaccines according to the Compulsory Vaccination Programme to doctors and monitor the implementation of the Vaccination Programme in their area. They report cases of infectious diseases to the Service for the Epidemiology of Infectious Diseases of the CNIHP and to their respective county institutes. They are in direct contact with the CNHIP Service and implement all the measures required by the national epidemiological service.

The second level is secondary level epidemiology within County Institutes of Public Health (21 institutes of public health at county level). At this level the Microbiology Service also operates, as a necessary diagnostic body for monitoring and carrying out anti-epidemic tasks carried out by the epidemiological service. It is extremely important from the epidemiological point of view that, in most counties, the microbiological service also covers the needs of county hospitals. Secondary level epidemiological operations include HE units in the area in which the Institute is located. The Epidemiological Service of the Institute assists its units and provides microbiological and ecological diagnostic services. In cases of larger, more complex epidemics or other incidents or situations, it is directly involved in anti-epidemic operations in the field. It also provides individual epidemiological protection (vaccination units) and anti-rabies protection. It is the main distributor of vaccines in counties, supervises the Vaccination Programme and intervenes when the Programme is not being carried out properly. County epidemiological services monitor the trends of infectious diseases in their areas, ensure that epidemiology is in a state of constant alert (24 hours a day, seven days a week) for emergency interventions, proposes health care measures based on the Programme of Health Care Measures for Croatia, and participates in their implementation at county level. It supervises disinfection and pest control preventive activities at county level and implements measures proposed by the Service for the Epidemiology of Infectious Diseases of the CNIPH. It is in constant contact with the Service for the Epidemiology of Infectious Diseases of the CNIPH (releases notifications of all epidemics and particularly risky occurrences/diseases, through an early warning system, and is consulted on anti-epidemic measures).
The third level (national level) is the Service for the Epidemiology of Infectious Diseases of the Croatian National Institute of Public Health, which carries out microbiological and ecological laboratory operations, and which incorporates the Reference Centre for Epidemiology of the Ministry of Health. In the area of infectious diseases, it has the function of a centre for disease control. Apart from the national task of monitoring infectious diseases, the Service for the Epidemiology of Infectious Diseases is a focal point for WHO International Health Regulations (IHR) and a partner in the European Centre for Disease Control (ECDC). The Service co-ordinates the work of all epidemiological services in

Croatia, acts as a consultative body and maintains an epidemiological IT system at the level of Croatia, including an epidemiological early warning system at the national level. It is also part of the IHR and EWRS early warning system of the European Union. This service also intervenes in the field in cases of large outbreaks, epidemics which cross county borders, epidemics which are difficult to control, epidemics of unknown diseases, bio-terrorism and similar exceptionally risky and extraordinary situations, as well as cases in which infectious diseases threaten other countries. This work requires own microbiological and ecological diagnostic services. Apart from these diagnostic services for the needs of the CNIPH Epidemiological Service, the CNIPH microbiological laboratories are national public health

laboratories, which confirm the findings of other laboratories, in line with epidemiological precautionary measures, and according to the requirements of the WHO and the EU, and the Act on Protecting the Population from Infectious Diseases, in cases of particularly dangerous, rare or other infectious diseases with great epidemic potential. The entire epidemiological service, with its microbiological operations, is under constant supranational surveillance and participates on equal terms in all activities of the European region of the WHO and the EU (including membership in EU bodies for monitoring infectious diseases). Along with intervention and emergency epidemiology at all three levels of health operations, the Service for the Epidemiology of Infectious Diseases of the CNIPH also carries out the following tasks, required by law: daily monitoring of infectious diseases in the country, weekly reports to the Minister of Health, monthly publications (Epidemiological Herald and Epidemiological Bulletin), annual reports and epidemiological scientific analyses of the situation in the country and in the world. It is the expert service of the Ministry of Health and Social Welfare in the area of monitoring infectious diseases (Reference Centre) and co-operates with other ministries, providing expert opinions and epidemiological analyses as required by them. It produces the Programme of Health Protection Measures against Infectious Diseases in Croatia and evaluates its implementation. It proposes the Compulsory Vaccination Programme for Croatia to the Minister of Health and monitors its implementation in three separate epidemiological IT systems, and intervenes in cases of clusters of side effects or other exceptional occurrences relating to the Vaccination Programme. It maintains the Croatian Register for HIV/AIDS, the Croatian Register for Tuberculosis, the Register of the Side Effects of Vaccination for Croatia, the Register of Legionnaires' Disease Patients in Croatia and the Register of Abdominal Typhus Patients. The Service also has a vaccination unit for individual epidemiological protection. It issues its own publications and instructions for epidemiological fieldwork, instructions for all health workers (it co-operates with all health institutions in the country, including doctors in private practice), and scientific and expert studies in its own field. It forms part of all WHO telematic monitoring systems for infectious diseases and, to a large extent, of the EU monitoring system for infectious diseases, It acts as a focal point, i.e. a point uniting all activities for emergency notification of any incidents (biological, toxic or radioactive) in the IHR early warning system. It ensures that the epidemiology is in a state of constant alert (24/7) for the needs of the country and the European early warning system.

The Act on Protecting the Population from Infectious Diseases, with its ordinances, regulates most compulsory anti-epidemic and preventive activities carried out by the epidemiological service, and is the source of expert instructions on carrying out the work. The Service for the Epidemiology of Infectious Diseases produces additional instructions and guidelines on epidemiological fieldwork. The Service also acts as a consultative service for all epidemiologists in Croatia, and actively co-ordinates all anti-epidemic activities and monitoring of infectious diseases, including daily fieldwork carried out by epidemiologists, in which it intervenes as necessary. The instructions and guidelines of the ECDC and WHO are

also used. It is important to mention that anti-epidemic activities at all levels of health protection are carried out by highly qualified specialist epidemiologists, who upon completing specialisation, receive ongoing training in their area of expertise.
Every year, about 60,000 - 70,000 people suffering from infectious diseases are reported to the Epidemiological Service, in cases requiring the intervention of an epidemiologist. Every year, the epidemiological service intervenes in 100 to 200 epidemic outbreaks, which require complex anti-epidemic measures in order to prevent further spreading. Every year there are several tens of thousands of cases of influenza, sometimes more than 100,000. Population groups who are at particular risk are offered influenza vaccines, in order to bring down the number of high-risk patients who may suffer complications and even die. Every year, 13-15 doses of vaccine per 1,000 inhabitants are distributed in Croatia. The vaccine is free of charge to those over 65, the chronically ill and health workers.
All epidemiological activities concerned with infectious diseases are free of charge to the patients, their contacts, Croatian citizens and foreigners residing in Croatia.
Treatment for infectious diseases within the entire health system, including hospital treatment, is free of charge, according to the Act on Protecting the Population from Infectious Diseases.

Present state

Vaccination coverage against infectious diseases

The most successful preventive large-scale medical measure in Croatia is undoubtedly the Compulsory Vaccination Programme, thanks to all who have participated in it in any way. The continuous implementation of the Programme, with constantly high vaccination coverages, resulted in the epochal improvement of the health condition of the population and complete suppression of the once numerous, terrible and terminal illnesses. Pursuant to Article 42 of the Act on Protecting the Population from Infectious Diseases and the Ordinance on the modes of implementing immunisation, seroprophylaxis and chemoprophylaxis against infectious diseases and on the persons subject to this obligation (OG 164/04), vaccination is obligatory against tuberculosis, diphtheria, tetanus, whooping cough, poliomyelitis, measles, mumps, rubella, hepatitis B and diseases caused by Haemophilus influenzae type B (the Compulsory Vaccination Programme in Croatia).
The current favourable health situation in terms of infectious diseases is due to systematic efforts to improve the immunity of the population through planned vaccinations. Mass vaccination has a very long tradition in Croatia, and there is also a long history of good vaccination results. Systematic vaccination is carried out on the basis of a country programme, which specifies the diseases to be covered, vaccines to be applied and groups of the population to be vaccinated in a particular year.
Since the introduction of the Programme, expert epidemiological proposals to this effect have been drawn up by the Service for the Epidemiology of Infectious Diseases of the Croatian National Institute of Public Health, and adopted by the Ministry of Health and Social Welfare in the form of a binding health document. For the Programme to be successful, the planned vaccinations of particular groups (mostly children and youth, but also older people) should be carried out integrally and timely. More than 500,000 persons are vaccinated each year, with about 900,000 individual doses of vaccine. This huge effort, which has been successfully performed by our vaccinators (doctors of different profiles – paediatricians, general practitioners, school medicine practitioners, epidemiologists, etc.) for a number of decades now, is usually expressed as a percentage of persons that were supposed to be covered according to the Programme and referred to as "vaccination coverage".

Table 61 Primovaccination (%) in Croatia in 2011

Vaccination	**2011**	2010	2009	2008
	%	%	%	%
Diphtheria-Tetanus-Pertussis (DiTePer)	**96.2**	96.5	96.3	96.1
Poliomyelitis	**96.2**	96.5	96.2	96.3
Morbilli–Parotitis–Rubella (MoPaRu)	**95.8**	96.0	95.0	95.5
Hepatitis B	**98.2**	97.8	97.0	97.7
Tuberculosis (BCG)	**98.8**	98.7	97.8	99.1
Haemophilus influenzae Type B (Hib)	**96.2**	96.4	96.3	96.1

Data source: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Croatian National Institute of Public Health, June 2012

Regular analyses of all annual reports on vaccinations performed in Croatia by the Epidemiological Service of the Croatian National Institute of Public Health have shown that these percentages have constantly been high, above the prescribed average (95% for measles, 90% for other diseases).

Data on the high percentage of coverage is completely in accordance with the small number of reported patients suffering from these diseases. It should be pointed out that data on morbidity related to diseases against which vaccination is carried out has been obtained irrespective of the data on immunisation coverage, that is, from individual reports of infectious diseases, and can be used to verify the authenticity of data from the vaccination reports. It is clear that favourable but unrealistic percentages would soon be discredited if the morbidity were high, however, as can be observed, this is not the case in Croatia (see reference to trends of infectious diseases).

The diseases against which vaccination is performed have either completely disappeared (diphtheria, poliomyelitis) or incidence has been drastically reduced by over 90% and in some cases by more than 99% (measles, rubella, mumps, whooping cough, tetanus).

It should be emphasised that poliomyelitis has completely disappeared, which was officially confirmed in 2001 by the official Eradication Certificate of the World Health Organisation for the entire European region and thus for Croatia as well. This is the crown of the hard work done in preventing poliomyelitis through systematic vaccination, which has been conducted in this country since 1961 and a magnificent success by our preventive medicine in the protection of the health of the population.

For specific groups of the population and individuals exposed to greater risk, according to the Programme of Compulsory Immunisation, Seroprophylaxis and Chemoprophylaxis, vaccination is obligatory against tuberculosis, hepatitis A and B, yellow fever, cholera, typhus, tetanus, malaria, streptococcal disease and meningococcal disease.

Every year before the arrival of influenza a campaign is conducted of vaccination against the

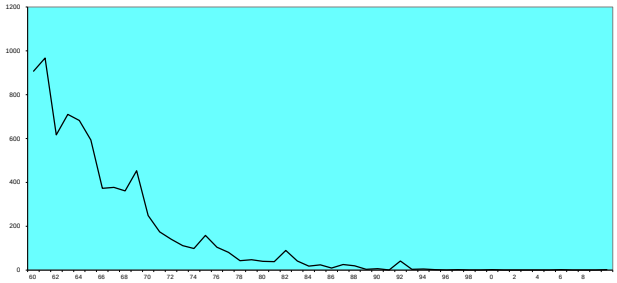
flu, primarily aimed at older persons and persons with more vulnerable health.

State of infectious diseases in Croatia

Foodborne diseases

Typhus abdominalis (abdominal typhus). No cases have been recorded in 2011, which reflects the achievement of a very favourable epidemiological condition.

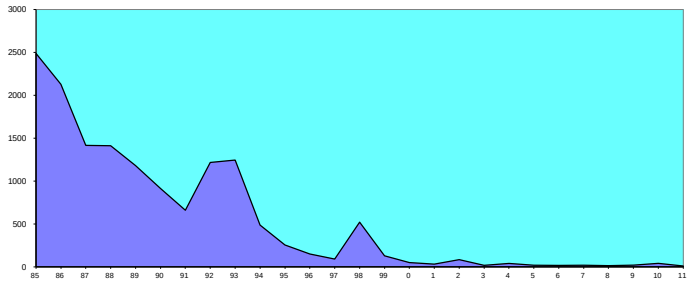
Chart 15 Typhus abdominalis



Data source: preparation of the 7th implementation of the Charter, Croatian National Institute of Public Health, June 2012 Documentation for the report on the European Social

Dysenteria bacillaris. The situation is favourable. In 2011 only 9 cases were recorded, which is the lowest number so far.

Chart 16 Dysenterria bacillaris



Data source: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Croatian National Institute of Public Health, June 2012

Hepatitis A (infectious jaundice). In recent years, the number of hepatitis A cases is low, which is a very favourable condition. In 2011,10 cases were recorded, which is the lowest number so far. During the period of the greatest frequency of its occurrence (1968), over 14000 cases were recorded.

The three diseases listed above: abdominal typhus, bacillar dysentery (shigellosis) and infectious jaundice (hepatitis A) are known as diseases caused by dirty hands and a low living standard. The rare reports of the occurence of these diseases imply that our country and people have undergone a complete transformation in that respect and have risen to the standards of the developed countries of Europe and the world, although both our country and the others cannot be fully satisfied with the existing hygienic condition and standards, and must continue to undertake efforts to secure and improve their state.

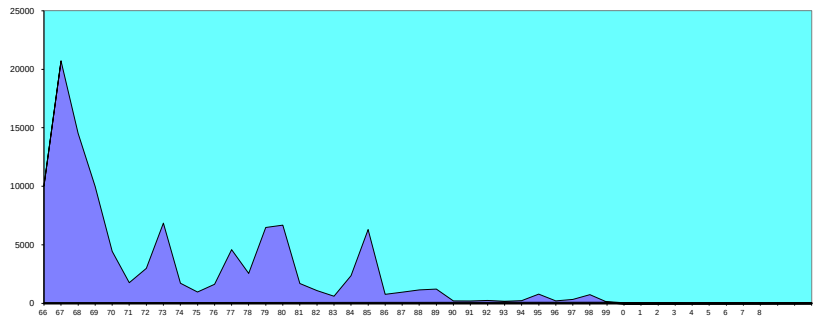
Salmonellosis. Salmonella infections are relatively frequent. However, the disease is not necessarily linked to low hygiene and living standards, but, on the contrary, to high standards, characterized by the appearance of mass, public food preparation and the rearing of animals

and processing of their products for human consumption. Its frequency is easily understandable, given that this is an anthropozoonosis (zoonosis) which is common in almost all animals, including ones that are reared for human subsistence, and in humans as well. Nevertheless, owing to the continous implementation of preventive and anti-epidemic measures, in the last decade the number of occurrences has decreased, with expected yearly oscillations. In 2011, it has amounted to 2399.

Vaccine-preventable diseases

Hepatitis B. The number of cases continues to decrease. Only 56 cases have been recorded in 2011 (2009: 116, 2010: 58), which is the lowest number of occurrences recorded per year. This reduction can be attributed to systematic vaccination. There have been no cases in generations by now completely covered by vaccination and among health workers, which are one of the first groups under increased professional risk to have undergone systematic vaccination.
Pertussis (whooping cough). The occurrence of whooping cough is maintained at a low level, much lower than that before the introduction of vaccination, with small yearly oscillations. In 2011, the number of cases was slightly higher than last year (105: 45) but about the same as in the year before the last (102), as a favourable result of systematic vaccination carried out in Croatia from 1959.
Morbilli (measles). Measles are quite rare in Croatia due to vaccination: 11 cases in 2011, as opposed to 20000 per year before the implementation of the vaccination programme. However, considering that in many European countries the occurrence of this disease is frequent, even up to epidemic proportions, as a result of insufficient vaccination coverage, all nonvaccinated or non-imune Croatian are constantly exposed to the risk of infection, due to the extreme infectiousness of this disease and the modern intensive international human transport . Therefore, in every individual case of the disease, regardless of its origin (in recent years, under the conditions of very low frequency of occurrence of the disease in Croatia, it was relatively easy to establish that the cause in the majority of cases was import, i.e. contamination of nonvaccinated or non-immune persons in foreign countries or during contact with infected persons from abroad), it is necessary to immediately vaccinate all those who have not been vaccinated or do not possess documentation on vaccination, in order to prevent spreading of the disease. This anti-epidemic procedure is regularly applied by the Croatian Epidemiological Service, with favourable results and only a small number of diseased, as is visible from the data on the number of cases.

Chart 17 Morbilli

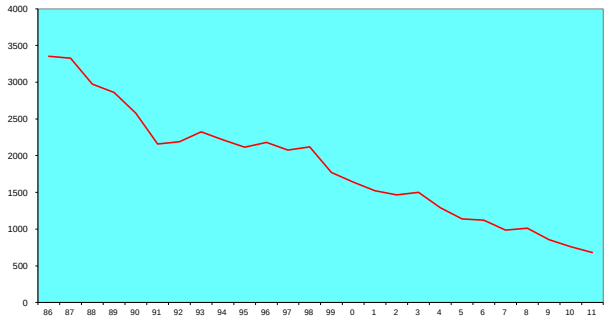


Data source: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Croatian National Institute of Public Health, June 2012

Rubeola (German measles). Owing to systematic vaccination, the occurrence of this disease is

quite rare in Croatia, with 0 cases in 2011.
Parotitis epidemica (mumps). Infection with mumps, the third disease covered by threefold MRP vaccination, has disappeared almost entirely due to vaccination and is maintained at very low levels, along with small yearly oscillations.
Tuberculosis activa. After the standstill caused by war, there has been a favourable continuation of the trend of decline of the frequency of tuberculosis, with expected small yearly oscillations. Although still significant, the number of recorded cases in 2011 (683) is the lowest recorded so far and results in a relatively favourable rate of 15 to 100000 inhabitants, incomparably less than the incidence in the 1950s, when the rate amounted to 444o/oooo. Along with timely, proper and full treatment which, apart from benefiting patients, also prevents the spreading of the disease and the resistance of the agent (the resistance level of Mycobacterium tuberculosis in Croatia is low, being under 3%), systematic vaccination is also carried out in Croatia, and accounts for the complete absence of heavy disseminated forms of tuberculosis (meningitis, miliary tuberculosis) in children: there have been no cases in persons up to the age to 19 in the last five years. The continuation of all activities within the National Tuberculosis Programme amended in 2010 is expected to result in further improvement of the situation. (for more details, see the section below on diseases covered by a special national programme).

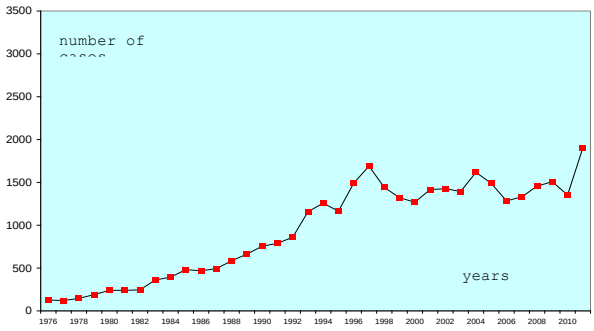
Chart 18 Tuberculosis activa



Data source: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Croatian National Institute of Public Health, June 2012

Mononucleosis infectiosa. This contact viral infection which cannot be prevented by vaccination, is gradually becoming more frequent in Croatia. 1901 cases have been registered in 2011. The reasons for this increase are not entirely clear. In the first years of occurrence, they have probably been linked to the accessibility of laboratory diagnostics of the Epstein Baar virus, but in the past decades these conditions have become permanent. In this period, the increase of frequency is certainly partially caused by constant improvement of the general sanitary and hygienic conditions in Croatia, which is why this frequent infection has gradually moved from preschool children, in which it can remain unrecognised to adolescents, when its clinical appearance is prominent.

Chart 19 Mononucleosis infectiosa



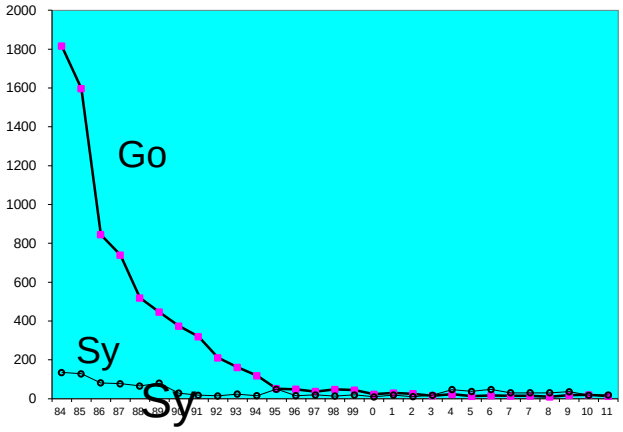
Data source: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Croatian National Institute of Public Health, June 2012

Sexually transmitted diseases

Gonorrhoea. The favourable situation of low frequency continued in 2011, with 13 recorded cases (20 in 2009).

Syphilis. Its frequency in 2011 has remained at a roughly equal, low level as in the previous years (20), within the usual yearly oscillations in the generally favourable trend of low frequency. in previous periods, i.e. during the sixties, more than 2000 new cases per year were recorded. However, all efforts of health service should be directed towards treating every diagnosed case of this serious disease, in order prevent its spreading and successfully cure those infected with it.

Chart 20 Syphilis



Data source: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Croatian National Institute of Public Health, June 2012

Chlamydiasis. The recorded frequency of chlamydiasis depends considerably on the availability and use of laboratory diagnostics. Thus, in recent years, visibly less cases were reported than in the several previous years, least of them in the last year (304), and the situation probably has not changed significantly.

Chart 62 Chlamydiasis

year	2003	2004	2005	2006	2007	2008	2009	2010	2011
number of cases	996	902	737	966	374	549	463	552	**304**

Data source: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Croatian National Institute of Public Health, June 2012

AIDS/HIV. The number of newly discovered cases of AIDS remains roughly the same year after year, leading to a favourable stationary trend of low frequency. In 2011, the number is slightly higher than in the previous years (23: 19), amounting to slightly more than the highest yearly figures recorded up to the present (20). This was caused by the occurrence of the disease in several persons who had returned to Croatia after a long stay in foreign countries with a high frequency. In any case, it would be alarming if further monitoring would show that this number represents the onset of a previously unrecorded unfavourable exit trend of incidence.

The relatively low and mostly uniform frequency is partially due to increasingly successful treatments and prolonged condition of HIV-carrier without the onset of AIDS, as well as the impact of all prevention measures, envisaged within the National Programme. The possibility of free anonymous testing and counselling in ten cities in Croatia has led to the increased coverage of examinations and a certain increase in the number of discovered new cases of HIV infection in recent years. There were 76 newly discovered cases of HIV infection in 2011, which is somewhat more than last year (70).

Table 63 AIDS in Croatia

year	00	01	02	03	04	05	06	07	08	09	10	11
number of cases	**19**	**8**	**19**	**11**	**13**	**19**	**20**	**9**	**18**	**15**	**19**	**22**

Data source: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Croatian National Institute of Public Health, June 2012

Since the first cases were recorded in 1986 and until 2011, the total number of registered AIDS patients in Croatia (cumulative incidence) amounted to 350, out of which 154 died (44%). The prevalence, i.e. the total number of HIV/ AIDS patients in the Croatia at the end of 2011 was 724 (for more details, see end of document, section on diseases covered by special national programmes).

New (emerging) diseases

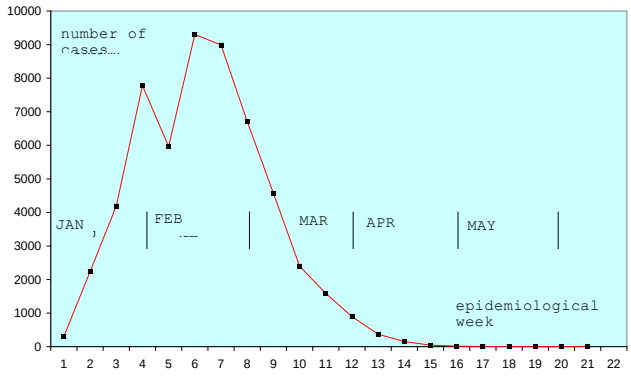
Dengue fever. In 2010, the presence of autochthonous dengue fever, normally typical of tropical and subtropical areas, has been confirmed in Croatia for the first time. One patient was registered and the infection was retrospectively cofirmed in case of another member of his family which was infected somewhat earlier. A case resulting from exposure in Croatia was also confirmed. The disease was also confirmed in a foreign tourist who became ill after coming home from the summer holidays in Croatia. At the same time, the first European autochthonous cases of dengue (after the epidemics in Greece in 1927) were recorded independently in France, obviously as a consequence of the naturalization of the vector

mosquito Aedes albopictus in the entire Southern Europe and the repeated import of the infection by intensive international passenger transport, which has previously led to occasional diagnoses of imported cases, but without the disease being transmitted and spread locally. Unfortunately, these developments have confirmed the earlier estimates of the posssibility of the occurrence of the disease (see the reviews of infectious diseases in Croatia published in recent years) and imposed additional tasks on the Croatian Epidemiological Service and the entire health care system, in the first place, the necessity of a better and more thorough control of mosquitos and Phlebotomus, which can be vectors for this and other transmissible diseases (malaria, chikungunya, yellow fever, leishmaniasis, heartworm etc.), and a systematic epidemiological, virological and entomological observation of the state and distribution of dengue in Croatia, for the purpose of undertaking all other measures, along with the general ones, to control mosquitos, in order to protect the health of Croatian population and numerous tourists. These epidemiological operations were started immediately after the establishment of the occurrence of the autochthonous dengue in the fall of 2010 and have continued up to the present. Intensive desinsection measures have also been carried out along with the constant monitoring of the state of the disease. We are pleased to inform that there were no cases of autochthonous dengue in Croatia during 2011. Work on intensive monitoring of this disease has continued.

Respiratory diseases

Influenza (flu). In the flu season of 2011, more than 50 000 cases of the disease have been recorded, similar to the previous pandemic 2009/2010 season.

Chart **21** Influenza



Data source: Documentation for the preparation of the 7th report on the implementation of the European Social Charter, Croatian National Institute of Public Health, June 2012

At the beginning of the season, the agent was exclusively the A/H1N1/2009pdm (pandemic) virus, to which the influenza B virus was later added as agent. vaccination against the flu has been carried out for years in Croatia before the start of the flu season, and is intended primarily for older persons and persons with damaged health, for whom the flu is potentially most dangerous. Pursuant to the decision of the Croatian Institute for Health Insurance, vaccination was free for these categories and for health workers in the 2010/11 season. Organised vaccination against the flu causes the decrease of the number of persons with severe or fatal flu and thus reduces the so-called seasonal surplus mortality which can be indirectly attributed to the flu. In addition, a large number of vaccinated persons causes, in all probability, the decrease of the total number of persons affected with flu.

Diseases under special National programme for prevention and control

Because of their special importance, some of the infectious diseases, apart from being monitored, studied, prevented and controlled as determined and ensured by the Act on Protecting the Population from Infectious Diseases and its ordinances as well as by the Programme of Health Protection Measures in Croatia, also have their own special national programmes. For the purpose of a more detailed insight into the situation in Croatia, more particulars and data on these diseases will be provided.

AIDS/HIV in Croatia

Besides from the data and commentary included in the general overview of the situation in Croatia concerning infectious diseases (see above), some other data, which show the complex monitoring of HIV/AIDS in Croatia, will be provided here. These data additionally confirm the assessment that the situation regarding this disease is under control and relatively favourable.

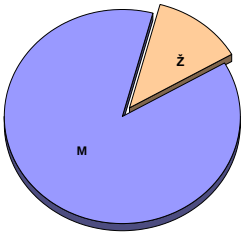
Table 64 Number of people who had AIDS and died of AIDS, in Croatia from 1986 until 2011

Year	infected	dead
1986	2	1
1987	8	3
1988	9	5
1989	3	7
1990	9	4
1991	11	7
1992	8	8
1993	10	7
1994	17	8
1995	15	8
1996	18	12
1997	17	12
1998	13	10
1999	17	3
2000	19	9
2001	8	4
2002	19	4
2003	11	6
2004	13	2
2005	19	3
2006	20	6
2007	9	1
2008	18	7
2009	15	5
2010	19	9
2011	**23**	**3**
Total	**350**	**154**

Source of data: Documentation for the preparation of the seventh report on implementation of the European Social Charter, Ministry of Health, June 2012

Table 65 People with AIDS in Croatia, by gender, from 1986 until 2011, with graphic representation of the proportion of infected people by gender

gender	number of infected people	%
men	306	87.4
women	44	12.6
total	350	100.0



Source of dana: Documentation for the preparation of the seventh report on implementation of European Social Charter, Ministry of Health, June 2012

Table 66 People with AIDS, by high-risk groups in Croatia from 1986 until 2011

Epidemiological category	Infected	%
HOMO/BISEX	169	48.1
PROMISCUITY	102	29.2
DRUG INJECTIONS	25	7.2
PARTNER OF AN HIV-POSITIVE PERSON	30	8.6
HAEMOPHILIA	8	2.5
CHILDREN OF HIV-POSITIVE MOTHERS	4	1.1
UNKNOWN	12	3.4
Total	350	100.0

Source of data: Documentation for the preparation of the seventh report on implementation of European Social Charter, Ministry of Health, June 2012

It can be noticed on the basis of these tables and graphs that, during the last 26 years (since the first recorded cases in 1986), the incidence of AIDS in Croatia has been one of the lowest in Europe. The comparison between the situation regarding HIV/AIDS in Croatia and elsewhere in the world, can be seen in the official publications of WHO and ECDC. The last available data for 2010 show that the annual rate of incidence per 100000 population was in the WHO-EURO region 13.7 (the average), in the EU EEA countries 5.7 and in Croatia 0.4. Such low incidence rate in Croatia can be explained by systematic implementation of prevention measures, from monitoring human blood compounds to health education, carried out in Croatia since the first incidences, that is, since 1983.

The degree to which HIV infection has spread among population is being constantly monitored in several independent ways so that this data can complete the data on incidence of sick or infected persons. One of the methods is review of the share of HIV-positive persons among voluntary blood donors, large number of which provides a good insight into the situation regarding adult population. In 2010, among donors (first blood donation, which has higher frequency), out of 257928 samples tested, none was positive; this share was also low in the earlier years and it was from 0.04-0.05%. The share of HIV- positive persons among the

users of anonymous HIV counselling centres in Croatia is also being monitored. This share is bigger and it amounts to 1.7%.
The structure of groups of people suffering from HIV (in total, i.e. all registered people suffering from HIV) by epidemiological categories, shows that the largest share is that of the homo/bisexual (male) persons, and that the share of people injecting drugs is the smallest. There is a rather large share of promiscuous heterosexual people (second by share), and this requires an explanation, with regard to the data on the low total incidence of HIV infection in Croatia. Epidemiological medical histories of these people show that almost all of these people suffering from HIV got infected outside of Croatia, during a long-term stay in a foreign country, mostly in some of the countries with high HIV infection incidence rate. In 2011, as well as in the previous year, there were no new hemophiliacs among the people suffering from HIV, due to systematic control and safety of blood compounds in Croatia. The share of the group "unknown" is still relatively small (3.4% of all cases), which indicates that in Croatia the spreading of infection is still only within the known high-risk groups, without the "penetration" into the general population. This condition needs to be preserved through systematic implementation of all the preventive measures that were planned, and if necessary through additional measures, based on analyses and possible changes of the epidemiological characteristics of the disease. Therefore, the small but noticeable increase in the number of new persons with AIDS in 2011 (22) was specially analyzed and it was concluded that these were mostly people who spent a long time in foreign countries, i.e. in European countries with high incidence rate, probably got infected there, and sought and received medical help in Croatia due to advanced characteristic symptoms.
It certainly needs to be emphasized that all HIV patients in Croatia receive modern therapy and all the other care necessary, e.g. vaccination, etc. This kind of therapy, besides prolonging life and ensuring better quality of life, also reduces infectiousness of such people, thus reducing the possibility of HIV spreading in the country.
Maintenance of this relatively favourable situation certainly depends on further, equally persistent and thorough, implementation of all preventive and anti-epidemic measures ensured by our laws, by programmes of measures and by the special national Programme.

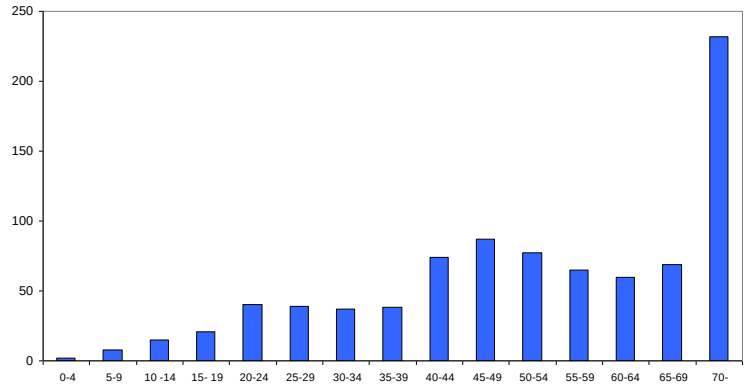
Tuberculosis in Croatia

Besides from the data and commentary included in the general overview of the situation in Croatia concerning infectious diseases (see above), which are also relevant here and should be observed together, some other data, which show the complex monitoring and control of tuberculosis in Croatia, will be provided here.

These data additionally confirm the assessment that the situation regarding this disease in Croatia is constantly improving and that the incidence is decreasing, due to various measures. Such measures are, for example, vaccination, which ensures that there are no cases of disseminated, deadly forms of tuberculosis, and all other measures among which the correct and complete modern treatment, available to all the infected persons, even those with no health insurance, is very important. The importance of these measures lies in the fact that the treatment has a significant effect not only on the patient but also on prevention of transmission of the disease to other people. Also, a correct treatment prevents the development of strains of agents resistant to medications, and such resistance can become a big problem. Data provided by our public health laboratories show that there is a very low level of resistance in Croatia (below 0.3%). This, along with the favourable disease incidence trend, shows that treatment of the disease and implementation of the measures concerning the disease are very successful in Croatia.

The age structure of tuberculosis patients in Croatia is the same as in developed countries, with the highest morbidity rate among the oldest group of people.

Graph 22 The age structure of tuberculosis patients in Croatia



Source of data: Documentation for the preparation of the seventh report on implementation of European Social Charter, Ministry of Health, June 2012

Cases of life-threatening and disseminated forms of tuberculosis in children (meningitis, miliary tuberculosis) are very rare and exceptional in Croatia, due to the large share of vaccinated children, which is a constant in Croatia (98.8% in 2011). There were no recorded cases of tuberculosis meningitis or miliary tuberculosis in children from 0 to 19 years of age in 2011, as well as in the previous year.

Table 67 Patients suffering from tuberculosis meningitis in Croatia, in the 0-19 age group

	AGE			
Year	**0-4**	**5-9**	**15-19**	**10-14**
1992	2	-	-	-
1993	1	-	-	-
1994	-	-	-	-
1995	-	1	-	-
1996	-	-	-	-
1997	-	-	-	-
1998	-	-	-	1
1999	1	-	-	-
2000	-	-	-	-
2001	2	-	-	-
2002	-	-	1	-
2003	-	-	-	-
2004	-	-	1	-
2005	-	-	-	-
2006	-	-	-	-
2007	-	-	-	-
2008	-	-	-	-
2008	-	-	-	-
2009	-	-	-	-
2010	-	-	-	-
2011				

Source of data: Documentation for the preparation of the seventh report on implementation of European Social Charter, Ministry of Health, June 2012

There is a need for continuation of very intensive work in accordance with the Act on

Protecting the Population from Infectious Diseases, Programme of health care measures and national programme - Guidelines on prevention and control of tuberculosis (amended in 2010), due to the existing differences in incidence rates across particular areas or counties in Croatia, as well as due to the overall, still considerable, although smaller incidence rate (15 per 100000 in 2011).

Conclusion and assessment of the situation concerning infectious diseases in Croatia

The epidemiological situation in Croatia concerning infectious diseases in 2011, as in the previous years, can be assessed as ***moderately good***, thanks to the general life conditions as well as to the work of our health system. The favourable assessment of the situation is based on the following indicators and facts. Diseases linked to low living standards and poor hygiene standards along with ignorance of the people, are today very rare or even absent (*abdominal typhus, bacterial dysentery and hepatitis A*). Diseases for which systematic vaccination is being carried out, have been suppressed and some have been eliminated and eradicated (*poliomyelitis, diphtheria*). The classic sexually transmitted diseases, such as gonorrhoea and syphilis, are rare in occurrence and under control, and there is also a low incidence of HIV/AIDS during the last 26 years since the first registered case. The preventive health measures for ensuring safe public water supply and safe nutrition are effective. In 2011, as well as in the previous years, there were no epidemics linked to industrially manufactured food or food products. Hydric epidemics are very rare and exceptional, and in 2011 there was only one occurrence.

The situation concerning infectious diseases in general makes Croatia equal to the other developed European and world countries, and now this also includes tuberculosis with a favourable downward trend and rate 15/10000. Nevertheless, this rate is still significant.
However, along with this favourable facts, it should be remembered that in some places there are still unsatisfactory hygiene conditions, particularly in relation to safe disposal of waste. In addition, consequences of war, wartime and post-war human migration are still present, and these represent risk factors. Also, as a result of intensive international transport of goods and people, a new mosquito *Aedes albopictus*, a potential vector of various human infectious, has spread to our warmer areas, which led to additional work and activity in the implementation of systematic disinfestation. Therefore, due to these unfavourable factors and also due to the general possibility of development and spreading of new diseases in the world affected by climate changes, etc (see section on dengue fever in Croatia), the situation should be regarded as *potentially unsafe* and dependent on further, uninterrupted anti-epidemic and preventive work.

Therefore, all the measures in connection with monitoring of infectious diseases are still a priority in Croatia. Among these, the need to continue with complete implementation of the vaccination programme is prominent, as well as the need to manage the safety of public water supply, public nutrition and food supply and safe disposition of waste products (sewerage), and all of this along with constant, intensive preventive and anti-epidemic work of the epidemiological services and work of proper system for reporting and monitoring infectious diseases. It should be noted that, as a part of accession process of Croatia to the European Union, our country has been included in European systems for infectious diseases control, as well as in the global IHR system of the World Health Organization, that is, of the United Nations. Morbidity and mortality monitoring is the best method to verify if the measures for prevention and control of diseases are effective. Our data, part of which is presented here, clearly show that the effect of the measures is very favourable and that, in this area, Croatia

became equal to the developed countries, and that in some examples (for example, implementation of vaccinations, monitoring anthropozoonosis) Croatia even ranks among the better countries. Of course, human health can always improve in some areas, and therefore it can also improve in the area of current infectious diseases.

Table 68 Infectious diseases recorded in Croatia in 2011

DISEASE	cases/deaths	DISEASE	cases/deaths
Salmonellosis	2599/2	Trichinellosis	8
Toxiinfectio alimentaris	6704/2	Echinococcosis	16
Enterocolitis	6087	Malaria	7 (import)
Campylobacteriosis	1345	Leishmaniasis cutanea	1
Dysenteria bacillaris	9	Scabies	531
Dysenteria, EHEC	2	Toxoplasmosis	24
Hepatitis A	11	Meningoencephalitis ixodidea	26
Hepatitis B	56/1	Febris hemorr.. & sindr. renale	22
Hepatitis C	153	Meningitis purulenta	34
Hepatitis E	1	Legionellosis	32/1
Hepatitis vir. non identif.	10	Enterovirosis	639
Botulismus	10	Pediculosis	274
Angina streptococcica	7827	Pneumonia	7767
Scarlatina	2162	Herpes zoster	3951
Tetanus	2	Lyme borreliosis	499
Pertussis	105/2	Influenza	55508
Morbilli	11	Chlamidiasis	304
Varicella	20184	Helminthiasis	527
Parotitis epidemica	88	Typhus murinus	1
Meningitis epidemica	54/4	Mediterranean spotted fever	2
Meningitis virosa	136	Rickettsiosis	5
Encephalitis	40/3	Creutzfeldt Jakob*	1/1
Leptospirosis	42/1	Amoebiasis	4
Mononucleosis infectiosa	1901	Sepsis bacterialis	163/15
Erysipelas	1491	Hib - invasive disease	1
Tuberculosis activa	683/31	Str. pneum. – invasive disease	16
Gonorrhoea	13	Yersiniosis	19
Syphilis	20	Lambliasis	80
AIDS	22/3	Listeriosis	4/1
Q febris	20	Gastroenteritis virosa	630
Brucellosis	2	Psittacosis	1

* not the new variant (vCJD)

Source of data: Documentation for the preparation of the seventh report on implementation of European Social Charter, Ministry of Health, June 2012

Table 69 Trend in more important infectious diseases in Croatia, 2008-2011

Disease	2008	2009	2010	2011
Typhus abdominalis	1*	1	2*	0
Enterocolitis	7448	4869	4239	6087
Dysenteria bacillaris	13	13	40	9
Salmonellosis	3691	3163	2098	2599
Toxiinfectio alimentaris	6394	4.611	5297	6704
Campylobacteriosis		1423	1581	1345
Hepatitis virosa A	31	20	11	11
Hepatitis virosa B	127	116	58	56
Hepatitis virosa C	208	172	147	153
Hepatitis virosa	19	4	7	10
Poliomyelitis	0	0	0	0
Diphtheria	0	0	0	0

Pertussis	102	102	45	105
Tetanus	1	9	4	2
Meningitis epidemica	53	61	43	54
Meningitis virosa	254	299	151	136
Morbilli	51	2	7	11
Leptospirosis	23	22	41	42
Tularemia	5	0	2	0
Q febris	41	22	24	20
Malaria	6**	3**	8**	7**
Dengue fever			1	0
Tuberculosis activa	1013	857	768	683
Scarlatina	2886	4055	2623	2162
Str. angina & erysipelas	9418	10778	9216	9318
Anthrax	1	2	0	0
Kala Azar	2	1	3	0
Echinococcosis	13	16	10	16
Trichinellosis	1	41	7	8
Rubeola	1	0	1	0
Parotitis epidemica	110	57	40	88
Varicella	17607	17563	16024	20184
Mononucleosis inf.	1461	1512	1352	1901
Syphilis	33	36	18	20
Gonorrhoea	10	18	20	13
Chlamydiasis	529	466	552	304
Scabies	497	405	405	531
AIDS	18	15	19	22
Influenza	54121	107832	3425	55508
Encephalitis	50	71	52	40
Lyme borreliosis	439	435	492	499
Tick-borne encephalitis	20	44	36	26
Febris hemorrh. sind renale	40	13	16	22
Legionellosis	25	37	53	32
Creutzfeldt Jakob disease*	2***	2***	5***	1***
Hib invasive disease	2	2	1	1
Str. pneumoniae invas.dis.	19	26	15	16
Listeriosis	4	6	7	4

* typhus abdomilanis: imported
** malaria: all imported
*** Creutzfeldt Jakob: not the new variant vCJD
Source of data: Documentation for the preparation of the seventh report on implementation of European Social Charter, Ministry of Health, June 2012

General measures taken in the area of public health

A)

1. Prevention of air pollution

In accordance with the Air Protection Act (OG, no. 130/11) and the Ordinance on Air Quality Monitoring (http://narodne-novine.nn.hr/clanci/sluzbeni/290530.html OG, no.155/05) Croatian Environment Agency is obliged to prepare an annual Report on air quality monitoring in the territory of the Republic of Croatia. Report includes data on air quality provided by State Network for the Permanent Air Quality Monitoring, processed data from county, local networks for air quality monitoring and data from special purpose stations. These data were delivered to the Agency by institutions performing air quality monitoring or

by owners of special purpose stations, in accordance with the Air Protection Act, Ordinance on Air Quality Monitoring and Ordinance on the Exchange of Data from Permanent Air Quality Monitoring Networks.
Measurement of air quality in the Republic Of Croatia is performed through system of State Network for Permanent Air Quality Monitoring (under the authority of Ministry of Environmental and Nature Protection and State Meteorological and Hydrological Service) and through local networks (under the authority of counties, City of Zagreb, cities and municipalities) and through contaminators which have to perform air quality monitoring through special purpose stations.
The Annual Report on Air Quality Monitoring in the Republic of Croatia includes data on networks and stations, summation of air pollution concentration around measurement station, frequency of occurrences of high pollution concentrations, dates of occurrences of concentrations above Limit Values (LVs) and long-term ozone goal, Tolerant Values (TV) and goal values for ozone and categorisation of air quality around the measurement station.

On the basis of the results obtained through categorization of air quality during 2011, it can be noticed that out of the total number of measurement stations on which categorization was carried out (137), concetration of pollutants above Limit Values (LVs) was determined on 27 of them, and the air around these stations was secondary category air i.e. polluted.
With regards to pollutants, concetration of which was above LV during 2011, the occurrence of the same specific problems concerning air pollution is obvious.

Concentration of PM10 particles above LV was recorded in city stations near roads (Zagreb-1, Zagreb-3, Ksaverska cesta, Đorđićeva, Pešćenica, Prilaz baruna Filipovića, Siget and Susedgrad, Osijek-1), some of which are also near industrial facilities (Sisak-1, Sisak-2 and Sisak-3, Kutina-1), which is a consequence of the impact of transport and industry. Also, concentration of PM10 particles above LV was recorded on Viškovo landfill. Concentration of PM2,5 particles above LV was recorded in 4 measurement stations, of which three are located in Zagreb (Ksaverska ulica, Đorđićeva and Siget) and one is located in Slavonski Brod (Slavonski Brod-1).
The long-term ozone goal (LV for ozone) and/or goal values for ozone (TV for ozone) were exceeded at five measurement stations in Zagreb (Zagreb-3, Ksaverska cesta, Đorđićeva, Prilaz baruna Filipovića and Siget), two in Istra County (Sv. Katarina and Ripenda), and in Primorje-Gorski Kotar County (Rijeka-2, Krešimirova, Krasica-Urinj in Bakar, Opatija Gorovo, Paveki and Marišćina).
The GV for nitrogen dioxide was exceeded at five measurement stations in Zagreb (Ksaverska cesta, Đorđićeva, Prilaz baruna Filipovića, Pešćenica and Siget), and at one station in the center of Split (Poljud), in Šibenik (town centre) and in Rijeka (Ulica F. la Guardia). Air pollutions by NO2 are mostly connected to transport.
Air pollution by H2S represents a specific problem because LV for H2S was exceeded at six stations, out of which one is in Slavonski Brod (Slavonski Brod-1), one is in Sisak (Sisak-1), three are in the area of the city of Rijeka (Krasica-Urinj Bakar, Urinj and Trogirska ulica) and one at Viševac landfill. Air pollution by H2S is connected with industrial facilities and landfills.
During the last few years, for the purpose of air quality improvement, a number of regulations on air protection were passed, including the new Air Protection Act (OG 130/11), passed in November 2011. These regulations, among other things, include measures which regulate the assessment of air quality condition and division of territory according to levels of pollution. They also include measures defined through remediation programmes for the areas where LV was exceeded, and also measures for gas pipeline installation in cities in North Croatia and

measures for heating pipeline construction.
During the last few years, for the purpose of air quality improvement, a number of regulations on air protection were passed, including measures which regulate the assessment of air quality condition and division of territory according to levels of pollution. These regulations also include measures defined through remediation programmes for the areas where LV was exceeded, and also measures for gas pipeline installation in cities in North Croatia and measures for heating pipeline construction.
The Agency has developed an IT database under the title „Data on air quality in the Republic of Croatia“ which includes data on exceeding warning thresholds and notification threshold and also air quality values calculated per hour at automatic measurement stations of state and local networks. In spite of the fact that this database was developed at the beginning of 2009, until today 9 city stations of state network have been connected to it (12 secondary stations which are still in the testing phase of work are not connected to it) and 12 automatic measurement stations of local networks (out of existing 27). Given that according to the Air Protection Act and the Ordinance on monitoring air quality, the owner and/or user of the automatic station for air quality monitoring must ensure a continuous transfer of the measured data to the Air Quality Information System, the Agency has, in the last four years, directed a number of official letters/invitations to local authorities to undertake activities through which continuous transfer of measured data to the Air Quality Information System will be ensured.

In Croatia, institutes for public health have been monitoring for several years pollen concentration changes of trees, grass and weed in 16 cities (Zagreb, Bjelovar, Varaždin, Sisak, Kutina, Karlovac, Osijek, Našice, Đakovo, Beli Manastir, Virovitica, Slatina, Slavonski Brod, River, Split and Dubrovnik). On the basis of the measured concentration, pollen calendars and pollen forecasts are made, which are available online and in other media, and which enable pollen sensitive people and their physicians to choose a method of prevention and to receive therapy in time, and also to plan daily activities, journeys and holidays. Also, institutes for public health together with Meteorological and Hydrological Service and hospitals make daily bioprognosis.
Air quality control of enclosed spaces includes a number of parameters such as radon concentration, emission from construction materials (asbestos, formaldehyde), level of pollutants (CO, NO2) created by combustion of open flame and heating units and by smoking, and also amount of humidity and mold. This control is not performed in a planned manner, so there are no relevant data on quality of air which surrounds the population in their homes or at work, and the possible consequences on health.
Situation regarding air quality has been much more favourable during the last decade. In general, emissions of air pollutants have been reduced. This is partly due to the fact that large sources of emission stopped working in the nineties, and partly due to the implementation of measures for compliance with international conventions and protocols on air quality. The percentage of cities and towns where the air is clean or only slightly polluted has increased, due to constant control of industrial pollution emission, control of fuel quality, gas pipeline installation in towns and cities and expansion of distance heating in cities. A total of ten counties has an established local network for air quality measurement, and in these counties almost 68% of inhabitants live.

Sedimentation of a particular component in rainfall depends, to a large extent, on the amount of rainfall and on the concentration alone. In 2011, sulfate ion deposition, nitrate deposition, ammonium deposition and magnesium deposition, were around 2-6kn/ha, while sea salt deposition was around 70 kg/ha (Na+) and 120 kg/ha (Cl-) in the area of Southern Adriatic sea. At the same time, it needs to be taken into consideration that 2011 was an exceptionally

drought year and that the amount of sedimentation was significantly smaller in comparison with the average amount. Sedimentation of sulphuric and nitric ions and sedimentation of ammonium ions show that there is still too much of acid compounds in Mountain Croatia and in Northern Croatia, but these amounts are still significantly smaller than in the period up until 2000. Large amount of all rainfall components in the area of Eastern Slavonia show that these increased amounts are not only caused by the source of pollution in the area of Northern Bosnia and Herzegovina but also by the source of pollution in the area of Hungary, considering that the flow from the north-northeast direction is relatively frequent.
Regulation on Limit Values of Pollutants in Air prescribes limit values of total sedimentary matter (Ukupna taložna tvar, UTT) and limit values of the share of metal of arsenic (As), lead (Pb), cadmium (Cd), nickel (Ni), mercury (Hg) and thallium (TI) in the total sediment matter. The only criterion for determining category of air quality with regards to total sedimentary matter and metals of Pb, Cd, Ni, TI, As and Hg in total sedimentary matter is yearly mean value which is calculated as an average of monthly samples. If the values are above the limit value the air is categorised as second category air. Measurements of total sedimentary matter are carried out at 92 measurement stations. Measurements of Pb and Cd in total sedimentary matter are carried out at 76 measurement stations, measurements of Ni in total sedimentary matter are carried out at 65 measurement stations, measurements of TI in total sedimentary matter are carried out at 44 measurement stations, measurements of As in total sedimentary matter are carried out at 18 measurement stations and measurements of Hg in total sedimentary matter are carried out at 10 measurement stations. It has been noticed that in 2011, concentrations of total sedimentary matter and metals of Pb, Cd, Ni, TI, As and Hg in total sedimentary matter were, at all places where the measurement was carried out, below the limit value and that the air there was second category air.
Through implementation of international and national laws and numerous projects the consumption of substances which damage the ozone layer (TOOS) in the Republic of Croatia has decreased. Since 2010, the use of chlorofluorocarbons, Freon, halon, carbon tetrachloride and methylchloroform has been prohibited. Hydrobromofluorocarbon, HBFC and methyl bromide were prohibited in 2006, and the use of hydrochlorofluorocarbon HCFC is allowed until 31 December 2015. Replacement substances (HCFC), which are used in refrigerating and the air-conditioning sector, make the largest share in the use of TOOS, or 99.7% of the total consumption of TOOS in 2008.

The Plan for Protecting and Improving Air Quality in the Republic of Croatia 2008-2011 (OG, no.61/108) was prepared by the Ministry for Environmental Protection, Physical Planning and Construction (today this is Ministry of Environmental and Nature Protection) and it was adopted by the Government in 2008.
The goal set in the Plan is to achieve the first category of air quality throughout the territory of Croatia by the end of 2011. The Plan for Protecting and Improving Air Quality is the implementing document of the Strategy for Air Protection, which is an integral part of the Strategy for Environmental Protection. The Plan covers a period of four years, from 2008 to the end of 2011.
Within the plan for protecting and improving air quality, the firs priority goal is a gradual reduction in air pollution, with the aim of protecting human health, the environment, and material goods, with the following individual goals:

- in areas in which the first category of air quality has been achieved, preventive measures must be implemented to prevent deterioration in air quality and facilitate continual improvement;

- the first category of air quality is to be achieved throughout the territory of Croatia by the end of 2011. The deadline for ozone is still to be established. According to the Air Protection Act, this means levels of concentration indicating that the air is clean or imperceptibly polluted, and that limit values have not been exceeded for even one pollutant;
- intervening measures must be ensured wherever there is a risk of pollution occurring to levels above critical values;
- the effects on the eco-system, crops and material goods due to acidification, eutrophication and ground-level ozone must be reduced.

The Plan envisages measures for stimulating scientific research programmes, particulary in the field of climate change. This goal implies active co-operation between scientific institutions and state administrative bodies, in developing and implementing research and technological projects related to atmosphere research issues, the reduction of pollutant emissions and the adaptation and reduction of harmful effects on individual components of the environment.
The Programme contains an assessment of the air quality situation in the territory of Croatia, the goals of protection and air quality improvement, all existing protection and air quality improvement measures, and prescribes additional measures to be taken in order to reduce emissions of greenhouse gases, and increase energy efficiency and use of renewable sources of energy.
Climate change is a predominant global environmental problem in the 21 century. The effects of climate change are more and more obvious and are recognised in a number of occurrences: temperature changes, levels of precipitation, water resources, raised sea levels, frequent extreme meteorological conditions, changes to the eco-system, bio-diversity, agriculture, forestry and health, and economic damage.
Scientists predict that these changes will become more and more noticeable. Due to its geographical position, ecological and environmental peculiarities and economic orientation, Croatia can be considered particularly sensitive to climate change.
In this sense, it is necessary to invest extra effort in reducing pressure and it is necessary to alleviate the consequences of climate changes by adaptation. The Ministry of Environmental and Nature Protection has therefore prepared a draft National Strategy for Implementing the UN Framework Convention on Climate Change and the Kyoto Protocol, along with an action plan, whose goals and measures are included in this document
Regulation on Siting of National Network Stations for Continuous Air Quality Monitoring (Official Gazette, No. 4/02), Programme on Air Quality Measurement in the National Air Quality Monitoring Network (Official Gazette, No. 43/02), Regulation on Ozone in the Air (Official Gazette, No. 133/05), Regulation On Limit Values of Pollutants in Ambient Air (Official Gazette, No. 133/05), Regulation on Alert Thresholds for Pollutants in Ambient Air (Official Gazette, No. 133/05), Regulation on the Quality of Biofuels (Official Gazette, Nos. 141/05 and 33/11), Ordinance on Air Quality Monitoring (Official Gazette, No. 155/05), Ordinance on Information Exchange of Data from the Network for Continuous Air Quality Monitoring (Official Gazette, No. 135/06), Regulation on Technical Standards of Environmental Protection from Volatile Organic Compound Emissions by Storage of Petrol and its Distribution (Official Gazette, No. 135/06), Regulation on Unit Charges, Corrective Coefficients and Detailed Criteria and Benchmarks for Determination of the Charge for Carbon Dioxide Emissions into the Environment (Official Gazette, Nos. 73/07 and 48/09), Ordinance on the Method and Deadlines for Calculation and Payment of the Charge on Carbon Dioxide Emissions into the Environment (Official Gazette, No. 77/07), Regulation on Limit Values of the Content of Volatile Organic Compounds in Certain Paints and Varnishes

and Vehicle Refinishing Products (Official Gazette, No. 94/07), Programme for Monitoring the Quality of Petroleum Derived Liquid Fuels for 2008 (Official Gazette, No. 120/07), Ordinance on the Availability of Data on Fuel Economy and CO2 Emissions of New Passenger Cars (Official Gazette, No. 120/07), Plan for Protecting and Improving Air Quality in the Republic of Croatia 2008-2011 (Official Gazette, No. 61/08), Regulation on Designation of Zones and Agglomerations According to Categories of Air Quality (Official Gazette, No. 68/08), Regulation on Emission Quotas for Certain Pollutants in the Republic of Croatia (Official Gazette, No. 141/08), Regulation on Implementation of the Kyoto Protocol Flexible Mechanisms (Official Gazette, No. 142/08), Decision on the Adoption of the National Plan for the Implementation of Stockholm Convention on Persistent Organic Pollutants (Official Gazette, No. 145/08), Decision on Adopting the Plan on Reduction of Emissions of Sulphur Dioxide, Nitrogen Oxides and Particulate Matter from Major Combustion Plants and Gas Turbines in the Territory of the Republic of Croatia (Official Gazette, No. 151/08), Programme for Monitoring the Quality of Petroleum Derived Liquid Fuels for 2009 (Official Gazette, No. 5/09), Plan on Allocation of Greenhouse Gas Emission Quotas in the Republic of Croatia (Official Gazette, No. 76/09), Programme for Gradual Emission Reduction of Certain Pollutants in the Republic of Croatia for the Period until the End of 2010, with Emission Projections for the Period from 2010 to 2020 (Official Gazette, No. 152/09), Programme for Monitoring the Quality of Petroleum Derived Liquid Fuels for 2010 (Official Gazette, No. 13/10), Decision on Adoption of the Fifth National Communication of the Republic of Croatia under the United Nations Framework Convention on Climate Change (Official Gazette, No. 24/10), Programme for Monitoring the Quality of Petroleum Derived Liquid Fuels for 2011 (Official Gazette, No. 144/10), Regulation on Technical Standards of Environmental Protection for the Reduction of Volatile Organic Compound Emissions during the Filling of Motor Vehicles with Petrol at Petrol Stations (Official Gazette, No. 5/11), Regulation on the Quality of Petroleum-derived Liquid Fuels (Official Gazette, No. 33/11), Programme for Monitoring the Quality of Petroleum Derived Liquid Fuels for 2012 (Official Gazette, No. 139/11), Decision on Establishing the Annual Quantity of Petroleum Derived Liquid Fuels Allowed to be Placed on the Domestic Market without Meeting the Limit Values and other Quality Characteristics for Petroleum Derived Liquid Fuels (Official Gazette, No. 154/11), Ordinance on the Manner of Free Allocation of Emission Allowances to Installations (Official Gazette, No. 43/12), Regulation on the Method of Greenhouse Gas Emission Allowance Trading (Official Gazette, No. 69/12), Regulation on Greenhouse Gas Emission Monitoring, Policy and Measures for their Reduction in the Republic of Croatia (Official Gazette, No. 87/12), Regulation on Substances Depleting the Ozone Layer and Fluorinated Greenhouse Gases (Official Gazette, No. 92/12), Regulation on Limit Values of Pollutant Emissions from Stationary Sources into the Air (Official Gazette, No. 117/12), Regulation on Levels of Pollutants in Ambient Air (Official Gazette, No. 117/12) - effective as of 1st January 2013, Decision on the Auctioneer for Emission Allowances Auctions and Selection of the Auctioning System (Official Gazette, No. 124/12), Ordinance on the Monitoring of Pollutant Emission from Stationary Sources into the Air (Official Gazette, No. 129/12), Ordinance on Greenhouse Gas Emission Monitoring in the Republic of Croatia (Official Gazette, No. 134/12)."

List of other legal regulations in the field of air quality protection: Regulation on Siting of National Network Stations for Continuous Air Quality Monitoring (Official Gazette, No. 4/02), Regulation On Substances that Deplete the Ozone Layer (Official Gazette, No. 120/05), Regulation pn Ozone in the Air (Official Gazette, No. 133/05), Regulation on Limit Values of Pollutants in Ambient Air (Official Gazette, No. 133/05), Regulation on Alert Thresholds for Pollutants in Ambient Air (Official Gazette, No. 130/05), Regulation on the Quality of Biofuels (Official Gazette, No. 141/05 and 33/11), Ordinance on Air Quality Monitoring

(Official Gazette, No. 155/05), Ordinance on Monitoring Pollutant Emissions from Stationary Sources into the Air (Official Gazette, No. 01/06), Ordinance on Issuing of Licence or Approval for Performing the Activities of Monitoring Air Quality and Emissions into the Air from Stationary Sources (Official Gazette, No. 79/06), Ordinance on Information Exchange of Data from the Network for Continuous Air Quality Monitoring (Official Gazette, No. 135/06), Regulation on Technical Standards of Environmental Protection from Volatile Organic Compound Emissions by Storage of Petrol and its Distribution (Official Gazette, No. 135/06), Regulation on Greenhouse Gas Emission Monitoring in the Republic of Croatia (Official Gazette, No. 01/07), Regulation on Alert Thresholds for Pollutants from Stationary Sources into the Air (Official Gazette, Nos. 21/07 and 150/08), Chapter VI of the Guide for the Implementation of the Regulation on Alert Thresholds for Pollutants from Stationary Sources into the Air (Official Gazette, No. 21/07), Regulation on Unit Charges, Corrective Coefficients and Detailed Criteria and Benchmarks for Determination of the Charge for Carbon Dioxide Emissions into the Environment (Official Gazette, Nos. 73/07 and 48/09), Ordinance on Monitoring Pollutant Emissions from Stationary Sources into the Air (Official Gazette, No. 129/12), Ordinance on the Method and Deadlines for Calculation and Payment of the Charge on Carbon Dioxide Emissions into the Environment (Official Gazette, No. 77/07), Regulation on Technical Standards of Environmental Protection for the Reduction of Volatile Organic Compound Emissions during the Filling of Motor Vehicles with Petrol at Petrol Stations (Official Gazette, No. 5/11), Regulation on the Method of Greenhouse Gas Emission Allowance Trading (Official Gazette, No. 69/12), Regulation on Limit Values of the Content of Volatile Organic Compounds in Certain Paints and Varnishes and Vehicle Refinishing Products (Official Gazette, No. 94/07), Ordinance on the Manner of Free Allocation of Emission Allowances to Installations (Official Gazette, No. 43/12), Ordinance on Monitoring Pollutant Emissions from Stationary Sources into the Air (Official Gazette, No. 134/12), Ordinance on the Availability of Data on Fuel Economy and CO2 Emissions of New Passenger Cars (Official Gazette, No. 120/07), Regulation on Designation of Zones and Agglomerations According to Categories of Air Quality (Official Gazette, No. 68/08), Calculated Level and Permitted Consumption for Controlled Substances that Deplete the Ozone Layer, Annex C, Group I, (Official Gazette, No. 129/08), Regulation on Greenhouse Gas Emission Monitoring, Policy and Measures for their Reduction in the Republic of Croatia (Official Gazette, No. 87/12), Regulation on Limit Values of Pollutant Emissions from Stationary Sources into the Air (Official Gazette, No. 117/12), Regulation on Levels of Pollutants in Ambient Air (Official Gazette, No. 117/12) - effective as of 1st January 2013, Regulation on Emission Quotas for Certain Pollutants in the Republic of Croatia (Official Gazette, No. 141/08), Regulation on Implementation of the Kyoto Protocol Flexible Mechanisms (Official Gazette, No. 142/08), Regulation on Greenhouse Gas Emission Quotas and the Method of Emission Allowance Trading (Official Gazette, Nos. 142/08 and 113/10), Decision on the Adoption of the National Plan for the Implementation of Stockholm Convention on Persistent Organic Pollutants (Official Gazette, No. 145/08), Decision on Adopting the Plan on Reduction of Emissions of Sulphur Dioxide, Nitrogen Oxides and Particulate Matter from Major Combustion Plants and Gas Turbines in the Territory of the Republic of Croatia (Official Gazette, No. 151/08), Programme for Monitoring the Quality of Petroleum Derived Liquid Fuels for 2009 (Official Gazette, No. 5/09), Plan on Allocation of Greenhouse Gas Emission Quotas in the Republic of Croatia (Official Gazette, No. 76/09), Programme for Monitoring the Quality of Petroleum Derived Liquid Fuels for 2012 (Official Gazette, No. 139/11), Programme for Monitoring the Quality of Petroleum Derived Liquid Fuels for 2008 (Official Gazette, No. 120/07), Programme on Air Quality Measurement in the National Air Quality Monitoring Network (Official Gazette, No. 43/02), Programme for Gradual Emission Reduction of Certain Pollutants in the Republic of Croatia for the Period

until the End of 2010, with Emission Projections for the Period from 2010 to 2020 (Official Gazette, No. 152/09), Programme for Monitoring the Quality of Petroleum Derived Liquid Fuels for 2010 (Official Gazette, No. 13/10), Decision on the Auctioneer for Emission Allowances Auctions and Selection of the Auctioning System (Official Gazette, No. 124/12), Decision on Adoption of the Fifth National Communication of the Republic of Croatia under the United Nations Framework Convention on Climate Change (Official Gazette, No. 24/10), Programme for Monitoring the Quality of Petroleum Derived Liquid Fuels for 2011 (Official Gazette, No. 144/10), Decision on Adopting the Plan on Reduction of Emissions of Sulphur Dioxide, Nitrogen Oxides and Particulate Matter from Major Combustion Plants and Gas Turbines in the Territory of the Republic of Croatia (Official Gazette, No. 151/08), Decision on the Adoption of the National Plan for the Implementation of Stockholm Convention on Persistent Organic Pollutants (Official Gazette, No. 145/08), Decision on Establishing the Annual Quantity of Petroleum Derived Liquid Fuels Allowed to be Placed on the Domestic Market without Meeting the Limit Values and other Quality Characteristics for Petroleum Derived Liquid Fuels (Official Gazette, No. 154/11), Regulation on the Quality of Petroleum-derived Liquid Fuels (Official Gazette, No. 33/11).

2. Prevention of water pollution

Legislation related to water management consists of the Water Act, the Water Management Financing Act and the Food Act, along with approximately 30 secondary acts.

The Water Act contains the institutional framework for the management of water resources, regulates the legal status and ownership of water; different methods of water management; assigns jurisdictions to different levels of authority, local governments and legal entities; establishes Hrvatske vode (a public company) as a legal entity responsible for water management. The Water Act contains the concept of water management at the level of the catchment/river basin area, so that the territory of Croatia is divided into four river basin districts, i.e. territorial units for water management purposes. Water basins contain one or more river basin districts with water courses and includes surface- and groundwaters. The area of the City of Zagreb is defined as a separate unit. The Act regulates the following elements of water management: protection from adverse effects of water, water use and water protection. The Act specifies that water supply for the population has priority over other types of water use. The Water Act prescribes the preparation of water management plans for river basin districts. The management plans must contain data on investment needs for the fulfillment of water management objectives.

According to Article 38 of the Water Act, the quality of the water for water supply must comply with the requirements established by water classification (class I of water) and the Act and its subordinate legislation. This primarily refers to emission control, ie. the prohibition of wastewater discharges. Area to which finds the spring or the other bedding of water which uses or has been booked for the public water supply, as well as the area to which for same needs invades the . An area containing a source or other water deposit which is used or has been reserved for public water supply, as well as as the area in which water from rivers, lakes, reservoirs etc. is collected for the same purpose, has to be protected from pollution and intentional or accidental contamination and from other influences which could adversely affect the health safety of water or its abundance.. For this purpose, water protection is carried out in accordance with the decision on the protection of sources which determines, based on previously carried out water inspection operations, the scope and limits of sanitary protection zones, sanitary and other maintenance conditions and other safety measures, the sources and the method of their financing, as well as the penalties for the violation of its provisions. Sanitary protection zones established by the decision on the protection of sources, as well as

areas reserved for sanitary protection zones for which no decision has been adopted, must be included in the physical planning documents of the area in which these zones extend.
The Ordinance on the Sanitary Quality of Drinking Water (OG 47/2008) has been harmonised with the Directive on the Quality of Water Intended for Human Consumption (98/83/EC). This Ordinance prescribes the implementation of the Drinking Water Sources Monitoring and the Monitoring of the Health Safety of Drinking Water from the Distribution Network. The reasons for the implementation of these types of monitoring are (among others) the following:

1. knowledge of the quality of raw water at public disposal;
2. the technological processes which need to be applied in order to achieve health safety of water in all places of consumption
3. knowledge on the health safety of drinking water in places of consumption.

The ultimate objective of the implementation of monitoring is the determination of the health safety level of drinking water on the entire territory of Croatia. It is estimated that approximately 84.3% of the population of Croatia is connected to the public water supply system while approximately 55% of the population connected to the local water supply system. The remaining part of the population is supplied with water via individual water supply systems (wells, rainwater tanks, water courses...). The Monitoring Plan for 2011 adopted by the Ministry of Health and Social Welfare at the proposal of the Croatian Institute of Public Health covered approximately 89% of the population (public and part of the local water supply system).

Control levels of the health safety of drinking water:

1. The Croatian waterworks company (Hrvatska grupacija vodovoda i kanalizacije g.i.u.) is primarily responsible only for the health safety of water supplied via the public water-supply network (more than 50 persons or 10 m3/day), and not for that of water supplied via the internal networks of facilities.
2. The monitoring of the public water supply is carried out by competent county institutes of public health, while the frequency of sampling depends on the quantity of supplied water, population and the natural structure of water.
3. The Sanitary Inspection carries out monitoring according to a special programme which is harmonised with the Framework Programme of Monitoring of Environmental Factors according to the Health Care Act.
4. According to the provisions of the Sanitary Inspection Act, the Sanitary Inspection of the Ministry of Health supervises all public water-supply facilities which supply more than 50 000 inhabitants.

The Ministry of Health is competent for drinking water from the public water supply, the health safety of which is systematically controlled by county institutes of public health, which send the results of their analyses to the Croatian Institute of Public Health. In 2011, only data obtained from obligatory monitoring of drinking water, which is carried out from default locations in all water supply systems in Croatia, was published. Due to the inexistence of the electronic database on the health safety of drinking water in Croatia, which should include data from all county institutes of public health and the Croatian Institute of Public Health, it is impossible to separately process data for public and local water supply. Since data from the local water supply have also been processed, For the percentage of unrepresentative samples in the public water supply is much higher than in the previous years. The most obvious example is the water supply in the Krapinsko – zagorska and Varaždinska County, in which

the state of the public water supply is excellent, but the large number of local water supply systems negatively affects the reports on water health safety. We hope that it will be possible to provide a correct account of water health safety will after the setting up of a database, which is essential, among other things, to the purpose of correct reporting to the European Commission.

According to general information on the Croatian water supply system in 2011, there are 544 water mains, 128 of which are public, for a population of 4,290,612, while the number of consumers is 3,617,169, 84,3% of which are connected to the public water supply. There are 405 local water mains with 220,773 consumers, which account for 5.1% of those connected to the local water supply.

According to the implementation plan of this monitoring for 2011, 1,360 samples were to be taken on the entire territory of Croatia. 428 samples for complete C analysis and 932 samples for complete B analysis of raw water from the well field were planned to be taken. The implementation of the plan was assessed as "very good", since approximately 62% more samples than planned were taken. This represents an improvement with regard to last year, when the Monitoring of Drinking Water Sources was carried out with less than 60% of the planned number of samples. No water samples from the source intended for water supply were taken in Bjelovarsko – bilogorska County and the City of Zagreb, which is why these areas are classified as counties in which the implementation of the planned monitoring was unsuccessful.

Somewhat more than 56% of a total of 850 samples were inadequate due to one or more indicators, according to the Ordinance on Sanitary Quality of Drinking Water. The percentage of inadequate samples ranged from 0% in the Međimurska County to 100% in the Brodsko–posavska County. The most common reason for the inadequacy was the microbiological pollution of raw water. In two counties, microbiological pollution was the only reason for non-compliance with the provisions of the Ordinance. The physical and chemical pollution of raw water differed from region to region. The reasons for non-compliance with the provisions of the Ordinance were increased turbidity in eight counties, ammonia in three counties, manganese in five counties, iron in three counties and nitrates in two counties. These values were mostly recorded in continental counties with the exception of Dubrovačko–neretvanska and Istarska County, in which an increased quantity of aluminium was also recorded. Increased levels of arsenic were recorded in the Osječko-baranjska County. Results of salinisation of raw waters, as well as increased quantities of sodium, potassium, chlorides and sulfates, were recorded in the Dubrovačko-neretvanska and Zadarska County. All other tested indicators were below the values specified by the Ordinance on Sanitary Quality of Drinking Water. The implementation of the Monitoring of Drinking Water Sources was observed by all main water supply systems. This is not true of the smaller systems and especially of the local water mains, which respect neither the provisions of the Ordinance on Sanitary Quality of Drinking Water, which is a by-law of the Food Act, nor the provisions of the Water Act. At the same time, however, they sell drinking water of unverified health safety.

According to the plan for the carrying out of monitoring activities from 2011, 29,766 samples were to be taken on the entire territory of Croatia. Approximately 80% of these were collected for basic "A" analysis. It was planned to collect 25,765 samples for "A" analysis and 4,001 samples for extended "B" analysis of processed drinking water. The implementation of the plan was assessed as GOOD, given that 11,382 samples were collected in 2011, which is somewhat less than 38.2% of the planned number of samples. The number of treated samples is higher than in 2010. The monitoring has been carried out differently in each county. For example, less 1% of the planned number of samples, has been collected in Vukovarsko – srijemska County, which is why the monitoring in that county was assessed as UNSATISFACTORY.

The samples were not collected mainly due to the failure of the county authorities to secure financial resources, which are they obliged to do according to the Art. 8 of the Ordinance on Sanitary Quality of Drinking Water. On the other hand, more than the planned number of samples was collected in the Istarska County. A little more than 13.5 % samples has were inadequate due to one or more indicators from the Ordinance. This number is somewhat higher than in 2010. The percentage of inadequate samples was highest in the Krapinsko-zagorska County (approximately 57%). This high percentage
is primarily the result of a large number of local water mains in which there is no processing of water. It is estimated that the percentage of inadequate samples would be much lower than 10% if only samples from public, and not local, water supply had been analysed. The main reason for the inadequacy of samples was the microbiological drinking water pollution, usually by a high number of aerobic bacteria at 22°C and 37°C. In ten counties, none pf the physical and chemical indicators exceeded the MAC values in the Ordinance. The physical and chemical drinking water pollution from the distribution network differed from region to region. The main causes of the pollution were high turbidity, ammonia, nitrates, iron and manganese, which were sporadically above the values in the Ordinance. These values were mostly recorded in continental counties. A heightened content of arsenics was recorded in the Osječko-baranjska and Vukovarsko– srijemska County. The consequences of the salinisation of raw water and increased quantities of sodium, potassium, chlorides and sulfates were recorded in the Dubrovačko– neretvanska and Zadarska County. All other tested indicators were lower than the MAC values specified in the Ordinance on Sanitary Quality of Drinking Water.

CONCLUSION

The Monitoring of Drinking Water Sources and the Monitoring of Drinking Water from the Distribution Network have been carried out since 2009, and differ from county to county. The legislation clearly defines who finances the implementation of the monitoring: companies which carry out water supply activities (monitoring of drinking water sources – according to the provisions of the Food Act, included in the Ordinance on Sanitary Quality of Drinking Water, and the Water Act) and the counties, along with the City of Zagreb (monitoring of drinking water from the distribution network - according to the provisions of the Food Act, included in the Ordinance on Sanitary Quality of Drinking Water). However, they fulfil their obligations to different degrees. Therefore, the legislator (the Ministry of Health) should undertake adequate measures for the non-implementation of monitoring, including, if necessary, coercion by way of informing the public on the inefficient carrying out of the prescribed monitoring. Regardless of their equipment, water-supply companies are not allowed to carry out monitoring in their laboratories, since it must be carried out by independent laboratories of the Croatian Institute of Public Health authorised by the Ministry of Health (Art. 97 - 100 of the Health Care Act). The water-supply companies are also not allowed to finance the monitoring of drinking water from the distribution network. This is the exclusive obligation of the state authority, i.e. the the county authority, according to the Ordinance on Sanitary Quality of Drinking Water. An evident conflict of interest would arise from failure to act in the manner prescribed by law. The obligation of establishing a database on the health safety of drinking water is unquestionable, not only because of the obligation of reporting to the European Commission on the health safety of drinking water, but also because of the availability of the collected data for use by various state authorities (ministries, Hrvatske vode, the Croatian Environment Agency, the Croatian Metereological and Hydrological service, Croatian Geological Survey, universities,…), under specific terms.
Water for recreational use

The network of institutes of public health also monitors the health safety of water for recreational use in swimming pools, but by using a nonuniform, non-standard methodology, as a consequence of which the laboratory results of county institutes of public health are not always mutually comparable, nor are they systematically obtained on a national level. Results of the testing of sea water quality on beaches show the Croatian sea water is of high quality, since more than 98.5% of the total analysed samples meets the strict criteria prescribed by the Regulation.

3. Prevention of soil contamination

According to Article 10 of the Environmental Protection Act (Official Gazette, No. 110 / 07), "Soil is a non-renewable asset and must be used in a sustainable manner and its functions preserved. Adverse effects to the soil must be avoided to the greatest possible extent.". Article 20 of the Act states the following:

1) Soil protection includes the preservation of the health and functions of the soil, prevention of soil damage, monitoring the status of the soil and changes in its quality as well as remediation and restoration of damaged soil and locations.
2) Pollution or damage of soil shall be considered to be an adverse effect on the environment while establishment of acceptable limit values of soil quality shall be carried out on the basis of special regulations.

In Croatia there is no systematic, national monitoring of soil pollution. Individual and uncoordinated activities of monitoring soil condition within projects (e.g. the Pilot Project of Monitoring Forest Soils and the Pilot Project of Monitoring Contaminated Soils) are still carried out, which is insufficient for the purposes of a systematic monitoring of soil condition and changes. Parallel with the implementation of the "Development of the Croatian Soil Monitoring Programme with a Pilot Project" project, the Croatian Environment Agency has initiated the phase of the setup of the Soil Information System of Croatia (SISC), in the course of which a spatiotemporal georeferenced computer-based databases on soils has been set up. Along with the main database which will contain all available pedological data collected mainly within research projects and studies, a Web interface which enables the input and processing of data from continuous monitoring of soils has also been set up.
The preparation of the Countinuous Soil Monitorings Programme (CSMP), as the source document for ensuring the harmonised collection of data on soil condition. The Continous Soil Monitoring Programme will define the parameters required for the establishment of the Continous Monitoring of Agricultural and Forest Soils and Contaminated Areas System.
Once established, the Continous Soil Monitoring System, with a clearly established positioning of stations and standardised methods of collection and analysis of samples, will represent a source of information on the monitoring of soil condition within the Soil Information System of Croatia (SISC), as part of the Environmental Information System (EIS), which is the key government instrument of adoption of practices of sustainable development of soils and optimal agricultural systems, monitoring legislation and developing environmental protection strategies and policies on the national level, applied within the Croatian Environment Agency.
The Project represents the background for the Rulebook and Program of Continuous Soil Monitoring, as source documents for the collection of harmonized data on soil condition, taking into consideration the specific agricultural and environmental conditions in Croatia,

EU recommendations and
Member States' experiences.
The Continous Soil Monitoring Programme will contain:
• a list of data and characteristics which will be monitored at stations and points of continuous monitoring,
• a list of methods and standards for the collection, analysis, processing and presentation of data,
• a definition of the extent and temporal dynamics of the collection, processing and presentation of data,
• recommendations regarding the locations of stations and points for continuous monitoring (agricultural, forest, potentially contaminated and contaminated soils) on the territory of the Republic of Croatia,
• proposal for the financial structure for development and maintenance,
According to available data, 1 056 potentially contaminated and 69 contaminated locations have been confirmed. The number of potentially contaminated localities is probably even higher, and therefore the correct determining of information related to it is important for the Republic of Croatia. Soil is the most neglected resource, due to, among other reasons, the nonexistence of a comprehensive protective policy of soil in the Republic of Croatia.
Salinisation is the process of accumulation of soluble salts (Na, Ca, Cl etc.) which can have a negative influence on the fertility of soil. It also enables increased presence of metals in soil, especially cadmium, thereby facilitating the inclusion of this toxic metal into the food chain. The majority of saline soils are located in the valley of the Neretva, in the area of the Vransko basin, and in the lower course of the Mirna and Raša rivers in Istria. The salinisation of soils in these areas is mostly connected with the penetration of sea-water into the hinterland and its use for irrigation. Use of saline water results in the reduction of the yield of cultivated crops and soil degradation. The salinisation problem needs to be systematically dealt with. The possible solutions which are being studied include supplying enough fresh water and construction of movable bulkheads which prevent the penetration of sea-water in the hinterland.

B) Prevention of contamination by radioactive substances

The State Office for Radiological and Nuclear Safety was founded in 2010, on the basis of the Act on Radiological and Nuclear Safety (Official Gazette, No. 28/10), as the state administration body responsible for activities related to nuclear safety in Croatia, formerly within the competence of the State Institute of Radiation Protection and the State Office for Radiological and Nuclear Safety.
The Office's operations include the monitoring and supervision of all activities with sources of ionising radiation, protection from ionising radiation, nuclear activities, nuclear safety, systematic testing and monitoring of the types and activities of radioactive substances in air, soil, sea, rivers, lakes, groundwaters, solid and liquid precipitations, drinking water, food and objects for general use, residential and working spaces, monitoring of the ecological load caused by the operation of a nuclear facility and of its consequences, supervision of radioactive waste used nuclear fuel disposal, and the preparation of a plan and programme of protection in case of an emergency. Every two years, or more often if necessary , the Institute submits a report to the Government of the Republic of Croatia on protection from ionising radiation and nuclear safety for the previous period. The Department for Radiation Protection of the Sanitary Inspection of the Ministry of Health carries out administrative, legal, expert and inspection activities of sanitary inspection of sources of ionising and non-ionizing radiation.

An important activity of the Office is informing the public, and consists of educating the public and informing them during a nuclear accident.
The population of areas of increased risk is regularly educated on the nuclear accident response system, as well as measures and activities which is necessary undertaken in case nuclear accidents. In cooperation with the State Directorate for Protection and Rescue (SDPR), the Office organises specific education of the public through the organisation of public seminars in secondary schools and buildings of local self-government in high-risk areas. Workshops periodically organised for various population (the SONS staff of the Technical Assistance Centre - TAC, civil protection staff and specific target public groups such as experts, the media, the general public etc.) have an important role. Periodic drills, aimed at providing training to the staff of the 112 Service, the TAC and the Emergency Centre of the SDPR and improving their communication and coordination, are also organised. The Office is also actively included in international drills organised by the International Atomic Energy Agency (CONVEX) and the European Commission (ECURIE).
Nuclear materials are subject to a control system, according to the Ordinance on the Control of Nuclear Material and Special Equipment (Official Gazette, No. 15/08). Annexes to the Ordinance contain a list and categorization of nuclear materials. With regard to the total amount of nuclear materials, the control system and protection measures are applied as follows:

- Class I - a full system of control and protection measures;
- Class II - a limited system of control and protection measures;
- Class III - no system of control and protection measuresis is applied.

At a distance of up to 1,000 km from the territory of the Republic of Croatia, i.e. from its largest population centers, (Zagreb, Osijek, Split and Rijeka), there are 40 nuclear power plants in operation. These nuclear power plants contain 89 power reactors (1 to 4 reactor units per power plant), which differ in capacity, service life and technology (see Figure 1).

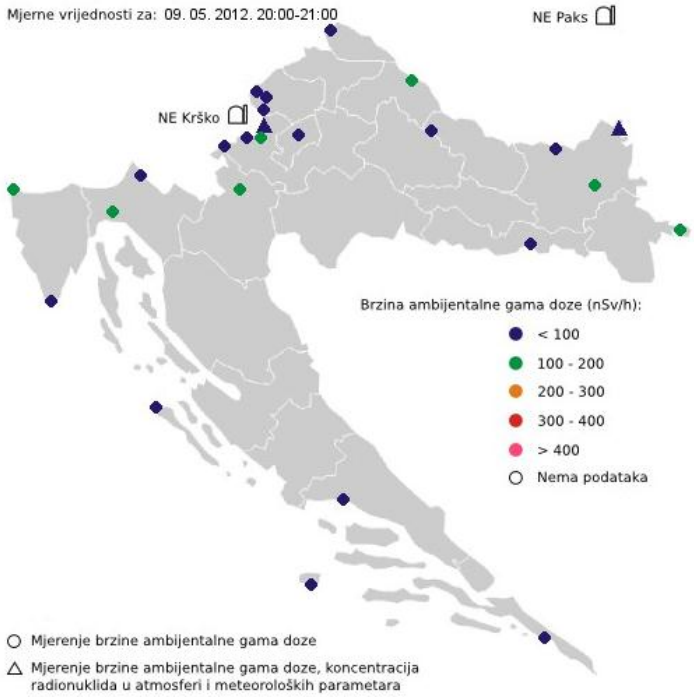
Figure 1 Locations of nuclear power plants at a distance of up to 1,000 km from the territory of the Republic of Croatia

The State Office for Radiological and Nuclear Safety manages the Croatian Early Warning System (CEWS). The CEWS represents an important component of the national nuclear accident preparedness system. It gives alert in cases of an increased level of radioactivity in the environment and provides input data for dose assessment for the population. In case of an accident, the main users of CEWS will be the members of the Emergency Centre of the State Office for Radiological and Nuclear Safety. The CEWS consists of 25 measurement stations

and central units in which measurement results are collected, analysed and archived. Each station continuously monitors ambient gamma dose rate. At two stations, radionuclide concentrations in the atmosphere and certain meteorological parameters are also measured. The data from the measurement stations is fed back to the central unit after each measurement cycle. If elevated radiation levels are detected, an alarm system is automatically triggered and measurement data is examined by the SONS duty officer, who determines the causes of the deviation. A map of the locations of all measurement stations belonging to the CEWS and their data in real-time are publicly available online, the colour of the mark of each station indicating the average gamma dose rate for the last available one-hour measurement interval (http://www.dzns.hr/aktivnosti/pripravnost/pravodobno_upozoravanje).

All measurement results gathered with CEWS are continuously sent to the EURDEP system managed by the European Commission. The EURDEP is a system for the exchange of radiological monitoring data in which the majority of the European countries is participating. Independently of the EURDEP, measurement results are exchanged with Slovenia and Hungary based on bilateral agreements covering assistance in the field of nuclear emergency preparedness.

Figure 2 Locations of radioactivity level measurement stations in the environment, by clicking on which a description of the station and the table of data in real-time are shown..

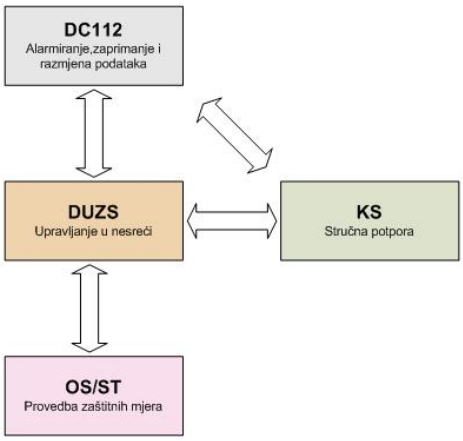


CROATIAN	ENGLISH
Mjerne vrijednosti za: 09.09.2012.	Measured values for: 09/09/2012
NE Paks	Paks NPP
NE Krško	Krško NPP
Brzina ambijentalne gama doze	Ambiental gamma dose rate

Nema podataka	No data
Mjerenje brzine ambijentalne gama doze	Ambiental gamma dose rate measurements
Mjerenje brzine ambijentalne gama doze, koncentracija radionuklida u atmosferi i metereoloških parametara	Ambiental gamma dose rate, radionuclide atmospheric concentrations and metereological parameters measurements

The Croatian Emergency Preparedness System is based on the Act on Radiological and Nuclear Safety (Official Gazette, No. 28/10) and the State Plan and Programme for the Ionizing Radiation Countermeasures and Interventions in Case of an Emergency (Official Gazette, No. 49/08). The main participants in the Croatian Emergency Preparedness System are the National Centre 112 (NC112), the Crisis Headquarters of the State Office for Radiological and Nuclear Safety (CH), the National Protection and Rescue Directorate (NPRD) and the Operational Forces and Special Teams (OF/ST) (see Figure 3).

Figure 3 Main participants in the Croatian Emergency Preparedness System



CROATIAN	ENGLISH
DC112 Alarmiranje, zaprimanje i razmjena podataka	NC112 Alarming, receiving and transmitting information
DUZS Upravljanje u nesreći	NPRD Crisis management
OS/ST Provedba zaštitnih mjera	OF/ST Countermeasures implementation
KS Stručna potpora	CH Expert support

Crisis management in the case of a nuclear accident is the task of the National Protection and Rescue Directorate (NPRD). This institution makes decisions concerning countermeasures and supervises their implementation.

The National Center 112 operates 24 hours a day and is responsible for gathering initial information about accidents and activating the emergency preparedness system. During the accident itself, the NC112 receives and passes on data from various international and national institutions, organizations and individuals. The Crisis Headquarters of the State Office for Radiological and Nuclear Safety is the leading support body in the case of a nuclear accident. Its main duty is to gather and distribute required information, prepare expert bases necessary for the decision-making process related to countermeasures implementation and carry out timely and accurate public informing.
Implementation of the countermeasures is the duty of the operational

forces and special teams. The operational forces are formed from the professional state and local government units, firefighters, civil protection units and specialized companies personnel. The special teams are units specially trained and equipped for carrying out tasks such as decontamination, damage repair or radiological monitoring installation.

International Coventions and Agreements

Act on the Ratification of the Joint Convention on the Safety of Spent Fuel Management and on the Safety of Radioactive Waste Management (Official Gazette, No. 03/99); Act on Ratification of the Agreement between the European Atomic Energy Community (Euratom) and Non-Member States of the European Union on the Participation of the Latter in the Community Arrangements for the Early Exchange of Information in the Event of Radiological Emergency (ECURIE) (Official Gazette, No. 08/07); Convention on nuclear safety (Official Gazette, No. 13/95); Convention on Early Notification of a Nuclear Accident (Official Gazette, No. 01/06); Convention on Assistance in Case of a Nuclear Accident or Radiological Emergency (Official Gazette, No. 01/06); Agreement between the Republic of Croatia and the Republic of Slovenia on the Early Exchange of Information in the Event of a Radiological Emergency (Official Gazette, No. 09/98); Corrigendum of Agreement between the Republic of Croatia and the Republic of Slovenia on the Early Exchange of Information in the Event of a Radiological Emergency (Official Gazette, No. 03/00); Agreement between the Government of the Republic of Croatia and the Government of the Republic of Hungary on the Early Exchange of Information in the Event of a Radiological Emergency (Official Gazette, No. 11/99). Dose limits for the population (1 mSv) and occupational exposure (100 mSv in five years, where the yearly dose must not exceed 50 mSv) are regulated by
Ordinance on the limits of exposure to ionising radiation, and on the conditions of exposure in special circumstances and in emergency situations (Official Gazette No. 125/06). This Ordinance also regulates the dose limits for emergency situations (nuclear power plant accidents). Protection from contamination in the workplace is regulated by the Ordinance on the conditions and measures for protection against ionising radiation for carrying out activities with radioactive sources (Official Gazette No. 125/06), Ordinance on the methods, extent and time intervals of personal exposure monitoring for exposed workers and patients, surveillance of the sources of ionizing radiation and work conditions, on measuring of prescribed elements and quality control, on control of radioactive contamination of persons, objects, environment, rooms and air in the rooms in which the practices are performed or the radioactive sources are stored, on contents of the measurement and surveillance reports, reporting procedure and on obligation of records and registries maintenance, their contents, maintenance methods and periods of retention (Official Gazette No. 127/07), Ordinance on the conditions, manner, places and deadlines for systematic testing and monitoring of the type and activity of radioactive substances in the air, soil, the sea, rivers, lakes, ground waters, solid and liquid precipitation, drinking water, foodstuffs and general use products and dwelling and working spaces (Official Gazette No. 60/08) and the Regulation on conditions and method of disposal of radioactive waste, spent sealed radioactive sources and ionising radiation sources which are not intended for further use (Official Gazette 44/08).
Safety measures in case of an emergency event are regulated by the State Plan and Program of Ionising Radiation Protection Measures and Emergency Interventions (Official Gazette, No. 49/08). All documents comply with the IAEA Recommendations.
C) Protection from noise pollution
In spite of the adoption of the Noise Protection Act (Official Gazette, No. 30/09) and corresponding bylaws, no system of continuous monitoring of noise level in the environment

has yet been established in Croatia, and neither have any assessment studies on the impact of noise on the health of the exposed population been carried out. The present activities of the sanitary inspection, as a structural unit of the Ministry of Health competent for noise protection of the population, include measuring noise levels for the purpose of confirming compliance with the minimum technical requirements for specific facilities, as well as measuring noise intensity in cases of individual appeals of citizens stating transport and catering facilities as the prevailing source of noise. According to legislation which regulates the noise protection activity, cities with more than 100 000 inhabitants and owners and concession holders of industrial areas, main roads, railway lines and airports are obliged to make a strategic noise map, for the purpose of comprehensive assessment of the exposure of the population to noise from different sources. With regard to this, it is necessary to introduce systematic monitoring of the noise levels, assessment of the impact of noise on human health, as well as propose and implement measures for noise reduction to prescribed levels. in relation to this, a biannual IPA project is being implemented with the aim of preparing a noise protection strategy and action plan.

The existing secondary legislation which, along with the Noise Protection Act (Official Gazette, No. 30/09), regulates noise protection is the following:: the Noise Protection Act (Official Gazette, No. 20/03), Ordinance on the maximum permitted noise levels in an environment in which people work and live (Official Gazette, No. 145/04), Ordinance on the method of creating and the contents of noise maps and action plans (Official Gazette, No. 05/07), Ordinance on activities which require the implementation of noise protection measures (Official Gazette, No. 91/07), Ordinance on protection of workers from exposure to noise (Official Gazette, No. 46/08), Ordinance on conditions regarding the premises, equipment and employees of legal persons which perform professional noise protection activities (Official Gazette, No. 91/07).

D) Food hygiene and safety inspection

During 2007 the Parliament of the Republic of Croatia adopted legislation on food safety, which was fuly harmonised with the Regulation (EC) 178/02, i.e. the “General Food Law” and the "Hygienic Package” of the EC.

Regulation 852/2004 on the hygiene of foodstuffs established the general rules of hygiene in the production of all foodstuffs, the producer's liabilities (for all food business operators - from primary producers to distributors) and guidelines for good production practice. It also placed special emphasis on the system of self-control (HACCP) and responsibility of all participants in the food production chain which must ensure the health safety of food.

Considering that food of animal origin is related to specific dangers (microbiological, chemical and physical), Regulation 853/2004 (EC) lays down special hygienic regulations for this sector, which include, among other rules, the general standards referring to the transport of animals to the slaughterhouse, requirements for slaughterhouse and cutting plant construction, design and equipment, hygienic standards for the production of food of animal origin, as well as for the slaughter, cutting up, separation of meat from bone, emergency slaughter and conditions of meat storage and transport.

Regarding the specific risks related to meat production and meat products, Regulation 854/2004 (EC) defines the rules concerning official veterinary supervisions, which include checking of food chain information (FCI), ante-mortem inspection, checking of implementation of the regulations on animal welfare, post-mortem inspection, supervision of hazardous material and slaughter by-products, as well as laboratory analyses.

in addition to Regulation 854/2004 (EC) which refers to official inspections of foodstuffs of animal origin, Regulation 882/2004 also regulates official inspections carried out for the purpose of verification of the implementation of the Food Act and regulations on animal feed, health and welfare. The Regulation refers to the method of organisation of official

inspections, competent authorities, laboratory organisation, taking samples and emergency measures.
The harmonization of legislation was achieved through Croatia's pre-accession process and was applied in Chapter 12 - Food safety. The process consisted of the review of legislation, bilateral negotiations and, finally, of the harmonization of legislation on food safety.
According to the Food Act (Official Gazette, No. 46/07) the competent authority for food safety and risk management is the Ministry of Agriculture, Forestry and Water Management. The Croatian Food Agency carries out the risk estimate and part of the risk communication. The Food Act regulates the legal foundation for ensuring the high level of health protection and food-related consumer, particularly taking into consideration the differences in the provision of foodstuffs, including traditional products, while simultaneously enabling the effective functioning of markets. The Act determines the basic principles and responsibilities, the scientific basis and effective organisational structures and procedures which support decision-making related to food and animal feed safety. The Food Act regulates: scope of application and definitions, general provisions of food regulations, the Croatian Food Agency, the system of rapid alert, emergency measures and crisis management, food and animal feed hygiene, official inspections, new food products, genetically modified food and animal feed, food and animal feed quality, signs of traditional food reputation, authenticity and geographical origin of food and the powers and responsibilities of the competent authority. The Act applies to all production, processing and food and animal feed distribution phases, except to primary production intended for personal use in the household or to the preparation, handling and storage of food intended for personal consumption in the household. The bodies competent for conducting inspections are the Ministry of Agriculture, Fishery and Rural Development, the Ministry of Health and the State Inspectorate.
The official inspection of food safety and hygiene is carried out by:

a) at the level of primary production and corresponding activities:

- for food of animal origin: veterinary inspection;
- for food of plant origin: agricultural inspection.

b) at the level of production and processing:

- food of animal origin: veterinary inspection;
- food of non-animal origin: sanitary inspection;
- food which contains ingredients of animal and non-animal origin: veterinary or sanitary inspection according to the implementing regulation enforced by the head of the competent authority.

c) at the level of retail trade, sanitary inspection, except in facilities approved by the competent authority, where official inspection is carried out by the veterinary inspection;
d) at import:

- food of animal origin, border veterinary inspection;
- food of non-animal origin, border sanitary inspection;
- food which contains ingredients of animal and non-animal origin, border veterinary or sanitary inspection according to the implementing regulation enforced by the head of the competent authority.

On the local level, monitoring of the implementation of regulations is carried out by 21

county offices (20 county offices and the office of the City of Zagreb), with more than 800 veterinary inspectors and more than 200 sanitary inspectors. The veterinary and sanitary border inspections also operate within the system, carrying out inspections of food consignments at import.
The laboratory network which performs food analyses and includes 30 laboratories authorised by the Ministry of Health has been set up to cooperate with the Croatian Veterinary Institute and the Croatian National Institute of Public Health. A total of approximately 50 000 food samples is inspected per year in these laboratories, and the results of laboratory analyses are regularly publish in the Croatian Health Service Yearbook, other publications and on the websites of the Croatian National Institute of Public Health and the Croatian Food Agency.
The county institutes of public health send summary analytical reports on the microbiological and chemical safety of foodstuffs to the Croatian National Institute of Public Health, which also carries out safety analyses of food of homemade origin and imported food. Results of the microbiological analyses of food samples in Croatia for the period from 1997 to 2010 have been indicated in Table 2.

Diagram 71. Total number of microbiologically tested foodstuffs and number and percentage of unsafe samples in Croatia in the period from 1997 to 2011

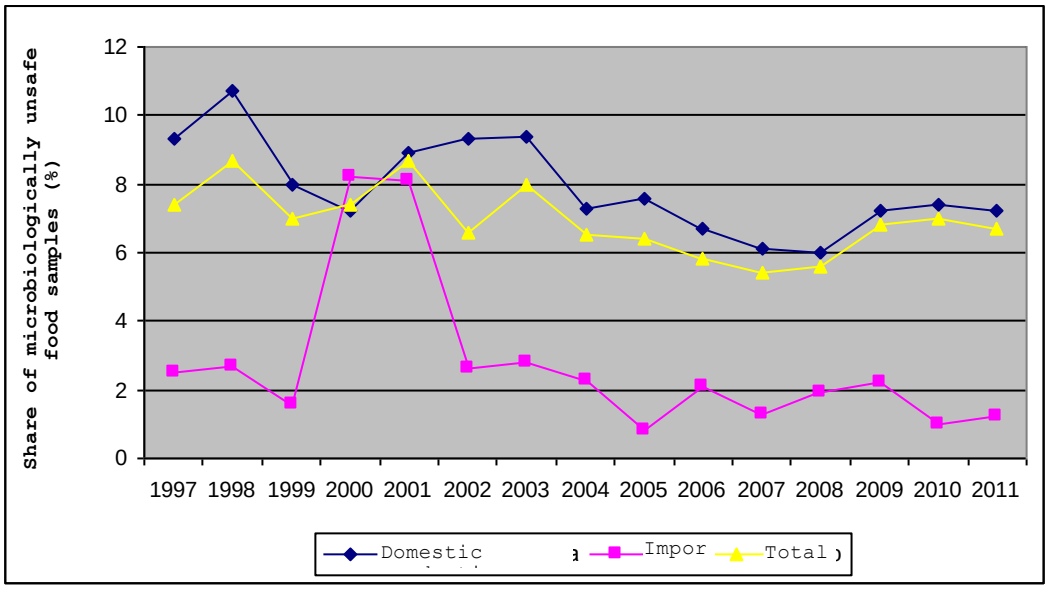
Year	DOMESTIC PRODUCTION			EXPORT			SVEUKUPNO		
	Total	Unsafe %		Total	Unsafe %		Total	Unsafe %	
1997	33.624	3.113	9,3	12.402	314	2,5	46.026	3.427	7,4
1998	34.389	3.669	10,7	11.136	296	2,7	45.525	3.965	8,7
1999	35.405	2.830	8,0	11.417	186	1,6	46.822	3.260	7,0
2000	35.241	2.543	7,2	8.614	706	8,2	43.855	3.249	7,4
2001	39.453	3.501	8,9	10.936	884	8,1	50.389	4.385	8,7
2002	33.624	3.113	9,3	12.790	339	2,6	47.454	3.156	6,6
2003	37.656	3.558	9,4	10.265	290	2,8	47.921	3.848	8,0
2004	37.919	2.773	7,3	7.023	162	2,3	44.942	2.935	6,5
2005	34.353	2.610	7,6	7.515	59	0,8	41.868	2.669	6,4
2006	33.041	2.216	6,7	7.950	167	2,1	40.991	2.383	5,8
2007	36.099	2.221	6,1	6.486	87	1,3	42.583	2.308	5,4
2008	38.668	2.330	6,0	4.875	93	1,9	43.543	2.423	5,6
2009	33.306	2.407	7,2	2.964	64	2,2	36.270	2.471	6,8
2010	31.875	2.369	7,4	2.498	24	1,0	34.373	2.393	7,0
2011	33.805	2.423	7,2	2.630	33	1,25	36.435	2.456	6,7

Source of data: Croatian Health Service Yearbook for 2011

There are 7% of microbiologically unsafe samples of foodstuffs, in which hygienic unsafety is mostly caused by the presence of aerobic mesophilic bacteria, enterobacteria, Escherichia coli, yeast and mold, whereas the Salmonella of spp. and Listeria monocytogenes bacteria are the most common cause of the health unsafety of food samples.

Analytical data have shown that the share of microbiologically unsafe samples in the last 8 years is smaller than 8% (Chart 24).

Chart 24. Development in the share of microbiologically unsafe samples of foodstuffs analysed in Croatia in the period from 1997 to 2011.



Source of data: Croatian Health Service Yearbook for 2011

There are less than 5% chemically unsafe samples of foodstuffs, mostly due to incorrect declarations of ingredients, inadequate sensory characteristics, content of artificial sweeteners and other additives (preservative agents, organ colorants and other), pesticides, heavy metals and microtoxines above the permitted amount, as well as iodine in salt below the permitted amount.

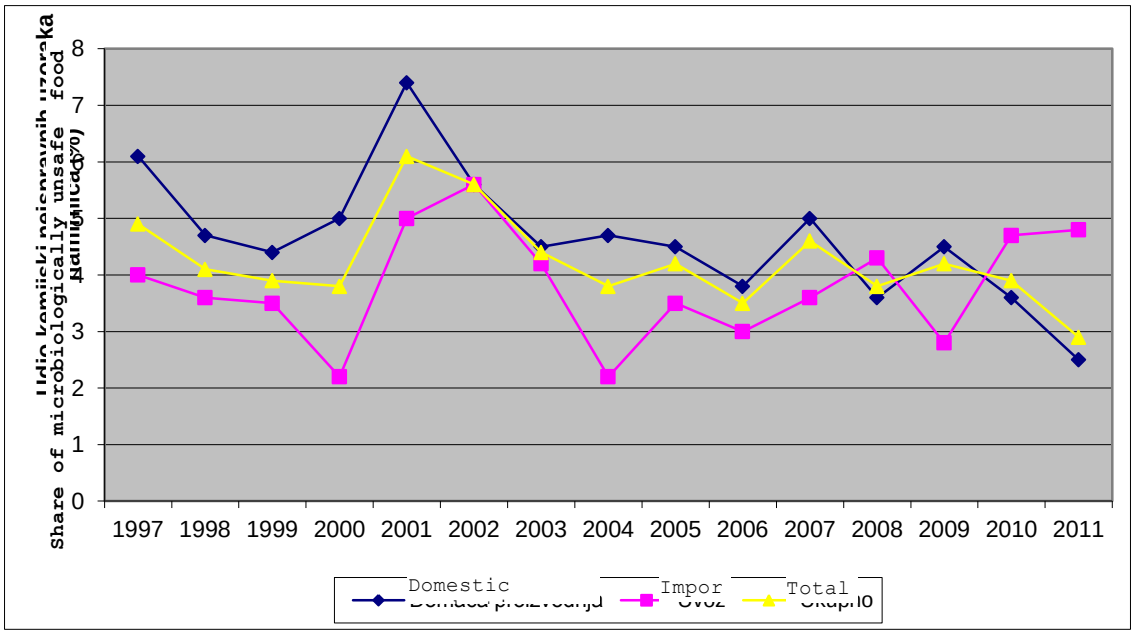
Diagran 72. Total number of chemically tested foodstuffs and number and percentage of unsafe samples in Croatia in the period from 1997 to 2011.

Year	DOMESTIC PRODUCTION			IMPORT			TOTAL		
	Total	Unsafe	%	Total	Unsafe	%	Total	Unsafe	%
1997	12382	755	6,1	16206	645	4,0	28588	1400	4,9
1998	13763	651	4,7	14667	525	3,6	28430	1176	4,1
1999	11636	512	4,4	14351	501	3,5	25987	1013	3,9
2000	16367	817	5,0	12242	268	2,2	28609	1085	3,8
2001	14668	1092	7,4	16952	843	5,0	31620	1935	6,1
2002	13802	779	5,6	17745	998	5,6	31547	1777	5,6
2003	15284	693	4,5	15855	666	4,2	31139	1359	4,4
2004	16147	761	4,7	9846	220	2,2	25993	891	3,8
2005	18067	820	4,5	11152	392	3,5	29219	1212	4,2
2006	19802	754	3,8	11506	345	3,0	31308	1099	3,5
2007	18 787	947	5,0	9 420	336	3,6	28 207	1 283	4,6
2008	19.134	685	3,6	7.834	339	4,3	26.968	1.024	3,8
2009	17.633	798	4,5	4.402	125	2,8	22.035	923	4,2
2010	14.669	522	3,6	5.993	282	4,7	20.662	804	3,9
2011	14.751	365	2,5	3.728	179	4,8	18.479	544	2,9

Source of data: Croatian Health Service Yearbook for 2011

The analysis of development in the share of analysed samples of foodstuffs which do not comply with the chemical safety standards shows that in the last 9 years, this share has amounted to 5% (Chart 25)).

Chart 25. Development in the share of microbiologically unsafe samples of foodstuffs analysed in Croatia in the period from 1997 to 2011.



Source of data: Croatian Health Service Yearbook for 2011

Monitoring of infectious diseases transmitted by food is carried out by the Epidemiological Unit of the Croatian National Institute of Public Health and by the county institutes of public health and its on-site branches, pursuant to the Act on the Protection of the Population from Infectious Diseases. Data on these diseases are part of the central epidemiological information system and are regularly published.

Regulations within the Hygiene Package have been implemented in the Croatian legislation in 2007 as a group of the following ordinances published in the Official Gazette (Official Gazette, No. 99/07): Ordinance on the hygiene of foodstuffs, Ordinance on the hygiene of food animal origin, Ordinance on official controls on foodstuffs of animal origin and the Ordinance on official controls carried out for the purpose of verification of compliance with the provisions of regulations on food and animal feed and on animal health and protection. All subjects in the food business applying for the opening of new facilities must meet the requirements prescribed by these regulations and the Food Act. Other ordinances in the area food health safety are: Ordinance on the food health safety of materials and objectS which come into direct contact with food (Official Gazette, No. 48/08), Ordinance on aromas (Official Gazette, No. 53/08), Ordinance on specifying the nutritive value of food (Official Gazette, No. 60/08), Ordinance on microbiological criteria for food (Official Gazette, No. 74/08), Ordinance on the maximum permissible volumes of certain contaminants in food (Official Gazette, No. 154/08), Ordinance on food additives (Official Gazette, No. 62/10), Ordinance on the labeling, advertising and presentation of food (Official Gazette, No. 63/11).

The Department of Food Quality and Safety was established within the Ministry of

Agriculture, Forestry and Water Management in order to enable a unified approach to ensuring the safety of food of animal and non-animal origin in the area of the Republic of Croatia, as well as coordination among competent authorities and other institutions involved in the system of ensuring food safety.
The Department is responsible for the coordination of the activities of institutions involved in the system of ensuring food safety, that is, the Ministry of Agriculture, the Ministry of Health and Social Welfare, the Croatian Food Agency, the Croatian Veterinary Institute, the Croatian National Institute of Public Health and others.
The competent authority needs to ensure the cooperation of bodies responsible for carrying out official controls, as well as establish cooperation with the competent authorities for food safety feeds in EU and EFSA countries.
E) Asbestos
Croatia has prohibited the production, selling and use of asbestous fibers (crocidolite, amosite, anthophyllite, actinolite, tremolite and chrysotile) and products to which these fibers were intentionally added (Official Gazette, No. 29/05). However, exempted from this prohibition is the selling and use of diaphragms with chrysotile for existing electrolysis facilities for the duration of their operative life-span or until an appropriate replacement facility which does not contain asbestos is available, whichever is earlier. By 1 June 2011 data had to be prepared on the availability of replacement facilities for electrolysis which do not contain asbestos, on efforts undertaken towards the development of such alternatives, on worker health protection in facilities, on the source of supply and quantity of chrysotile, on the source of supply and quantity of diaphragms which contain chrysotile and on the planned date of cessation of the exemption. This data must be made publicly available. In addition, further use of the mentioned products which contain asbestous fibers installed and/or in use before 1st January 2005 is permitted until their disposal or the end of their operative life-span. Nevertheless, the use of these products can be limited, prohibited or regulated by special requirements before their disposal or end of operative life-span, for the purpose of health protection.
The following legislation regulates the use of asbestos: List of toxic substances the production, circulation and use of which is prohibited (Official Gazette, No. 29/05), List of dangerous chemicals the transport of which is prohibited or limited (Official Gazette, No. 39/10); Official Gazette, No. 37/11) and Ordinance on Asbestos-Containing Waste Management Methods and Procedures (Official Gazette, No. 42/07). A number of legislative acts which regulate the rights and protection of workers professionally exposed to asbestos: Ordinance on the protection of workers from risk caused by asbestos exposure (Official Gazette, No. 40/07), Act on Obligatory Health Surveillance of Workers Professionally Exposed to Asbestos (Official Gazette, No. 79/07), Act on the Conditions for the Acquisition of the Right to Service Pension for Workers Professionally Exposed to Asbestos (Official Gazette, No. 79/07), Act on Indemnity for Workers Professionally Exposed to Asbestos (Official Gazette, No. 79/07) and the Ordinance on limit values of professional exposure to dangerous substances and biological limit values (Official Gazette, No. 13/09).
In relation to the obligation of owners of residential and public buildings to control the concentration of asbestos in these residential areas, the provision of Article 28 of the Ordinance on the safety of lifts (Official Gazette, No. 135/05), in force as of 31st March 2006, regulates the obligations of co-owners and owners of buildings with lifts and, in relation to safety improvements of lifts in buildings, prescribes that the brake linings of engines must not contain asbestos.
F) Measures for the prevention of smoking, alcohol and drug abuse, as well as multiple dependences
The field of drug abuse is regulated by national laws and international agreements. The basic

legal framework for the prevention of drug abuse and trafficking in the Republic of Croatia consists of the following legislative acts:

- Act on the prevention of narcotic drug abuse ("Official Gazette", no. 107/01, 163/03, 141/04, 40/07, 149/09 and 84/11), which regulates all basic issues of drug abuse: conditions for the farming of plants from which narcotics can be obtained, conditions for the preparation, possession and transport of drugs and substances that can be used for the preparation of narcotics (so-called precursors); monitoring of the farming of plants from which narcotics can be obtained and of the preparation, possession and transport of narcotics and substances that can be used in the preparation of drugs; measures for the prevention of drug abuse; system for the prevention of addiction and assistance provided to addicted persons and occasional drug users; international cooperation.
- Criminal Code, Art. 173 (drug abuse); Title Thirteen (XIII): criminal offences against values protected by international law include the prohibited use (possession), production, transport, mediation in sale or purchase of narcotics and any other way of placing narcotics into unauthorized transport.

The Republic of Croatia is a party to the most important international conventions that regulate issues of narcotics: The UN Single Convention on Narcotic Drugs of 1961 ("Official Gazette - International agreements" 04/94), Protocol on amendments to the Single Convention on Narcotic Drugs from 25 March 1972 ("Official Gazette - International agreements" 04/94), UN Convention on psychotropic substances from 21 February 1971 ("Official Gazette - International agreements" 04/94) and the UN Convention against illegal trafficking of drugs and psychotropic substances from 20 December 1988 ("Official Gazette - International agreements" 04/94).

The following strategic documents that also regulate this area: The National strategy for the prevention of drug abuse in the Republic of Croatia for 2006-2012 ("Official Gazette", no. 147/05), Action Plan for the prevention of drug abuse for the 2009-2012 period (as well as the implementation programmes of the Action plan for the particular year), Strategic plan of the Office for the prevention of drug abuse for the 2012-2014 period. Plan and programme of health care measures under the compulsory health insurance ("Official Gazette", no. 126/06).

The Office for the prevention of drug abuse of the Government of the Republic of Croatia was established in 2002 as a coordinating body for the field of drug abuse prevention. The system of prevention and treatment functions via addiction prevention centres in county institutes of public health, which are coordinated by the Croatian National Institute of Public Health. Strategic documents and legal regulations are fully coordinated with EU documents in the field of informing the public about the possibilities of treatment of drug addicts, counselling, education in schools, available methods of treatment which include the free methadone and buprenorphine programmes as well as the control of infectious diseases. In accordance with EU recommendations, the standardised collection of data on persons treated in the health care system for psychoactive drug abuse is ensured via a register managed by the Croatian National Institute of Public Health and the network of county institutes of public health. Control and protection measures ensure the prevention of the illegal trafficking of substitution drugs. Prisoners in custody are ensured total availability of substitution drug treatment, with medical supervision.

Free of charge inoculation against Hepatitis B, as well as HIV and Hepatitis B and C testing in cooperation with the Public Health Institute, the Red Cross and non-governmental organisations are also ensured.

Query of the Committee

- The Committee requested that, as part of the following report, detailed information on trends in the consumption of alcohol be provided.

Prevention and suppression of alcohol-related health issues

The field of prevention and suppression of the harmful impact of excessive consumption of alcohol is regulated by interdisciplinary regulations and documents such as the Health Care Act ("Official Gazette", No. 121/03, 48/05, 85/06, 150/08, 71/10, 139/10, 22/11 and 84/11), Road Traffic Safety Act ("Official Gazette", No. 105/04, 142/06 and 67/08), Food Act ("Official Gazette", No. 117/03, 130/03, 48/04, 85/06 and 46/07; Decree on amendments to the Food Act ("Official Gazette", No. 155/08), Occupational Safety and Health Act ("Official Gazette", No. 59/96, 94/96 and 114/03), Act on Amendments to the Occupational Health and Safety Act ("Official Gazette", No. 86/08 and 75/09), Act on Catering Activities ("Official Gazette", No. 138/06), Act on Amendments to the Act on Catering Activities ("Official Gazette", No. 43/09), Act on to the prevention of riots at sports competitions ("Official Gazette", No. 117/03, 71/06, 43/09 and 34/11), Special Tax on Alcohol Act ("Official Gazette", No. 136/02), Act on amendments to the Special Tax on Alcohol Tax ("Official Gazette", No. 107/07), Family Act ("Official Gazette", No. 116/03, 17/04 and 136/04), Ordinance on the conditions and method of informing consumers about the characteristics of alcoholic beverages, tobacco and manufactured tobacco products, which are not considered advertising ("Official Gazette", No. 62/96, 40/98), Ordinance on the advertising of wines with controlled geographical origin and fruit wines ("Official Gazette", No. 105/04) and the 2002 National Programme of Action for Youth, the 2006-2012 National Plan of Activities for the Rights and Interests of Children and the 2010 Croatian Action Plan on Alcohol .

Legislation and practice in Croatia has been harmonised with the acquis communautaire (Conclusion (2001/C 175/01) and Recommendation (2001/458/EC)) regarding the collection of data on harmful effects caused by alcohol, international cooperation and activities in the local community. Treatment and rehabilitation of alcoholics in Croatia is carried out according to the concept of the Zagreb School of Alcohol Studies, which after dismissal from hospital, includes the alcoholics and their families in the system of treatment and rehabilitation (through the network of clubs of recovering alcoholics). Croatia promotes research on all different problems related to alcohol consumption of young people, especially children and adolescents.

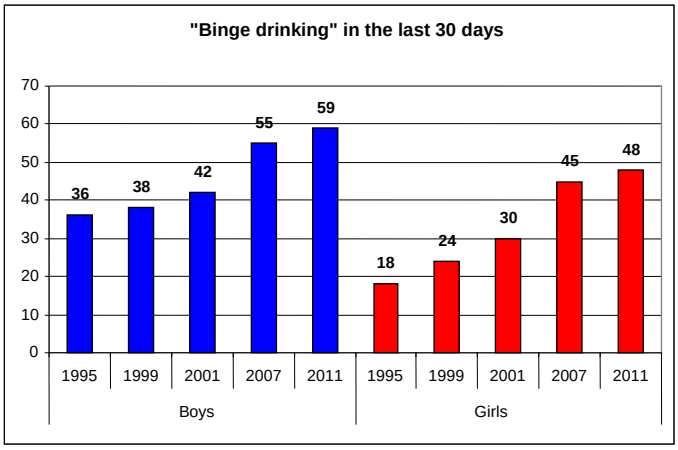
The area in which young people, and especially adolescents, are protected from possible influences of alcohol abuse is regulated by legal regulations and bylaws in accordance with EU recommendations. The areas of research of the distribution and reasons for drinking, education and prevention programmes, early secondary prevention, special attention for young drivers, prohibition of sale and serving of alcoholic beverages to juveniles in stores and catering facilities and during sports events.

Additional harmonisation is required in the field of advertising, prohibition of the use of young people for the purpose of advertising, control of advertising particularly attractive to young people, the inclusion of young people in the adoption of strategic and implementing

regulations and activities and education programmes involving the owners of catering facilities and servers in such facilities.

According to the penultimate estimate of the WHO for the 2003-2005 period, the annual consumption of pure alcohol per capita in Croatia 15+ was very high (15.1 l.). According to the last estimate published in 2012, consumption was 12.76 l.
According to the results of research carried out among young people, consumption of alcohol is still very high and the trend, judging according to the ESPAD research, is on the rise. In 2011, compared to the previous period (the ESPAD research was carried out in 1995, 1999, 2003 and 2007), the number of schoolchildren who smoke regularly was on the rise. The share of children who smoke regularly (at least one cigarette a day in the last 30 days) increased from 26% in 1995 to 29% in 2007 and 31% in 2011 for boys, whereas the share of girls increased from 19% in 1995 to 26% in 2007 and 27% in 2011. High-risk alcohol consumption (drinking 6 and more times in the last month) is also on the rise. In 1995, 13% of the boys and 4% of the girls drank this much in the first class of secondary schools, whereas in 2007 almost three times more boys drank this much (39%) and four times more girls (16%), and in 2012, 30% of the boys and 18% of the girls. When it comes to marijuana use from 1995 to 2011, first a sudden rise is recorded and then stagnation or even reduction. In 1995, 12% of the boys and 5% of the girls experimented with marijuana. This share was on the rise and in 2003 it doubled for boys (24%) and more than tripled for girls (17%). In 2007, the number and share of those experimenting with marijuana at this age decreased somewhat compared to 2003 and amounted to 20% for boys and 15% for girls, and in 2011 it amounted to 18% for boys and 17% for girls.
Especially risky is binge drinking, which is present Europe in countries of the Mediterranean and continental way of drinking.

Chart 26. "Binge drinking" in the past 30 days



Source: Internal data of the Croatian National Institute of Public Health

Among somewhat younger children, (HBSC research in 2010, a slight drop in the consumption of beer compared to 2006, but increase compared to 2002 has been recorded (one or more beer per week 26% - 34% and 30% of boys 15 years of age, and 7% - 13% and 9% of girls). Risk behaviour such as intoxication two or several times in life is present among 38%-48 % and 44% for boys and 21% - 38% and 26% for girls. Although the practice of alcohol consumption according to these results shows a specific stagnation, compared to other countries of the HBSC study, Croatia still ranks very high for particular variables of drinking among 15-year olds.

Query of the Committee

- The Committee requested that as part of the next report, detailed information on trends of tobacco consumption be provided.

Regarding the consumption of tobacco products, the share of tobacco products in the average annual consumer spending in households oscillates, according to studies (Table 1). The share of tobacco products in the turnover of retail trade is dropping (in 2001 it was 5.12%, and in 2005 it was 3.85%). The number of sold cigarettes is dropping from 2003 (19,554 mil. pcs.), it was the lowest in 2009 (10.872 mil. pcs.), somewhat higher in 2010 (12.773 mil. pcs.), but much lower than in previous years. In 2011, it shows a negative trend (11.345 mil. pcs.). The import of cigarettes shows an increase in recent years, and export in 2010 shows an increase, and in 2011 it again began to drop.

Table 70. Production, distribution and consumption of tobacco

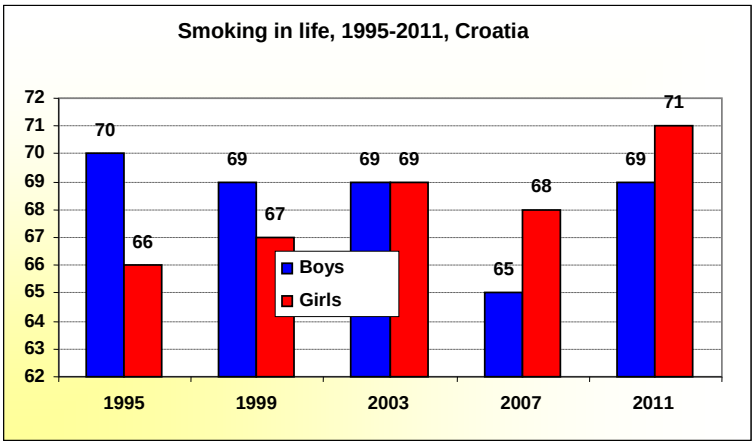
	Year										
Indicator	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
Share of tobacco in the average annual consumer spending per member of a household (%)	/	2.39	2.40	2.35	2.38	2.10	2.26	2.09	2.10	2.34	/
Share of tobacco in turnover in retail trade (%)	5.12	4.09	4.14	3.90	3.85	/	/	/	/	/	/
Number of sold cigarettes (mil. pcs.)	14716	15047	19554	14149	14490	14153	14173	/	10872	12773	11345
Import (mil. pcs.)	/	/	65	53	139	1173	2117	/	1694	2059	2719
Export (mil. pcs.)	/	/	7478	7483	7254	7227	7420	/	6718	8093	7193

Source: Croatian Bureau of Statistics, Statistical yearbook 2003-2012

Tobacco consumption among young people, according to the results of available research (ESPAD and HBSC in continuity since 1995 and 2001) points to the following:
experimenting with tobacco as well as regular smoking among young people in Croatia is in relative stagnation, especially among boys. Girls experiment slightly more often than boys (children that are 15 - 64% for both sexes, children that are 15-16 - 69% for boys and 71% for girls). Regular smoking is more common among boys (21% of 15-year old boys and 19% of 15-year old girls smoke every day). Compared to other European countries. Croatian 15-year

old children smoke more than the European average, although there is no upward trend of distribution.

Chart 23. Smoking in life, 1995-2011



Source: Documentation for the preparation of the 7th report on the implementation of the European Social Charter,
Ministry of Health, June 2012

Limiting the use of tobacco and tobacco products

The prevalence of smoking in Croatia in the last 30 days prior to the research was 41% (38%), more than the average of the European countries, which was 28%. The percentage of young people who had any kind of alcoholic drink in the last 12 months was above the European average (85% (84%) in Croatia, 79% (82%) the average of all countries), as well as the percentage of young people who were intoxicated in the same period (42% (43%) in Croatia, 37% (39%) the average of all countries). Cannabis use is within the European average (18% (18%) of the examinees have tried cannabis in their life in Croatia, 17% (19%) on average in all countries) while the use of other drugs is much lower than in other countries (5% (4%) would try any drug other than cannabis in their life in Croatia, 6% (7%) in other countries).

Croatia signed and ratified the World Health Organisation Framework Convention on Tobacco Control

The basic regulation regulating health aspects to the use of tobacco and tobacco products is the Act on Limiting the use of Tobacco Products ("Official Gazette", nos. 125/08 and 55/09) and the Act on Amendments to the Act on Limiting the use of Tobacco Products ("Official Gazette", no. 119/09). Inspectional supervision of the implementation of the Act is carried out by the State Inspectorate, sanitary inspectors, health inspectors and school inspectors, each within their own scope prescribed by special acts. The sanitary safety of tobacco products is monitored by authorised laboratories of the Croatian Institute of Public Health and county institutes of public health, on the basis of the Items in General Use Act ("Official Gazette", no. 85/06). As needed, other authorised laboratory institutes carry out laboratory analysis for them, including the laboratory of the Tobacco Institute, which works according to HRN ISO standards identical to those stipulated in Directive 2001/37/ EC of European Parliament and the Council of 5 June 2001 on the approximation of the laws, regulations and administrative provisions of the Member States concerning the manufacture, presentation and sale of tobacco products and Directive 2003/33/EC of the European Parliament and the Council of 26 May 2003 on the approximation of acts and other regulations of the Member States relating to the advertising and sponsorship of tobacco products. The preparation of the new Directive on the

approximation of acts and other regulations of the Member States relating to the advertising and sponsorship to tobacco and tobacco-related products is under way. The HRN ISO 3308:1991 standard is used for the routine analytical cigarette smoking machine. Existing acts and subordinate regulations have been aligned with the acquis communautaire.
This Act is also harmonised with Directive 2001/37/EC on the production, presentation and sale of tobacco products, with provisions on the permitted levels of tar, nicotine and carbon monoxide per cigarette, on the data and warnings which must be placed on individual tobacco packages and with the Directive 2003/33/EC on advertising and sponsorship of tobacco products.

The Act also takes into consideration recommendations of the Resolution of the Council and the Ministers for Health of the Member States, meeting within the Council of 18 July 1989 on banning smoking in places open to the public. The Act determines the following: Measures aimed at reducing harmful effects of tobacco products and health warnings, measures for reducing and limiting the use of tobacco products, preventive measures against smoking, the control of the implementation of the Act, penal provisions.
Measures aimed at reducing harmful effects of tobacco products and health warnings are the following: limiting the amount of harmful ingredients (10 mg of tar, 1 mg of nicotine 10 mg of CO per cigarette), warnings which must be placed on tobacco packages (according to the measures of the Convention and the EU), prohibition of the use of expressions "Light", "Mild" etc.
Measures for reducing and limiting the use of tobacco products are the following: it is prohibited to promote events, activities and individuals with the purpose or effect of direct and indirect advertising of tobacco products and tobacco use, direct and indirect tobacco advertising is prohibited, it is prohibited to promote products which are not considered tobacco products, and which promote the use of tobacco products through their shape, name or purpose, tobacco product must not be sold to persons under the age of 18, tobacco products must not be sold by persons under the age of 18, tobacco internet sales are prohibited, tobacco vending machines are prohibited, it is forbidden to smoke during public performances and it is forbidden to show people who are smoking on television, it is prohibited to smoke in all closed public places, smoking areas are not allowed in areas where health care services are provided, along with educational activities (apart form psychiatry), smoking areas must be labelled and must meet certain technical conditions.
Preventive measures are defined separately, including the obligation to promote awareness of the harmful effects on the health of using tobacco products, and the role of the Ministry of Health's Commission for Combating Smoking in preventive activities. Preventive measures against smoking are the following: educational institutions are obliged to implement the Program for promoting awareness of the harmful effect of tobacco product use on health among all ages of children and youth (the Program is adopted the Minister of Education with the approval of the Minister of Health), the Minister of Health establishes and appoints the National Commission to Combat Smoking.
The supervision over the implementation of this Act has been defined, and penalties for disregarding the Act are high for legal entities and individuals.
Reporting to the Conference of the Parties is defined by this Act: in accordance with the obligation from Article 21, 2 years after the entry into force of the Convention, the report in the form of an answer to a comprehensive questionnaire on tobacco use was submitted.
Further harmonisation is envisaged with regard to measures for suppressing illegal trade, support for alternative cultures, environmental protection concerning growing and producing tobacco, monitoring, evaluation and reporting and international cooperation in terms of supervising tobacco, in accordance with the Framework Convention on Tobacco Control.

With the Act on amendments to the Act on the Restriction of the Use of Tobacco Products, published in "Official Gazette", no. 119/09, the conditions which must be met regarding the smoking area were changed (the area must be arranged in such a way that air contaminated by tobacco smoke cannot flow into another area, the surface of the area cannot be smaller than 10m2, the area cannot take more than 20% of the total surface area of the public premises, i.e. 20% of total catering service area in catering facilities, the area is not intended for transit into other areas, neither food nor drink may be consumed in the area.

In the same Act, a new category, the so-called "smoking area" was introduced in catering facilities that serve only drinks and that cannot meet the conditions regarding the size of the smoking area (the surface of the area cannot be smaller than 10 m2, the area cannot take more than 20% of the total surface area of the public premises, i.e. 20% of total catering service area in catering facilities).The same Act introduced the new category of the so-called "smoking area" in catering facilities that serves only drinks and that cannot meet the conditions the with regards to size of the smoking area (the space surface area cannot be smaller than 10 m2 and the area cannot cover more than 20% of the total surface of public space or 20% of the space surface area for serving in catering facilities). The owner, i.e. the user of the object, may intend the catering service area for the smoking area, and in this area there must be a smoking permission sign and the following conditions must be met: the smoking area must have a ventilation system that enables a ventilation range of at least 10 air changes per hour, the flow of air contaminated by tobacco smoke from the smoking area into the open area must be ensured by the filtering system, the area must be equipped with promotion materials on the awareness of the harmful effect of tobacco product use (posters, leaflets, labels, etc).

LEO

Measures undertaken for the purpose of improving the use of health care by persons insured with the Croatian Health Insurance Institute and summaries of some projects on the national level

Since 2006, the National programme for the early detection of breast cancer is carried out, with the aim of the early detection of breast cancer and the reduction of mortality from breast cancer by 25% within five years from the beginning of the implementation of the programme. The programme is aimed at all women within the ages of 50 and 69, who are called to take a mammography every two years. The basic method is mammography, which can discover changes in the breast as early as two years before the tumour can be felt. So far, the National programme for the early detection of breast cancer has completed 2 cycles, and the third cycle is under way. In the first cycle a total of 720,980 women were called to take a free mammography with a response of 63%, and a total of 1,605 of breast cancers were discovered. In the second cycle, a total of 680,640 women were called to take a mammography with a response of 57%, and 841 cases of breast cancer were discovered. In the third cycle, until now a total of 141,382 women were called to take a mammography.

From December 2012, the implementation of the National programme for the early discovery of cervical cancer began. The programme objective is to reduce the incidence of invasive cervical cancer by 60% within 8 years from the beginning of the programme and will reduce the mortality from invasive cervical cancer by 80% within 13 years from the beginning of the programme. The programme includes all women within the ages from 25 to 64, every three years. The basic method of the selection is the conventional pap smear. So far, 100,000

women were called within the first cycle.

In mid October 2007, the "National programme for the early detection of colon cancer" began. The goal of the programme was to reduce the mortality from colon cancer by 15% 10-13 years from the beginning of the implementation of the programme. The programme includes women and men within the ages from 50 and 75, every two years. The basic method is a faecal occult blood test. The plan is for 600,000 persons to receive the faecal occult blood test with instructions and a return envelope sent to the home address. The respondents who test positive will be called to a colonoscopic examination.
This project is unique in Europe since the Republic of Croatia will be the first country in which such a colon cancer early detection programme will be carried out on the territory of the entire country.
The first calls for the faecal occult blood test within the National programme of early colon cancer detection were sent at the beginning of 2008. So far, a total of 1,261,695 calls were sent to persons born between 1933 and 1958.
So far, 249,103 envelopes with filled-out questionnaires were returned, and 215,276 persons sent a correctly applied stool sample on 3 test-cards.
14,239 or 6.6% positive persons were discovered, and so far 9,575 persons have undergone a colonoscopy. In 531 persons colorectal cancer was confirmed (0.22/1000), and in as many as 3,464 persons (39.0%) one or several polyps were removed, which prevents the occurrence of carcinoma!
Of the other pathological findings, in 1728 persons diverticula and their bowel disease were discovered, and in 2,662 persons haemorrhoids were discovered.

Since 2004, general medicine or family medicine doctors that have signed contracts with the Croatian Health Insurance Institute have been carrying out preventative examinations of insured persons above the age of 50. By the end of 2010, about 60,000 insured persons have undergone preventative examinations, covering about 25% of the target population. In about 40% of the examined persons pathological conditions were discovered, and about every fifth examined person was sent to additional diagnostics and treatment.

In mid October 2007, the "National programme for the early detection of colon cancer". The goal of the programme was to reduce the mortality from colon cancer by 15%, 10-13 years from the beginning of the implementation of the programme. The programme includes women and men within the ages from 50 and 75, every two years. The basic method is a faecal occult blood test. The plan is for 600,000 persons to receive the faecal occult blood test with instructions and a return envelope sent to the home address. The respondents who test positive will be invited to a colonoscopic examination.
This project is unique in Europe because the Republic of Croatia will be the first country in which such a colon cancer early detection programme will be carried out on the entire territory of the country.
The first calls for the faecal occult blood test as part of the National Programme for the early colon cancer diagnostics were sent at the beginning of 2008. Until now, a total of 1,150,582 calls was sent to persons born between 1933 and 1945 and 1948 and 1957.
Until now, a total of 227,249 envelopes with filled out surveys have been returned, and 200,934 person have sent and correctly applied a sample of stool on 3 test cards.
13,539 or 6.9% tests were positive and until now, 8,690 persons have undergone colonoscopy. In 504 persons (0.22/1000) colorectal cancer was discovered, and in as many as 3,449 persons (39.7%) one or several polyps were removed, preventing the occurrence of cancer!
Of the other pathological findings, diverticula were discovered in 1,255 persons, other

diseases of the intestine in 334 persons, and hemorrhoids in 2,425 persons.

The right to health care under the compulsory health insurance is ensured on equal terms for all persons insured with the Croatian Health Insurance Institute, which includes the Roma population. With regard to the monitoring of the immunization coverage of the Roma population in infants, preschool children and school children, in accordance with the Decade for the Roma Action Plan, the Croatian National Institute of Public Health sent in February 2011 letters to all county institutions for public health for the purpose of collecting epidemiological data on the immunization coverage levels of Roma children. In the majority of counties, the immunization coverage levels of the Roma children are at the immunization coverage levels of the general population, especially when it comes to school-age children, who are vaccinated in schools. In the draft National Roma Programme, which is currently being prepared, two new activities have been included in order to increase the sensitization of workers in the health care system for working with the Roma population, and improving the communication of the Roma population with doctors of family medicine and other health service providers. In order to realize this goal, specific training of health care professionals is envisaged, especially in areas with higher numbers of the Roma population, in connection with a more intense cooperation with family services especially in cases of suspicion of abuse and neglect of the health of children. In accordance with the 2005-2015 Decade for the Inclusion of the Roma Action Plan, the Ministry of Health is carrying out the following measures:

1. Improving the health of Roma infants and children by harmonising the immunization coverage of Roma children with that of the rest of the population;
2. Improving the health of Roma infants and children by carrying out measures of educating parents, as well as preventative and remedial health care measures;
3. Health education on family planning and the preservation of reproductive health as well as measures of safe maternity, especially groups of pregnant women and young mothers;
4. Improvement of hygienic and sanitary conditions in apartments and populated areas by implementing pest control measures for the purpose of creating hygienic preconditions for the prevention of contagious diseases;
5. Educating and training of members of the Roma community for medical professions. As part of 3rd Measure of the Action Plan (the health education on family planning and preservation of reproductive health and measures of safe maternity, especially in groups of pregnant women and young mothers).

The Ministry of Health worked on the prevention of cervical cancer and breast cancer of women, who are members of the Roma national minority, who do not have health insurance and who live on the territory of the City of Zagreb.

Disabled persons

Based on the Act on the Croatian Register of Disabled Persons ("Official Gazette" No. 64/01) data for this register is collected from various sources. In 2010, 529,103 disabled persons lived in the Republic of Croatia, 316,557 of which were male (59.8%) and 212,546 female (40.2%). Disabled persons make up 11.9% of the total population. The majority of disabled persons, 286,523 (54.2%) were of working age (19-64). One can see that disability is present in all age groups, with incidence among children between the ages of 0 and 19 amounting to 7% The largest number of disabled persons had their permanent residence in the City of Zagreb and Splitsko-dalmatinska County. About 29.7% of the overall number of disabled

persons lived in these counties, but if one considers the share of disabled persons in the overall population of a county, it turns out the largest share was in the Krapinsko-zagorska County. The highest prevalence among children was in the Međimurska County, among the working population in the Krapinska County, and among the population above 65 the highest prevalence was in the Splitsko-dalmatinska County. In January of 2012, the Croatian Institute for Public Health published on its official website the most recent data on disabled persons. On 12 January 2012, 518,081 disabled persons lived in Croatia, 311,995 of which were male (60.2%) and 206,086 of which were women (39.8%). Disabled persons make up about 12.1% of the overall population of the Republic of Croatia. The highest number of disabled persons, 284,505 (54.9%), is of working age, that is between 19 and 64, and 195,380 (37.7%) of them are in the 65+ age group (Table 1). In Table 1, one can see that the prevalence of disability among persons aged 0 and 19 is 7.4%. The greatest number of disabled persons have their permanent residence in the City of Zagreb and the Splitsko-dalmatinska County. About 29.7% of the overall number of disabled persons lived in these counties, but if one considers the share of disabled persons in the overall population of a county, it turns out the largest share was in the Krapinsko-zagorska County. The highest prevalence among children was in the Međimurska County, among the working population in the Krapinska County, and among the population above 65 the highest prevalence was in the Splitsko-dalmatinska County. If this report is compared with the 2010 report, one can notice that the number of living disabled persons has dropped. This is the result of a better system of the registration of personal identifiers (unique personal identification number – JMBG - and personal identification number - OIB) that reduced the error in the unambiguous connection and registration of the death of disabled persons.

Table 73 Number of disabled persons according to sex, county and age group

County of permanent residence	Age groups						Total
	0-19		20-64		65+		
	m	f	m	f	m	f	
BJELOVARSKO-BILOGORSKA	901	607	5280	2686	2792	3688	**15954**
BRODSKO-POSAVSKA	875	562	8305	2400	3003	2960	**18105**
DUBROVAČKO-NERETVANSKA	557	381	4845	2077	2068	1539	**11467**
CITY OF ZAGREB	5492	3275	27018	19790	15998	19907	**91480**
ISTARSKA	751	476	4938	2697	2673	2410	**13945**
KARLOVAČKA	446	283	5883	2345	3136	4193	**16286**
KOPRIVNIČKO-KRIŽEVAČKA	945	592	4131	2194	1807	2121	**11790**
KRAPINSKO-ZAGORSKA	1026	576	6949	4393	3853	4090	**20887**
LIČKO-SENJSKA	194	133	2628	841	1633	1183	**6612**
MEĐIMURSKA	1029	733	3481	2319	1762	2194	**11518**
OSJEČKO-BARANJSKA	1605	1144	14964	5742	5536	5736	**34727**
POŽEŠKO-SLAVONSKA	378	256	4380	1658	2067	1827	**10566**
PRIMORSKO-GORANSKA	527	368	8183	4846	5397	6680	**26001**
SISAČKO-MOSLAVAČKA	733	420	8974	3190	4087	3666	**21070**
SPLITSKO-DALMATINSKA	2889	1848	23135	12378	11623	11022	**62895**
ŠIBENSKO-KNINSKA	267	186	5988	2118	3413	3195	**15167**
VARAŽDINSKA	782	528	7169	4590	3955	5133	**22157**
VIROVITIČKO-PODRAVSKA	334	243	4507	1533	1590	1812	**10019**
VUKOVARSKO-SRIJEMSKA	898	615	8888	3093	3335	3084	**19913**
ZADARSKA	723	385	6755	2339	3532	2629	**16363**
ZAGREBAČKA	1882	1109	11977	6701	5567	4671	**31907**
Unspecified	152	90	12323	3874	9081	3732	**29252**
Total	**23386**	**14810**	**190701**	**93804**	**97908**	**97472**	**518081**

Source: Croatian Institute for Public Health, Register of disabled persons

Note: 1. data processing is also possible according to five-year age groups

2. Unspecified – county of permanent residence has not been indicated or the town/city is not in the official code book of populated areas

Table 74. Number of disabled persons in the total population of the county and in the respective age groups - prevalence of disability per 100 inhabitants

County of permanent residence	Prevalence of disability (%)	Prevalence of disability in the 0-19 age group (%)	Prevalence of disability in the 20-64 age group (%)	Prevalence of disability in the 65+ age group (%)
KRAPINSKO-ZAGORSKA	15.7	4.8	13.3	33.9
ŠIBENSKO-KNINSKA	13.9	1.7	12.6	30.1
SPLITSKO-DALMATINSKA	13.8	4.0	12.8	34.2
POŽEŠKO-SLAVONSKA	13.5	2.8	12.3	28.8
BJELOVARSKO-BILOGORSKA	13.3	4.7	10.2	28.2
LIČKO-SENJSKA	13	2.9	11.6	23.1
KARLOVAČKA	12.7	2.5	9.9	25.9
VARAŽDINSKA	12.6	2.9	10.6	32.2
SISAČKO-MOSLAVAČKA	12.2	2.8	11.1	23.1
VIROVITIČKO-PODRAVSKA	11.8	2.5	11.1	22.6
CITY OF ZAGREB	11.5	5.1	9.6	30.1
OSJEČKO-BARANJSKA	11.4	3.4	10.4	22.8
BRODSKO-POSAVSKA	11.4	3	10.5	22.3
VUKOVARSKO-SRIJEMSKA	11.1	2.8	10	21.7
KOPRIVNIČKO-KRIŽEVAČKA	10.2	5.2	8.5	19.1
MEĐIMURSKA	10.1	5.7	8.1	24.5
ZAGREBAČKA	10	4	9.9	23.8
ZADARSKA	9.6	2.7	9.6	24.2
DUBROVAČKO-NERETVANSKA	9.3	3	9.6	18.4
PRIMORSKO-GORANSKA	8.8	1.4	6.8	24.4
ISTARSKA	6.7	2.7	6	15.8
Reopublic of Croatia	**12.1**	**3.6**	**10.7**	**28.2**

Source: Croatian Institute for Public Health, Register of disabled persons

Note:

- for the calculation of the total prevalence in the Republic of Croatia and counties, data from Table 1 and the results of the 2011 census was used;
- for the calculation of the prevalence of disability among the respective age groups, data from Table 1 and the results of the 2001 census was used since the currently available data of the 2011 do not contain age group distribution.

Breastfeeding Promotion Programme

According to the National Plan of Activities for the Rights and Interests of Children for the 2006-2012 period, the National Committee for the Promotion of Breastfeeding was established, and the implementation of the project "Maternity wards-friends of children" is under way. In order to receive the title, maternity wards need meet 10 criteria for successful breastfeeding. The programme has improved 3 significant areas: breastfeeding, the humanization of the hospital stay of mothers and children from the beginning of life and the creation of conditions for rooming-in, better hygienic and general conditions in maternity wards.

On 1 December 2011, the state in Croatian maternity wards when it comes to the "Maternity wards-friends of children "programme was the following: out of 31 maternity wards, 21 has the title of "Maternity ward-friend of children": Vukovar, Rijeka, Sv Duh – Zagreb, Dubrovnik, Sinj, Gospić, Koprivnica, Pula, Čakovec, Zabok, Slavonski Brod, Zadar, Varaždin, Karlovac, Vinkovci, Osijek, Virovitica, Split, Pakrac, Ogulin and Metković. With the goal of standardising prenatal classes, the Ministry, in cooperation with UNICEF, started preparing a guide for the training teachers of prenatal classes. The programme ”Counselling centres for children-friends of breastfeeding” has been initiated, as part of which, for the third consecutive year, training for teams of primary health care and domiciliary care is carried out. In 2011, the first 8 teams were evaluated and received the title "Counselling centre for children-friend of breastfeeding”.

In 2011, 76.2% of infants between the ages of 0-2 months examined at a general medical examination were exclusively breastfed ("exclusive breastfeeding"), while after the first three months this percentage diminishes, and among children between 6 and 11 months it amounts to 54.2%.

Prevention of Excessive Body Mass

According to the results of the Croatian Health Survey (2003), a worrying trend of the increase of excessive body mass and obesity is present, whose prevalence has acquired epidemic proportions. The results show that over 60% of men and 50% of women suffer from excessive body mass, which makes Croatia one of the countries with a very high prevalence of excessive bodyweight. In Croatia, men and women have roughly the equal share of obesity (about 20%), and more than 40% of adults have the visceral type of obesity (waist circumference $\geq$ 102 cm in men and $\geq$ 88 cm in women, WHO criteria). The abdominal type of obesity, in which the existing visceral adipose tissue represents a very active endocrine "organ", is specifically characterized by the incremental risk of developing insulin resistance, cardiovascular and cerebrovascular diseases, as well as the increased general and specific mortality due to cardiovascular and malignant diseases. According to data of the monitoring of the nutrition of children in the ages between 7 and 14 in the period between 2005 and 2009, 26.4% of school children had excessive body mass, 15.2% of which had increased body mass, and 11.2% of which were obese.

Considering that obesity, apart from being a disease itself, represents a risk factor for the development of a wide range of chronic non-infectious diseases, the reduction and prevention of excessive body mass and obesity is one of the leading public-health priorities in Croatia. In this sense, in 2010 the Government of the Republic of Croatia has adopted its 2010-2012 Action Plan for the prevention and reduction of excessive bodyweight and obesity, which, in the long term, should contribute to the reduction of morbidity and premature death in connection with excessive body mass and obesity and the accompanying comorbidities, as

well as the expenses for the treatment of such diseases. The action plan aims at the adoption of correct eating habits and habits of regular physical activity for the purpose of preserving and improving the health of citizens The action plan determines general and specific objectives and measures with regard to three target population groups: children, adults and the elderly. In accordance with the envisaged activities of the action plan, National Guidelines have already been prepared regarding the nutrition of children in preschool institutions as well as National Guidelines regarding the nutrition of the elderly. In 2011, the preparation of National Guidelines regarding the nutrition of schoolchildren in elementary schools began, which will serve as a resource in schools for the implementation of the standard specification for the nutrition of pupils in elementary schools passed by the Minister of Health. In particular county institutions for public health and non-governmental organisations, counselling centres for the reduction and prevention of excessive body mass and obesity have been established as independent counselling centres (mostly for adults) or as part of existing multipurpose counselling centres that are part of school medicine services (for school-age children). Also, at the county and local level there is a wide range of projects mostly financed by the local government for the purpose of educating the general population and raising awareness about obesity as a health problem and the importance of proper nutrition and regular and sufficient physical activity in achieving and maintaining the desirable body mass. A series of accompanying educational material in the form of brochures and leaflets was printed, and local and national media (TV, radio, print) are regularly contacted since they are significant for the education on and promotion of proper nutrition and regular physical activity. Also, according to guidelines of the World Health Organization, draft national guidelines are currently being prepared regarding the regulation of advertising food and non-alcoholic beverages directed at children and young people. In 2011, a lecture was held on the public-health significance of the excessive intake of salt as part of a professional gathering of the baked goods food industry, at which three types of bread with 30% less salt were presented. The significance of the prevention of obesity has also been pointed out in the Strategic development plan of public health which was prepared in 2012.

National Programme of Health Care of Persons with Diabetes

Diabetes is one of the most significant public health problems of modern society and it is estimated that in Croatia about 300,000 persons have diabetes; it is one of the 10 leading causes of death and a very important risk factor in the development of cardiovascular diseases and disability. In order to improve health care and the monitoring of epidemiological and clinical indicators on the national level, the CroDiab register has been established, a system developed based on global quality indicators, which accelerates the everyday work of doctors in the care of persons with diabetes, reduces the number of unnecessarily repeated examinations, improves the quality of the documentation and at the same time is a means of data collection for the national register. At its session held on 17 June 2011, the Croatian Parliament adopted the Resolution on Diabetes, taking into consideration all European and global recommendations and the current epidemiological situation based on the "Croatian model" of the National Programme for diabetes and the initiative of the committee members for the implementation of the National Programme and the employees of the University Clinic Vuk Vrhovac, Clinical Hospital Merkur.

The resolution emphasizes the significance of diabetes and the burden it represents for society, and calls on all competent institutions, economic operators, media and non-governmental organisations to get more actively involved in the prevention, early detection, treatment and rehabilitation within the scope of their possibilities and available resources. The

resolution is thus the crowning activity of all previous public health activities, but also a roadmap for all future public-health activities in the field of diabetes.

4. Legislation of the Republic of Croatia regarding Article 13 of the European Social Charter

With its Constitution, the Republic of Croatia declared itself a welfare state in which certain categories of the population are given special protection, especially the weak, helpless, neglected and unemployed persons, who are ensured the right to assistance in meeting the basic life needs. The state provides particular care to the protection and social inclusion of disabled persons, children without parents and children whose parents do not provide care.
The need to use the available funds to meet the increasingly complex and numerous user needs, and the need for the welfare system to be harmonised with all the initiated reforms and changes in the field of social policy are the reason why, in the period between 1 January 2008 and March 2012, two Social Welfare Acts were passed.

Since the last Report, the following regulations have been passed and amended:

Acts

1. Social Welfare Act ("Official Gazette", number 57/11);
2. Act on Activities of Social Work ("Official Gazette", number 124/11);
3. Act on Special Education and Rehabilitation Activities ("Official gazette", number 124/11);
4. Act on the Organisational Structure and Scope of Work of Ministries and Other Central Bodies of State Administration ("Official Gazette", number 150/11 and 22/12);
5. Social Welfare Act ("Official Gazette", number 33/12).

During the short implementation of the Social Welfare Act ("Official Gazette", number 57/11), which was implemented from 2 June 2011 to March 2012, difficulties were noted primarily concerning the centralisation of the system and the organisation of the operations of Social Welfare Institute and its branch offices, which is additionally explained in relation to Article 13 Paragraph 3 of the European Social Charter. Therefore, after only eight months of implementation, in March of 2012, the new Social Welfare Act was passed ("Official Gazette", number 33/12).

This Act takes into consideration new approaches and methods in working with beneficiaries, and resolves issues noted during the implementation of the Act from June of 2011. The Act better regulates principles of the social welfare system, and regulates more clearly the rights of beneficiaries and the procedure for the recognition of these rights, including the right to social services, improves the procedures for the provision of services and regulates the implementation of administrative and inspection supervision.

4. ARTICLE 13 – THE RIGHT TO SOCIAL AND MEDICAL ASSISTANCE

With a view to ensuring the effective exercise of the right to social and medical assistance, the Contracting Parties undertake:

1. to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition;

2. to ensure that persons receiving such assistance shall not, for that reason, suffer from a diminution of their political or social rights;

3. to provide that everyone may receive by appropriate public or private services such advice and personal help as may be required to prevent, to remove, or to alleviate personal or family want;

4. to apply the provisions referred to in paragraphs 1, 2 and 3 of this article on an equal footing with their nationals to nationals of other Contracting Parties lawfully within their territories, in accordance with their obligations under the European Convention on Social and Medical Assistance, signed at Paris on 11th December 1953.

The constitutional provisions related to this Article of the European Social Charter have not changed in the Republic of Croatia during the reporting period.

In the period from 1 January 2008 to 31 December 2011, the welfare system in the Republic of Croatia was marked by changes and developments towards a more active social state, during which it is necessary to accentuate and support social cohesion, and help and protect vulnerable community members, in partnership with all providers of social services.
The period was marked by an economic and financial crisis, which strongly influenced the strategic approach in the area of social protection and social inclusion. During the past three years, the efforts of the Government of the Republic of Croatia were mostly directed towards alleviating the negative consequences of the drop of the GDP and to retain the current levels of social welfare rights, particularly for the most vulnerable groups outside of the labour market.

At the end of 2011, the ministries underwent organisational and structural changes. At its session held on 22 December 2011, the Croatian Parliament passed the Act on the Organisational Structure and Scope of Activities of Ministries and Other Central Bodies of State Administration ("Official Gazette", No. 150/11, 22/12).
In accordance with the organisational changes, the Ministry of the Family, Veterans' Affairs and Intergenerational Solidarity and the Ministry of Health and Social Welfare ceased to exist, and their activities were taken over by the newly formed Ministry of Social Policy and Youth, Ministry of Veterans' Affairs and the Ministry of Health. The Directorate for Family and the Directorate for Intergenerational Solidarity from the structure of the former Ministry of the Family, Veterans' Affairs and Intergenerational Solidarity as well as the Directorate for Social Welfare of the Ministry of Health and Social Welfare continued with their activities within the new organisational structure of the Ministry of Social Policy and Youth.

In November of 2011, the Act on Activities of Social Work ("Official Gazette", number 124/11) and the Act on Activities of Special Education and Rehabilitation ("Official Gazette", number 124/11) were passed. The goal of these Acts was regulating the content and method of functioning, educational standards and requirements for the provision of these activities.
These acts prescribe the establishment of chambers as independent professional organisations

that are legal persons with public authorities.

The purpose of establishing these chambers is regulating the standards of the respective professions, as well as the promotion, representation and harmonisation of the interests of qualified professionals employed in social welfare and other systems, such as health, the judiciary, economy and the civic sector. Also, one of the goals of establishing such chambers is the supervision of the conscientious, responsible and professional work of qualified professionals of the respective professions.

2011-2016 Strategy of Social Welfare Development in the Republic of Croatia

During 2010, the 2011 -2016 Strategy of Social Welfare Development in the Republic of Croatia was adopted. The Strategy contains the development priorities of the social welfare system, as well as measures whose implementation is planned in order to achieve the objectives of the Strategy. The priority objectives of the development are the following: raising the efficiency of the welfare system, decentralisation of social care, increasing the availability and access of social services (deinstitutionalization and prevention of institutionalization), computerisation of social care, improving the cooperation with non-governmental organisations, empowerment of local communities in the process of the social planning of services, the development of standards for the monitoring and evaluation of social service delivery, the advancement of the cooperation between different levels and bodies of public authority.

The first efforts in the development of social welfare were made in the implementation of the Social Welfare Development Project financed with the means of the World Bank, and with the signing of the Joint Inclusion Memorandum.

Social Welfare Development Project

The Social Welfare Development Project was implemented in the 2006 to 2009 period in order to modernise the system and additionally harmonise it with the criteria and standards applicable in European Union member states. The project included the implementation of activities aimed at improving the social service delivery via the development of welfare programs and a new organisations of operations in social welfare centres, strengthening the informational and control system of social welfare, and infrastructure improvement in social welfare institutions for the purpose of raising the quality of life of the system beneficiaries.

The Social Welfare Development Project was carried out through three components.

Component I (improvement in social service delivery)

As part of Component I of the project, all planned project activities were complete on 30 September 2009, after which the implementation of the reform was continued.

1. *The standards of quality of social services* in the field of social welfare were prepared within the Social Welfare Project and were passed with a Decision of the Minister of Health and Social Welfare on 7 December 2009. The standards describe what high-quality social services need to look like and represent a baseline for the measurement of the quality of social services. In the process of developing these standards, the Ministry of Health and Social Welfare, along with the ensured technical assistance, involved different stakeholders in

the consulting process, carried out a pilot project of introducing quality standards with six providers of social services, and collected the opinions and proposals of experts employed in social welfare centres, welfare homes and non-governmental organisations. The quality standards were revised during training programmes carried out for qualified professionals of providers of social services at which the standards were tested in November of 2008, and April and May 2009. The final draft of the standards are a result of the active work of six different providers of social services (welfare home, social welfare centre and non-governmental organisations). Several training workshops for service providers were held as well as the closing conference on the quality standards, at which 200 stakeholders gathered. Quality standards are an important part of the quality system, and they ensure the following: permanent and predictable quality of services; professional operation of the services system; permanent improvement of the quality of the services; satisfaction with and trust in the quality of the services; the responsibility of service providers towards clients and service users, as well as the wider community.

During 2011, in accordance with the Guidelines for the introduction of quality standards for social services, the introduction of these standards was continued in all social welfare institutions established by the Republic of Croatia. Considering that the service quality standards that are being introduced into the welfare system emphasize the focus on the needs of the beneficiaries and represent a baseline for the measurement of the quality of social services, which enables the precise and transparent evaluation of each service provider, workshops on the analysis of the self-evaluation reports were organised with each of the above mentioned service providers - 80 social welfare centres with 27 branch offices and 11 offices as well as 72 welfare homes. Also, the preparation for the training programme of quality teams of other service providers established by the Republic of Croatia was carried out.

2. Changes in the Organisation of the Operation of Social Welfare Centres

The idea of the welfare reform presumes the creation of a system that focuses on the needs of the beneficiaries, that adjusts to the beneficiaries and that is result-oriented. In this sense, on 07 December 2009, the Ministry of Health and Social Welfare passed a decision on introducing a new organisation of the operation of social welfare centres and their branch offices – the one-stop-shop, and the new model was introduced in 19 social welfare centres.
The concept of the "one-stop-shop" presumes structural and qualitative changes in the operation of the centres by forming admissions offices in order to ensure a high-quality first contact with the beneficiary, and to carry out an initial needs assessment of the beneficiary. Activities concerning financial benefits have been separated from social welfare services, and social welfare is organised within three units (Department for financial benefits, Department for children, young people and the family, and the Department for adults. Social workers in social welfare centres have taken over the role of case managers, who are responsible for the formation and arrangement of the best possible services and benefits to which the user is entitled. The beneficiaries actively participate in the preparation and monitoring of individual plans, as well as their family and professionals from other fields, and the plan should be revised in accordance with changes of the specific needs and circumstances of beneficiaries in order to ensure high-quality case management, which presumes a quality needs assessment of the beneficiary, as well as a plan of the changes in question. During 2011, for all social welfare centres educational workshops were organised, at which experts were trained for the implementation of these methods. At the same time, social welfare centres are harmonising their operation with the quality standards in social services. The harmonisation is in its last

year of implementation.

3. Social Planning

In accordance with the Government Policy on Prevention, Deinstitutionalization, Reintegration and Inclusion, during 2009 the Ministry began with the introduction of social planning. The goal is to provide assistance in the development of tools (mechanisms) that could help units of local and regional government and social welfare centres in the planning of the provision of social welfare services. Until September of 2009, during the implementation of the Social Welfare Development Project, social welfare plans were developed for three pilot counties (Vukovarsko-srijemska, Zadarska, Splitsko - dalmatinska). In the continuation of the reform implementation, social welfare plans for an additional 7 counties were developed (Zagrebačka, Koprivničko-križevačka, Virovitičko-podravska, Šibensko-kninska, Ličko-senjska, Sisačko-moslavačka and Karlovačka County).
These social welfare plans comprise a detailed analysis of the capacities, availability of the social welfare services network and specific goals of the development of institutional and non-institutional social welfare services, with special focus on services for groups at a greater risk of social exclusion.

4. Programme for Innovation and Learning

The programme is part of the Social Welfare Development Project whose goal is to encourage and support cost-effective high-quality services that are focused on the prevention of institutionalization, deinstitutionalization and the reintegration of beneficiaries in the local community, and will develop non-institutional forms of social services in the local community. Within the framework of the programme for innovation and learning, EUR 3.7 million was spent from 34 grants given to social welfare institutions and non-governmental organisations for the initiation and introduction of innovative programmes from the area of social welfare. All projects were successfully carried out until 30 September 2009. After the completion of the financing, the project managers expect that the local community or other donors will finance the projects to a certain extent. Some of them already have signed partnership agreements concerning the financing, and others have orally agreed on the financing from local budgets with local authorities. The projects were visible in local communities and have been recognized as valuable and useful in the fulfilment of the needs of the local community. The financing by the Ministry of Health and Social Welfare and the World Bank has shown to be a good reference for the continuation of financing by different donors. Some projects will continue their activities, but to a smaller extent, depending on the available resources. No project will stop all activities after the completion of the financing by the Programme, but some of them will continue their activities in a significantly reduced scope when compared to what was agreed in the partnership agreements due to the current economic situation and problems in particular financially weak local communities. All of these innovative models that have been recognized through the Programme for Innovation and Learning have shown to be useful and goal-oriented and should be implemented in the entire country.

Component II (Computerisation of the System)

During 2009, within the framework of the Social Welfare Development Project, the SocSkrb information system was created and implemented in social welfare centres in three pilot counties. Employees of social welfare centres have begun with the data input on users, and while doing so they identify and eliminate errors and work on advancing the system. Also, a training programme was carried out for the employees of 36 social welfare institutions in the pilot counties (344 employees). The software for the computer-based connection with other systems -'e-Razmjena' as well as the project "Harmonisation of the existing and proposal of new statistical reports of the Ministry of Health and Social Welfare". The public tender for the procurement and installation of computer equipment and systematic software support for the extension of the information system to the national level is complete.

Through the project "Project design, directing and coordinating the computer-based control system for the computer-based connection with other institutions outside of the welfare system" an IT solution was created that will ensure data exchange from the welfare system with other systems that have participate in the supply or reception of various data and documents on the beneficiaries of the social welfare system. The computer-based connection would improve financial and administrative controls, reduce the possibility of multiple payments of social benefits or other errors.
During July and August of 2011, for the purpose of the implementation of the entire system and the establishment of its complete functionality, as well as the maintenance and management of the system, procurement procedures and activities for the purpose of the implementation of the training for all employees of social welfare institutions outside of the pilot counties and harmonisation of the application with changes due to the entry into force of the new Social Welfare Act have been initiated.

For the activities carried out under Component II of the project, a total of USD 405,260 was spent from the grant of the Swedish International Development Coordination Agency (SIDA), and EUR 2,501,770.48 from World Bank loan assets for the Social Welfare Development Project. The contracted obligations for the activities under way amount to a total of EUR 1,476,822.13 from the loan funds, and for the planned activities a total of EUR 2,500,000 of the World Bank loan assets was ensured.

Component III (infrastructure improvement)

The goal of this component was to ensure the infrastructure in special welfare centres in accordance with the administrative reorganisation of these institutions, and to improve the living conditions of beneficiaries living in welfare homes.
Through this component, a training programme was carried out for the employees of the Ministry of Health and Social Welfare in the area of conducting procurement procedures and financial management in projects financed by World Bank loan assets, the reconstruction and adaptation in welfare homes on 45 location across the Republic of Croatia were carried out with the primary goal of improving the living conditions of beneficiaries and conditions for the operation in 14 social welfare centres:

- 9 new social welfare centres (Osijek, Koprivnica, Vinkovci, Čakovec, Krk, Daruvar, Novska, Našice and Krapina) were opened;
- 4 social welfare centres (Velika Gorica, Dugo Selo, Đurđevac and Garešnica) were reconstructed and upgraded and the Rijeka social welfare centre was renewed

For this a total amount of EUR 33.36 million was envisaged, EUR 22.8 million of which is financed by the International Bank for Reconstruction and Development.

Joint inclusion memorandum of the Republic of Croatia (JIM)

The Ministry of Health and Social Welfare, as the coordinator of pre-accession activities of cooperation between the Republic of Croatia and the European Union in the field of social inclusion, prepared the Joint Inclusion Memorandum of the Republic of Croatia (JIM). The JIM was jointly signed by the Government of the Republic of Croatia and the European Commission on 5 March 2007.
In accordance with the signed document, the Republic of Croatia is obliged to submit a report on the implementation of the JIM to the European Commission and partners once an year.
After signing the Joint Inclusion Memorandum of the Republic of Croatia on 5 March 2007 Croatia, entered the implementation phase of the measures envisaged by the JIM and its monitoring. Considering that it is necessary to continuously adjust the measures to new circumstances and challenges, Croatia completed in 2009 the new National implementation plan for the period from 2009 to 2010, which is took into consideration the challenges from the previous implementation plan, but also measures that were not included in the earlier implementation plan.
On 31 March 2009, the third conference after signing the JIM was held in Zagreb, which was aimed at presenting the new National implementation plan for the 2009-2010 period, enabling the exchange of ideas on the implementation of measures and activities included in the JIM and the implementation plan, discussing key forthcoming reform challenges and problems that make the successful vertical and horizontal process management difficult, which is important from the aspect of the implementation of the JIM. In mid 2009, the second implementation report for the JIM and the national implementation plan for the 2007-2008 period was prepared. The European Commission submitted the evaluation report on the implementation of the measures for the period from the beginning of 2008 to March 2009. In this evaluation report, the progress made in particular areas of social inclusion was emphasized and as well as further challenges such as: the acceleration of the deinstitutionalisation and decentralisation process, the protection of older persons without pension, the employment and social inclusion of ethnic minorities, the promotion of lifelong learning, the protection of vulnerable groups from the impact of the economic crisis, the comprehensive monitoring of measures undertaken. Starting with the evaluation report and guidelines regarding the preparation of the 2009 report, the implementation report for the Joint Inclusion Memorandum of the Republic of Croatia began in 2009. This means that the structure of this Report was coordinated with the requirements and guidelines of the EC. The report consists of two main parts and statistical and other annexes. In the first part, an overview of the social, economic and demographic situation is provided, the comprehensive strategic approach in dealing with the challenges of poverty and social exclusion during 2009 is presented and the framework of the strategic approach in the 2010-2011 period is provided. The second part contains information on the implementation of the priorities and measures accepted in the JIM and the 2009-2010 National Implementation Plan.

In June of 2011, the Implementation Report for the 2010 JIM was prepared and submitted to the European Commission. Special reference was given to the social effects and mitigation measures of the impact of the economic and financial crisis. For every measure of the JIM, a review is given for every target group, a comparison of the progress of the measures in the observed period with respect to the previous year and with respect to the start of the process

in 2006 is given, and the connection between the IPA process and the Joint Memorandum on Policy Priorities Employment (JAP) is presented In February of 2011, the third National Implementing Plan for Social Inclusion for the 2011 – 2012 period was accepted. The implementation plan contains measures that have been continuously carried out since the adoption of the JIM - since 2007 - and new measures necessary in order to adjust to new circumstances and the monitoring of the new Strategy of the European Union, Europa 2020, characterized by a smart, sustainable and inclusive growth, which will result in high levels of employment, productivity and social cohesion. The 2011-2012 National Implementing Plan for Social Inclusion includes priority activities that are planned to be carried out, the target groups at which the activities are directed, indicators based on which the level of the achievement of the activity will be measured, the competent state authorities and institutions (organisations) responsible for the implementation of activities as well as sources of financing for these activities. During 2012 the fifth implementation report for the 2011 JIM was prepared In the process of JIM, 3 JIM conferences and two joint JIMS/JAP conferences were held, gathering a large number of different stakeholders who exchanged their views and identified the best decisions on particular issues.

Economic recovery programme

In accordance with the implementation activities plan of the Economic Recovery Programme adopted by the Government of the Republic of Croatia, measures under Paragraph 10 were adopted. Social insurance system with the goal of ensuring a long-term sustainability of the system under the conditions of an aging population and the increase of social transfers directed exclusively to those that need it.
The Ministry of Health and Social Welfare is the designated competent authority for the measure " System analysis of social benefits, harmonisation of benefits that are granted on the same basis and complete application of the Personal Identification Number as an instrument of directing measures of social policy ".
Within the framework of this measure, in December of 2010, the Ministry of Health and Social Welfare, in coordination with other state authorities, made an analysis of all social benefits in order to harmonise the rights that are exercised on the same basis and to update the list of all social benefits. Also, a proposal for the rationalisation of social benefits was prepared, a uniform definition of the family (household) was adopted, a uniform methodology for the identification of the property census was determined as well as a proposal of the amount of the census for receiving social benefits; the draft amendments of particular legal regulations were prepared as well as the proposal of the administrative rationalisation of the system in the direction of establishing a single location for the payment of social benefits.

Introduction of data collection management

In order to plan and monitor the state of social welfare and for scientific research and statistical purposes in the area of social welfare (Art. 180 of the Social Welfare Act) data collection management is introduced, which includes the entire national social welfare system.

The ministry competent for social welfare activities is the manager of the central data collection on cash benefits and social services, and data from this collection can be exchanged with other authorities only under circumstances prescribed by law.
The ministry is in charge of the maintenance, use, insurance of security-related conditions and the supervision of the database and the entire SocSkrb IT system, as well as the provision of

IT support to the social welfare system.
The data is collected directly from the beneficiaries and the members of their families as well as from other official data collection managed by authorities authorised to do so in the Republic of Croatia.
The provisions of the Personal Data Protection Act ("Official Gazette", number 103/03, 118/06 and 41/08) apply to the collection, processing, storage, mediation and use of data from data collections and for the protection of the information privacy of individuals.

4.1. Paragraph 1 – ADEQUATE ASSISTANCE FOR EACH PERSON IN NEED

The entire social security system is marked by significant changes in the field of family policy, education, employment, pension insurance, health care system and health insurance. In this system, social welfare represents the last social protection net with the purpose of providing care to and inclusion into society of the most disadvantaged population or disadvantaged groups.
The social welfare system in the Republic of Croatia is prescribed by the Social Welfare Act ("Official Gazette" No. 33/12), which is in effect from 24 March 2012. The Act was passed considering that the monitoring of the effects of the previous Social Welfare Act ("Official Gazette", number 57/11) determined that it has led to the centralization of the system, although the welfare reform needs go towards the decentralisation of the system.
The new Social Welfare Act takes into consideration new knowledge and methods in working with the beneficiaries, and it better deals with problems that were noticed in the course of the implementation of the previous Acts from June 2011.

The Act better regulates principles of the social welfare system, and regulates more clearly the rights of beneficiaries and the procedure for the recognition of these rights, including the right to social services, improves the procedures for the provision of services and regulates the implementation of administrative and inspection supervision, in accordance with the provisions of the State Administration System Act.

According to this Act, social services will be provided based on public tender procedures for filling out the network of social services, and not via concessions as it was prescribed by the previous Act
The new Social Welfare Act creates preconditions for the further social welfare system reform as an important part of the public sector according to the following principles:

- the creation of conditions for the financing and development of a network of services in the local community based on the needs of beneficiaries through the development of social planning,
- connecting the basis for social welfare benefits to the relative poverty line,
- promotion of employment of working-age persons who are social welfare recipients through the organisation of public works and a clear definition of the cooperation,
- shortening the procedure for the realisation of social services,
- partnership in the provision of social welfare services,
- obligation of professional training and promotion of skilled workers,
- introduction of uniform data collection on beneficiaries of the right to cash benefits and social services,

- comprehensive continuous administrative and inspection supervision for the purpose of monitoring the quality of services provided, the legality of activities and the satisfaction of the beneficiary.

The Social Welfare Act ensures a minimum living standard of the most endangered segment of the population and the appropriate fulfilment of personal and family needs of disadvantaged groups with particular emphasis on European Union directives in the field of social inclusion.

Means for the financing of activities of social welfare are mostly ensured from the state budget, with about 96 %, whereas the remaining 4 % is ensured from special purpose revenues in accordance with the Social Welfare Act and the Ordinance on the participation and method of payment of beneficiaries and other parties obliged to pay accommodation expenses outside of their families ("Official Gazette", number 112/98 and 5/02). Revenue for special purposes are obtained from funds with which beneficiaries and the parties obliged to pay support participate in the payment of care outside of their families. To a lesser extent, units of local and regional government participate in the financing of social welfare.

Table 75. Funds for social welfare

SOURCE OF FUNDS	2008		2009		2010	
	Amount	**%**	**Amount**	**%**	**Amount**	**%**
1. State budget Total (1.1. to 1.4.)	**2,624,862,514**	**96.1**	**2,876,424,081**	**96.3**	**2,746,416,008**	**95.8**
1.1. Assistance and benefits in social welfare	1,600,376,441	58.6	1,820,299,413	60.9	1,798,184,094	62.7
1.2. Gross salaries and other income of employees of public institutions in social welfare (social welfare centres and social welfare homes)	655,818,872	24.0	679,845,044	22.8	675,935,078	62.7
1.3. Material expenses and other expenses of state welfare homes	251,549,122	9.2	256,400,245	8.6	255,904,821	8.9
1.4. Expenses for procurement, construction and investment maintenance of capital goods	117,118,078	4.3	119,879,379	4.0	16,392,015	0.6
2. Own resources of public institutions of social welfare	**105,744,600**	**3.9**	**110.229.244**	**3,7**	**119.401.993**	**4.2**
3. GRAND TOTAL (1.+2.)	**2,730,607,114**	**100.0**	**2,986,653,325**	**100.0**	**2,865,818,001**	**100.0**

Source: Annual report of the Ministry of Health and Social Welfare

Social welfare beneficiaries are single persons and families who do not have enough means to pay for their basic life needs, pregnant women or parents with children up to the age of one without family support and suitable living conditions, children with disabilities or mentally ill children and children who receive or should receive measures of family-law or criminal-law protection, persons who are in distress because of disturbed relationships in the family or

other forms of socially unacceptable behaviour, and adult persons who are in need of assistance due to disability, age, mental illness, permanent changes in their health status, addiction or other reasons. The Social Welfare Act from June 2011 introduces the term of the homeless person which means person that has no residence or means to pay for residence and is temporarily placed in a shelter or resides in public or other locations not intended for residence.

Below, a table is given showing the basic characteristics of social welfare beneficiaries in the 2008-2010 period according to data of the Ministry of Health and Social Welfare (based on data processing collected from social welfare centres). Considering that the Ministry is obliged to prepare the annual statistical report on beneficiaries and assistance in the social welfare system of the Republic of Croatia for 2011 by September of 2012, we are not able to provide a comprehensive overview of beneficiaries for 2011.

Table 76. Social welfare beneficiaries (%)

	2008	2009	2010
Share of beneficiaries in the total population of the Republic of Croatia	2.1	2.1	2.3
According to sex of recipient			
M	49.9	50.49	50.26
F	50.1	49.50	49.73
According to personal characteristics			
Single	23.58	23.37	22.90
Adult person-family member	76.41	76.62	77.09
According to age of recipient			
Up to 7	11.95	11.80	12.98
7-15	16.22	16.26	16.20
15-18	6.22	6.17	6.14
18-30	9.40	9.89	9.68
30-40	12.08	12.14	12.30
40-50	14.52	14.62	14.50
50-60	12.14	12.24	11.77
60-75	12.41	12.12	12.10
75 and above	5.02	4.71	4.28
According to employment status of recipient			
Unemployed	43.33	41.94	42.23
Employed	0.49	0.47	0.48
Engaged in independent business activity	0.03	0.03	0.02
Pensioner	1.27	1.50	1.34
Farmer	0.87	1.15	0.81
Children and young people attending regular education	30.16	32.28	32.42
Adult completely incapable of working	18.11	14.97	17.15
Other	5.70	4.45	5.50
According to period of receiving assistance			
Up to 6 months	8.74	9.70	11.49
6 m – 1 year	10.55	10.19	11.06
1-2 years	16.50	18.99	18.39
2-5 years	25.69	24.27	24.42
5-10 years	25.89	24.06	22.66
10 and more	12.59	12.76	11.95
According to the education of person who applied for assistance (single person or head of family)*			
No school education	15.91	12.59	12.52
Incomplete elementary school	24.32	25.47	25.40
Elementary school (low education qualification)	31.41	33.23	33.92
Secondary education diploma (secondary education qualification)	26.36	26.82	26.54
Two-year post-secondary school qualification	1.09	1.12	1.58
University degree and higher	0.88	0.75	0.81

* The person who applied for assistance is the person who submitted the application for assistance and who receives the assistance for herself/himself and his family, whereas the term "beneficiary" includes both the person who applied for assistance and the members of their families who use it.

Source: Annual report of the Ministry of Health and Social Welfare

Rights in the social welfare system

Rights in the social welfare system are the following: livelihood assistance, assistance for the

payment of housing expenses, one-time assistance, education assistance, personal disability allowance, help and care allowance, status of parent-caretaker or caretaker, pre-employment assistance, inclusion benefit and social services.

1. Livelihood assistance

Livelihood assistance can be received by persons who have no means for their livelihood in the amount prescribed by law, and cannot obtain them by selling their assets, renting or leasing their assets that do not serve them or the members of their family for meeting basic life needs. It is prescribed that working-age unemployed persons must be properly registered with the competent service for employment and are not to refuse work offered to them.
The amount of the assistance depends on specific features of each family such as: number of family members, age, work disability, pregnancy and single parents, and this is determined in a percentage of the basis for social payments. This right is intended for the beneficiaries to ensure the payment of their most basic life needs (usually nutrition, and other most basic personal needs). It is presumed that everyone is obliged to take care of meeting their own life needs and the needs of persons they are obliged to support by law or other legal grounds, and that they are obliged, through work, income and their assets, to contribute to the prevention of their own social endangerment, as well as the members of their family, especially children and other members who cannot take care of themselves. In the sense of the provisions of the Act, it is considered that a person can support herself/himself if they can create income through the sale of assets or by renting or leasing assets that does do not serve them or the members of their family for the payment of the basic life needs. Residential space that satisfies basic housing needs is considered to be an apartment or house 35 m2 in useable space for one person, and for disabled persons it is 20 % larger (42 m2), increased by 10 m2 for every additional person, with a possible deviation of up to 10 m2.
The basis for determining the amount of livelihood assistance is determined by the Government of the Republic of Croatia in the amount that cannot be less than 22.5% of the monthly amount of the relative poverty line for a single-person household. The monthly amount of the relative poverty line for a single-person household is determined in the amount of one twelfth of the annual amount of the relative poverty line, which is published by the State Bureau of Statistics.
With the Social Welfare Act from June of 2011, the equivalent scale was amended so that assistance is ensured to single persons in a more just way. Also, the basis used to determine the amount of the assistance has been tied to the relative poverty line.
The amount of the livelihood assistance is determined in a percentage of the basis, and for a working-age single person the amount of 120 % of the basis was determined, which is HRK 600,00. For working-age persons who live with their families the amount of the livelihood assistance is 80% of the basis or HRK 400.00. Furthermore, depending on the age of family members, for children up to 7 years of age it amounts to 80% of the basis - HRK 400.00, for children between the ages of 7 and 15 it amounts to 90% of the basis - HRK 450.00, and for children between the ages of 15 and 18, or until the completion of regular education – 100% of the basis or HRK 500.00.
Livelihood assistance is increased by a certain percentage of the basis if the beneficiary is: a person completely incapable of working who lives alone by 50% of the basis or HRK 250.00, a person completely incapable of working who lives with their family by 30% of the basis or HRK 150.00, a pregnant woman after 12 weeks of pregnancy and young mother up to 2 months after birth by 50% of the basis or HRK 250.00, a child of a single parent by 25% of the basis or HRK 125.

Persons capable of work who receive livelihood assistance and other material assistance are entitled to and have the obligation to participate in activities that allow their social inclusion. When receiving the livelihood assistance, unemployed persons capable of work or partially capable of work are obliged to accept employment in accordance with the regulations on employment and the activity plan of the beneficiary.

In the Republic of Croatia, livelihood assistance, as the most significant form of assistance in the prevention of poverty is received by 104,179 persons (data of the Ministry of Health and Social Welfare for December of 2011). In December of 2011, beneficiaries of livelihood assistance make up 2.3% of the total population of the Republic of Croatia, which is a greater share when compared the same period in 2008, 2009 and 2010. In 2008, livelihood assistance was received by 92,819 persons, in 2009 by 94,849 persons, and in 2010 by 102,668 persons.

Table 77. Livelihood assistance

	2008	2009	2010
1. total assistance (given to single persons and families)	42,541	43,246	46,246
2. total number of persons covered	92,819	94,849	102,668

Source: Annual report of the Ministry of Health and Social Welfare (data collected based on processing of data collected from social welfare centres)

2. The right to the assistance for the payment of housing expenses is intended for covering the costs of rent, utility-service fees, electricity, gas, heating, water and the sewer system. This assistance can be granted to a single person or family if their monthly income in the last three months before they apply for the assistance or before proceedings are initiated ex officio, does not exceed the amount of the livelihood assistance prescribed by the Social Welfare Act. Assistance for the payment of housing expenses is approved by units of local government monthly, up to half the amount of the livelihood assistance granted to single persons or families prescribed by the Act. Within the framework of this right, beneficiaries who use wood for heating can be granted 3 m2 of wood once a year or a sum of money for the payment of this cost (the funds for this are ensured by the units of the regional government.

Table 78. Assistance for the payment of housing expenses

	2008	2009	2010
Assistance for the payment of housing expenses (granted to single persons and families)	32,575	27,456	29,038
Assistance for fire wood (granted to single persons and families)	46,889	41,538	41,602

Source: Annual report of the Ministry of Health and Social Welfare (data collected based on processing of data collected from social welfare centres)

3. Right to help and care allowance - depending on changes in their health status, beneficiaries can be granted this right in a reduced extent - 70% of the basis or HRK 350.00

or in the full amount, 100% of the basis or HRK 500.00. The help and care allowance is a financial aid intended for persons who cannot meet their basic life needs due to which they need help and care from another person in the organisation of nutrition, the preparation and taking of meals, procurement of food, cleaning and tidying of apartment, dressing and undressing, maintenance of personal hygiene as well as in the provision of other basic life needs.
Persons have a right to the help and care allowance if they do not have a signed contract on lifelong care, and if the average income of a single person does not exceed the amount of 250% for the realisation of rights from social welfare (HRK 1,250.00) or if the average monthly income of family members does not exceed the amount of 200% of the basis (HRK 1.000,00).

The help and care allowance is approved in the complete or reduced amount depending on whether the extent of the need for the help and care from another person. The need for constant help and care from another person in the full extent refers to the need of persons with severe disability, persons with severe permanent changes in their health status and blind, deaf and deaf-blind persons that are not capable of independent life and work.

Blind, deaf and deaf-blind persons who are enabled for independent life and work and persons completely deprived of their business capacity have the right to the help and care allowance in the reduced amount.
The severity of the impairment is determined by an expert evaluation body in accordance with criteria prescribed by the Ordinance on the structure and way of functioning of expert evaluation bodies in the procedure of granting rights from the social welfare system and other rights based on special regulations ("Official Gazette", number: 64/02, 105/07 and 145/11). The criterion for determining the severity of the impairment or permanent changes in the health status is not the diagnosis itself, but the difficulties that arise from a certain condition or disease.

In the Republic of Croatia, 79,654 persons receive the help and care allowance (data of the Ministry of Health and Social Welfare for December of 2011). Of this number, 53,898 persons receive the full amount, and 25,756 persons the reduced amount. The table below demonstrates the number of beneficiaries who receive the help and care allowance in the 2008-2010 period according to the data of the Ministry of Health and Social Welfare (based on data processed by and collected by social welfare centres).

Table 79. Help and care allowance

	2008	**2009**	**2010**
1. full amount (100% of the basis)	51,720	54,067	55,529
2. reduced amount (70% of the basis)	25,152	25,564	25,844
TOTAL (1.+.2.)	76,872	79,631	81,373

Source: Annual report of the Ministry of Health and Social Welfare (data collected based on processing of data collected from social welfare centres)

4. Education assistance

The Social Welfare Act prescribes the following forms of education assistance:

4.1. Assistance for accommodation expenses in student dormitories

Secondary school students, whose family receives livelihood assistance, has the right to receive assistance for accommodation expenses in student dormitories. This right is granted to families of the average monthly income per family member does not exceed the amount of 1150% of the basis for social welfare (HRK 750.00) or if the secondary school student is a child of a single parent and the income does not exceed 250% of the basis (HRK 1,250.00). Also, children with developmental difficulties and children placed in foster families if they attend school outside of the place of permanent residence of their foster families and if their schooling cannot be ensured in their place of permanent residence, also have the right to receive assistance for accommodation expenses in student dormitories.

4.2. Transport cost assistance

The right to transport costs assistance for transport to the place of permanent residence is granted to disabled persons and children with developmental difficulties who attend special programme secondary education classes or training for self-care outside of the place of their permanent residence.

4.3. School textbooks assistance

Livelihood assistance beneficiaries and beneficiaries of foster family care, who are elementary or secondary school students, will be granted once an year by the social welfare centre a one-time financial aid for the procurement of the obligatory school textbooks in the amount of 50% of the value of new school textbooks and accompanying materials for a particular grade.

4.4. Assistance for regular university studying

Regardless of the financial standing and income of the beneficiaries, beneficiaries of the right on permanent accommodation have the right to monthly assistance in the amount of the fourfold basis (HRK 2.000,00). On the date of enforceability of the decision on the recognition of the right to this assistance, the beneficiary no longer has the right to permanent accommodation. According to data of the Ministry of Health and Social Welfare for December of 2011, education assistance was used by 13,888 persons, the largest number of which used the school textbooks assistance (8,938 persons) and the transport costs assistance (4,469 persons).

5. Personal disability allowance

The right to personal disability allowance is granted to persons with severe disability or other severe permanent changes in their health status for the purpose of satisfying needs for inclusion in the everyday life of the community.

The Social Welfare Act from June of 2011 amended provisions concerning the realisation of the right to the personal disability allowance that were prescribed by the previous Social Welfare Act ("Official Gazette" no. 73/97, 27/01, 59/01, 82/01, 103/ 03, 44/06 and 79/07), which recognized the right to the personal disability allowance only if such impairment or medical condition occurred before the age of 18. Since June of 2011 the right to the personal disability allowance is not limited by the age of the beneficiary.

The personal disability allowance amounts to 250% of the basis per month (HRK 1,250.00) for persons that do not have their own income or assets prescribed by the Social Welfare Act. If the person generates income on any basis, the personal disability allowance is determined as the difference between the earned income and the amount of the personal disability allowance and the average income of the previous three months.
If the parent of a personal disability allowance beneficiary is on maternal leave or parental leave or uses the benefit of working half-time for the purpose of increased care of a child with severe developmental disorders or suspension of employment status up to the child's age of three if the child stays for 4 hours and more daily in preschool, school or a medical institution, welfare home or at the other care services, the personal disability allowance is paid out in the amount of 125% of the basis, that is HRK 625.00.
In the Republic of Croatia, 18,948 persons receive the personal disability allowance (data of the Ministry of Health and Social Welfare for December of 2011). 18,383 persons receive the full amount and 565 persons the reduced amount.
The table below shows the number of personal disability allowance beneficiaries for the 2008-2010 period according to data of the Ministry of Health and Social Welfare (based on data collected by social welfare centres).

Table 80. Personal disability allowance

	2008	**2009**	**2010**
1. full amount (250% of the basis)	14,910	15,782	16,220
2. reduced amount (125% of the basis)	743	550	560
TOTAL (1.+.2.)	15,653	16,332	16,780

Source: Annual report of the Ministry of Health and Social Welfare (data collected based on processing of data collected from social welfare centres)

6. Pre-employment assistance

The right to pre-employment assistance in the amount of 70 % of the basis (HRK 350.00) is granted to children with developmental difficulties or disabled persons whose physical, mental, intellectual or sensory impairment was determined after the completion of primary-school, secondary-school or higher education, at the earliest at the age of 15.
The decision on the recognition of the right to pre-employment assistance is passed by the social welfare centre, and the funds are ensured by the Fund for professional rehabilitation and employment of disabled persons. This right is terminated when the beneficiary is employed, and the right can be recognized again if the employment stops regardless of the will of the beneficiary and if she or he does not receive other benefits during the employment on the basis of other regulations. The beneficiary cannot simultaneously receive the pre-employment assistance and the help and care allowance.

The table below presents the number pre-employment assistance beneficiaries in the 2008-2010 period according to data of the Ministry of Health and Social Welfare (according to data collected by the social welfare centres).

Table 81. Pre-employment assistance

	2008	2009	2010
1. full amount (250% of the basis)	14,910	15,782	16,220
2. reduced amount (125% of the basis)	743	550	560
TOTAL (1.+.2.)	15,653	16,332	16,780

Source: Annual report of the Ministry o Health and Social Welfare
(data collected by social welfare centres)

7. Status of parent-caretaker or caretaker

The right to the status of parent-caretaker, based on which income benefits in the amount of 5 bases, or HRK 2,500.00 are received, is granted by the social welfare centre to one parent of a child with developmental difficulties, or of a disabled person, who is completely dependent on the assistance and care of other persons and who for his or her subsistence needs the provision of specific medical and technical care.
This right is also granted to one parent of a child with developmental difficulties or a disabled person, who is completely immobile even with the aid of orthopaedic aids and the parent of a child with developmental difficulties or a disabled person with several types of severe impairments (physical, mental, intellectual or sensory), because of which it is completely dependent on the assistance and care of other persons and resides less than 4 hours a day in preschool, school, an educational or medical institution or social welfare home.
The novelty with this right was introduced in June of 2011, and according to it, if the child with developmental difficulties or the adult person has no parents or neither of the parents lives with the child and does not take care of it or lives with the child but is not able to provide care, this right can be granted to one of the family members. Also, the right can, *in loco parentis*, be granted to the spouse or extramarital partner with whom the child or adult person lives.
The person who is granted this right cannot realize the right to compulsory insurance on any other basis considering that the person with the status of parent-caretaker is considered an employed person according to a special regulation. Social welfare centres pass decisions on this right in agreement with the Ministry competent for social welfare activities.
In the Republic of Croatia, 2,704 persons have the right to the status of parent-caretaker or the status of caretaker (data of the Ministry of Health and Social Welfare for December of 2011). Of these, 2,531 persons were parents and 173 were family members.
The table below presents the number of users with the status of parent-caretakers in the 2008-2010 period according to data of the Ministry of Health and Social Welfare (based on data collected by social welfare centres).

Table 82. Status of parent-caretaker or caretaker

	2008	2009	2010
Status of parent caretaker	1,398	1,873	2,187

Source: Annual report of the Ministry of Health and Social Welfare
(data collected by social welfare centres)

8. ***One-time assistance*** is a one-time financial benefit or benefit in kind that the social welfare centre grants to a single person or family who due to temporary financial difficulties is not able to pay for basic life needs, and which occurred due to the birth of a child, the education of a child, disease or death of family member, natural disaster etc.
The novelty prescribed by the Social Welfare Act from March of 2012 is that the total amount of the one-time assistance cannot amount to more than five bases for social benefits (HRK 2,500.00) annually.
If the amount of the required assistance is greater than the fivefold amount of the basis, i.e. HRK 2.500,00, the social welfare centre must obtain the approval of the ministry competent for social welfare activities. This form of assistance is given in cash or in kind.
On 31 December 2011, 73,847 one-time assistance benefits were granted in the Republic of Croatia (data of the Ministry of Health and Social Welfare for December of 2011). Of this, 65,985 one-time assistance benefits were in cash, and 7,862 were in kind.
The table below shows the number of approved one-time assistance benefits in the 2008-2010 period, according to data of the Ministry of Health and Social Welfare (based on data collected by social welfare centres). The economic crisis brought about a considerable increase in the number of applications for one-time assistance in 2010.

Table 83. One-Time Assistance

One-time Assistance	**2008**	**2009**	**2010**
In cash	73,432	77,411	89,038
In kind	2,767	3,944	4,025
TOTAL (1.+.2.)	76,199	81,355	93,063

Source: Annual report of the Ministry of Health and Social Welfare
(data collected by social welfare centres)

9. Inclusion benefit

The most important new financial aid of the Social Welfare Act, with postponed implementation, is the inclusion benefit, intended for disabled persons for the purpose of creating conditions for the inclusion into everyday life. The conditions, areas and method of evaluation of the level of the required benefit given to disabled persons, the amount of the benefit and other issues related to the inclusion benefit will be regulated by a special act whose preparation is under way.
The inclusion benefit would be granted to persons with permanent physical, mental, intellectual or sensory impairments, which in can prevent them in the full and effective participation in society on an equal basis footing with others, because of which there is a need for a benefit for the purpose of inclusion in everyday life. The level of the benefit would be determined based on an evaluation of the functional abilities of the person (according to the International classification of functioning, disability and health), and the inclusion benefit would be granted in different amounts, depending on the level of the evaluated need. The level of the benefit would be evaluated in areas in which the needs of the person can be comprehensively determined, depending on her or his distinctive characteristics. The areas of the evaluation relate to self-care and independence, psychosocial functioning, mobility, work and occupational activities, socialisation and free time, and on the functioning of the person with regard to the environment. This way, the diversities in the functional ability of a person could be taken into consideration, which would result in differences between the amounts of the benefits.

10. Social services

One of the fundamental goals of the social welfare system reform, aimed at deinstitutionalisation, that is aimed towards providing extra-institutional care services, will be obtained through the introduction of a new system of 10 basic social services and the possibility of using several services in the same time period.
Emphasis is put on the priority recognition of extra-institutional services and the prohibition of the placement of children under the age of seven in social welfare homes. If necessary, children are to be places in homes of relatives or foster families.
The Social Welfare Act prescribes 10 social services that comprise all activities, measures and programmes aimed at the prevention, recognition and resolution of problems and difficulties of individuals, families, groups and communities and the improvement of their lives in the community.

These social services are the following:

1. primary social service (information, recognition and initial assessment of needs),
2. consulting and help services,
3. service of family mediation,
4. service of home care and assistance,
5. service of professional assistance in the family (domiciliary care),
6. service of early intervention,
7. service of assistance in the inclusion in education programmes (integration)
8. residence services,
9. placement services
10. professional assistance services in the performance of activities and employment.

Social welfare services are provided in accordance with the quality standards of social services and guidelines for their introduction.

4.2 Paragraph 2 - RIGHT TO SOCIAL AND MEDICAL ASSISTANCE

Article 3. of the Constitution of the Republic of Croatia prescribes the highest values of the constitutional order of the Republic of Croatia, including freedom, equality, national equality and gender equality, social justice and the respect for human rights. Article 14. of the Constitution prohibits discrimination declaring that everyone in the Republic of Croatia has rights and freedoms regardless of their race, skin colour, gender, language, religion, political or other belief, national or social origin, financial standing, birth, education, status or other characteristics.
The Anti-Discrimination Act ("Official Gazette", number 85/08) ensures the protection and promotion of equality as the highest value of the constitutional order of the Republic of Croatia, creates preconditions for the realisation of equal opportunities and regulates the protection from discrimination on the basis of race or ethnicity or skin colour, gender, language, religion, political or other beliefs, national or social origin, financial standing, membership in trade unions, education, status, marital or family status, age, health status, disability, genetic inheritance, gender identity, expression or sexual orientation. This Act applies to the acts of all state authorities, bodies of units of local and regional government, legal entities with public authority and all legal and natural persons, especially in the following areas:
Article 125 of the Criminal Code (Official Gazette, number 12 / 11) prescribes that anyone

who on the basis of race, ethnicity, religion, language, political or other
beliefs, financial standing, birth, education, social status or other characteristics, gender, skin colour, nationality or ethnic origin, violates the fundamental rights and freedoms recognised by the international community shall be penalized.
Also, the Social Welfare Act prescribes the fundamental principles on which the welfare system in the Republic of Croatia shall be implemented.
Based on the principle of the respect for human rights and integrity of beneficiaries, Article 13 of the Social Welfare Act prescribes that that the beneficiary is entitled to social welfare in keeping with his human rights, physical and psychological integrity, safety and respect of his ethical, cultural and religious beliefs. In accordance with the principle of non-discrimination, the provisions of Article 14 of the Act prohibit indirect and direct discrimination of the social welfare beneficiary.

Query of the Committee

- *In its most recent conclusions (Conclusions XVIII, Croatia, p. 173), the Committee requested from Croatia that it indicate any other legal instruments that include the positive guarantee of rights of persons who receive assistance, that their political or social rights are not reduced in any form, such as the right to vote and to be elected. The last report did not contain any information regarding this query set by the Committee. In order to determine the compliance of the Republic of Croatia with Article 13 Paragraph 2 of the European Social Charter, the Committee hereby repeats its question.*

According to the Health Care Act, the health care of the population of the Republic of Croatia is carried out based on principles of universality, continuity, accessibility and comprehensive access to primary health care, and specialised access to specialist-consultation and hospital health care. The universality of health care includes the entire population of the Republic of Croatia in the implementation of appropriate measures of health care in accordance with the law. The continuity of health care is achieved through the organisation of health services, especially at the level of primary health services that provides constant health care to the population in all ages. In the insurance of continuous services, the system of health services in the Republic of Croatia must be functionally connected and coordinated. The availability of health care is achieved through a distribution of medical institutions, trading companies that carry out health services and of health care professionals on the territory of the Republic of Croatia that will enable roughly equal conditions of health care to the entire population, especially in primary health services. The availability of health care in the all areas of units of regional government is ensured through the organisation of health care in institutions established by this government, through the granting of concessions for carrying out public health services, the coordination of their activities and the participation in the funding for the implementation of health care in all areas. The principle of the comprehensive access to primary health care is ensured through the implementation of integrated measures for the advancement of health and the prevention of disease as well as treatment and rehabilitation. The principle of specialised access is ensured through the organisation and development of specialised clinical, public-health developments and knowledge and their application in practice.
According to the Act on the Protection of Patient Rights, the patient is considered to be every person, ill or healthy, who requests or who is provided specific measures or services for the purpose of the preservation and advancement of health, prevention of disease, treatment or health care and rehabilitation. Every patient is guaranteed the general and equal right to high-quality and continuous health care appropriate for their health status, in accordance with

universally accepted professional standards and ethical principles, in the best interest of the patient in keeping with her or his personal attitudes. The protection of patient rights in the Republic of Croatia is carried out on the basis of principles of humanity and accessibility. The principle of humanity of the protection of patient rights is achieved: – by ensuring the respect of the patient as a human being, – by ensuring the right to the physical and mental integrity of the patient, – the protection of the personality of the patient including the respect of his privacy, world-view as well as ethical and religious beliefs. The principle of accessibility of the protection of patient rights presumes the equal opportunity of the protection of the rights of all patients on the territory of the Republic of Croatia.

The Anti-Discrimination Act („ Official Gazette "number 85 / 08) ensures the protection and promotion of equality as the highest value of the constitutional order of the Republic of Croatia, creates preconditions for the achievement of equal opportunities and regulates the protection from discrimination on grounds of race or ethnicity or skin colour, gender, language, religion, political or other beliefs, national or social origin, financial standing, membership in trade unions, education, status, marital or family status, age, health status, disability, genetic inheritance, gender identity, expression or sexual orientation. Discrimination is considered to be the putting in a more unfavourable position of any person and persons related to that person through family or other ties. Discrimination is also considered to be the putting of a certain person in a more unfavourable position based on the misconception of the existence of a basis for discrimination. This Act applies to the treatment of all state authorities, bodies of units of local and regional government, legal entities with public authority as well as all legal and natural persons, especially in the following areas: labour and labour conditions; the possibility of carrying out self-employment services, including the selection criteria and requirements in employment and promotion; the access to all types of career orientation, professional training and development and retraining, education, science and sports, social security, including the area of social welfare, pension and health insurance and unemployment insurance, health care, judiciary and administration, residence, public information and media, access to goods and services and the provision of goods and services, membership and activity in trade unions, civil society organisations, political parties or any other organisations, and the participation in cultural and artistic creation.

4.3. Paragraph 3 - PREVENTION, REMOVAL OR ALLEVIATION OF WANT

Social welfare services are carried out by social welfare institutions, non-governmental organisations, religious groups and other legal persons, natural persons as a professional activity and foster families.
Social welfare institutions are the following: social welfare centres, welfare homes, Centres for assistance and care and family centres.

Social welfare centre

Social welfare centres, as public institutions established by the Republic of Croatia by a decision of the ministry competent for social welfare matters, decide on social welfare rights.
A social welfare centre is established for the area of one or several municipalities or towns of the same county, or for the City of Zagreb.
The Social Welfare Act from June of 2011 prescribes the establishment of 21 Social Welfare Institutes with 79 branch offices and 22 offices. This act prescribes the establishment of

social welfare institutes in counties and branch offices with the goal of rationalisation on the principle of a single administrative location, and the earlier social welfare centres (80 social welfare centres, 27 branch offices and 11 offices), have become branch offices; a part of the former social welfare centres lost the status of branch offices and became headquarters of the Social Welfare Institute.
Such a structure, in accordance with the established jurisdiction of the branch office of the social welfare centre and the social welfare institute, for some beneficiaries services have become inaccessible or much more expensive, and in the majority of institutes no preconditions have been created for the payment of cash benefits in a way that would satisfy the needs of the beneficiaries.
Considering such an organisation and dispersion of branch offices, the communication between branch offices with the Institute regarding the jurisdiction in employment and other rights from labour relations of all workers of the Institute was made difficult and slow.
Also, the regular functioning of the branch offices regarding material expenses necessary for the regular functioning was aggravated, which slowed the handling of cases and timely visits of beneficiaries.
The application of this Social Welfare Act caused a lack of the continuity of systematic activities aimed at the implementation of the Social Welfare Development Project given that instead of decentralisation, centralization occurred, and the carrying out of public services became inefficient and more inaccessible to citizens. The goal envisaged by the Act was not realised, that is the creation of a new, more rational and more efficient welfare system directed towards the most disadvantaged citizens and groups, harmonised with criteria and standards applicable in European Union member countries.
Therefore, after only eight months of the application, in March of 2012, the new Social Welfare Act was passed ("Official Gazette", number 33/12).
The new Act prescribes that social welfare centres be again established as public institutions for the area of one or several municipalities or cities in the area of the same county, that is for the territory of the City of Zagreb.

Authorities of social welfare centres

A social welfare centre renders first-instance decisions on social welfare rights, family-law and criminal-law measures, and other rights under special regulations; it conducts the enforcement procedure in respect of its own decisions; keeps the prescribed registers; issues certificates and other attestations; provides courts with information on family situation, and gives opinions and proposals in court proceedings relating to family-law and criminal-law protection; appears before courts and other state bodies in the capacity of a party or intervenor, when the protection of personal interests of children and others is at issue. In addition to these public functions, social welfare centres also carry out other expert tasks, as specified in Article 82, paragraph 3 of the Social Welfare Act.
Social welfare centres are managed by the administrative board that performs activities in accordance with the provisions of the Institutions Act. The social welfare centre lead the director who is appointed by the administrative board based on the public tender procedure with the prior approval of the minister competent for activities of social welfare. The social welfare centre has a panel of experts that is made up of all qualified professionals of the social welfare centre.

Qualified professionals of social welfare centres

Professional work at social welfare centres is performed by social workers, psychologists,

lawyers and special education experts, who have all passed the state exam (Art. 197 of the Social Welfare Act). The qualified professionals of the social welfare centre are obliged to carry out activities in accordance with due professional care and respect the personality of the beneficiaries, their dignity, and integrity of their personal and family life. Furthermore, the qualified professionals are obliged to keep as a professional secret all what they learn about the personal and family life of the beneficiaries (Art. 198 of the Social Welfare Act). The observance of professional secrecy applies to all other workers of social welfare institutions and other service providers.
Qualified professionals who work in social welfare services are entitled to and have the obligation to continuously go through professional training and development programmes approved by the Ministry competent for social welfare activities (Art. 202 of the Social Welfare Act).
Persons who have been non-appealably convicted for a criminal offence against sexual freedom, criminal offence of sexual abuse or exploitation of children, against marriage, family and youth, against official duty, against property, against the safety of the payment system and business activities, against the authenticity of documents, against values protected by international law and for a criminal offence against the Republic of Croatia cannot be employed to carry out executive activities of social welfare services or activities of qualified professionals in social welfare services (Article 205 of the Social Welfare Act).

The table below presents the number and structure of the employees of social welfare centres according to the data of the Ministry .

Table 84

	2008	**2009**	**2010**
I Qualified professionals			
Social worker (University degree)	686	708,5	726,5
Social worker (two-year post-secondary school qualification)	273	254	240
Jurist	219,5	217,5	225,5
Administrative law specialist	35	34	33
Psychologist	143	149	153
Special-education teacher	34,5	24,5	25,6
Social pedagogue	40	46	44,5
Sociologist	4	4	4
Other	18,5	16	9
Total	1.453,5	1.453,5	1.462
II Director of social welfare centre, head of branch office, office manager	111,5	114	115
III Other			
Administrative employees	221	210	202
Financial-accounting employees	216	213,5	213
Technical employees (driver, telephone operator, cleaner, custodian)	113,5	114	109,5
Total	550,5	537,5	524,5
TOTAL (I+II+III)	**2.115,5**	**2.105**	**2.101,5**

Source: Annual report of the Ministry of Health and Social Welfare
(data collected by social welfare centres)

Procedure for the realisation of rights from social welfare

The social welfare centre initiates the procedure for the recognition of rights prescribed by the Social Welfare Act at the request of the party and ex officio. During the procedure for the recognition of the right, the centre is obliged to prepare an individual welfare plan based on a needs assessment, and determine the purpose of the plan, and carry out measures to help persons in an unfavourable position to care about themselves and their family members. In the preparation of the individual plan, the social welfare centre is obliged to cooperate with the person who turned to the centre and the family members of that person (Art. 190 of Social Welfare Act). The procedure for the realisation of rights under the social welfare system is urgent, and the social welfare centre is obliged to issue a decision and submit it to the party at the latest within 15 days from the day of the institution of the proceedings.
If it is necessary to conduct the special inquiry procedure, the social welfare centre is obliged to issue a decision within 30 days from the day of submission of the application or the institution of proceedings ex officio (Art. 191 pf the Social Welfare Act).
Appeals lodged against individual administrative acts passed by social welfare centres are decided by the ministry competent for social welfare activities. A lawsuit can be filed against first-instance and second-instance decisions of the ministry to the Administrative Court of the Republic of Croatia.
Given that in procedures regarding social welfare rights provisions of the General Administrative Procedure Act apply, every citizen can address an official at the territorially competent social welfare centre, and obtain information on social welfare rights and the conditions that need to be met in order to realize these rights. Also, if an official person, with regard to the circumstances, finds out or assesses that a citizen has the basis for the realization of a certain right, he is obliged to tell him so, and is obliged to make sure that the lack of knowledge of the party is not to the detriment of the rights of the party (Article 7 of the General Administrative Procedure Act).
The quality of services in social welfare institutions is monitored through the implementation of internal supervision in social welfare institutions, and administrative, inspection and professional supervision that is carried out by the ministry competent for activities of social welfare. Supervision of the work of foster families is carried out by the social welfare centre.
Services provided by social welfare centres are free of charge for the user. The costs of the procedure in connection with the realisation of rights under the social welfare system, for which funds are ensured in the state budget are covered by the ministry competent for activities of social welfare. For all social welfare system beneficiaries, funds are ensured in the state budget.

4.4. Paragraph 4 - SPECIFIC EMERGENCY ASSISTANCE FOR NON-RESIDENTS

In accordance with the provisions of Article 29 of the Social Welfare Act foreign nationals and stateless persons with permanent residence in the Republic of Croatia are entitled to social welfare as well as Croatian citizens.
Foreigners and stateless persons with temporary residence in the Republic of Croatia, foreigners under subsidiary protection, foreigners with established trafficking victim status, asylum seekers and their family members who reside in the Republic of Croatia legally are entitled to social welfare in cases and under circumstances prescribed by law the Social Welfare Act and special acts.
Based on the Asylum Act ("Official Gazette", number 79/07 and 88/10), the Ordinance on the amount of the subsidy given to asylum seekers, persons with granted asylum, foreigners under

the temporary protection and foreigners under subsidiary protection was passed ("Official Gazette" 39/08). This ordinance prescribes that the amount of the subsidy is determined in a percentage of the basis for the realisation of rights under the social welfare system. In accordance with this Ordinance, asylum seekers and foreigners under subsidiary protection who do not generate income, do not possess property or their own resources, and who do not have a provider can realize social welfare rights in accordance with the Social Welfare Act like Croatian citizens.
Other persons who are not included by the provision of Article 29 of the Act can temporarily realise rights under the social welfare system under the circumstances prescribed the Act, if this is required by the life circumstances the have found themselves in.
Foreigners and stateless persons who do not have permanent residence in the Republic of Croatia, when their life and health are endangered, are granted the right to temporary housing (Art. 103 of the Social Welfare Act).
During temporary housing in emergency situations beneficiaries are granted temporarily residence, food, care, procurement of absolutely necessary clothing and footwear, compensation of costs of transport to the place of permanent residence to their own or foster family, welfare home or other institution and the service of expert support for social inclusion, as well as other services depending on the determined needs of the beneficiary.
Also, in accordance with the provision of Article 55 of the Act, these persons can be granted one-time assistance.

5. Article 14 – THE RIGHT TO BENEFIT FROM SOCIAL WELFARE SERVICES

With a view to ensuring the effective exercise of the right to benefit from social welfare services, the Contracting Parties undertake:

1. *to promote or provide services which, by using methods of social work, would contribute to the welfare and development of both individuals and groups in the community, and to their adjustment to the social environment;*
2. *to encourage the participation of individuals and voluntary or other organisations in the establishment and maintenance of such services.*

The Constitutional provisions related to this Article of the European Social Charter have not changed in the republic of Croatia during the reporting period.

5.1 PARAGRAPH 1 – PROVISION OR PROMOTION OF SOCIAL WELFARE SERVICES

Social welfare services are carried out by social welfare institutions, non-governmental organisations, religious groups and other legal persons, natural persons as a professional activity and foster families.
Social welfare institutions are the following: social welfare centres, welfare homes, Centres for aid and care and family centres.

Social welfare centre

Activities of the social welfare centre are described under Article 13.

Family Centre
In accordance with the Act on Amendments to the Social Welfare Act ("Official Gazette", number 44/06) the scope of activities of family centres includes counselling services and preventive activities relating to marriage, relationships between parents and children,

maintenance and other circumstances in which families seek professional support and help, the promotion and development of programmes of activities in the local community, volunteer work and the work of citizens' associations offering support to parents, families, children, young people and other socially vulnerable population groups, and the encouragement and implementation of programme activities aimed at educating and promoting family values.
The Social Welfare Act ("Official Gazette", number 57/11) has extended the activities of family centres. Now, family centres also provide the following services: primary counselling services concerning marriage, parenthood, family and partnership; counselling of parents whose children were caught outside of their home without the escort of an adult person contrary to regulations on family relations; organisation and implementation of the training of adoptive parents; family mediation. Family centres have also received two public authorities: mediation before consensual institution of divorce proceedings and carrying out of special obligations of juveniles in preliminary procedures under the provisions of special acts.
Currently, 18 family centres are active for the areas of the Istarska, Koprivničko-križevačka, Primorsko-goranska, Splitsko-dalmatinska, Sisačko-moslavačka, Vukovarsko-srijemska, Zadarska, Bjelovarsko-bilogorska, Dubrovačko-neretvanska, Krapinsko-zagorska, Ličko-senjska, Varaždinska, Virovitičko-podravska, Osječko-baranjska, Karlovačka, Požeško-slavonska, Šibensko-kninska counties and the City of Zagreb. Also, a family centre for the territory of the Međimurska county was established (total: 19 established centres).

Providers of social services

Welfare homes are founded in accordance with the Institutions Act and the Social Welfare Act. Welfare homes are managed by the administrative council appointed by the founder.
The manager of the welfare home is the director, appointed by the administrative council through a public tender procedure. The director of the welfare home organises and manages its operation, represents it, undertakes all legal acts on its behalf and to its account, represents it in all procedures before courts, administrative and other state authorities, as well as legal entities with public authority, and is responsible for the legality of its operations.
In addition, the welfare home has an expert board which consists of all qualified professionals. The expert board participates in defining the plan and programme of operation of the home, monitors their implementation, discusses and decides on professional issues, encourages and promotes expert work, and carries out other expert activities determined by the Social Welfare Act, the charter of foundation and the statute of the welfare home.
The employee structure in welfare homes is regulated by special secondary legislation - the Ordinance on the type and activity of welfare homes, care provision outside of one's own family, conditions regarding the premises, equipment and employees of welfare homes, treatment communities, religious communities, non-governmental organisations, other legal entities and home assistance and care centers (Official Gazette, No. 64/09).Elderly persons in Croatia mostly live at home with their families. According to population estimates of the Central Bureau of Statistics from 2010, in the Croatia there are accommodation capacities for 2.75% of the population with respect to the total number of persons over 65 years of age (a total of 20,875 vacancies with respect to 757,400 citizens over 65 years of age). In comparison with the data from a decade ago, when less than 2% of persons over 65 years of age in Croatia was able to get a place in a welfare home, it is evident that there has been an increase of total available capacities.
With the purpose of solving the existing problems, in the policy of care of the elderly, new solutions are being sought in the organisation and provision of care in local communities. In line with these efforts, the Ministry of Social Policy and Youth develops and supports non-

institutional models of care of the elderly, especially the development of social services for the elderly in their homes and local communities for the purpose of prolonging life in their own environment, improving their quality of life and enabling active participation of the elderly in the life of their communities.

The provision of these services is of importance to all elderly persons, especially the ones who live in hardly accessible areas. These are mostly single-person households, whose families do not live in the same area and are therefore unable to adequately care for them and assist them with the fulfilment of their daily needs. Care of the elderly in the Croatia is realised through institutional and non-institutional forms. These include a network of welfare homes and activities for different categories of users, centers for aid and care, and foster families. In accordance with the Social Welfare Act (Official Gazette, No. 33/12), social welfare services are provided by state welfare homes, decentralised homes for the elderly and disabled on the county level, religious communities and organisations, as well as other national and foreign legal and natural persons which provide accomodation of the beneficiaries. Along with 3 state welfare homes, Croatia has 45 county welfare homes and 91 homes founded by other entities. Apart from these welfare homes, 87 other legal persons carry out social welfare activities without founding homes for the elderly and disabled. According to the official statistical indicators of the Ministry, on 31st December 2010, a total of 14,919 persons were accomodated in state and county welfare homes and homes founded by other entities.
Homes for the elderly and infirm provide accommodation, meals, personal hygiene maintenance services, health care, nursing, professional social work, psycho-social rehabilitation, and occupational and leisure activities, depending on the type of accommodation.
Apart from the services listed, homes can provide day-care services and household assistance and nursing services. Within day-care, different services are provided for adults living on their own or with their families. Assistance and care services include organising food, carrying out
household chores, maintaining personal hygiene and satisfying other everyday needs.
Social welfare homes founded by the Republic of Croatia are financed from the State Budget, and from contributions made by beneficiaries participating in the costs of care outside their own families.
Homes founded by others are financed from revenue for services rendered (contracts signed with beneficiaries for services provided, and based on contracts between individual homes and the Republic of Croatia, for beneficiaries who have the right to care outside their own families). In exceptional cases, decentralised homes for the elderly and infirm are financed by internal revenue (predominantly realised through services rendered) and funds resulting from the Decision on minimal financial standards for decentralised financing of homes for the elderly and infirm, and funds from the equalisation fund.

Individual services for the elderly and infirm, and the implementation of certain programmes for this category of persons, are also financed by units of local and regional self-government. In recent years, different forms of non-institutional care of the elderly are becoming increasingly significant (family units, foster care, day care). The basic purpose of family units is care provision to beneficiaries in a family environment, i.e. the provision of services by the representative of the family unit, the family members which live together with the beneficiaries and other prescribed workers. There are 200 family units for the elderly and infirm currently operating in Croatia, which accomodated 2048 beneficiaries on 31st December 2010. In addition, according to the Register of Foster Families kept by the

Ministry, on 31st December 2011, 805 registered foster families for the elderly and infirm were registered in Croatia and accomodated 1961 persons. The new Foster Care Act has been adopted in July 2011 (Official Gazette, No. 90/2011). One of the primary objectives of the adoptions of this act is the better and faster development of foster care and enabling foster care of beneficiary groups for which there were no developed forms of high-quality foster care. Within the welfare reforms, special attentions was dedicated to the stimulation and development of non-institutional services and the improvement of foster care, especially the accommodation of children into foster families. The objectives of this Act are the standardization of quality of service provision by foster families, specialisation of foster families for particular types of beneficiaries, regional harmonisation of the number of foster families, decrease of the number of beneficiaries accommodated in welfare homes, development of quality of service standard in foster care, development of sufficient capacities for the provision of professional aid to foster families, a more precise definition of rights and obligations of foster families, as well as the responsibilities of competent authorities. The Foster Care Act specifies different types of foster care, according to the status of the foster family: kinship, non-kinship and professional foster care; and according to the needs of the beneficiary: traditional, specialised, emergency and respite foster care. The Act enables the combination of different types of foster, as well as the number and type of beneficiary, which must always be in his/her best interest, but also in the interest of the foster family which meets the prescribed requirements. Although foster care in Croatia can be considered a traditional form of care of the elderly, applicable to almost all categories of beneficiaries, such a form of care is mostly provided to the elderly and infirm. There are large regional differences with respect to the distribution of foster care, and it can be concluded that it is socially more acceptable in the northern part of Croatia. The extremely significant role of the foster family in the life of the accomodated beneficiary presupposes the adequate preparation of the family before the accommodation, the right to professional assistance and continuous support during accommodation. Such support is especially important given the fact that the needs of accomodated persons are becoming more and more complex, which makes the education of foster families before accommodation essential. Recently, there has been a lot of pressure on accommodation capacities for the elderly, which are expensive and unable to provide services to all interested elderly citizens. This circumstances have created the need for the development of non-institutional forms of care of the elderly in cooperation with local and regional self-government units, which have been implemented from 2004 as programmes of intergenerational solidarity. The programmes of intergenerational solidarity are focussed on the provision of social services to the elderly in local communities and are implemented directly in their households and in " day care centres" in which the elderly spend a part of their day. The programmes are implemented pursuant to the contract on the cooperation between the Ministry of Social Policy and Youth and the regional and/or local self-government units, based on a public invitation. The priority areas covered by the programme are areas with a high proportion of elderly population and low capacities for their institutional accommodation, areas with a poorly developed network of non-institutional services for the elderly, sparsely populated and hardly accessible areas (e.g. the islands), as well as areas of special state concern. By 2012, 91 service and day care programme related to intergenerational solidarity has been contracted in the area of 19 counties and 160 local communities, for the purpose of provision of free social services aimed at the improvement of the quality of life for 15,550 elderly citizens. The plan for the next period is to improve the quality of service provision and to widen the scope of programme implementation to include isolated geographical areas.

Care for the homeless is currently provided by local self-government units which organise shelters depending on the needs and their own capacities. The issue of homelessness is also

tackled by religious communities and civil society organisations, primarily Caritas and the Red Cross. Considering that this is a special social group confronted with extreme poverty and social exclusion, it has ben covered by the new Social Welfare Act for the purpose of enabling the provision of specific assistance and services.
The concept of the homeless person was introduced into the social welfare system by the Social Welfare Act from 2011, in order to enable new possibilities for the improvement of care for this disadvantaged group. A homeless person is defined as a person which has no place of residence or means to ensure one, and is temporarily placed in a shelter or lives in public or other areas not intended for residence. The Act determines that large cities and county headquarters are obliged to fund the services of soup-kitchens and homeless shelters in the manner regulated by it.

According to the records of the Ministry, which collects reports on homeless shelters in the Republic of Croatia through welfare centres, in 2011 there were 9 shelters for the homeless in the Republic of Croatia, while 294 homeless persons were using the services of shelters/safehouses on 31st December 2011. On the 4th On the National Meeting on the Homeless (October 2010), it was stated that there are approximately 1000 homeless persons in Croatia.

The issue and policy of asylums in the Republic of Croatia are dealt with by the competent authorities, i.e. the Ministry of the Interior, the Ministry of Social Policy and Youth, the Ministry of Science, Education and Sports, the Office for Human Rights and certain non-governmental and international organisations. The Croatian Law Centre also coordinates the operation of the informal Coordination for Asylum, the members of which are organisations and institutions which specifically deal with this issue. The issue of asylum in the Republic of Croatia is regulated by the Asylum Act which also regulates the institution of subsidiary protection. In accordance with the Asylum Act (Official Gazette, Nos. 79/07 and 88/10), and within the jurisdiction of the Ministry of Social Policy and Youth, asylum seekers and foreigners under subsidiary protection have the right to health care, accomodation and social welfare, pursuant to regulations concerning the field of social welfare of Croatian citizens.
It is an undisputed fact that the field of integration of asylum seekers is still in development and there is currently no significant practical experience in related matters in the Republic of Croatia, as well as that certain issues have not been adequately dealt with. Given that the service of accommodation provided to asylum seekers and foreigners under subsidiary protection differs significantly from the service of accommodation normally provided to beneficiaries within the welfare system, it can be concluded with certainty that the right to accommodation covers the accomodation of these persons for a period not longer than two years from the date of enforceability of the decision granting asylum or subsidiary protection.
Since the Ministry of Social Policy and Youth is not competent for accommodation, it does not dispose of a housing stock in which it would accomodate persons with a housing problem and other disadvantaged working-age persons. A smaller part of the issue of housing falls under the jurisdiction of the local self-government units and can therefore be resolved by the construction of "public housing units" for that part of the population whose income is insufficient to cover their housing needs. This jurisdictions of local self-government units (municipalities and cities), should be taken into consideration in high-quality and long-term accommodation of asylum seekers and foreigners under subsidiary protection. Taking into consideration the specified circumstances create preconditions for asylum seekers, following the cessation of the right to accommodation derived from the Asylum Act and its bylaws, and on the basis of the already exercised right to coverage of the housing costs by local self-government units, to continue living in a familiar environment and the same apartment, based

on the personally signed prolonged lease contract.
Apart from the right to assistance in the payment of housing costs, asylum seekers and the foreigners under subsidiary protection which do not generate income, own property or financial assets and are not supported are entitled to social welfare according to the regulations which covering the area of social welfare of Croatian citizens.
With respect to the need for a more systematic approach to the protection against family violence and ensuring the undertaking of necessary measures, numerous activities have been carried put in the Republic of Croatia over the recent years, including the drafting and adoption of new legislation. It is especially important to single out the Act on Protection against Family Violence (Official Gazette, No. 137/09 and 60/10) the purpose of which includes the prevention, sanctioning and suppression of all types of of family violence, implementation of appropriate measures against perpetrators and mitigation of the consequences of already committed violence by providing protection and help to victims of violence. Furthermore, within the definition of family violence, the concept of economic violence has been additionally defined, while the definition of family which includes former matrimonial and common-law partners, as well as the children of each and their mutual children, in case the motive of the conflict after the termination of the marriage or extramarital relationship were the former marriage or extramarital relationships. The new Act on Protection against Family Violence also raised the penalties for perpetrators of family violence, according to the provisions of the Misdemeanour Act.
The new Criminal Code (Official Gazette, No. 125/11), which enters into force on 1st January 2013, dismisses the previously determined criminal offence of abusive behaviour towards family members (Article 215a), but prescribes additional strengthening of protection of family members from violence, considering that violence against family members committed is qualified as a form of a series of criminal offences, for example murder, all forms of bodily harm, obtrusive behaviour, sexual intercourse without consent and others.
A particularly important document are the Rules of Procedure in Cases of Family Violence, which contain a series of detailed measures regarding the operation of competent authorities and the form, content and method of cooperation of bodies participating in the discovery and fighting of violence and provision of help and protection to persons exposed to any form or modality of family violence (police, social welfare centres, healthcare and educational institutions and judicial authorities). The Protocol is particulary focussed on the treatment of child victims of violence or witnesses of family violence by competent authorities.
Apart from the acts which regulate special protection of family members from violence, another important document is the National Strategy of Protection against Family Violence, which is adopted for a specific time period and regulates the measures aimed at the prevention of family violence and provision of help to its victims.

In connection with the provision of accommodation to victims of domestic violence, which is one of the more important measures of the National Strategy, it should be emphasized that civil society organisations, religious communities and other legal persons in the Republic of Croatia enable the accomodation of these victims in 18 shelters. The Social Welfare Act (Official Gazette, No. 33/12) provides legal and natural persons with the opportunity of founding shelters for victims of domestic violence. A service provider can conclude a a contract on cooperation with the Ministry of Social Policy and Youth and accomodate the beneficiaries on the basis of a decision of the social welfare centre, if the decision of the Ministry establishes that the provider meets the prescribed requirements regarding premises, equipment and required professional and other staff. Based on this model, the Ministry of Social Policy and Youth has signed contracts with nine legal persons carrying out the mentioned activity.

They are located on the area of the Bjelovarsko-bilogorska, Osječko-baranjska, Primorsko-goranska, Zadarska, Međimurska, Vukovarsko-srijemska, Šibensko-kninska and Varaždinska County and the City Of Zagreb. The service of temporary accommodation is provided to the beneficiaries for as long as needed, normally up to 6 months and up to one year in exceptional cases. During the accommodations of beneficiaries, services of nutrition, healthcare, personal hygiene and care maintenance and the provision of psychosocial treatment are ensured, while the parent is obliged to fulfil the everyday needs of his/her child. The activities carried out by this type of welfare home may include counselling for victims of domestic violence which are not provided with temporary accommodation. In addition to this model, there are seven autonomous women's shelters which provide accommodation to victims of domestic violence and receive aid from the Ministry of Social Policy and Youth, as well as cities and counties on the area of which they have been founded. These shelters operate on the territory of the City of Zagreb and the Karlovačka, Primorsko-goranska, Istarska, Brodsko-posavska and Sisačko-moslavačka County, providing necessary counselling to victims of violence, while the associated counselling centres provide assistance to all persons in need at their request.

Republic of Croatia signer is the series of international documents which regulates the problem trafficking in human beings, for example Council of Europe Convention on Action against Trafficking in Human Beings, the Convention on the Rights of the Child and the Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography, Joint Declaration of the National Anti-Trafficking Coordinators of South-East European (SEE) Countries on Enhancing Transnational Referral Mechanisms (TRM) and Strengthening Cooperation in Cases of Human Trafficking, the Brussels Declaration and others.

Significant national regulation protecting victims of trafficking in human beings includes the Aliens Act (Official Gazette, No. 130/11), which regulates temporary stay on humanitarian grounds, also for victims of trafficking in human beings. Other regulation in force includes the provisions of the Ordinance on the status and work of aliens and the Ordinance on travel documents, visas and procedure regarding aliens, which contain provisions on stay on humanitarian grounds for victims of trafficking in human beings and their status in the Republic of Croatia, the Protocol for the Identification, Assistance and Protection of Victims of HumanTrafficking, which implies the initiation of providing assistance and protection to victims of trafficking in human beings, and the Protocol on Proceeding during the Voluntary Return of Human Trafficking Victims. Furthermore, the National Plan for Combating Trafficking in Human Beings 2012 – 2015 represents a continuation of the already initiated activities in this field and an addition to the already established system of combating trafficking in human beings in the Republic of Croatia. The plan is a result of the experience of all competent authorities. For the purpose of improving the system of the provision of assistance and protection to victims of trafficking in human beings, in 2008 an agreement was signed between the ministry competent for internal affairs, the ministry competent for social welfare activities, the Croatian Red Cross and the Organisation for Integrity and Prosperity from Split. In the recent years, two shelters for victims of trafficking in human beings, for adult ones in Rijeka and for underage ones in Split, managed by the Ministry of Social Policy and Youth, have been fully equipped and put into operation. In addition, passive and active duty service of four county coordinators and members of mobile teams in Zagreb, Split, Rijeka and Osijek has been ensured, which are obliged to implement and coordinate activities from the field of social welfare in individual cases of trafficking of children in the area of each county.

According to regulations related to social welfare, in addition to the basic accommodations and provision of assistance and protection in shelters in Rijeka and Split, victims of trafficking in human beings are also provided with alternative accommodation. This form of

assistance is provided to the victim in cases when it is estimated to be the most appropriate and in the best interest of the victim. Alternative forms of assistance and protection have been provided within the existing professional and spatial capacities of social welfare institutions.
With the aim of raising public awareness of these issues and preventing trafficking in human beings, numerous publicity campaigns have been organised and an SOS phone line has been introduced (0800 7799) by which it is possible to request assistance and obtain all relevant information, as well as report potential cases of trafficking in human beings.
Abuse of addictive substances is regulated by the Criminal Code (Official Gazette, Nos. 110/97, 27/98, 50/00, 129/00, 51/01, 111/03, 190/03, 105/04, 84/05, 71/06, 110/07, 152/08, 57/11 and 125/11) which determines the criminal offences of drug abuse and unauthorized possession, production and drugs trafficking, and the Drug Abuse Prevention Act (Official Gazette, Nos. 107/01, 87/02, 163/03, 141/04, 40/07, 149/09 and 84/11) which regulates all key issues related to drug abuse. Also in force are the provisions of the National Strategy for the Prevention of Alcohol Abuse and Disorders Caused by Alcohol for the period from 2011 to 2016, National Strategy on Combating Drug Abuse for the period from 2006 to 2012 and Action Plan of Combating Drug Abuse 2009 – 2012, which regulate the undertaking of necessary measures in the field of combating addiction and represent the upgrade and further development of the already established systems of combating addiction. A significant factor in care for persons addicted to alcohol, drugs or other intoxicating substances is the provision of services of psychosocial rehabilitation in treatment communities (normally for upt to two years) to persons motivated for full withdrawal (the drug-free procedure) after medical treatments, along with the simultaneous development of addiction prevention programmes. The Ministry of Social Policy and Youth has signed agreements with 5 providers of social welfare services, i.e. treatment communities for the accommodation of a total of 208 adult addicts in the area of the Splitsko-dalmatinska, Osječko-baranjska and Krapinsko-zagorska County and the City of Zagreb. Furthermore, the Ministry of Social Policy and Youth, via the social welfare centres, participates in the implementation of the project of resocialization of drug addicts which have completed certain withdrawal and rehabilitation programmes in treatment communities or prisons and addicts in outpatient treatment which have been in stable withdrawal for a longer time period and adhere to the prescribed manner of treatment. The Project is being implemented since 2007 and is aimed at finding jobs and providing professional training for addicts for specific occupations, as a precondition of their successful affirmation in society.
As a member of the United Nations and Council of Europe and signer of all the key conventions and standards in the field of social and economic safety of citizens, the Republic of Croatia has taken on the obligation of protecting and promoting the human rights of disabled persons, especially in the field of equal opportunities for persons with disabilities, in order to ensure their equal participation in civil, political, economic, social and cultural areas of life. The commitment of the Republic of Croatia to the full realisation of all basic human rights of disabled persons has also been confirmed by the signing of the UN Convention on the Rights of Persons with Disabilities in March 2007, ratified by the Croatian Parliament on 1st June 2007. The Constitution of the Republic of Croatia directly guarantees the special care of the state for the protection of disabled persons and their social inclusion and, through the application of general principles, establishes the right to equality of living conditions through the adoption of special legislation. In 2010, a total of 99,423 persons with physical, intellectual or sensory damages - social welfare beneficiaries - were registered in the social welfare system, which represents 2.3% of total population.
Given that, according to the WHO estimate, the percentage of physically, intellectually or sense- impaired persons in the total population (4,290,612) amounts to approximately 10%, it can be concluded that 0.23% of the total number of disabled persons in the Republic of

Croatia was included in the social welfare system in 2010.
In Croatia there are curently 51 service providers for children with developmental difficulties and physically, intellectually or sense-impaired adults, 28 state and 12 non-state homes, and 11 legal persons which carry out social welfare activities. Of these, 3 are homes for the sight-impaired, 3 are for the hearing-impaired, 4 are for the physically-impaired, 1 is for the person with mental deficiencies and disorders, and 40 are for persons with mental deficiencies. In these institutions, different forms of care are provided to a total of 6,066 persons, of which 2324 children with developmental difficulties and 3742 disabled adults. Although some homes and other legal entities are registered exclusively as homes for children or adults, a part of them carry out activities for both groups of beneficiaries, normally in separated facilities or separated residential units inside the facilities. Out of the total number of children, 1012 of them are permanently or temporarily accommodated, while 1312 children are covered by non-institutional services.
The grounds for the accommodation of these children are different, one of the more significant being the inability to include the child in educational or rehabilitation programmes in its area of residence. Out of 1012 temporarily or permanently accomodated children, 715 of them are accomodated for the purpose of education, and 297 of them are severely impaired children, usually without adequate parental care. This means that the ratio of children accomodated for the purpose of education and those accomodated for other reasons is 71% to 29%. Out of 715 children accomodated for educational purposes, 434 of them (43% of the total number of children) attends primary school, while 281 of them (28% of the total number of children) attends secondary school. Considering the growing importance of the development of inclusive education, primary education of children with developmental difficulties is increasingly carried out in the local community. On the other hand, given that secondary education is not available in every local community and a single school covers a wider area, some children must be accomodated in student dormitories during their secondary education. Therefore, the primary goal is the reduction of the number of children with developmental difficulties included in primary education.
With regard to physically, intellectually or sense- impaired adults, out of a total of 3742 adults accomodated in state and non-state homes and other legal entities, 2004 of them are accommodated permanently or on a weekly basis, while 1738 of them are covered by non-institutional services and organised housing with assistance. A part of them requires whole-day or intensive care, which should be taken into consideration during the planning of specialisation of specific homes and non-institutional forms of accommodation. This group of homes also includes the non-state home which provides care for adult beneficiaries in which mental deficiency and disorder are simultaneously present . This is the only institution registered for the provision of care outside of family for persons with such a type and degree of impairment. This home provides care for beneficiaries from all of Croatia because of the specific combination of their diagnoses, manifested as severe disorder. Namely, these beneficiaries are often subject to mood changes, anxiety and impulsive reactions manifested as reduced tolerance to frustration, emotional instability and an inclination towards abrupt aggressive outbursts which directly endanger property, personal safety and the safety of others. Home also provides care for beneficiaries which, apart from having a combination of disorders, also display a tendency to commit criminal offences, as a result of which some of them have served a prison sentence, after which it was not possible to take care of them within their families or in some other manner.
There have traditionally been large regional differences in the development of foster care for physically, intellectually or sense- impaired persons. Foster care is well-developed in the Varaždinska, Bjelovarsko-bilogorska, Virovitičko-podravska, Osječko-baranjska, Zagrebačka and Zadarska County. An extremely low proportion of foster care is noticeable in Brodsko-

posavska, Dubrovačko-neretvanska, Ličko-senjsks, Požeško-slavonska and Primorsko-goranska County. It can be generally remarked that the number of foster families and family units is insufficient in the majority of counties. Data on organised housing as a non-institutional form of accommodation indicate that has recently been provided for a growing number of physically, intellectually or sense- impaired adults. Over the last three years, there has been a decrease of 3% in the overall coverage of physically, intellectually or sense-impaired persons by foster care and family units (from 968 to 942 - decrease by 26 beneficiaries). 13 % of all children in foster care are children with developmental difficulties, while 21% of all adults in foster care are physically, intellectually or sense- impaired adults.
The existing 28 welfare homes for adults with mental deficiencies are located in 18 counties, while there are no such homes in the area of the Brodsko-posavska and Karlovačka County. In the area of the Ličko-senjska County there is a branch of a home with headquarters in the Varaždinska county. The majority of beneficiaries is accomodated in homes in the area of the Krapinsko-zagorska, Varaždinska, Požeško-slavonska, Istarska and Osječko-baranjska County. A minor part of the total number of beneficiaries of homes for mentally ill adults is located in the Dubrovačko-neretvanska and Šibensko-kninska County. Facilities for permanent accommodation are predominantly concentrated in northern Croatia, especially the Krapinsko-zagorska and Varaždinska County, where as many as 36% of all beneficiaries of this type of social welfare in Croatia are accomodated. All homes for mentaly ill adults mostly provide long-term intensive care services within permanent accommodation (42% of all beneficiaries in 2009 were accommodated in intensive care units), however, these services are less available in private homes (they are used by 28% of all beneficiaries of private homes and 45% of all beneficiaries of state homes). State homes account 79% of the overall capacities and accomodate 80% of all beneficiaries, which implies that care for mentally ill adults is still predominantly provided within state homes. Almost all private homes have a lower-than-average number of beneficiaries (up to 100), and only four homes have up to 50 beneficiaries, which entails care of higher quality, primarily because of adequate capacities. According to available data, homes for mentally ill adults provide an extremely modest scope of non-institutional services, which is even more noticeable in non-state homes. Namely, only 5 out of 28 homes provide a very modest scope of other types of services (apart from permanent accomodation). The services of professional assistance in the family (domiciliary care) are unavailable, while two state homes have begun providing services of organised housing with assistance.
In addition to the data on services for disabled persons, it is important to mention that, for the purpose of improving protection of disabled persons in the welfare system, all the relevant provisions contain the definition of disabled person specified by the Convention. The definition of disability as a result of interaction of persons with impairments with the barriers resulting from their surroundings and the predominant standpoint towards them, which hinder their full and effective participation in society on an equal basis with others. Wit the help of a qualified professional, the beneficiary actively participates in the choice of the rights and services which he/she will benefit from, with the aim of the promoting his/her independence and autonomy and the respect of his human, civil and social rights. Apart from the completed harmonisation of legal regulations, during 2011, activities related to the establishment of a new method of determining disability (expert examination) have been carried out, for the purpose of realisation of specific rights related to disability.
Namely, according to the international classification of WHO (World Health Organization), various conditions (such as diseases, impairments, injuries etc.) are primarily classified in the ICD-10 (abbreviation for the International Classification of Diseases manual, tenth revised edition), which provides the etiologic framework, and the which has so far been used in the social welfare system for the purpose of conducting expert evaluations. Functioning and

disability related to health conditions are classified in the ICF - International Classification of Functioning, Disability and Health, which should be a basis for a new method of expert evaluation, based on which the required (disability) support level could be more adequately determined, with respect to the definition in the Convention.

Introduction of a uniform definition of disabled persons based on ICF, at the level of the Republic of Croatia, which would apply to all systems, would improve the quality of data collection for the Croatian Registry of Persons with Disability (kept by the Croatian National Institute of Public Health), facilitate the realisation of beneficiaries' rights on the basis of disability, since it would be possible to use a single medical report in all systems, whereas the introduction of a single body responsible for carrying out expert evaluations would unify the criteria in the expert examination procedure and reduce the costs of carrying it out, given that a single expert evaluation body operates for all systems.

In addition, for the purpose of integration of disabled persons into everyday life, the National Plan of Deinstitutionalization and Transformation of Social Welfare Homes and other Legal Entities which carry out Social Welfare Activities in the Republic of Croatia 2011 - 2018 has been adopted, and represents the basis for the planning of a network of social welfare homes and activities. The purpose of the National Plan is to reduce admittances into institutions and increase release from them into new forms of care, especially by stimulating reintegration into the family (along with providing one or more assistance services to families in the local community), which should be harmonised with the priorities of the development of a network of services at the local level, at the same time taking into account regional uniformity in development.. On the basis of the National Plan, priority financial investments in the development of a network of social services will be defined, for which funds can be secured from the state and local and regional self-government units budget, with special emphasis on the possibility of funding from the pre-accession and structural EU funds or other funding instruments. The National Plan includes general quantitative and time projections of the required reduction of institutional care capacities (permanent or weekly accommodation in homes and other legal entities) with respect to groups of beneficiaries, as well as planned projections of capacity expansion in non-institutional forms of accommodation and the provision of equally available services in all regions and counties.

As evident from the table below, today the largest share of social welfare beneficiaries for which care (accommodation) outside of their own families had to be provided, is still accomodated in institutions (approximately 71% of them are accomodated), which is why one of the priority tasks of the welfare system is the development of alternative forms of care and assistance for the purpose of reducing the number of persons of accomodated in institutions and ensuring a more adequate way of life for them.

Table 85

ACCOMODATION on 30th September 2011 (total)	20,456
1. in a foster family	
1.1. children and youth	2,100
1.2. adult and elderly persons	3,165
Tptal (1.1. + 1.2.)	5.,65
2. in a fanily unit	
2.1. children and youth	62
2.2. adult and elderly persons	558
Total (2.1. + 2.2.)	620
3. in a social welfare home	
3.1. children and youth	3,905
3.2. adult and elderly persons	10,666
Total (3.1. + 2.2.)	14,571

The preparation of new legal regulations has also enabled the provision of required support and education of foster families, in order ensure their ability to handle the growing challenges and needs of persons placed in foster care. Approximately 26% of the total number of accomodated persons today benefits from this type of care (see Table).

Table 86

	FOSTER CARE IN CROATIA 30th September 2011	capacity	beneficiaries	number of care givers	availabl e places	accommod ated above capacity
1	children - without adequate parental care	1756	1369	987	433	46
2	children - bez roditelja	126	118	73	12	4
3	children - bez roditelja ili children koju roditelji zanemaruju	5	4	3	1	0
4	children - HIV pozitivna	3	3	2	0	0
5	children - iz socijalno ugroženih obitelji	68	54	43	16	2
6	children - koju roditelji zanemaruju ili zlorabe svoju roditeljsku dužnost	359	293	202	78	12
7	children - poremećaj u ponašanju	1	1	1	0	0
8	children - s tjelesnim ili mentalnim oštećenjima	324	258	169	78	12
I	UKUPNO -children	2642	2100	1480	618	76
1	adults - addicted to alcohol, drugs or other intoxicating substances	13	13	4	0	0
2	adults - mentally ill	839	772	264	75	8
3	adults - physically or mentally impaired	429	407	301	26	4
4	adults - pregnant/women with children	2	2	1	0	0
5	elderly and infirm adults	2456	1971	801	497	12
II	TOTAL-adults	3739	3165	1371	598	24

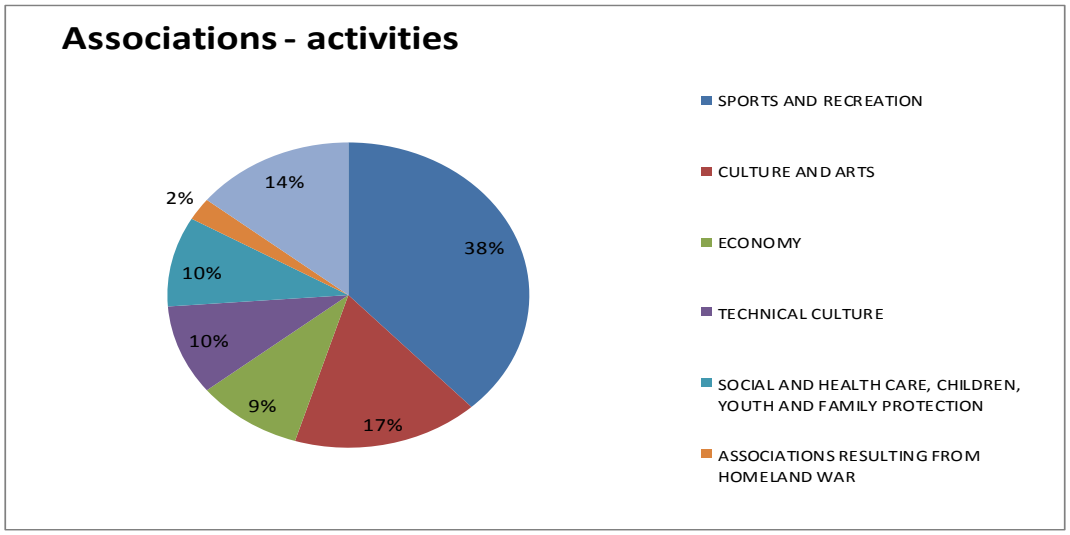
Questions of the Committee

Article 14 - The right to benefit from social welfare services, Paragraph 2 - Public participation in the establishment and maintenance of social welfare services

The Committee takes note of the information contained in the report submitted by Croatia. The Committee notes the adoption of the Volunteer Act (No. 58/07 of 6 June 2007), which lays down the principles and conditions for the activities of volunteers, along with their rights and obligations and the arrangements for supervising their activities. The main focus of the voluntary organisations' work in co-operation with the local authorities and public service providers is to provide local services for elderly people and people with disabilities (primarily home help including housework, psychological counselling, child care, educational and cultural programmes and language courses). These organisations also work in co-operation with other non-profit-making organisations (such as foundations and religious associations) to provide disadvantaged families and other vulnerable categories (such as children, drug addicts, victims of violence and homeless people) with psychological advice and information and advice services with regard to social assistance within the meaning of Article 13§3 of the Charter. They are generally recruited through a call for tenders and are awarded state grants. In 2005, 13 voluntary organisations were recruited in this way.
The Committee asks what is the total annual amount allocated to those organisations. In 2007, an advisory body representing voluntary organisations, called the National Committee for the Development of Voluntary Work, was set up. Its main aim is to promote the development of the voluntary sector. A code of ethics for the work of volunteers is currently being drawn up.
The Committee asks again the activities of voluntary organisations are monitored.
Conclusion
Pending receipt of the information requested, the Committee concludes that the situation in Croatia is in conformity with Article 14§2 of the Charter.

In terms of the number of CSOs in Croatia, according to the data from December 2011, there are 45.018 registered associations, 179 registered foundations, 12 funds, 131 foreign citizens associations, over 600 private institutions and more than 500 trade unions and employers' associations, together with 52 religious communities and 2014 legal persons of the Catholic Church, and 428 legal person of the Orthodox Church. The number of associations is constantly increasing.
According to the Law on Associations (Official Gazette 88/2001), an association is any form of voluntary association of natural or legal persons which, in order to protect and promote issues of public or mutual interest, environmental, economic, humanitarian, informative, cultural, ethnic and national, educational, social, professional, sports, technical, health care, scientific and other interests and goals as well as their beliefs, and without the intention of gaining profit, submit themselves to the rules that regulate organizations and activities of that form of association.

Figure: Associations according to the field of registered activities.



Source, Register of Associations, 2011

Generally speaking, sources of public funding for CSOs in Croatia can be divided into State sources, local government sources, State or local government owned foundations or funds, international donor agencies and EU pre-accession funds. The majority of funds are still aimed towards supporting initiatives and organisations in the area of culture and sport.

Table 87: Total amounts of allocated financial resources for CSOs' projects and programmes from the State budget and lottery funds.

	2008	2009	2010	2011
Kunas	624.170.075,33	529.596.954,21	489.012.308,40	532.837.344,94
Euros	86.450.149	72.250.608	67.172.020	71.714.313

Source: Annual Report on Financing Projects and Programmes of CSOs in 2011

According to the Annual Report on Financing Projects and Programmes of CSOs in 2011, there were 71.714.313 Euros spent from the State budget and lottery funds for projects and programmes of CSOs (including voluntary organisations, networks of organisations, religious communities).

Table 88: Amounts of allocated financial resources for CSOs' projects and programmes, according to the area of finance, Source: Annual Report on Financing Projects and Programmes of CSOs in 2011

General Area of Finance	**%**
Sports	25,4
Support to people with disabilities and socially excluded groups	21,3
Protection and promotion of culture, cultural and historical heritage and nature protection	19,7
Participation of public minorities in Croatia's public life	9,1
Democratisation, civil society and volunteering development, strengthening social cohesion and developing philanthropy	7,8
War veterans	3,2
Technical culture	2,5
Addiction prevention and prevention of behaviour disorders of children and youth	2,0
Health, psychological - physical integrity protection and quality of life improvement	1,8
Tourism	1,3
Science associations	1,2
Human rights promotion and protection	1,1
Economy activities	0,9
Promotion of creativity and life skills of children and youth improvement	0,7
Environment protection and sustainable development	0,6
International cooperation and integration of Croatia to the EU	0,5
Youth support	0,3
Protection and rescue	0,3
Children support	0,2
Vocational training	0,09
Animal protection	0,01
Total:	**100,0**

Source: Annual Report on Financing Projects and Programmes of CSOs in 2011

On the regional level[1] there is also a clear tendency to provide substantial support to sports associations, with almost 68% of regional government funding allocated to this group. By comparison, social protection of people with disabilities and vulnerable groups, the third largest recipient group of CSOs, received 17.9% of national funds, while only 2.6% and 5.1% at regional and local level, respectively. The level of support to democratization and civil society development amounted to 33.6 million kunas (around 4.5 MEUR), while only 0.5 i.e. 1 % at the national and local level were allocated to human rights issues.

Apart from other activities, civil society organisations provide a variety of social services targeted to disadvantaged groups: provision of sheltered accommodation/accommodation in small housing units, rehabilitation activities and other additional support provided through orientation and mobility trainings, courses on reading and writing Braille, sign language, day care centres or clubs for disabled/mentally ill persons, multidisciplinary mobile teams for mentally ill persons, personal assistants for persons with disabilities and mentally ill persons, activities aimed at the development of competences necessary on the labour market as well as other activities necessary for their successful inclusion in the society, organisation of in-house care and assistance for people with disabilities, social alarm services (care-lines) - remote assistance over the telephone with special alarm devices, childcare services, prevention of behaviour disorders and addiction programmes, counselling services, hospices, etc.

The activities of associations are monitored in several ways: the members of associations can warn the Statutory bodies of the association on any irregularities in the implementation of the

[1] The data on regional level financing is available for year 2010, while the data for 2011 is currently being analysed, and is expected to be available by July 2012.

association's Statute (if the warning is not taken under consideration within 30 days of the submission of a written warning and these irregularities have not been tackled, the member can file a law suit to the county court – according to the place of registration of the association); administrative monitoring of the implementation of the Law on associations is performed by the Ministry of Administration of the Republic of Croatia; the inspection is performed by the State administration offices in counties, and the City office for general administration of the City of Zagreb; also, for those associations that are financed through public sources of funding, the spending of the allocated funds is monitored by the bodies that have allocated the financial resources to them (public administration bodies that have allocated funds for CSOs through open calls for proposals from the State budget and lottery funds, local authorities, the National Foundation for Civil Society Developments, as well as national authorities that are in charge of allocating EU funds – such as the Central Finance and Contracting Agency).

Also, the Government Office for Cooperation with NGOs is the body responsible for drafting and coordinating the activities related to the National Strategy for the Creation of an Enabling Environment for Civil Society Development. The mentioned Strategy provides basic guidelines for the goals we seek to achieve by 2011 in order to improve the existing and create a new legal, financial and institutional framework of support for civil society development, and to create an enabling environment for the further development of civil society in the Republic of Croatia. The objective of the Strategy is to create conditions for community development in which citizens and civil society organisations, in synergy with other sectors, actively, equally and responsibly, on the basis of the principles of sustainable development and acting for public benefit, participate in the building of a society of wellbeing and equal opportunities for all. The first National Strategy was valid for the period 2006 – 2011, while the new National Strategy will be valid for the period 2012 – 2020. The status of the implementation of the National Strategy is being reported to the Government of Croatia each year, and is published on the website of the Government Office for Cooperation with NGOs.

Regarding the provision of social services by civil society organisations, in Croatia, this area is regulated by the Social Welfare Act (Official Gazette 33/2012) that was passed in March 2012 (to replace the Social Welfare Act of June 2011). The last two versions of the Social Welfare Act were passed to adjust the system to the on-going reform processes of the social welfare system and the changes in social policy approaches to beneficiaries in general.

In general, there is a lack of service providers because of the lack of continuous financial support to their development. The State has been financing the civil society sector to develop new social services (broadened the network of services), however, due to the economic crisis, the funding available is not sufficient - social services are insufficiently developed, especially alternative (non-institutional) services, and there is a deficit particularly of day care and in house care and assistance. It is necessary to develop services that will be better suited to the needs of the various user groups (including the possibility of choice) and to expand the social services network so that they better cover all areas of Croatia. For the purpose of better accessibility and quality of services, it is necessary to decentralise and deinstitutionalise social services to a more significant extent. In the whole country, particularly in small towns and rural areas, there is a huge need for services of day care, prevention, rehabilitation and integration but most of the mentioned services are located in big cities or do not exist. Also, in the majority of Croatia foster care is underdeveloped. The goal is for the users to receive services in their homes and local communities (community-based services), thus creating conditions for integration and rehabilitation within the community itself. In order to achieve further development of social services, the state, private sector and civil society organisations will have to cooperate and establish partnerships.